Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of the announced monitoring assessment at Connolly Hospital, Blanchardstown, Dublin

Monitoring Programme for the National Standards for the Prevention and Control of Healthcare Associated Infections

Date of announced on-site monitoring assessment: 29 November 2012

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is the independent Authority established to drive continuous improvement in Ireland's health and personal social care services, monitor the safety and quality of these services and promote person-centred care for the benefit of the public.

The Authority's mandate to date extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, the Health Information and Quality Authority has statutory responsibility for:

- **Setting Standards for Health and Social Services** – Developing person-centred standards, based on evidence and best international practice, for those health and social care services in Ireland that by law are required to be regulated by the Authority.

- **Social Services Inspectorate** – Registering and inspecting residential centres for dependent people and inspecting children detention schools, foster care services and child protection services.

- **Monitoring Healthcare Quality and Safety** – Monitoring the quality and safety of health and personal social care services and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health Technology Assessment** – Ensuring the best outcome for people who use our health services and best use of resources by evaluating the clinical and cost effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.

- **Health Information** – Advising on the efficient and secure collection and sharing of health information, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

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1. Background

The Health Information and Quality Authority (the Authority or HIQA) has the national statutory role[±] for developing standards for the quality and safety of healthcare services. The *National Standards for the Prevention and Control Healthcare Associated Infections* (NSPCHCAI) were approved by the Minister for Health and Children on 26 May 2009. Under the Health Act 2007, the Authority has the statutory responsibility, amongst other functions, for monitoring compliance with National Standards and advising the Minister for Health as to the level of compliance.

The NSPCHCAI provide a framework for health and social care providers to prevent or minimise the occurrence of Healthcare Associated Infections (HCAIs) in order to maximise the safety and quality of care delivered to all health and social care service users in Ireland. The NSPCHCAI aim to drive a culture of responsibility and accountability among all staff involved in the management and delivery of health and social care services – all of whom must play their part in preventing and controlling HCAIs. While services may differ in terms of scale, service-user population, the nature of care provided, staffing levels, location and history, the principles for the prevention and control of HCAIs are applicable to all health and social care services.

This phase of monitoring is a contributory phase towards preparing service providers for the eventual monitoring of services against the *National Standards for the Safer, Better Healthcare*. In line with this aim, the Authority reviewed the NSPCHCAI and framed them within three themes of the *National Standards for Safer, Better Healthcare*. These themes are:

- Theme 1: Leadership, Governance and Management
- Theme 2: Workforce
- Theme 3: Safe Care.

1.1. Essential elements for safe, high quality care

To facilitate the overall NSPCHCAI monitoring programme, the NSPCHCAI and their respective criteria were reviewed and amalgamated in order to develop **essential elements** which would be representative of what an organisation must have in place as the foundation for the provision of safe, high quality care through the prevention and control of Healthcare Associated Infections (see Appendix 1). Accordingly, the monitoring methodology was developed to assess organisations for their compliance with these overarching essential elements. Therefore it is important to note that the Authority is not assessing against each of the individual standards

[±] The Authority is given the remit for setting standards for quality and safety in healthcare services under section 8 of the Health Act 2007.

and their criteria. It should also be noted that hygiene forms only one component of this announced assessment approach.

2. Overview

2.1. Connolly Hospital

Profile
Connolly Hospital is located in the West Dublin Village of Blanchardstown. It services a catchment population of 331,000 in Dublin West, (including Finglas West and Lucan) North Kildare and South County Meath and is one of the fastest growing catchment population areas in the country.

Connolly Hospital is a Major Academic Teaching Hospital providing a range of acute medical and surgical services, acute psychiatric services, long stay care, day care, outpatient, diagnostic and support services. Emergency services are provided on a 365-day, 24 hour basis. Multidisciplinary teams representative of medical, nursing, allied health professionals, management and general support staff play a pivotal role in the development, delivery, monitoring and evaluation of these services.

The Hospital is affiliated to the Royal College of Surgeons in Ireland (RCSI) for medical education, to Dublin City University (DCU) for nursing education and to University College Dublin (UCD), Trinity College Dublin (TCD) and the Institute of Technology for allied health professional education. A Regional Centre for Nurse Education is located on site.

Hospital Specialties
Specialty areas included in service provision in Connolly Hospital are outlined below:

Anaesthesia and Intensive Care	General Medicine	Orthopaedics
Acute Medicine for the Elderly / Rehab / Day Hospital / Extended Care	General Surgery	Pathology
Cardiology	Gynaecology	Plastic Surgery
Dermatology	Haematology	Radiology
Emergency Department	Intensive Therapy	Respiratory Medicine
Endocrinology	Microbiology	Rheumatology
ENT	Neurology	Urology
Gastroenterology	Oncology	Vascular Medicine
General Adult Psychiatry Psychiatry of Old Age	Ophthalmology	Nephrology

Bed Numbers
Total Bed Capacity 407
Includes Acute and Non Acute Beds

3. Findings

The findings of the announced monitoring assessment at Connolly Hospital, Blanchardstown, Dublin, are described below.

Authorised Persons from the Authority, Margaret Cahill, Hilary Coates, Breeda Desmond, Ide Batan and Antoinette Russell carried out the onsite component of the monitoring assessment on 29 November 2012 between 08:30hrs and 13:45hrs. The Authorised Persons from HIQA commenced the monitoring assessment in the Emergency Department (ED).

The areas assessed were:

- Beech Ward
- Redwood Ward

During the course of the monitoring assessment, the Authority identified a number of specific issues that they believed may have presented immediate serious risks to the health and welfare of patients receiving care at Connolly Hospital. These issues were brought to the immediate attention of the Hospital Manager who put in place the actions necessary to mitigate these immediate risks.

3.1. Risks identified

On the day of the on-site assessment, the Authority identified the following specific issues that they believed may have presented immediate serious risks to the health or welfare of patients. The Authority observed that:

- Care being provided to a patient in the Emergency Department (ED) was not compliant with Standard 7 of the NSPCHCAI. In particular, a patient with a known transmissible disease was being cared for in a cubicle in the ED for over 30 hours; the cubicle opened directly to a corridor where other patients were being cared for. This posed a potential risk of spread of Healthcare Associated Infections (HCAIs) to these patients.
- The cleaning process in the room of a patient with a known communicable/ transmissible infection did not comply with Standard 3 of the NSPCHCAI.

In line with the Authority's Risk Escalation Process (Appendix 2), the Authorised Persons from HIQA brought these risks to the immediate attention of the Hospital Manager who put in place the actions necessary to mitigate these risks.

The Authority also had concerns that Connolly Hospital did not have in place the arrangements to effectively govern and manage the prevention and control of Healthcare Associated Infections (HCAI).

This issue was discussed, on the day of the on-site assessment, with the Hospital's Executive Management Team who outlined a number of initiatives that were being undertaken to strengthen the clinical governance arrangements at Connolly Hospital, particularly in relation to designated clinical responsibilities.

The Authority notified the persons accountable for the services at Connolly Hospital; the Hospital's General Manager and the HSE Dublin North East Regional Director of Operations; of the identified risks on 30 November 2012 (see Appendix 3).

The persons accountable for the services, formally reported back to the Authority with a comprehensive action plan to reduce and effectively manage the risk on 07 December 2012 (see appendix 4).

3.2. Overall findings

Theme 1: Leadership, Governance and Management

Robust leadership, governance and management structures and processes underpin what hospitals should have in place to assure the public and themselves that the arrangements for the prevention and control of Healthcare Associated Infections (PCHCAI) are effective.

There are robust local, monitoring and reporting arrangements in place thereby ensuring infection control is managed at a consistently high level of quality with minimal variation in the delivery of that care. There are effective regional and national PCHCAI reporting arrangements in place, infection control activities provided are compliant with the relevant legislation, clinical care programmes and evidenced-based practice, and the organisation is acting on national standards and recommendations from statutory bodies.

