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:	Swinford District Hospital
Address of healthcare service:	Oznam Place Swinford Co. Mayo F12 K229
Type of inspection:	Announced
Date(s) of inspection:	13 and 14 November 2024
Healthcare Service ID:	OSV-0005693
Fieldwork ID:	NS_0102

About the healthcare service

Model of hospital and profile

Swinford District Hospital is a model one* rehabilitation and community inpatient healthcare service owned and managed by the Health Service Executive (HSE). At the time of inspection, it was part of HSE Community Healthcare Organisation 2 (CHO2)† and was beginning its transition to the new HSE regional health structures under the governance of Integrated Healthcare Area, Mayo, within the HSE West and Northwest health region. At the time of inspection, CHO2 and Community Healthcare West (CHW) were terms that were used interchangeably for the same geographical area.

Services provided by the hospital include:

- Rehabilitation
- Convalescence
- Step down care
- Respite
- Transitional care
- Palliative care

The following information outlines some additional data on the hospital.

Number of beds	40

Out-patient physiotherapy and a designated Day Care Room, which averaged 20 attendees per day, were located on the hospital grounds but were not under the governance of the hospital and therefore outside the scope of this inspection.

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* as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare.

* The National Acute Medicine Programme's model of hospitals describes four levels of hospitals. Model-1 hospitals are community and or district hospitals and do not provide surgery, emergency care, acute medicine (other than for a select group of low risk patients) or critical care.
† CHO2 comprises 16 community nursing units (residential care) and four district hospitals (rehabilitation and in-patient community hospitals) serving the populations of Galway, Mayo and Roscommon.

To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publically available information since last inspection.

During the inspection, inspectors:

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

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 in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

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 hospital. 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

[‡]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.

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 of this report.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
13 November 2024 14 November 2024	13:30 – 17:15hrs 09:00 – 16:35hrs	Robert McConkey	Lead
		Éilish Browne	Support

Information about this inspection

An announced inspection was conducted of Swinford District Hospital on 13 and 14 November 2024.

The hospital had a total of 40 beds, equally divided between the 'Male' and 'Female' wards. At the time of inspection, eight beds were closed to admissions, leaving 32 beds available. These included six respite beds and 26 beds for patients requiring rehabilitation, convalescence, step-down, palliative or transitional care before discharge or transfer to a long-stay bed in a community nursing unit. The 26 beds were allocated based on need, gender requirements and availability. If any of these beds were unoccupied, they could be reallocated as additional respite beds.

This inspection focused on 11 national standards from five of the eight themes[§] of the *National Standards for Safer Better Healthcare*. The inspection focused on four key areas of known harm:

- infection prevention and control
- medication safety
- the deteriorating patient[**] (including sepsis)[††]
- transitions of care.[‡‡]

The inspection team visited one clinical area:

- Male Ward

[**] Using Early Warning Systems in clinical practice improves recognition and response to signs of patient deterioration.
[††] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[‡‡] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

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

- Representatives of the hospital's Executive Management Team:
  - Acting Director of Nursing (DON) who was the senior accountable office for the hospital and also assumed responsibility for:
    - Discharge Coordination and Bed Management
    - Complaints Management
    - Human Resources Management
    - Medication Management
  - Manager for Older Persons' Services (CHW)
- A general practitioner (GP) who was providing Medical Officer cover for the hospital
- A staff representative for each of the following areas:
  - The Deteriorating Patient
  - Quality and Patient Safety (QPS)
  - Infection Prevention and Control (IPC).

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank people using the healthcare service who spoke with inspectors about their experience of receiving care and treatment in the service.

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

During the inspection, inspectors spoke with several patients about their experience of care. Patients expressed satisfaction with the care they received and were complimentary about the staff in the hospital. A patient's visitor also spoke with an inspector, praising the hospital, the staff, and their experience of kindness and caring interactions.

