Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection against the *National Standards for Safer Better Healthcare*.

Name of healthcare service provider:	St Camillus Hospital, Rehabilitation and Community Inpatient Healthcare Service
Address of healthcare service:	Shelbourne Road Limerick V945V24
Type of inspection:	Announced
Date(s) of inspection:	7 March 2023
Healthcare Service ID:	OSV-007272
Fieldwork ID:	NS_0030

About the healthcare service

St. Camillus' Hospital is a statutory hospital owned and managed by the Health Service Executive (HSE) and under the governance of the HSE Mid-West Community Health Organisation (CHO) 3.* The Rehabilitation Unit is located within St. Camillus' Hospital campus and comprises:

- a Rehabilitation/Stroke unit: 12 general rehabilitation beds and 6 acute stroke rehabilitation beds.
- Treaty unit: rehabilitation 15 beds.

Patients in the units had access to a wide ranging multidisciplinary team which included for example a Consultant-led medical team, physiotherapy, occupational therapy, dietetics and psychology. Admission to the unit was through referral from a Consultant Geriatrician and a Consultant in Medicine, University Hospital Limerick (UHL) and or following an episode of acute care in one of the hospitals in the University Hospital Limerick Group (UHLG) or directly from the community.

How we inspect

Under the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the National Standards for Safer Better Healthcare. To prepare for this inspection, inspectors† reviewed information which included previous inspection findings, information submitted by the provider, unsolicited information‡ and other publically available information. During the inspection, inspectors:

- spoke with people who used the service to ascertain their experiences of the service
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the unit
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors.

* HSE Mid-West Community Health Organisation 3 area consists of Limerick, Clare and North Tipperary.

† Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare (2012)

‡ Unsolicited information is defined as information, which is not requested by HIQA, but is received from people including the public and or people who use healthcare services.

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with the national standards monitored during this inspection are presented under two dimensions of *Capacity and Capability* and *Quality and Safety*.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality and safe service is being sustainably provided in the unit. It outlines whether there is appropriate oversight and assurance arrangements in place and how people who work in the service are managed and supported to ensure high-quality and safe delivery of care.

2. Quality and safety of the service

This section describes the experiences, care and support people using the service receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centred and safe. It also includes information about the environment where people receive care.

A full list of the national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
7 March 2023	08.45hrs -17.30hrs	Geraldine Ryan	Lead
		Emma Cooke	Support

Information about this inspection

The inspection focused on national standards from five of the eight themes of the *National Standards for Safer Better Healthcare*. The inspection focused in particular, on four key areas of known harm:

- infection prevention and control
- medication safety
- the deteriorating patient
- transitions of care.§

The inspection team visited the Treaty Unit and conducted a walk-through of the Rehabilitation /Stroke unit.

During this inspection, the inspection team spoke with the following staff:

- Director of Nursing, St Camillus Hospital
- Clinical Nurse Manager 2, Treaty unit, St Camillus Hospital
- Clinical Nurse Manager 2, Rehabilitation/Stroke unit
- Clinical Lead, Treaty unit, St Camillus Hospital
- Senior Pharmacist, St Camillus Hospital
- Quality and Risk and Patient Safety advisor, CHO3
- Infection Prevention and Control advisor, CHO3
- General Manager, CHO3 and Head of Service, CHO3.

Acknowledgements

HIQA would like to acknowledge the co-operation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank people using the service who spoke with inspectors about their experience of the service.

What people who use the service told us and what inspectors observed

Throughout the day of inspection inspectors spoke with patients accommodated in the unit. Patients stated they were happy with the care they received and were very complementary of staff and care received.

Inspectors observed that staff actively engaged with patients in a respectful and kind manner and ensured patients' needs were promptly responded to. This observation was validated by the many patients spoken with. Patients' comments referenced that staff

§ Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

"*were very attentive"* and *"are always around", "they have put everything in place for me"* (patient going home) *"would be nice to have your own room, that's all, a bit of privacy"*.

Inspectors observed effective communication approaches used by staff to support patients and for those patients who may have difficulties with communication.

Staff were also observed engaging in a positive manner with patients' relatives and with other staff. Visitors were welcome to the ward and the Clinical Nurse Managers (CNMs) outlined the visiting times and stated that the arrangement worked well.

Most people spoken with knew who to speak to if they wished to raise an issue and stated they could speak with staff if they had a concern or complaint.

Capacity and Capability Dimension

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

Organisational charts setting out the hospital/unit's reporting structures detailed the direct reporting arrangements for hospital management, the governance and oversight committees and reporting and accountability relationship to the Chief Officer (CO), CHO3.