Essential Element 1(a). A comprehensive corporate and PCHCAI governance structure supported by an integrated organisational framework is in place. The governance arrangements will include PCHCAI specific strategies, aligned cost effective initiatives and defined responsibilities for externally contracted services.

Findings Essential Element 1 (a).

PCHCAI governance

Infection Prevention and Control Committee (IPCC)
The Hospital Manager, as identified in the IPCC terms of reference, was accountable for the overall management and monitoring of the infection prevention and control (IPC) programme.

The IPCC, chaired by the Hospital Manager, was the key management forum for infection prevention and control. Executive responsibility for hygiene services was delegated to the Director of Nursing.

The Hospital Manager reports on behalf of the IPCC, at a local hospital level, to the Clinical Governance and Quality Committee and to the Executive Management Committee; and at regional level to the Health Service Executive (HSE) Dublin North East, Area Manager and Regional Director of Operations.

Infection Prevention and Control Team (IPCT)

The Hospital has a designated IPCT which includes consultant microbiologists, infection control nurses, an antimicrobial pharmacist and a surveillance scientist.

The Authority found that there was a proactive infection prevention and control programme at Connolly Hospital. The Infection Prevention and Control (IPC) annual programme 2012 identified specific priorities in regard to infection prevention and control. These included a defined process for PCHCAI surveillance and reporting as well as promotional campaigns.

The Hospital identified IPC targets for all wards for 2012, these included:

- Reduction in rates of methicillin resistant *Staphylococcus aureus* (MRSA) acquisition
- Reduction in rates of clostridium difficile
- Achieve 100% compliance with hand hygiene
- Ensure 100% attendance at annual infection prevention and control training
- Achieve 100% care bundle compliance.

The IPCT carry out root cause analyses (RCA) on all hospital acquired *Staphylococcus aureus* bacteraemia and clostridium difficile infections including infections related to use of invasive medical devices. The reports are disseminated to the IPCC, the Clinical Director and the identified clinical team, the ward involved and the risk management department. However, the RCA report does not designate any clinical responsibility for corrective action.

This will be further discussed in Section 3(c).

Recommendation 1. *The Hospital should ensure that Root Cause Analyses reports include designated clinical responsibility for corrective action.*

Antimicrobial stewardship

The Hospital had established a joint Antimicrobial Stewardship Committee (ASC) with Beaumont Hospital. Evidence found that this Committee meets every three months and was chaired by one of the Connolly Hospital consultant microbiologists up to June 2012. The role of the committee to develop, agree and disseminate strategies on good prescribing practice and antimicrobial use within both hospitals. The Authority found that one of the strategies including the development of a smart phone app to provide ease of access to the antimicrobial guidelines. The efficacy of this development should be evaluated and the results shared with other organisations.

The Authority reviewed the terms of reference of the joint ASC committee which identified that reporting arrangements are through the Drugs and Therapeutic Committee in both hospitals. However, on review of the documentation provided it was identified that the Connolly Hospital Drugs and Therapeutic Committee had not

been convened in 2012. The Hospital advised that governance arrangements had changed and that ASC currently reports through the Infection Prevention and Control Committee and Infection Prevention and Control Team. Documentation provided confirmed this.

The Hospital demonstrated quarterly monitoring of antibiotic consumption with reports submitted to the Hospital, the Joint Beaumont/Connolly Antimicrobial Stewardship Committee and nationally to the Health Protection Surveillance Centre. In addition, each ward (and relevant prescribers for each ward) in the Hospital are provided with an individual quarterly report of antimicrobial consumption in their area. The Hospital's IPC annual programme for 2012 set a target for antibiotic consumption[1] at 69.5. Documentation provided demonstrated the antibiotic consumption of 68.5, September 2012.

Corporate Governance arrangements to support compliance with the NSPCHCAI

The Hospital Manager, identified in the organogram provided, had overall accountability for the quality and safety of services provided at Connolly Hospital. Documentation provided identified that the Hospital Manager chaired the Executive Management Committee as well as the Clinical Governance and Quality Committee.

There were a variety of organograms provided in relation to the governance of infection prevention and control. However, a single organogram to demonstrate the overall governance of PCHCAI was not available.

Recommendation 2. *The Hospital should develop a single structure to demonstrate the overall governance of PCHCAI.*

The corporate and clinical roles and responsibilities for the management of adverse incidents related to the use of invasive medical devices were not clear. The IPCT carry out root cause analyses (RCA) on all hospital acquired *Staphylococcus aureus* bacteraemia and clostridium difficile infections including infections related to use of invasive medical devices. The IPCT reported that the RCA reports were disseminated to the IPCC, the Clinical Director, individual consultants and the identified clinical team, clinical nurse managers and the Risk Management Department. However, there were no arrangements in place to implement recommendations or corrective actions from these RCAs.

The Executive Management Team reported that, at the time of the assessment, that there was no single forum for the Executive Management Team or the Clinical Director to engage with the clinicians in relation to the prevention and control of

[1] Antibiotic Consumption is measured in Defined Daily Dose (DDD) / 100 bed days used (BDU)

HCAIs. The Clinical Director meets with the consultants in a number of fora, including the Clinical Governance and Quality Committee, Medical Board and surgical and medical "cogwheel" meetings. However, these structures were not demonstrated in the Hospital's organogram. There were no information provided to the Authority that demonstrated that the prevention and control of HCAIs, RCAs and the clinical responsibilities in relation to PCHCAI-related adverse events were discussed at these meeting

The Authority found that the corporate and clinical governance arrangements in place were not sufficiently robust to ensure the Hospital-wide use of care bundles. In addition, from the evidence reviewed the Authority found that the Hospital did not have the effective arrangements in place to respond and learn from the aforementioned PCHCAI related adverse events.

During the course of the monitoring assessment, it was identified to the Authorised Persons from HIQA that initiatives had been undertaken to strengthen the clinical governance arrangements at Connolly Hospital. This included designating clinical responsibility, for corrective action following PCHCAI-related adverse events.

Recommendation 3 *The Hospital should ensure that it continues to strengthen the governance arrangements, both clinical and corporate, at the Hospital, including through the addressing of the findings of this report, and national and international best practice.*

Essential Element 1(b). There is clear monitoring and reporting of defined PCHCAI performance metrics, with trend analysis, reciprocal quality improvement initiatives and reporting at a local, regional and national level.

Findings Essential Element 1 (b).

The Authority reviewed the terms of reference of the IPC programme, together with minutes of meetings and reports of audits and reviews. This confirmed that the IPCC and IPCT utilise surveillance and audit data, review trends in information and monitoring compliance against 17 PCHCAI key performance indicators and reporting of adverse incidents.

There is a system in place for the reporting of PCHCAI related incidents. The IPCT focused on reporting delays in isolating patients with a known infection and incidence of blood stream infections related to invasive medical devices. However, the lack of a robust clinical and corporate governance structure, as discussed above, may prevent the effective management and response to PCHCAI adverse incidents.

The Hospital demonstrated a system of reporting PCHCAI related data or statistics, standardised surveillance data and any outbreaks at local, regional and national level.

Essential Element 1(c). A clear PCHCAI communication strategy, supported by robust operational arrangements, to assure the effective communication of appropriate and timely information throughout the service, to service providers and appropriate agencies is in place.

Findings Essential Element 1 (c).

An effective communication strategy which helps to disseminate useful and important information, both internally and externally, can improve the quality of service users' care. It can also help to inform service users, visitors and staff on how they can prevent and control the spread of HCAIs.[2]

The Hospital provided a clear Infection Prevention and Control Communication Strategy. A variety of PCHCAI related communication tools were demonstrated. The Authority identified a number of innovative practices including the development of a smart phone app to provide ease of access to the antimicrobial guidelines, quarterly IPC newsletter, biannual hand hygiene awareness days, hand hygiene talking posters and IPC surveillance and performance indicator reports.

The effectiveness of this communication strategy is monitored through audits of compliance with the IPC guidelines. The audits carried out by the IPCT demonstrated one of the main reasons for non compliance with IPC guidelines related to not documenting if the patient had been informed of the infection. Documentation provided demonstrated results of audits were communicated to the relevant teams and included in the IPC newsletter.