Patients commented that staff "*always answer the call bell if I need anything*", "*the food is good, plenty of choice*", and "*there is an outside area with tables and chairs where I can sit with my family when they visit*". Two well-maintained outside courtyards with seating and potted plants were available to patients and their relatives, and one was observed being enjoyed by a patient and their visitor on the day of the inspection. Food menus with a wide variety of choices were displayed in all the patient rooms visited.

Inspectors noted that staff used effective communication approaches to support patients who may have difficulties with communication. Patients reported that staff were "*nice and friendly*", "*always took the time to have a chat*", and said that "*they can have a laugh with them*". Patients' curtains were observed to be drawn when staff were attending to personal care, and inspectors witnessed staff assisting patients with mobility, paying

careful attention to the patients' abilities. One patient commented that there was "*lots of space in the room, and good privacy*".

Patients spoken with knew who to speak to if they wished to raise an issue and stated they would speak with a nurse if they had a concern or complaint. A HSE *Your Service Your Say*[§§] information poster, which explained how to make a complaint, concern, or compliment, was seen on a notice board at the entrance to the hospital. Posters about patient advocacy services were observed on display on the walls in the corridors of the patient areas.

The hospital had an oratory onsite where religious services were celebrated once a month, and the room was available for any patients to visit for quiet moments, prayer or reflection.

It was evident to inspectors that management and staff supported and cared for patients in a person-centred manner which was consistent with the human rights-based approach to care promoted by HIQA.

Capacity and Capability Dimension

Key inspection findings and judgments from national standards 5.2, 5.5 and 5.8 from the theme of leadership, governance and management and national standard 6.1 from the theme of workforce are described in the followings sections.

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

Organisational charts were reviewed setting out the hospital's reporting structures and detailing the direct reporting arrangements for hospital management and the governance and oversight committees. The reporting and accountability relationship to CHW was clearly outlined on the organisational charts. An organisational chart outlining the organisational structure within the hospital was prominently displayed in the foyer of the hospital and on the ward, providing patients and visitors with clear information about the hospital's management and staff roles.

The Acting DON was responsible for the operational management of the hospital and reported to the Manager for Older Persons' Services (OPS), who then reported to one of two General Managers (GMs) with responsibility for CHW services. The GMs reported to the Head of Services (HOS) for OPS, who in turn, reported to the Chief Officer for CHW.

[§§] 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

The Acting DON was responsible for the organisation and management of all staff at the hospital apart from the medical officers.

Inspectors were told that, in line with ongoing changes in the overall HSE structures whereby acute and community care were being integrated under the management of six Regional Executive Officers, that governance arrangements may change. Inspectors were informed this transition was expected to be completed for CHW by the end of quarter one 2025.

The Medical Officer role provided clinical oversight and leadership at Swinford District Hospital. The Medical Officer post holders reported operationally to the manager for OPS. Out-of-hours medical services were provided by 'Westdoc'.***

Nursing staff on the Male Ward reported to the acting CNM2 who reported to the Acting DON.

Inspectors were told about community-wide committees involved in the governance of Swinford District Hospital as follows:

Director of Nursing Governance Meeting CHO2

According to its terms of reference (TOR), the chair of the meetings alternated monthly between the two managers for OPS. Membership included the DON from each of the 16 community nursing units in the area (residential care). While the DONs of the district hospitals were not explicitly listed as members of the committee in the TOR, the DONs of the CHW district hospitals or their representatives were noted to be in attendance recorded in the meeting minutes. The TOR outlined that meetings were to be scheduled monthly.

The TOR for this committee, which were undated and unsigned, outlined the vision, purpose, and accountability of the committee. However, the approval mechanism for the TOR was not specified.

Inspectors reviewed minutes of the last three meetings and found that the committee had not been meeting in line with its terms of reference. Three meetings were held between December 2023 and August 2024. Those meetings were well attended with representation from Swinford District Hospital noted at all three meetings (by either the DON or the Quality and Patient Safety representative from Swinford District Hospital). Two of these meetings were held in-person and one virtual meeting was hosted on an online meeting platform.