While inspectors found that the unit had formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for healthcare services at the hospital and CHO3 level, there was scope for improvement at hospital level. It was evident from interviews and meeting minutes that medication safety was discussed at hospital meetings, however, pharmacy was not represented on the terms of reference (ToR) membership of any hospital committee. Additionally, a committee title as noted in the respective ToR needs to concur with the title of the meeting minutes (Senior Management Team minutes).

The Director of Nursing (DoN) was responsible for the operational management of the hospital campus and reported to the General Manager (GM) for Older Persons Services, CHO3 who reported to the Head of Social Care, who in turn reported to the CO. The CO reported to the National Director Community Operations, Health Services Executive (HSE). The DoN was supported in their role across campus by three Assistant Directors of Nursing (ADONs).

Nursing and support staff within the unit reported to the CNM2. Health and social care health professionals for example dietitians, physiotherapy, occupational therapy reported within the CHO3 community structures.

A Consultant Physician and Geriatrician and a Consultant in Medicine, UHL were responsible for the medical care of patients admitted to the units. Both provided clinical

oversight and leadership in the Rehabilitation/Stroke and Treaty units and reported within the governance structures of UHLG.

At CHO3 level

The Quality, Safety & Service Improvement Committee (QSSI)
Under the governance of the CO, and led by a Head of Service, the QSSI was set up to drive quality, safety and service improvement strategies through a systematic approach and standardisation of all aspects of services in CHO3. A Quality Patient Safety (QPS) Manager QSSI, reported to the Head of Service, QSSI. The Quality Risk and Patient Safety advisor, CHO3 who reported to the QPS manager, worked with and supported local management/key stakeholders in services in CHO3 on all matters relating to identifying quality improvement opportunities including reduction of common causes of harm. This is discussed further in standard 2.8.

Older Persons Residential Services Quality and Safety Committee CHO3
The aim of the quality and safety committee was to develop, deliver, implement and evaluate a quality and safety programme for CHO3.
The committee, chaired by the GM, Mid-West Older Persons Residential Services, CHO3 met monthly and was accountable to the Older Persons Residential Services Quality and Safety committee, CHO3 who reported to the Mid-West Community Healthcare Quality and Safety Committee. Membership was multidisciplinary and representative of core disciplines.

Meeting minutes reviewed evidenced that while meetings followed an agenda, it was not always clear if time-bound assigned actions were noted or monitored from meeting to meeting.

Directors of Nursing (DoN) Management Committee/meeting Older Persons Residential Services
This meeting was chaired by the GM, Mid-West Older Persons Residential Services, CHO3, with DoNs from nine community hospitals/community nursing units within CHO3 including St Camillus Hospital and reported to the Older Persons Quality and Safety Committee.
A review of sample minutes reflected that time-bound assigned actions were noted or monitored from meeting to meeting. However it was not clear if this group had a ToR or an agenda.

Drugs and Therapeutics Committee Mid-West Community Healthcare (MWCH) (Primary Care, Older Persons and Services for People with Disabilities)
CHO3 had a Drugs and Therapeutics Committee established by the CO, CHO3, to provide strategic direction for prescribing and therapeutics across Primary Care and Social Care MWCH. The committee, chaired by the Chief 2 Pharmacist, MWCH, was assigned responsibility for the governance and oversight of medication safety practices in MWCH. The committee met bi-monthly and the ToR reflected multidisciplinary representation including the DoN, St Camillus Hospital. Minutes of meetings reviewed aligned with the

agenda and previous actions were reviewed and all new actions were time-bound and assigned to an identified person. This committee reported to the OPQS committee.

St Camillus Hospital:

Hospital management had a number of committees to ensure that appropriate and effective systems were in place to cover all aspects of quality and patient safety:

Hospital Management Committee

The Hospital Management Committee, chaired by the DoN, met monthly and had collective responsibility for ensuring the delivery of high-quality safe healthcare at the units/hospital. The committee was operationally accountability to the GM, CHO3 and reported to the DoN Governance, St Camillus and up to the DoN, Nursing office, CHO3.

Meeting minutes reviewed evidenced that while meetings followed an agenda, no time-bound assigned actions were noted or monitored from meeting to meeting.