Theme 1: Leadership, Governance and Management – Conclusion

The effective prevention and control of HCAIs is underpinned and dependent upon an effective governance structure with clear lines of accountability and responsibility. The PCHCAI governance arrangements in place at Connolly Hospital included an IPCC and IPCT. Evidence provided demonstrated a proactive approach to the prevention and control of Healthcare Associated Infections by the IPCC and IPCT.

The corporate governance arrangements in place at Connolly Hospital included an Executive Management Committee (HMC), Clinical Governance and Quality Committee. However, from the evidence provided, it was not clear how these governance arrangements had the clear lines of accountability and responsibility to effectively support the prevention and control of Healthcare Associated Infections.

[2] NSPCHCAI, Standard 5, Rationale.

The Authority found that the corporate and clinical governance arrangements in place were not sufficiently robust to ensure the hospital-wide use of care bundles. In addition, from the evidence reviewed the Authority found that the Hospital did not have the effective arrangements in place to respond and learn from the aforementioned PCHCAI related adverse events.

During the course of the monitoring assessment, it was identified to the Authority that initiatives had been undertaken to strengthen the clinical governance arrangements at Connolly Hospital. This included designating clinical responsibility, for corrective action following PCHCAI-related adverse events.

Theme 1: Leadership, Governance and Management – Recommendations

Recommendation 1. *The Hospital should ensure that Root Cause Analyses reports include designated clinical responsibility for corrective action.*

Recommendation 2. *The Hospital should develop a single structure to demonstrate the overall governance of PCHCAI.*

Recommendation 3. *The Hospital should ensure that it continues to strengthen the governance arrangements, both clinical and corporate, at the Hospital, including through the addressing of the findings of this report, and national and international best practice.*

Theme 2: Workforce

The hospital should always be in a position to assure the service users, the public and themselves that everyone working in the service is contributing to the prevention and control of Healthcare Associated Infections. The individual members of the workforce must be skilled and competent, they must be supported to continuously update and maintain their knowledge and skills, whether they are directly employed or in contractual employment.

Essential Element 2(a). Members of the core PCHCAI team must have the appropriate qualifications, specific training, skills and competencies in infection control, antimicrobial stewardship and HCAI surveillance. They must undergo continuing professional education and development on a regular basis.

Findings Essential Element 2(a).

The Authorised Persons from the Authority found that the IPC programme at Connolly Hospital had a number of arrangements in place to ensure that the core

team had the appropriate qualifications, specific training, skills and competencies in infection control, antimicrobial stewardship and HCAI surveillance.

The Hospital demonstrated that the core team had undergone continuing professional education and development in the last two years.

An IPC Link Programme is being established to support the IPC programme at ward level. The Hospital reported that, to date, 9 nurses have completed the Royal College of Surgeons Ireland (RCSI) foundation course for infection prevention and control. The IPCT reported that these link practitioners will support the IPC programme at ward level for example through raising awareness of hand hygiene practice and compliance with IPC guidelines.

Essential Element 2(b) All hospital staff receive mandatory theoretical and practical training in relation to the prevention and control of Healthcare Associated Infections.

Findings Essential Element 2(b).

The Hospital reported to the Authority that the IPC standards precaution training which included hand hygiene practice was mandatory. The Hospital demonstrated records of training which demonstrated that 573 of 1017.77 WTE staff had attended the mandatory standards precautions training up to end of October 2012.

Essential Element 2(c) There are arrangements are in place to ensure visiting clinical, undergraduates and agency staff are competent in the core principles for the prevention and control of HCAIs.

Findings Essential Element 2(c).

The Hospital reported that all medical and nursing students attend the mandatory Standard Precautions for infection prevention and control training which includes hand hygiene technique.

Theme 2: Workforce – Conclusion

The Authority found that the IPC programme at Connolly Hospital had a number of arrangements in place to ensure that the core team had the appropriate qualifications, specific training, skills and competencies in infection control, antimicrobial stewardship and HCAI surveillance.

Theme 3: Safe Care

The hospital recognises that the prevention and control of Healthcare Associated Infections is paramount. The cleanliness of the physical environment and equipment is effectively managed and maintained. The hospital learns from all information relevant to the provision of safe PCHCAI services, in addition to when things go wrong.

There is an embedded focus on quality and safety improvement, evidence-based decision making and active engagement in local, national and international initiatives to minimise the risk of HCAIs.

Essential Element 3(a). There is 24-hour seven-days-a-week access to specialist microbiological advice and services.

Findings Essential Element 3(a).

There is 24-hour seven-days-a-week access to specialist microbiological advice. Microbiology laboratory services are provided Monday to Friday from 08:00hrs to 18:00hrs and on Saturday and Sunday mornings. The Hospital reported that out-of-hours Cerebral Spinal Fluid specimen processing is provided by Beaumont Hospital. It was reported that MRSA screening results are provided within 48 hours.

In September 2012, the Microbiology laboratory attained Irish National Accreditation Board (INAB) accreditation with a minor non conformance in regard to evaluating results report turnaround times. The Hospital reported that this was due to the reporting limitations of the laboratory information system.

Essential Element 3(b). There are specific care bundles and/or policies and procedures developed, communicated, implemented and their efficacy monitored with the use of:

- peripheral intravenous catheter

- urinary catheter

- central venous catheter.

One quarter of all HCAIs are related to the use of invasive medical devices (devices that are put into a patient's body or skin, for example urinary catheters, peripheral intravenous catheters or central venous catheters). To increase patient safety, all

services should have a specific set of processes to improve patient outcomes, for example, care bundles[3] for the prevention and control of invasive medical device related infections. In Connolly Hospital, the Authority reviewed the use of care bundles in the Emergency Department (ED) and Beech and Redwood wards.

Findings Essential Element 3(b).

The Hospital reported that care bundles for the management of urinary catheter (UC) and peripheral venous catheter (PVC) invasive medical devices were in place. The Hospital has introduced PVC insertion packs which include yellow stickers to record date of PVC insertion.

The Authorised Persons from HIQA spoke with staff in relation to care bundles for a urinary catheter and a peripheral venous catheter, and reviewed documentation in the areas assessed. In Beech and Redwood wards, care plans were in place for a UC and PVC with daily records in care plans signed by staff. However, daily recording for care bundle specific interventions and observations was not in place in Beech ward. In Redwood ward there was a daily care bundle sheet for PVCs to comprehensively record findings. However, this was not in place for UCs.

Although a pro forma CVC insertion sheet was in place. However, this sheet was not available in the ED. 2012 monthly reports of the Intensive Care Unit acquired intravascular catheter-related bloodstream infection surveillance programme were provided.

Recommendation 4. *The Hospital should implement care bundles across the hospital.*

Essential Element 3(c). There are defined PCHCAI performance metrics and audit process in place with a particular emphasis on:

- hand hygiene
- surgical-site infection rates
- environmental and equipment hygiene
- antimicrobial prescribing
- infection related to the use of invasive medical devices
- HCAI trend rates and analysis.

[3] A structured way of improving the process of care and patient/service user outcomes

Findings Essential Element 3(c).

To ensure a programme to prevent and control HCAIs is effectively coordinated and implemented there should be defined structures, systems and processes in place which advise on the management and implementation of this programme[4]. This includes monitoring the performance of the service in relation to the prevention and control of HCAIs through; audits of the implementation of policies, procedures and guidelines to prevent and control HCAIs; monitoring of IPC training; and reporting the findings of reviews, including performance indicators, to all relevant staff to promote learning.

The Hospital demonstrated that there are 17 defined PCHCAI performance metrics and an IPC audit process in place. The main focus was on monitoring:

- Hand Hygiene Compliance
- HCAI rates
- Audit of compliance with IPC guidelines
- Infection related to use of invasive medical devices
- Antimicrobial consumption

Hand hygiene

Hand hygiene is recognised internationally as the single most important preventative measure in the transmission of HCAIs in healthcare services. It is essential that a culture of hand hygiene practice is embedded in every service at all levels.