The agendas showed a consistent focus on quality and risk, health and safety, and flu and vaccinations. Medication management was referred to in the December 2023 meeting through reference to a medication management audit conducted earlier in 2023. Medication management was also discussed in the April 2024 meeting, where the

*** Westdoc is an out-of-hours urgent GP service.

formation of a Drugs and Therapeutics Committee was documented as a priority. The need for a medical officer and a pharmacist was noted, although the specific service area was not identified in the minutes. However, there was no record of medication management being discussed in the August 2024 meeting.

The minutes indicated that the meetings followed a structured format and were action-oriented, however, the actions were not time bound. There was limited evidence of follow-through on actions from one meeting to the next. Regarding the four key areas of harm, medication management was discussed, as previously mentioned. Transitions of care, specifically hospital admission management related to patient care needs and available resources, were discussed in the minutes in December 2023 and August 2024. However, there was no reference to infection prevention and control (IPC) or the deteriorating patient in any of the meeting minutes reviewed, a finding which was also highlighted in the previous HIQA inspection in August 2020.

Furthermore, inspectors were informed by staff from CHW and hospital management that communication between both parties was regular. However, this communication was often informal, and typically conducted via telephone calls or online meetings. There was no record held of such communication. This represents an opportunity for improvement for both the hospital and CHW.

Community Healthcare West Older Persons Services Quality and Safety Committee

The Community Healthcare West (CHW) Older Persons Services Quality and Safety Committee (QSC) operated under terms of reference (TOR) approved on 12 February 2020, with a revision dated March 2022. The committee's remit was broad and included oversight of risk management, serious reportable events (SREs), incident management, quality of care, local and national audits, implementation of recommendations, quality metrics, policies, procedures, protocols, and guidelines (PPPGs), mandatory training and education, monitoring of quality improvement plans (QIPs), and dissemination of lessons learned.

The committee was chaired by the Head of Service, with the GM of OPS serving as Vice-Chair. Membership included the Quality & Safety Risk Advisor, two Older Persons Managers, the DON (District Hospital) representative, the DON (Community Nursing Unit) representative, the Home Support Manager, and the Integrated Care Programme for Older Persons (ICPOP) Representative. The following were listed as members on an 'as required' basis: the NMPDU Representative or policy, procedure, protocol, and guidelines (PPPG) person, a representative from IPC and anti-microbial resistance (AMR), the Health and Safety Officer, the health and social care professional representative, and the Medical Advisor.

The committee met every four weeks in line with its TOR, and its reports included updates on HIQA inspections and compliance. The approval and review date section of

the TOR was blank. The chair of the CHW OPS QSC was operationally accountable to the Chief Officer of CHW.

While the TOR for the QSC lists the Health and Safety Committee as the only sub-committee directly reporting to it, the TOR did outline a list of committee reports to be presented at the meeting. However, none of these reports specifically referred to the four key areas of known harm: infection prevention and control, medication safety, the deteriorating patient and transitions of care. Nonetheless, IPC and AMR was an agenda item on each of the minutes reviewed.

Inspectors reviewed the agendas and minutes of the last three meetings of the QSC held in August, September and October 2024. A review of the listed agenda items included 'previous minutes and actions arising', 'Quality and Safety', and 'infection control and antimicrobial resistance'. The attendance reflected the presence of a DON representative from the district hospitals at both the September and October 2024 meetings, although there was no specific reference in any of the minutes to matters arising in Swinford District Hospital. The minutes showed that the meetings followed a structured format and were action orientated although not time bound. Progress in implementing actions was monitored from meeting to meeting.

Management and staff at the hospital informed inspectors that quality, patient safety, and risk issues were reported through the OPS manager, who in turn reported to the GM. However, staff indicated that there was no direct line of communication between the QSC and the hospital, despite the district hospitals being represented on the committee by a DON. This level of two-way communication represents an area for improvement to ensure effective communication and feedback mechanisms.