Senior Management Team/Committee

The Senior Management Team/Committee's aim was to develop, deliver, implement and evaluate quality and safety processes for St Camillus Hospital/units and was operationally accountability to the GM, CHO3. The committee, chaired by the DoN convened bi-monthly at the time of inspection and a plan was in place to schedule monthly meetings going forward. Attendees included the ADON/s, CNMs and or their deputies. From a review of the minutes it was evident that a particular format for discussion of matters was followed. However there was scope for improvement in how matters discussed were recorded, for example, while unit risk registers were to be presented at these meetings, it was unclear which unit presented and if there were any follow-up actions. Learning notices and policies were noted on the minutes but no record of what notice or policy was discussed was recorded. The ToR reflected that committee membership was predominantly nursing with a representative from Infection Prevention and Control (IPC), Medication safety and Health and Safety attending on an as required basis or by invitation.

Other hospital committees

Infection Prevention and Control Committee

Structures and committees were in place both locally and at CHO3 level to ensure the effective management of infection prevention and control. The committee met quarterly and was operationally accountable to the DoN and reportable the GM, CHO3. The chair of the IPC committee was rotated.

Meeting minutes reviewed reflected that while some actions were identified, they were not assigned to an identified person and actions were not time-bound or followed up in the next meeting. A ToR and an agenda for the committee were submitted to HIQA post inspection.

While the hospital did not have a medication safety committee, a deteriorating patient committee or a transitions of care committee, this was being considered by hospital management. This is discussed under standards 5.5 and 3.1.

Other meetings convened in the hospital:

Director of Nursing Governance meeting
This meeting was held monthly, chaired by the DoN and attended by the hospital ADONs. The Director of Nursing Governance group reported to the Directors of Nursing, nursing office, CHO3. A ToR for the group was not available. From a sample of minutes of meetings reviewed it was not clear if all matters on the meeting agenda were discussed. Additionally no time-bound actions were identified or reviewed at meetings.

In summary:
Formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare were in place in the unit, however there was scope for improvement with regard to the following:

- Hospital management need to review hospital committee membership, update the ToR of some hospital committees and ensure the committee title as noted in the respective SMT ToR concur with the title of the meeting minutes.
- A number of meeting minutes reviewed evidenced that while some meetings followed an agenda, no time-bound assigned actions were noted or monitored from meeting to meeting.

Judgment: Substantially compliant

Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.

Effective management arrangements were in place to support the delivery of safe and reliable healthcare in the unit. Inspectors observed and were informed by staff that senior management visited, continuously engaged with staff and provided additional staff when available. The unit had management arrangements in place in relation to the four areas of known harm:

Infection, prevention and control (internal)
The unit/hospital had IPC link practitioners who provided guidance and training on matters concerning infection prevention and control.

An IPC advisor CHO3, described the close links with the hospital's IPC link practitioners. This in turn was validated by the DoN and an IPC link practitioner inspectors met on inspection.

The DoN outlined plans to develop an infection prevention and control plan that set out objectives to be achieved in relation to infection prevention and control in 2023.

Medication safety (internal)
The hospital provided a pharmacy service led by a senior clinical pharmacist, CHO3, supported by a senior pharmacist technician, CHO3. Inspectors noted the extensive remit of the clinical pharmacist to the hospital and to multiple services within the CHO 3 area. This is further discussed under standard 6.1.

The deteriorating patient
While the hospital did not have a committee, processes were in place to guide and inform staff on how to manage and care for a patient whose health status was deteoriating. This is further discussed under standard 3.1.

Transitions of care
Inspectors were informed that while the unit did not have a formal transitions of care committee, the ADON and ward CNM2 were responsible for patient discharge/transfer and operationally accountable to the DoN. It was evident that bed management, admissions and transfers featured in other hospital committee meetings and at a weekly case conference meeting. Hospital management and the pharmacy department confirmed that pharmacy expertise was sought as and when required where discharge planning for patients involved complex medication regimes.

Judgment: Compliant

Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Hospital and CHO3 management had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of services provided. Minutes of meetings reviewed reflected that performance data was reviewed at meetings internally and at CHO3 level.

Monitoring service's performance
The unit/hospital/CHO3 collected data on a range of different measurements related to the quality and safety of healthcare services, for example, bed occupancy rate, average length of stay, scheduled admissions, delayed transfers of care, patient-safety incidents, IPC, and workforce. It was evident that collated performance data was reviewed at hospital and CHO3 level meetings.

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 with identified existing controls for each risk. However, while it was evident that the risk register was discussed and risks were reviewed at various meetings, dates of review need to be updated simultaneously as some review dates on the risk register had not been updated since 2019/2020. Risk registers should be reviewed in line with national guidance.[**]

Audit activity
The unit/hospital had a computerised software programme to manage a schedule of audit activity with monthly themes identified for the year. The schedule included audits, for example, on medication management and IPC. There was evidence that findings from audits were addressed in the clinical area audited (patient chart audits). Additionally, peer-to-peer audit of clinical areas was undertaken by the CNMs.