The Hospital reported to the Authority that the IPC standards precaution training which included hand hygiene practice was mandatory. The Hospital demonstrated records of training which demonstrated that 573 of 1017.77 WTE staff had attended the mandatory standards precautions training up to end of October 2012.

Documentation provided demonstrated that the IPC programme focussed on attendance of doctors at the IPC Standards Precautions, which included hand hygiene practice, mandatory training sessions and reported a 97% attendance rate from January to September 2012. The Hospital reported that the high attendance rate for doctors was in part as a result of the initiative to withhold parking permits until training was completed.

The Authorised Persons from HIQA observed that a hand hygiene awareness day had been held for patients, staff and visitors in October 2012. The Authority found staff they met in the areas assessed to be knowledgeable regarding hand hygiene best practice.

The Hospital demonstrated that hand hygiene practices were monitored through internal audit and the National hand hygiene compliance audits. The Hospital's IPC annual programme 2012 target is to achieve 100% compliance with hand hygiene

[4] NSPCHCAI, Standard 1, Rationale.

practice. The IPC, September 2012, Key Performance Indicators (KPI) reports provided demonstrated a 90% overall compliance with hand hygiene practice.

Further analysis of hand hygiene compliance audit carried out by the IPCT demonstrated that doctors' compliance rating was 65%; all other staff groups demonstrated compliance greater than 88%. The IPCT reported that a "yellow card" system had been introduced as part of the hand hygiene compliance audits; 8 yellow cards had been issued to 3 teams where sub optimal hand hygiene practice had been observed.

The clinical hand-wash sinks in the areas assessed complied with the the Health Service Executive's (HSE) Health Protection Surveillance Centre's Guidelines for Hand Hygiene (2005).

Alcohol-based gel was widely available for use. Laminated posters to demonstrate best practice hand hygiene were widely displayed throughout the Hospital.

Observation of hand hygiene opportunities

During the onsite component of the monitoring assessment, the Authority observed 17 hand hygiene opportunities. These comprised:

- five before touching a patient
- two after touching a patient
- eight after touching patients' surroundings
- two after body fluid exposure risk.

The Authority observed that 15 out of 17 hand hygiene opportunities were taken. However, of those, only nine were observed to comply with best practice hand hygiene technique. Non-compliance consisted of not following best practice technique for hand washing or not using a hands-free method to turn off the taps.

Whilst the Authority recognises that the Hospital had implemented a number of initiatives to improve hand hygiene, the reported compliance rates for the Hospital would indicate that a culture of hand hygiene is not yet embedded across the organisation. This must be addressed as a priority by the Hospital.

Recommendation 5. *The hospital must put in place clear accountability arrangements that ensure all members of the workforce are aware of their responsibilities in relation to hand hygiene practice.*

Surgical site infections

Surgical-site infections are one of the most common Healthcare Associated Infections (HCAI).[5] The rate of surgical site infections is recognised as an important indicator of patient care and quality. Documentation provided demonstrated that audit of surgical site infection rates was limited to an audit of post-operative surgical site infection in orthopaedic hip patients which commenced in July 2011.

***Recommendation 6**. As a matter of priority, the Hospital should progress initiatives to ensure the monitoring of all surgical-site infections.*

Environment and equipment hygiene audits

The Hospital reported that monthly environmental and equipment hygiene audits are completed by the contracted cleaning company and audit results were demonstrated. A programme of internal hygiene peer assessment was in place. However, it was reported that only 40 per cent of these peer assessments had been completed in 2012.

Antibiotic prescribing

The inappropriate use of antimicrobials is associated with the emergence and the rising levels of antimicrobial resistance. Antimicrobial resistance can be controlled with an effective antimicrobial stewardship programme.

The Hospital demonstrated quarterly monitoring of antibiotic consumption with reports submitted to the Hospital, the Joint Beaumont/Connolly Antimicrobial Stewardship Committee and nationally to the Health Protection Surveillance Centre. In addition, each ward (and relevant prescribers for each ward) in the Hospital are provided with an individual quarterly report of antimicrobial consumption in their area. The Hospital's IPC annual programme for 2012 set a target for antibiotic consumption[6] at 69.5. Documentation provided demonstrated the antibiotic consumption of 68.5, September 2012.

Three annual audits of compliance with surgical antimicrobial prophylaxis guidelines, carried out over a two week period, were provided. Audits of the antibiotic IV-PO switch, Vancomycin and Gentamicin dosing and two hospital-wide point prevalence audits have been undertaken.

Infections related to use of invasive medical devices

The Hospital reported that the Intensive Care Unit acquired intravascular catheter-related bloodstream infection surveillance programme had commenced in October 2011; monthly surveillance reports for 2012 were provided.

[5] "Surveillance of Surgical Site Infection in Ireland", SARI, Health Protection and Surveillance Centre

[6] Antibiotic Consumption is measured in Defined Daily Dose (DDD) / 100 bed days used (BDU)

The IPCT carry out root cause analyses (RCA) on all hospital acquired *Staphylococcus aureus* bacteraemia and clostridium difficile infections including infections related to use of invasive medical devices. The IPCT reported three serious incidents, in 2012, relating to use of invasive medical devices and that RCAs had been carried out on these.

The Authority reviewed these RCAs and found that two of the incidents had occurred in the ED. The Authorised Persons were not provided with any information as to how the recommendations from these RCAs had been implemented in the EDs. At the time of the assessment, care bundles for the management of PVC or CVC invasive medical devices were not in use in the ED.

There was one Central Venous Catheter (CVC) related incident identified which that a patient had acquired a blood stream infection secondary to the prolonged insertion of a CVC over 36 days. At the time of the assessment, care bundles for the management CVC invasive medical devices were not in use in Hospital.

The IPCT reported that the RCA reports were disseminated to the IPCC, the Clinical Director, individual consultants and the identified clinical team, clinical nurse managers and the Risk Management Department. However, there were no arrangements in place to implement recommendations or corrective actions from these RCAs.

HIQA found that corporate and clinical governance arrangements in place were not effective to respond and learn from PCHCAI related adverse events.

HCAI trend rates and analysis

The Hospital demonstrated a system of reporting PCHCAI related data or statistics, standardised surveillance data and any outbreaks at local, regional and national level. Documentation provided demonstrates infection rates are reported monthly as part of the IPC key performance indicator reports as well as detailed quarterly surveillance reports.

Analysis carried out by the IPCT demonstrated the main reasons for non compliance with IPC methicillin resistant *Staphylococcus aureus* (MRSA) and clostridium difficile guidelines related to not documenting if the patient has been informed of the infection or patients not being isolated within twenty four hours.

The Hospital reported that, from January to September 2012, 7% of patients have not been isolated within the 24 hour target. It was reported that there are 47 isolation/single rooms available for isolating patients when required. The Authority was informed that an audit of patients accommodated in these rooms in June 2012 identified 52% of patients were being isolated for infection control precautions.

It was reported that patients with known or suspected transmissible diseases were frequently cared for in cubicles in the ED, for long periods of time, while awaiting transfer to inpatient wards. The Hospital also identified that the infection alert on the

ED National information system was not permanent and had to be manually inserted at each attendance of patient with a known HCAI infection. Staff reported that this impacts early identification of patients with a known or suspected transmissible disease on attendance to ED. However, it was reported that permanent infection control alerts are inserted on the Hospital's patient administration system.

Essential Element 3(d). There is proactive reporting, identification, evaluation and management of information to include PCHCAI-related adverse events, risks, patients' complaints, audits and satisfaction surveys.

Findings Essential Element 3(d).

The Hospital demonstrated that there are systems in place for the reporting of PCHCAI related incidents with a focus on reporting delays in isolating patients with a known infection and incidence of blood stream infections related to use of invasive medical devices. Documentation provided demonstrated that 44 infection control incidents were reported from January to 20 November 2012. However, as previously reported, the corporate and clinical roles and responsibilities for the management of adverse incidents related to non adherence with best practice in the use of invasive medical devices, was not clear.