Infection Prevention and Control

The TOR for the Community Healthcare West (CHW) Community Healthcare Organisation (CHO) Infection Prevention and Control (IPC) and Antimicrobial Stewardship (AMS) Committee outlined appropriate functions, including reviewing IPC and AMS activities, advising on infection prevention and antimicrobial stewardship, promoting IPC and AMS in community healthcare settings, and supporting the implementation of annual IPC and AMS programmes. The TOR was in draft form, unsigned, undated, and did not appear to contain a process for reviewing it.

The committee's membership was broad and included representatives from various relevant disciplines, including the Head of Quality Safety & Service Improvement (QSSI) (Chair), Consultant Microbiologist (Co-Chair), Antimicrobial Pharmacist, Assistant Director of Nursing (ADON) IPC, Epidemiologist, and representatives from Public Health, Disability Services, OPS, Mental Health, Health & Wellbeing, Medical - General Practitioner (GP), Dental, Social Inclusion, Estates Manager, Quality & Risk Manager, Antimicrobial Resistance and Infection Control (AMRIC), Saolta, and Patient and Service User Engagement Officer.

The committee meetings were scheduled quarterly or 'as required'. The minutes of the three meetings in March, June and September 2024 were reviewed. There was no OPS representative at the March meeting and an action was raised to seek an OPS replacement representative. The meeting in June 2024 was curtailed due to low attendance numbers from services and an action was raised to discuss this at the next Senior Management Team meeting. Minutes reviewed indicated that the meetings were action-oriented, with responsible persons assigned to actions. Progress in implementing actions was monitored from meeting to meeting; however, the actions did not always appear to be time bound. Key discussions included IPC and AMS updates and standardising IPC and AMS information across services. OPS were represented in the September 2024 meeting by the DON from a nearby district hospital, however, it was not clear from the minutes if matters arising in Swinford District Hospital were discussed. Inspectors were told that, at the time of inspection, communication from CHW to the district hospitals was not occurring as effectively or as regularly on IPC matters as it could be. Inspectors were informed that, in future, CHW plans to formally provide feedback on matters arising from this committee to the DONs of the other district hospitals.

Overall, the committee was actively engaged in IPC and AMS activities.

Medication Safety

Inspectors were told that the pharmacist position within the hospital had been vacant for more than three years and efforts at recruitment were unsuccessful. Swinford District Hospital operated a fully stocked pharmacy with oversight and performance of ordering, stocking and dispensing of medication undertaken by the Acting DON and the acting CNM2. There was also no oversight of pharmacy services or medication reconciliation by a pharmacist external to the hospital. Documentation reviewed by inspectors revealed several issues with the hospital's PPPGs related to medication management. Some PPPGs were out of date, while others were not specifically developed for the hospital, instead referring solely to other district hospitals. These inconsistencies present challenges for staff in maintaining safe medication practices.

Inspectors were informed by management at the hospital and from CHW that, at the time of inspection, there was no committee within OPS specific to Drugs and Therapeutics or Medication Safety. Inspectors were informed that, as an action from a 2023 Medication Safety Audit (conducted across residential services and the district hospitals in OPS), a Drugs and Therapeutics committee (DTC) would be established for CHW. The initial meeting of the proposed CHW DTC was scheduled to take place on 20 November 2024 (one week after the inspection in Swinford District Hospital), and was to be chaired by one of the two GMs for OPS within CHW. Inspectors were informed that the purpose of the meeting was to agree TOR for the committee and to review alternative arrangements for filling the pharmacist post within the hospital, such as a shared pharmacist post with another district hospital.