Management of patient-safety incidents
Management stated that incidents were logged on the National Incident Management System (NIMS)[††] in line with the HSE's Incident Management Framework. This is discussed further under standard 3.3.

Judgment: Compliant

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.

The hospital had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. However, hospital and CHO3 management at level need to review the provision, sustainability and remit of current pharmacy services and staffing.

Inspectors noted and discussed the sustainability of the extensive remit of the clinical pharmacist to the hospital and to multiple services within the CHO3 area, (St Camillus Hospital (Older Persons Residential Services) and Units, St Ita's Hospital, Newcastlewest (47kms from St Camillus Hospital), community mental health, CHO3, and other dispensing arrangements within CHO3. It was not clear from a review of the hospital's risk register if a specific risk assessment had been completed in relation to the capacity and sustainability of the current pharmacy staffing resources within the hospital and the CHO3 area.

[**] HSE Integrated Risk Management Policy 2017
[††] 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.

The hospital's DoN was operationally responsible for recruitment. It was evident from meeting minutes and from interviews with senior management that workforce was reviewed daily and formally at meetings convened internally and externally at CHO3 level.

The DoN reported a very low turnover of staff in the unit/hospital. Hospital management were actively recruiting to fill unit CNM1 vacancies and interviews had been completed. A CNM2 was operationally responsible for the units at night. It was reported that Treaty unit's approved complement of nursing staff was 14 whole-time equivalent[‡‡] (WTEs) supported by four healthcare assistants (two HSE staff and two regular agency staff) and three multi-task attendants. Two actions from the previous inspection report were in relation to the number of hours assigned to housekeeping and the appointment of a Domestic Supervisor. The action relating to housekeeping hours had been addressed and it was confirmed by staff that housekeeping staff were rostered seven days per week. However, the post of Domestic Supervisor was still vacant and noted on the hospital's risk register.

A senior clinical decision-maker[§§] at consultant level was on-site in the units each day. The consultant was supported by a non-consultant hospital doctor at registrar grade and a Senior House Officer (SHO). Staff had access to an antimicrobial pharmacist (CHO3) and an antimicrobial microbiologist (UHL).

Security staff were on duty 8.00am to 9.00pm Monday-Sunday.

Staff training

The DoN and ADON who had oversight of staff training, had systems in place to monitor and record staff attendance at mandatory and essential training. It was evident from staff training records reviewed and from speaking with staff in the unit that they were up-to-date with training appropriate to their scope of practice.

Staff had access to external expertise and training in IPC from CHO3 community-based infection prevention and control advisors. Internally, infection control link practitioners facilitated staff training on hand hygiene and donning and doffing of personal protective equipment (PPE).

There was evidence that the CNM2 had oversight of the uptake of training for their clinical area. Staff who spoke with inspectors confirmed that they had completed training on a variety of topics on the HSE's online learning and training portal (HSELanD).

[‡‡] Whole-time equivalent - allows part-time staff working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to staff working full-time while 0.5 refers to staff working half full-time hours.

[§§] Senior decision-makers are defined here as a doctor at registrar grade or a consultant who have undergone appropriate training to make independent decisions around patient admission and discharge.

All nursing staff had completed training for staff on administration of intravenous*** medicines and in venepuncture (taking of blood samples).

In summary, while the unit had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare, the hospital and CHO3 management need to review and risk assess the provision and sustainability of the wide remit of current pharmacy services and staffing.

Judgment: Partially compliant

Quality and Safety Dimension

Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.

Staff promoted a person-centred approach to care and were observed by inspectors as being respectful and caring while maintaining patients' dignity and privacy at all times. Although areas of good practice were observed, it was noted that the ward accommodation in the Rehabilitation/Stroke unit was not designed in a way to promote the dignity, privacy and autonomy of patients, for example:

- male and female patients accommodated in the same room albeit separated by a partition and privacy curtain.
- an inadequate number of toilets and bathrooms for patients to attend to their personal hygiene which resulted in toileting being undertaken by the bedside. This matter was also identified for action on an inspection undertaken by HIQA, 3 September 2020 and had not been addressed to date. This is further discussed in standard 2.7.

Patients' personal information and charts in the clinical areas visited were stored in a secure manner. White boards at the nurses' station were designed to maintain the privacy of the patient.

In summary:

- the physical environment in Treaty unit promoted the privacy, dignity and confidentiality of patients receiving care. However, the provision of ensuite facilities and toilets was insufficient. This is further discussed in standard 2.7.
- the ward accommodation in the Rehabilitation/Stroke unit did not promote the dignity, privacy and autonomy of patients.