No infection control related patients' complaints were reported to the Hospital up to November 2012. The Hospital reported that user satisfaction surveys on the use of the antibiotic guidelines were completed and used to update the guidelines.

Essential Element 3(e). The cleanliness of the physical environment and equipment is effectively managed and maintained.

Findings Essential Element 3(e).

Environment and equipment
While following the patient journey, HIQA observed the Hospital entrance, stairs, stairwells and corridors to be clean and free from visible dust and dirt. The Authority observed all areas assessed to be generally tidy and clean. All signage was observed to be laminated.

The Authority observed that on high and low surfaces and skirting boards in Beech ward light dust was visible.

Work station equipment including telephones and keyboards were observed to be clean and free of dust in both clinical areas.

Cleaning schedules were observed in both clinical areas and completion of tasks were consistently recorded.

Patient equipment such as wash bowls and commodes were observed to be decontaminated and stored appropriately. However in Redwood ward there was a bed urinal which was quarter full on the floor beside a bed.

The 'dirty' utility room in Beech ward was observed to be clean, with separated hand-washing sinks available. However, in Redwood ward the 'dirty' utility area was unclean with visible dirt and dust in corners and on top of skirting boards.

Chairs and cushions were covered with a material that could be cleaned. However, the Authorised Person observed torn patient chairs in Redwood ward and in the Emergency Department.

In Redwood ward there was limited storage space which provided challenges for effective cleaning. On entry to the ward the HIQA Authorised Persons observed a large metal shelf which was used as a storage facility. It was cluttered and untidy. Patient equipment such as a hoist and chair was also stored in this area. Doors were not secure on cupboards in the 'clean' utility area. There was sticky residue present on other cupboards in this area. There was visible debris on the floor in the store room.

Medical equipment in both areas assessed was generally observed to be clean. However, in both areas the Authority saw that labels were attached to equipment to indicate when it had been cleaned. In both areas these labels did not record a date or signature therefore it was not possible to ascertain when or by whom the equipment had been cleaned.

In the Emergency Department, the top of the resuscitation trolley was observed to be unclean.

Isolation procedures

There were isolation procedures in place in Beech ward and in the Emergency Department at the time of the onsite monitoring assessment.

However, on Beech ward, the Authority observed that best practice was not followed, on the day of the on-site assessment, in relation to maintaining the cleanliness of the physical environment. On two occasions a member of household staff whilst wearing an apron and gloves left an isolation area to retrieve a clinical waste bag and a mop. This is not in line with best practice in relation to infection control procedures. The Authority brought this to the attention of the Ward Manager who immediately addressed the issue.

In the Emergency Department, Authorised Persons from the Authority observed that a patient with a known transmissible disease was being cared for in a cubicle for over 30 hours. In addition, the cubicle was open to the corridor and no notification that infection control precautions were required was displayed. This was identified as

an immediate serious risk and reported to the Hospital Manager who immediately addressed the issue.

***Recommendation 7**. The Hospital should ensure timely access to isolation rooms for patients with a known communicable/transmissible disease and that best practice cleaning procedures are adhered to.*

Waste segregation
The Authority found that staff that they met during the monitoring assessment were informed regarding safe segregation of healthcare waste.

Colour coded foot operated clinical and non clinical waste disposal bins were available in the clinical areas assessed. Clinical sharps bins were available.

Clinical waste posters identifying waste segregation were observed in both clinical areas assessed.

Linen
Best practice was observed by the Authority regarding the segregation of linen with colour coded linen trolleys in Beech ward.

In Redwood ward a laundry bag was observed to be overflowing. A staff member was observed handling infected linen without using personal protective equipment which is not in line with best practice.

Linen storage rooms in the areas assessed were observed to be clean and tidy.

It was reported in both clinical areas assessed that schedules for curtain changing were maintained by the Household Services and Linen Department. It was reported that curtains were changed following the management of an infectious patient by the relevant cleaning services. In Redwood ward records of curtain changing were kept at ward level.

Cleaning equipment
Cleaning equipment in the areas assessed was clean and a colour coding system was in place.

In Redwood ward there was a room labelled ‘disposal’ which contained three shelf units storing stationery. It also contained two cleaning buckets, one inverted with water on the floor, a mop brush and two small brushes.

Appropriate signage was available for the use of products for cleaning and disinfection. Cleaning products were stored in swipe access rooms.

Water outlet flushing
It was reported that water outlet flushing was managed by household staff. Records were demonstrated at area level.

Theme 3: Safe care – conclusion

The Authority found that the cleanliness of the environments and the equipment for patient use assessed at the Hospital was generally clean.

HIQA observed that best practice was not followed in relation to maintaining the cleanliness of the physical environment. In addition the Authority observed that care being provided to a patient in the Emergency Department (ED) was not compliant with Standard 7 of the NSPCHCAI. In particular, a patient with a known transmissible disease was being cared for in a cubicle in the ED for over 30 hours; the cubicle opened directly to a corridor where other patients were being cared for. This posed a potential risk of spread of Healthcare Associated Infections (HCAIs) to these patients.

The Hospital demonstrated that there are systems in place for the reporting of PCHCAI related incidents. However, the Authority found that the Hospital did not have effective arrangements in place to respond and learn from the PCHCAI related adverse events.

Theme 3: Safe care – recommendations

Recommendation 4. *The Hospital should implement care bundles across the hospital.*

Recommendation 5. *The hospital must put in place clear accountability arrangements that ensure all members of the workforce are aware of their responsibilities in relation to hand hygiene practice.*

Recommendation 6*. As a matter of priority, the Hospital should progress initiatives to ensure the monitoring of surgical-site infections.*

Recommendation 7*. The Hospital should ensure timely access to isolation rooms for patients with a known communicable/transmissible disease and that best practice cleaning procedures are adhered to.*

4. Overall Conclusion

4.1. Overview

On the day of the on-site assessment, the Authority identified the following specific issues that they believed may have presented immediate serious risks to the health or welfare of patients. The Authority observed that:

- Care being provided to a patient in the Emergency Department (ED) was not compliant with Standard 7 of the NSPCHCAI. In particular, a patient with a known transmissible disease was being cared for in a cubicle in the ED for over 30 hours; the cubicle opened directly to a corridor where other patients were being cared for. This posed a potential risk of spread of Healthcare Associated Infections (HCAIs) to these patients.
- The cleaning process in the room of a patient with a known communicable/ transmissible infection did not comply with Standard 3 of the NSPCHCAI.

These risks to the immediate attention of the Hospital Manager who put in place the actions necessary to mitigate these risks.

The monitoring assessment focused on the essential capacity and capability factors necessary to implement four of the practices that international research has shown to contribute significantly to reducing HCAIs and improve patient safety. These included hand hygiene compliance; the cleanliness of the environment and equipment; appropriate use of antimicrobial antibiotics and the prevention of HCAIs associated with invasive medical devices.

In Connolly Hospital, the Authority concluded the following:

Hand hygiene compliance

The Hospital reported to the Authority that the infection prevention and control (IPC) standards precaution training, which included hand hygiene practice, was mandatory. The Hospital demonstrated records of training which demonstrated that 573 of 1017.77 whole time equivalent (WTE) staff had attended the mandatory standards precautions training up to end of October 2012.

The Authority observed that a hand hygiene awareness day had been held for patients, staff and visitors in October 2012. HIQA found that staff that it met in the areas assessed were knowledgeable regarding hand hygiene best practice.

The Hospital demonstrated that hand hygiene practices were monitored through internal audit and the national hand hygiene compliance audits. These audits demonstrated that doctors' compliance rating was 65%; all other staff groups demonstrated compliance greater than 88%. The Infection Prevention and Control Team (IPCT) reported that a 'yellow card' system had been introduced as part of the

hand hygiene compliance audits; eight yellow cards had been issued to three teams where suboptimal hand hygiene practice had been observed.

The clinical hand-wash sinks in the areas assessed complied with the the Health Service Executive's (HSE) Health Protection Surveillance Centre's *Guidelines for Hand Hygiene* (2005).

Alcohol-based gel was widely available for use. Laminated posters to demonstrate best practice hand hygiene were widely displayed throughout the Hospital.

During the on-site component of the monitoring assessment, the Authority observed that 15 out of 17 hand hygiene opportunities were taken. However, of those, only nine were observed to comply with best practice hand hygiene technique. Non-compliance consisted of not following best practice technique for hand washing or not using a hands-free method to turn off the taps.

The Authority concluded that while the Hospital had implemented a number of innovative initiatives to improve hand hygiene, a culture of hand hygiene practice is not yet embedded at every level across the organisation.

Cleanliness of the environment

The Authority found that the cleanliness of the environments and the equipment for patient use assessed at the Hospital was generally clean.

HIQA observed that best practice was not followed, on the day of the on-site assessment, in relation to maintaining the cleanliness of the physical environment. In addition the Authority observed that care being provided to a patient in the Emergency Department (ED) was not compliant with Standard 7 of the NSPCHCAI. In particular, a patient with a known transmissible disease was being cared for in a cubicle in the ED for over 30 hours; the cubicle opened directly to a corridor where other patients were being cared for. This posed a potential risk of spread of Healthcare Associated Infections (HCAIs) to these patients.

Antimicrobial stewardship

The Hospital had established a joint Antimicrobial Stewardship Committee (ASC) with Beaumont Hospital. There was evidence that this Committee meets every three months, and was chaired by one of the Connolly Hospital consultant microbiologists up to June 2012. The role of the Committee is to develop, agree and disseminate strategies on good prescribing practice and antimicrobial use within both hospitals. The Authority found that one of the strategies including the development of a smart phone app to provide ease of access to the antimicrobial guidelines. The efficacy of this development should be evaluated and the results shared with other organisations.

The Hospital demonstrated quarterly monitoring of antibiotic consumption with reports submitted to the Hospital, the Joint Beaumont/Connolly Antimicrobial Stewardship Committee and nationally to the Health Protection Surveillance Centre. In addition, each ward (and relevant prescribers for each ward) in the Hospital are provided with an individual quarterly report of antimicrobial consumption in their area. The Hospital's infection prevention and control (IPC) annual programme for 2012 set a target for antibiotic consumption at 69.5[7]. Documentation provided demonstrated the antibiotic consumption of 68.5, September 2012.

The prevention of HCAIs associated with invasive medical devices

The Hospital reported that care bundles for the management of urinary catheter (UC) and peripheral venous catheter (PVC) invasive medical devices were in place. However, the Authority found that care bundles were at varying stages of implementation in each of the areas assessed. Care bundles for the management of (UC) and (PVC) invasive medical devices were not in place in the ED. A central venous catheter (CVC) care bundle was not in place.

The IPCT carry out root cause analyses (RCA) on all hospital acquired *Staphylococcus aureus* bacteraemia and clostridium difficile infections, including infections related to use of invasive medical devices. However, there were no arrangements in place to implement recommendations or corrective actions from these RCAs.

Workforce

The Authority found that the IPC programme at Connolly Hospital had a number of arrangements in place to ensure that the core team had the appropriate qualifications, specific training, skills and competencies in infection control, antimicrobial stewardship and HCAI surveillance.

Corporate and clinical governance of PCHCAI

The effective prevention and control of HCAIs is underpinned and dependent upon an effective governance structure with clear lines of accountability and responsibility. The PCHCAI governance arrangements in place at Connolly Hospital included an Infection Prevention and Control Committee (IPCC) and Infection Prevention and Control Team (IPCT).

The IPCC in place which is chaired by the Hospital Manager, who was accountable for the overall management and monitoring of the infection prevention and control (IPC) programme. The Hospital Manager reports on behalf of the IPCC, at a local

[7] Antibiotic Consumption is measured in Defined Daily Dose (DDD) / 100 bed days used (BDU)

hospital level, to the Clinical Governance and Quality Committee and to the Executive Management Committee; and at regional level to the Health Service Executive (HSE) Dublin North East, Area Manager and Regional Director of Operations.

The Hospital has a designated IPCT which includes consultant microbiologists, infection control nurses, an antimicrobial pharmacist and a surveillance scientist. The Authority found that there was a proactive infection prevention and control programme in place at Connolly Hospital.

The corporate governance arrangements in place at Connolly Hospital included an Executive Management Committee (HMC), Clinical Governance and Quality Committee. However, from the evidence provided, it was not clear how these governance arrangements had the clear lines of accountability and responsibility to effectively support the prevention and control of Healthcare Associated Infections.

The Executive Management Team reported that, at the time of the assessment, that there was no single forum for the Executive Management Team or the Clinical Director to engage with the clinicians in relation to the prevention and control of HCAIs. The Clinical Director meets with the consultants in a number of fora, including the Clinical Governance and Quality Committee, Medical Board and surgical and medical 'cogwheel' meetings. However, these structures were not demonstrated in the Hospital's organogram. There was no information provided to the Authority that demonstrated that the prevention and control of HCAIs and the clinical responsibilities in relation to PCHCAI-related adverse events were discussed at these meetings.

The Authority found that the corporate and clinical governance arrangements in place were not sufficiently robust to ensure the Hospital-wide use of care bundles. In addition, from the evidence reviewed the Authority found that the Hospital did not have the effective arrangements in place to respond and learn from the PCHCAI-related adverse events.

During the course of the monitoring assessment, it was identified to the Authority that initiatives had been undertaken to strengthen the clinical governance arrangements at Connolly Hospital. This included designating clinical responsibility, for corrective action following PCHCAI-related adverse events.

In conclusion, the Authority found Connolly Hospital to be partially compliant with the *National Standards for the Prevention and Control of Healthcare Associated Infections*.

Connolly Hospital must now develop a quality improvement plan (QIP) that prioritises the improvements necessary to fully comply with the *National Standards for the Prevention and Control of Healthcare Associated Infections*. This QIP must be approved by the service provider's identified individual who has the overall executive accountability, responsibility and authority for the delivery of high quality, safe and reliable services. The QIP must be published by the Hospital on its webpage on the

Health Service Executive (HSE) website within six weeks of the date of publication of this report.

The Hospital should ensure the continued monitoring of the Hospital's QIP as well as relevant outcome measurements and key performance indicators, in order to provide assurances to the public that it is implementing and meeting the *National Standards for the Prevention and Control of Healthcare Associated Infections* and is making quality and safety improvements that safeguard patients.

5. Recommendations

Recommendation 1. *The Hospital should ensure that Root Cause Analyses reports include designated clinical responsibility for corrective action.*

Recommendation 2. *The Hospital should develop a single structure to demonstrate the overall governance of PCHCAI.*

Recommendation 3 *The Hospital should ensure that it continues to strengthen the governance arrangements, both clinical and corporate, at the Hospital, including through the addressing of the findings of this report, and national and international best practice.*

Recommendation 4. *The Hospital should implement care bundles across the hospital.*

Recommendation 5. *The hospital must put in place clear accountability arrangements that ensure all members of the workforce are aware of their responsibilities in relation to hand hygiene practice.*

Recommendation 6*. As a matter of priority, the Hospital should progress initiatives to ensure the monitoring of all surgical-site infections.*

Recommendation 7*. The Hospital should ensure timely access to isolation rooms for patients with a known communicable/transmissible disease and that best practice cleaning procedures are adhered to.*