Judgment: Partially compliant

*** Intravenous is a way of administering medicines directly into the vein via an injection or infusion

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.

Overall, it was evident that a culture of kindness was actively promoted by all staff. Patients were communicated with in a sensitive manner and stated they were comfortable raising any issue with staff.

The hospital had introduced staff badges saying 'Hello my name is' to encourage staff to introduce themselves to patients. Additionally, staff confirmed that 'Good communication' was included in the hospital's induction programme. Some patients were aware of the HSE's '*Your Service Your Say'.*[†††] Leaflets informing patients and relatives on how to raise a complaint were noted in the units.

The hospital had arrangements in place to facilitate access for patients to independent advocacy services where required. Posters displayed within the units visited provided information on how to access advocacy services.

Judgment: Compliant

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

The DoN was the designated Complaints Officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. There was a culture of local complaints resolution in the unit visited.

The hospital had a complaints management system and used the HSE's complaints management policy '*Your Service Your Say*.'[‡‡‡] Staff recorded verbal and written complaints locally, implemented subsequent quality improvement plans, shared learning from complaints and described how they updated the person who raised the complaint. This is an example of good practice.

Updates on complaints received were captured in minutes of various hospital committees. At CHO3 level, it was noted in a sample of meetings minutes reviewed that complaints, if any, were tracked, trended and learning shared. Staff spoken with were aware of how to support a patient in raising a concern or making a complaint, and of the hospital policy. Staff stated that complaints were addressed at ward level and if a complaint could not be

[†††] Your Service, Your Say' is the name of the HSE's complaints process for all users of HSE funded services. In addition to being a complaints process, "Your Service, Your Say" is also a way to provide feedback to the HSE

[‡‡‡] Health Service Executive. *Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints*. Dublin: Health Service Executive. 2017. Available online from https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf.

resolved locally, they would escalate the complaint to management. Staff verified that informal complaints were tracked, trended and learning was shared with staff at staff handover meetings/safety pauses.

Inspectors were informed that management were putting a programme in place for all staff to attend training on how to assist people in making a complaint. Posters and leaflets on '*Your Service Your Say'* were observed in the hospital.

Judgment: Compliant

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.

On the day of inspection, inspectors visited two units and observed that overall the units' physical environment was clean. The Treaty unit was a new repurposed unit originally set up during the pandemic. The unit was bright, well maintained and clean. However, provision of toilets for 15 patients (three toilets/wash hand basins available for 14 patients, excluding the one isolation bedroom with ensuite) required review and storage for equipment was inadequate. In addition, one lift serviced both units and it was used to transport patients, visitors, clinical and domestic waste, soiled laundry and patients' food. Management was asked to undertake a risk assessment of the lift and this was completed prior to completion of inspection.

An inspector walked through of the Rehabilitation/Stroke unit to follow up on actions from the previous inspection undertaken by HIQA, 3 September 2020. Actions identified at that inspection included infrastructural issues, which had the potential to impact on infection prevention and control measures. Inspectors were informed that there were no formal plans in place to address the infrastructural deficits.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located with hand hygiene signage clearly displayed throughout the units. Inspectors noted that hand hygiene sinks throughout the Treaty conformed to national requirements.[§§§] Physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms in Treaty unit.

Infection prevention and control signage in relation to transmission based precautions was observed in areas visited.

Environmental and equipment cleaning was carried out by dedicated cleaners and multi-task attendants. Equipment was observed to be clean and there was a system in place to identify equipment that had been cleaned, for example, use of tags and checklists.

[§§§] Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf

While a domestic supervisor was not in post, inspectors were informed that all management staff had oversight of the cleaning and cleaning schedules in the unit visited, and stated they were satisfied with the level and standard of cleaning.

Hazardous material and waste were safely and securely stored in the unit. Appropriate segregation of clean and used linen was observed.

The hospital had implemented and staff described processes to ensure appropriate placement of patients.

In summary, while the environment was clean, inspectors were not assured that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care, especially vulnerable patients as there was:

- inadequate provision of toilets and showering facilities for patients
- insufficient storage for patient equipment
- one lift servicing both units was used to transport patients, visitors, clinical and domestic waste, soiled laundry and patients' food. This matter needs to be addressed.

Judgment: Partially compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.

Through oversight by hospital management and at CHO3 level, it was evident that the unit was effective in proactively and systematically monitoring, evaluating and responding to information from multiple sources to inform improvement and provide assurances to CHO3 on the quality and safety of the service provided to patients.

A weekly quality and safety report was compiled by the unit's CNM2, reviewed and collated by the ADON who submitted findings to the DoN. It was evident from a review of meeting minutes and from speaking with staff that the DoN shared findings internally with staff and at CHO3 level.

Other reports reviewed by inspectors included a QPS annual report 2022 which captured incidents based on NIMS data and a MWCH, CHO3 quarterly incident report which detailed the common causes of harm, for example, slips trips and falls.

Audit

A monthly auditing schedule was implemented by the hospital using a computerised software programme. Medication safety and IPC were included in the audit schedule.

Peer-to-peer audit was also undertaken by unit CNM2s. Staff outlined how actions from audits were implemented and closed.

Audits completed by the nursing department included nursing metrics, medication safety, and IPC. There was evidence that findings from audits were followed up and implemented in the unit visited and this was confirmed by staff.

The hospital reported performance data for the unit and this included, the number of admissions, patient discharges, transfer to acute services and mean length of patient stay. It was evident that performance data in relation to patient transfers and discharges was discussed at various internal and CHO3 management meetings.

Judgment: Compliant

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.

The unit/hospital had systems in place to identify and manage risks. Risks in relation to the service were recorded on a risk register and reviewed regularly by the DoN, the GM, OPRS, CHO3, and the Quality and Risk and Patient Safety advisor, CHO3.

Inspectors were informed that the hospital's risk register was formally reviewed at CHO3 level every three months and meeting minutes reflected this. Risks reviewed had controls and actions in place to manage and reduce recorded risks. Updating the register to reflect actual dates of review was discussed in standard 5.8.

Infection prevention and control
Risks in relation to IPC were included in the risk register and included testing for legionella and non-compliance with cleaning processes. However, the following was not identified clearly as a risk in the hospital's risk register:

- lack of isolation rooms, insufficient provision of toilets and showering facilities and insufficient storage in the units.

Additionally, while the risk of the one lift servicing two units was identified on the risk register with an associated action to establish the long term plan for the rehabilitation service within the context of the new build, no time-bound action plan was noted to address the risk. A time-bound action plan needs to be put in place to mitigate the risk of transporting patients, visitors, clinical and domestic waste, clean and soiled laundry and patients' meals in one lift.

The hospital had an IPC Team/Committee comprising IPC link practitioners who had access to the CHO3 IPC advisor and an antimicrobial pharmacist.Staff confirmed that patients were screened for multi-drug resistant organisms on admission to the unit as per national

guidance. Patients with a confirmed infection were isolated within 24 hours of admission or diagnosis as per national guidance.

During the pandemic, the hospital had the support of a multidisciplinary outbreak team convened to advise and oversee the management of COVID-19 outbreaks. Management provided a sample of a report completed post an outbreak and stated that learning was shared with staff; this was also confirmed by staff.

To guide and inform staff, the hospital had a suite of up-to-date infection prevention and control policies, procedures, protocols and guidelines which included for example, policies on standard and transmission based precautions, outbreak management and equipment decontamination.

Medication safety

Medication safety was included in the risk register and this related to ensuring that all processes relating to medication management were in line with local and national standards with mitigating controls identified.

The hospital had a list of high-risk medications. The CNM2 described the use of risk reduction strategies to support safe use of medicines in relation to for example, antibiotics, anticoagulants, insulin and opioids. The hospital had developed a list of sound-alike look-alike medications (SALADs).

Medication reconciliation

Inspectors were informed that formalised medication reconciliation[****] was not routinely carried out in the unit. Management stated that patients' prescriptions were received before or on the day of admission and retained for 24 hours. A verbal report was given to the unit from the referring hospital. Any discrepancies were followed up by the CNM2 with the referring hospital. It is recommended that the hospital implements formalised medication reconciliation for patients.

The unit had access to an antimicrobial pharmacist and access to the hospital pharmacy out-of-hours medication via the ADON or night CNM2 in charge. The pharmacist completed medicines record reviews for patients when requested and highlighted any transcription errors to the CNM who completed a national incident report form.

Medicines were stored in a secure manner. Designated fridges for medicines requiring storage at a required temperature were available. Fridge temperatures were noted as recorded on a daily basis.

The hospital also had a suite of up-to-date medication safety policies, procedures, protocols and guidelines which included guidelines on prescribing and administration of

[****] 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.

medication, high alert medicines and SALADs. Prescribing guidelines including antimicrobial prescribing could be accessed by staff at the point of care.

Deteriorating patient
The unit had documented processes in place for staff to follow in the event of a patient becoming unwell and staff spoken with were able to describe the procedures in place.