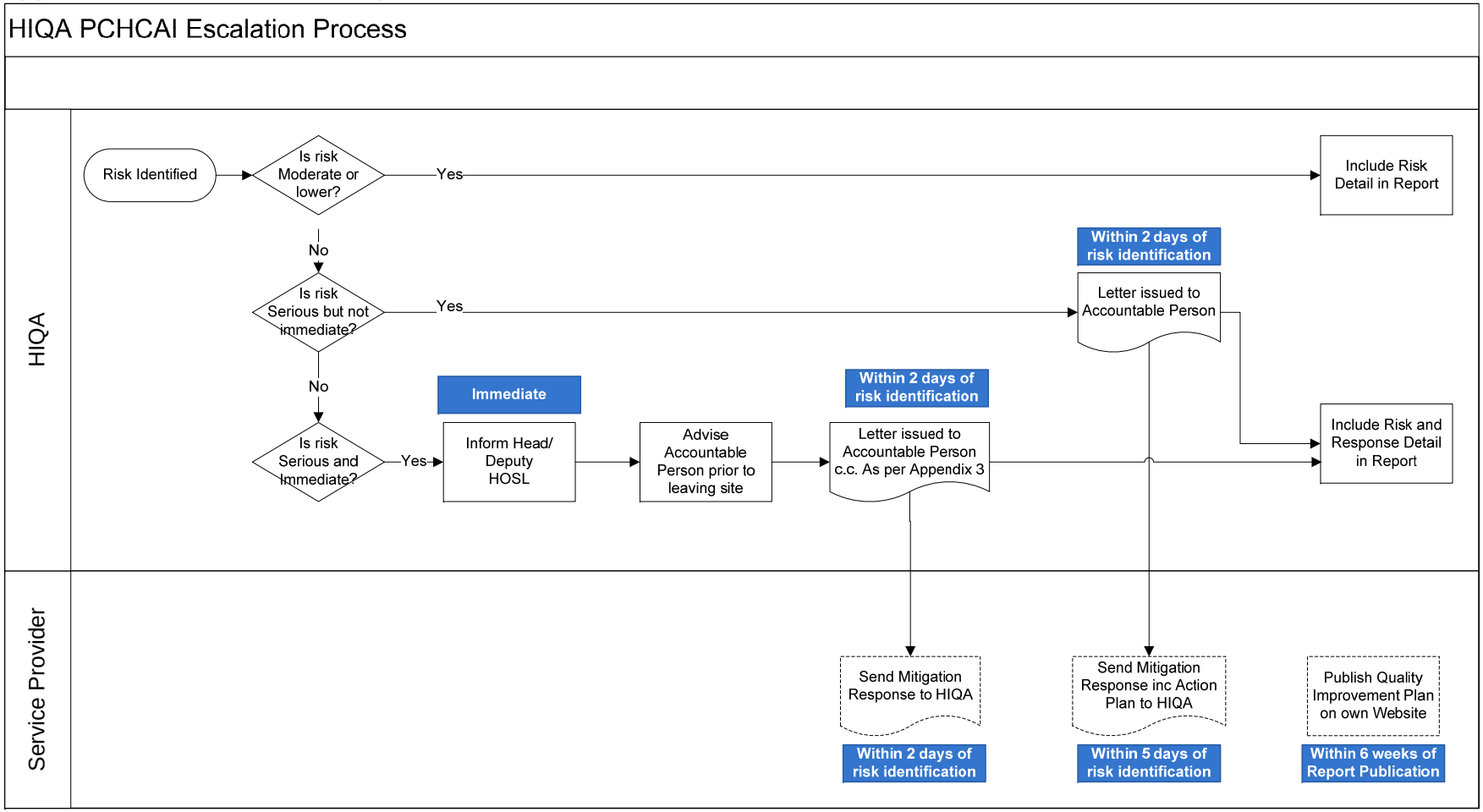
Appendix 1 – Themes and Essential Elements

NSPCHAI Standard	Theme	Essential Element
1,2,3, 4,5,6, 7,8,9, 10,11, 12.	**Leadership, Governance and Management** Robust leadership, governance and management structures and processes underpin what hospitals should have in place to assure the public and themselves that the arrangements for the prevention and control of Healthcare Associated Infections (PCHCAI) are effective. There are robust local monitoring and reporting arrangements in place thereby ensuring infection control is managed at a consistently high level of quality with minimal variation in the delivery of that care. There are effective regional and national PCHCAI reporting arrangements in place; infection control activities provided are compliant with the relevant legislation, clinical care programmes and evidenced-based practice; and the organisation is acting on national standards and recommendations from statutory bodies.	**1(a)** A comprehensive corporate and PCHCAI governance structure supported by an integrated organisational framework is in place. The governance arrangements will include PCHCAI specific strategies, aligned cost-effective initiatives and defined responsibilities for externally contracted services. **1(b)** There is clear monitoring and reporting of defined PCHCAI performance metrics, with trend analysis, reciprocal quality improvement initiatives and reporting at a local, regional and national level. **1(c)** A clear PCHCAI communication strategy, supported by robust operational arrangements, to assure the effective communication of appropriate and timely information throughout the service, to service providers and appropriate agencies is in place.

NSPCHAI Standard	Theme	Essential Element
1, 4, 5, 6.	**Workforce** The hospital should always be in a position to assure the service users, the public and itself that everyone working in the service is contributing to the prevention and control of Healthcare Associated Infections. The individual members of the workforce must be skilled and competent, they must be supported to continuously update and maintain their knowledge and skills, whether they are directly employed or in contractual employment.	**2(a)** Members of the core PCHCAI team must have the appropriate qualifications, specific training, skills and competencies in infection control, antimicrobial stewardship and HCAI surveillance. They must undergo continuing professional education and development on a regular basis. **2(b)** All hospital staff receive mandatory theoretical and practical training in relation to the prevention and control of Healthcare Associated Infections. **2(c)** There are arrangements in place to ensure that visiting clinical, undergraduates and agency staff are competent in the core principles for the prevention and control of HCAIs.

NSPCHAI Standard	Theme	Essential Element
1,2,3, 6,7,8, 9,11,12.	**Safe Care** The hospital recognises that the prevention and control of Healthcare Associated Infections is paramount. The cleanliness of the physical environment and equipment is effectively managed and maintained. The hospital learns from all information relevant to the provision of safe PCHCAI services, in addition to learning from when things go wrong. There is an embedded focus on quality and safety improvement, evidence-based decision making and active engagement in local, national and international initiatives to minimise the risk of HCAIs.	**3(a)** There is access to specialist microbiological advice and services, 24 hours a day, seven days a week. **3(b)** There are specific care bundles and/or policies and procedures developed, communicated, implemented and their efficacy monitored with the use of: ▪ peripheral intravenous catheter ▪ urinary catheter ▪ central venous catheter. **3(c)** There are defined PCHCAI performance metrics and audit process in place with a particular emphasis on: surgical site infection rates, environmental and equipment hygiene, antimicrobial prescribing, hand hygiene, infection related to the use of invasive medical devises, HCAI trend rates and analysis. **3(d)** There is proactive reporting, identification, evaluation and management of information to include PCHCAI-related adverse events, risks, patients' complaints, audits and satisfaction surveys. **3(e)** The cleanliness of the physical environment and equipment is effectively managed and maintained.

Appendix 2 – Risk escalation process



Note:
Accountable Person: identified individual who has overall executive accountability, responsibility and authority for the delivery of high quality, safe and reliable services.
HOSL: Healthcare Operations, Safety and Learning, HIQA

Appendix 3 – Risk Letter from the Authority

Mary Walshe

Hospital Manager

Connolly Hospital

Blanchardstown

Mary.walshe@hse.ie

Ref: PCHCAI/67

Date: 30 November 2012

Dear Mary,

National Standards for the Prevention and Control of Healthcare Associated Infections (NSPCHCAI) Monitoring Programme

I am writing as an authorised person under Section 70 of the Health Act 2007 (the Act) for the purpose of monitoring the NSPCHCAI pursuant to Section 8(1)(c) of the Act.

Under section 8(1)(c) of the Act, authorised persons of the Health Information and Quality Authority (the Authority) carried out an announced monitoring assessment in Connolly Hospital, Blanchardstown on 29 November 2012 for the purposes of monitoring compliance with the NSPCHCAI.

During the course of the monitoring assessment, the Authorised Persons identified specific issues that they believe may present immediate serious risks to the health or welfare of patients and immediate measures need to be put in place to mitigate these risks.

The following risks were brought to your attention yesterday in order that you manage and mitigate these immediate risks:

- The Authorised Persons observed that care being provided to a patient in the Emergency Department (ED) was not compliant with Standard 7 of the NSPCHCAI. In particular, a patient with a known transmissible disease was being cared for in a cubicle in the ED for over 30 hours. In addition, the cubicle was open to the corridor

where patients were waiting to be seen. This posed a risk to the health of other patients. It was reported that patients with known or suspected transmissible diseases were frequently cared for in cubicles in the ED, for long periods of time, while awaiting transfer to inpatient wards.

- The Authorised Persons observed that the precautions required to prevent, manage and control the spread of communicable/transmissible diseases were not being complied with during the cleaning process.

The Authorised Persons also identified that Connolly Hospital did not have in place the arrangements to effectively govern and manage the prevention and control of Healthcare Associated Infections (HCAI). In particular, the corporate and clinical roles and responsibilities for the management of adverse incidents related to non adherence with best practice in the use of invasive medical devices, was not clear.

While these issues and this correspondence will be referred to in the report of the monitoring assessment on its conclusion, the Authority believes it is important that these PCHCAI risks are brought to your attention now, in advance of this. This is being done so that you may act to mitigate and manage the identified risks as a matter of urgency.

Please formally report back to the Authority with an action plan to reduce and effectively manage these risks. This information is to be returned by 2pm on Friday, 7 December 2012 to qualityandsafety@hiqa.ie. Should you have any queries, please do not hesitate to contact me on 01-814 7447. Please confirm receipt of this letter by email (qualityandsafety@hiqa.ie).

I understand that Hilary Coates will be corresponding with you in relation to non compliance with the National Standards for Safer Better Healthcare.

Yours sincerely,

_____

MARGARET CAHILL

Authorised Person

CC: Stephen Mulvany, Regional Director of Operations, HSE DNE

Hilary Coates, Head of Operations, Safety and Learning, HIQA

Appendix 4 – Hospital response letter

Ms Margaret Cahill
Authorised Person
Health Information and Quality Authority
Dublin Regional Office
George's Lane
Dublin 7

7th December, 2012

Re: National Standards for the Prevention and Control of Healthcare Associated Infections (NSPCHCAI) Monitoring Programme

Dear Ms Cahill,

Further to your letter dated November 30th 2012, as requested I wish to formally report back to the Authority with the required action plan to reduce and actively manage the risks identified in your correspondence. Connolly Hospital is committed to providing a quality and safe service for all patients and is a high priority for the Hospital Management Team.

Please find attached action plan in response to the risks identified.

Yours sincerely,

Mary Walshe,
Hospital Manager

Connolly Hospital Action Plan to HIQA December 7th 2012

Risk identified	Action agreed	Responsibility	Target Date
1. *The Authorised Persons observed that care being provided to a patient in the Emergency Department (ED) was not compliant with Standard 7 of the NSPCHCAI.* *In particular, a patient with a known transmissible disease was being cared for in a cubicle in the ED for over 30 hours. In addition, the cubicle was open to the corridor where patients were waiting to be seen.* *This posed a risk to the health of other patients. It was reported that patients with known or suspected transmissible diseases were frequently* *cared for in cubicles in the ED, for long periods of time, while awaiting transfer to inpatient wards.*	1. Review the existing Bed Management procedures to explicitly include the prioritisation for admission, to a single or cohort room if appropriate, of patients with suspected or known transmissible disease. 2. A specific Standard Operating Procedure to manage patients with suspected or known transmissible disease in the Emergency Department is to be developed, agreed and a process to ensure that all Staff are oriented to this SOP will be evident. The identification of a specific cubicle(s) in the Emergency Department (ED) will be risk-assessed by the ED CNM, taking into consideration the proximity to other patients and ensuring the safety of all patients in the ED. The placement of the patient will also ensure the need for observation by the Nursing Staff based on triage category and the patient's condition. An audit tool will be appended to this procedure to facilitate monitoring of compliance. 3. Incorporate into the draft Integrated Admission and Discharge Planning	Head of Bed Management with Infection Prevention & Control Team. Assistant Director of Nursing (ADON) / CNM III Emergency Department in collaboration with Infection Prevention & Control Team Director of Nursing / Head of Bed	Draft 05/12/12 completed to be approved by December 21st 2012 Draft 05/12/12 completed to be approved by December 21st 2012 December 21st 2012

	Policy, the prioritisation of single rooms, when required, for the accommodation of patients with suspected or known transmissible disease over the accommodation of private patients.	Management	
	4. All patients with transmissible diseases to be red flagged as potential infection risk on the Emergency Department's 'Symphony' system to enable timely identification of patients colonised/infected with transmissible organisms. There is already a flag on the Patient Administration System.	CNM III Emergency Department with Infection Prevention & Control Team	Completed - December 4th 2012
	5. A special case file is currently available on the 'Symphony' system in which infection risk cases can be added, this will then enable the infection risk icon to be re-activated on subsequent attendances. This is currently not automated; the System Administrator will liaise with the provider (Ascribe) to enable this process thus ensuring a sustainable system for flagging.	ED CNM III and ICT Co-ordinator	December 21st 2012
2. *The Authorised Persons observed that the precautions required to prevent, manage and control the spread of*	1. A comprehensive review of the existing SOP for the Cleaning of Isolation Rooms and SOP to be agreed and	Household Services Manager with Infection Prevention & Control	December 21st 2012

communicable/transmissible diseases were not being complied with during the cleaning process.	approved by the Infection Prevention & Control Committee. 2. Refresher training/education programme to be developed and provision of training commenced for all Household Staff and all Contract Cleaning Staff on the above revised SOP. An audit tool will be appended to this procedure to facilitate monitoring of compliance.	Team Household Services Manager	December 21st 2012
3. *The Authorised Persons also identified that Connolly Hospital did not have in place the arrangements to effectively govern and manage the prevention and control of Healthcare Associated Infections (HCAI). In particular, the corporate and clinical roles and responsibilities for the management of adverse incidents related to non adherence with best practice in the use of invasive medical devices, was not clear.*	1. The current system of disseminating a Root Cause Analysis (RCA) which is conducted by the Consultant Microbiologists on patients with hospital acquired Staphylococcus Aureus bacteraemia and hospital acquired Clostridium Difficile will be reviewed to include designated clinical responsibilities on an action plan template (as a component of the existing RCA report) which is disseminated to the identified responsible persons to include timeframe for completion so that there is evidence of corrective action and feedback on each RCA (which reveals non adherence with best practice in the use of invasive medical devices and/or other non adherences to	Clinical Director/ Director of Nursing/ Department of Clinical Microbiology	December 21st 2012

	best practice), overseen by the Clinical Director.		
	1. Revision of the Clinical Governance and Quality Committee agenda to specifically include Review of RCAs done by the Department of Clinical Microbiology wherein there is trend analysis and assurance of closing-out all recommendations made in RCAs.	Hospital Manager & Chair of Clinical Governance & Quality Committee / Clinical Director	To be communicated at the next Clinical Governance & Quality Committee on December 12th 2012 and to begin review and trend analysis at 1st meeting in January 2013.
	2. Revision of Infection Prevention & Control Committee standing agenda to include review of RCAs to ensure implementation of recommendations of the RCA.	Hospital Manager / Chair of Infection Prevention & Control Committee (IPCC).	To be communicated at the next IPCC meeting on December 12th 2012 and to commence agenda item at first meeting in January 2013.
	3. PVC Bundles and PVC care plan to be extended to admitted patients in the Emergency Department.	ED CNM III with Infection Prevention & Control Team.	December 21st 2012
	4. CVC care bundles to be developed and implemented hospital-wide.	Director of Nursing / Nurse Practice Development Co-ordinator with Infection Prevention & Control Team	End of February 2013.

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For further information please contact:

Health Information and Quality Authority
Dublin Regional Office
George's Court
George's Lane
Smithfield
Dublin 7

Phone: +353 (0) 1 814 7400
Email: qualityandsafety@hiqa.ie
URL: www.hiqa.ie