Transitions of care
The unit had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services and support safe and effective discharge planning. The unit had transfer and discharge templates to facilitate and strengthen safe transitions of care. For example, the patient's personal details, medical history, current medications and infection status were recorded on the discharge and transfer templates. Discharge plans also included for example, home support, assessment by MDT, medication, contact and or correspondence with the public health nurse, patient's general practitioner (GP).

In summary, it was evident that the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of known harm — infection prevention and control, medication safety, the deteriorating patient and transitions of care. However, it is recommended that the hospital implements formalised medication reconciliation for patients.

Judgment: Substantially compliant

Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.

The hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. There was evidence that hospital and CHO3 management had oversight of the management of incidents. Staff were knowledgeable about how to report a patient-safety incident and were aware of the most common patient-safety incidents reported (slips, trips and falls, pressure ulcers and medication errors).

Reports and meeting minutes reviewed evidenced that patient-safety incidents were tracked and trended and a summary report submitted to the QPRS CHO3. Patient-safety incidents were also discussed at performance meetings with CHO3.

While the deteriorating patient or transitions of care were not a specific category where incidents were tracked and trended, the unit/hospital tracked and trended patient-safety incidents and there was evidence that quality improvement plans were put in place, for example, falls prevention and injuries to a patient's skin (pressure ulcers). As evidenced by inspectors, quarterly reports and an annual incident summary report were submitted to GM, CHO3 and the DoN. The hospital reported on the type of incidents, further divided

into, for example, types of hazard (behavioural, biological, physical and chemical) and the day of week an incident occurred. It was evident that in 2022, incidents were mostly reported to NIMS within 30 days as per national guidance (90% of incidents are entered into NIMs within 30 days of occurrence). Feedback on patient-safety incidents was provided to CNMs who stated that learning was shared with staff at shift handover meetings, ward meetings and safety pause meetings.

Judgment: Compliant

Conclusion

HIQA carried out an announced inspection of Treaty unit, St Camillus Hospital and a walk through of the Rehabilitation/Stroke unit, to assess compliance with national standards from the *National Standards for Safer Better Health* and to follow up on actions from a previous inspection conducted by HIQA September 2020. This inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care.

Capacity and Capability
The unit/hospital had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. Integrated strong links between CHO3 management and the unit/hospital. However, hospital management need to review hospital committee membership, update the ToR of some hospital committees, ensure that time-bound assigned actions are noted and monitored from meeting to meeting and check the committee title as noted in the respective SMT ToR concurs with the title of the meeting minutes.

The hospital had management arrangements in place to support the delivery of safe and reliable healthcare in the unit. However, it is imperative that hospital management and management at CHO3 level review and risk assess the provision and sustainability and wide remit of current pharmacy services and staffing for the unit/hospital/CHO3.

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality and safety of all services. All staff had undertaken mandatory and essential training appropriate to their scope of practice and at the required frequency.

Quality and Safety
Inspectors observed staff being kind and caring towards people using the service. People who spoke with inspectors were positive about their experience of receiving care in the unit and were very complimentary of staff.

However, infrastructural issues identified at a previous inspection conducted by HIQA in September 2020 which had the potential to impact on IPC measures had not been addressed and inspectors were informed that there were no formal plans in place to address same. To ensure that the physical environment supports the delivery of high-quality, safe, reliable care and protects the health and welfare of people receiving care, management at hospital and CHO3 level need to address this matter.

It is recommended that the unit implements formalised medication reconciliation for patients.

Following this inspection, HIQA, through the compliance plan submitted by hospital management, will continue to monitor progress of actions identified in this report.

Appendix 1 – Compliance classification and full list of standards considered under each dimension and theme and compliance judgment findings

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in any compliance plan submitted.

HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

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 on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, 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 people using the service 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 national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially compliant

Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan for St Camillus's Hospital - RCIHS

OSV-0007272
Inspection ID: NS_0030
Date of inspection: 07 March 2023

National Standard	Judgment
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially compliant

Outline how you are going to improve compliance with this standard. This should clearly outline:

- details of interim actions and measures to mitigate risks associated with non-compliance with standards.

Clinical Pharmacy Service :

The Clinical Pharmacist has completed a risk assessment in relation to the current capacity of the Clinical Pharmacy service to the Rehabilitation Units in St Camillus's Hospital. While it is acknowledged that the remit of the Clinical Pharmacist is extenisve, the following control measures are in place to mitigate risk for the patient:

- Patients are reviewed by medical team and medication review is completed prior to transfer.
- Interfacility form completed prior to transfer. Medication prescription is reviewed and clarified.
- Medical file and acute services's drug kardex accompany patient on transfer.
- Discharge script accompanies patient on transfer highlighting changes in medication prescription.
- Pharmacist links with acute service in the event of any query in prescription.
- Medical team admit the patient and st Camillus's Hospital drug kardex is commenced.
- Medication reconciliation is completed by nursing team ensuring kardex is a true reflection of documentation for the patient.
- Current medication is reviewed by Clinical Pharmacist on a case by case basis when Pharmacy input is sought.
- The Clinical Pharmacist is requested to meet with patient prior to discharge on case by case basis as required.
- A medium term plan, which requires investment, is to enhance the Clinical Pharmacy service to the Rehabilitation Units and actively manage the patients in Shelbourne Rehabilitation/Stroke Unit and Treaty Rehabilitation Unit to provide systematic support in line with best practice. This will involve increasing the WTE capacity within the service on a short term basis to test the concept of achieving best practise. This, in turn, will inform the medium term requirements for the service.

(b) where applicable, long-term plans requiring investment to come into compliance with the standard

Based on the outcome of trialing an increased resource to the Clinical Pharmacy service, a business case may be developed for budget allocation for additional resources to Clinical Pharmacy Services.

Timescale:

Interim measures: 31st July 2023

Longterm plans: 31st July 2024

National Standard	Judgment
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially compliant

Outline how you are going to improve compliance with this standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.

Service user dignity and privacy :

A review of the flow of traffic of personnel and staff in/out of the Shelbourne Rehabilitation/ Stroke unit has been completed.

The outcome of this review is to redirect direction of footfall away from the bedroom area as the first port of call to enhance the level of privacy and dignity for each patient while maintaining patient safety. This will be reinforced by new signage to direct same.

An option appraisal of possible approaches to accommodation lay out of the Shelbourne Rehabilitation/ Stroke Unit will be completed to identify if further optimisation of privacy and dignity can be achieved.

(b) where applicable, long-term plans requiring investment to come into compliance with the standard

Provision of ensuite facilities and toilets in the Treaty Unit:

The current infrastructure cannot facilitate the additionality of ensuite facilities and toilets . Due to the current infrastructural confinement, this will require additional building works which will require planning and investment. A review of the environmental needs of the

service to meet compliance with the Standards is required to develop an overall plan and design principles framework for the Residential Rehabilitation Services in Limerick.
Timescale: Interim measures: 31st May 2023 Long-term plans: 20th April 2024 to complete an overall plan and design principles framework for Residential Rehabilitation Services in Limerick.

National Standard	Judgment
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant

Outline how you are going to improve compliance with this standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.

One lift for transportation :

Prior to completion of inspection, a risk assessment of the lift was completed by Director of Nursing and Infection Prevention Control advisor.

Control measures that are in place to mitigate risks are:

- Lift is on regular cleaning schedule
- Cleaning staff are trained in cleanpass training and proficient in cleaning practices.
- Clean linen is brought up in a covered trolley
- Food trolley is enclosed and all food items are covered in transit.

Additional measures that have been put place to reduce risk are as follows:

- Increase touch point cleaning to 4 times from 8:00 to 20:00
- Staff are aware of the process to follow in the event of the lift area requiring disinfection
- Cleaning checklist
- Dirty linen to be brought down in an enclosed trolley
- Waste is removed during off peak times
- Liaise with EHO in respect of compliance with food management in this lift
- These measures involve a multidisciplinary approach to risk management.

Storage of Patient Equipment :

A review of storage options is required to optimise storage for patient equipment. This will require a whole hospital approach to storage management. A project group has been put in

place to establish the current need in respect of additional storage and this will be used to create a proposal for medium-long term solutions.

(b) where applicable, long-term plans requiring investment to come into compliance with the standard

Provision of ensuite facilities and toilets in the Treaty Unit :

The current infrastructure cannot facilitate the additionality of ensuite facilities and toilets. Due to the current infrastructural confinement, this will require additional building works which will require planning and investment. A review of the environmental needs of the service to meet compliance with the Standards is required to develop an overall plan and design principles framework for the Residential Rehabilitation Services in Limerick.

One lift for transportation :

There is one lift in the main hospital building which houses the Shelbourne Rehabilitaion/ Stroke Unit and Treaty Unit. This lift is responsible for the transporation of people and goods. The installation of a second lift will require planning and design and investment. This will be included in a review of the environmental needs of the service to develop an an overall plan and design principles framework for the Residential Rehabilitation Services in Limerick.