On the day after the inspection, HIQA wrote a letter to the Acting DON and Integrated Healthcare Manager outlining the challenges and high risks in relation to medication safety in Swinford District Hospital. HIQA received a response from the GM confirming that the initial meeting of the OPS Drugs and Therapeutic Committee was held on Wednesday, 20 November. In addition, the letter outlined current efforts by CHW to explore the potential for a pharmacist at a nearby District Hospital to provide support to Swinford District Hospital, as well as the challenges of recruiting a pharmacist to the hospital. Finally, the letter detailed a list of component parts of the hospital's medication management policies, however, some of these were not provided to inspectors for review at the time of inspection, and others such as the Sound Alike Look Alike Drugs (SALAD) and High Risk Medication Policy reviewed on inspection were developed by and for another district hospital, and made no reference to Swinford District Hospital.

Regarding the dispensing of medicinal products, best practice suggests that medications should be dispensed by a pharmacist and should only be undertaken by a nurse or midwife in exceptional circumstances. While the absence of a pharmacist in the hospital is recognised as an exceptional circumstance, the prolonged vacancy and the need for more timely implementation of alternative arrangements by CHW highlight areas for improvement in responsiveness.

Further elements of medication safety are discussed elsewhere in this report under National Standards 6.1 and 3.1.

The Deteriorating Patient

Inspectors noted that all patients transferred to the hospital had been medically discharged from acute services but had additional needs prior to returning home, with the final destination often undetermined on admission. These needs included physiotherapy, occupational therapy, convalescence, psychosocial support, housing adaptations, and determination of baseline status for discharge planning. Inspectors were provided with documentation and were informed by management and staff about the processes in place to identify and monitor deteriorating patients. These are outlined under National Standard 5.5.

Transitions of Care

Transitions of care to and from the hospital were managed by the CHW Integrated Discharge Management (IDM) team, which included the DON from a nearly hospital as a representative for the district hospitals. The district hospitals' representative DON also attended the weekly IDM rounds at Mayo University Hospital to discuss referrals and prioritise patient flow. Draft terms of reference for the 'Integrated Discharge Management Protocol for Delayed Discharges of Care (DTOC) across CHW, GUH, PUH, RUH, MUH' were reviewed by inspectors. The TOR was undated and unsigned. Its purpose was to facilitate integrated discharge planning processes between acute and community services, and within community services. The IDM Team reported to the HOS for OPS and the GM via

the team lead. Inspectors were informed that a site-specific IDM TOR was planned to be developed for each acute hospital in the HSE WNW group, with a meeting scheduled in Q3 2024 to finalise the TOR for Mayo University Hospital.

The Acting DON at Swinford District Hospital liaised daily with MUH on patient flow and delayed transfers of care (DTOCs), escalating issues to the IDM Lead.

To enhance communication and patient flow, several measures were in place, including weekly meetings of the Mayo Egress Group for DTOCs and complex cases, weekly attendance of the Acting DON at MUH IDM rounds, and weekly meetings between MUH and the hospital for referrals and patient flow.

The Acting DON from Swinford District Hospital was part of the local placement forum, which included three consultants (two psychiatrists and one geriatrician), a public health nurse and an advanced nurse practitioner for older persons. This forum reviewed applications for home help or long-term care based on the patient's assessed progress during their stay at the hospital. Recommendations for the most suitable care option for each patient were made through a shared decision-making process involving the patient and their family. This reflects a person-centred approach to discharge planning.

In summary, inspectors found that while there were some formalised corporate and clinical governance arrangements in place at CHW level for the hospital, several areas required improvement. There was no specific forum to escalate, manage, and monitor issues relating to medication safety between Swinford District Hospital and CHW and the pharmacist post had been vacant for over three years. Governance documents related to medication safety require further development to fully support safe medication practices within the hospital. While inspectors were informed that the initial meeting of a CHW DTC was held in the week following the inspection, this alone is not sufficient to address the concerns identified. Timely action at CHW level is needed to address the areas for improvement in the governance of medication safety in the hospital.

Some committees were not consistently meeting in line with their terms of reference, and there were areas for improvement in the documentation of committee work. The DON Governance meetings did not meet in line with its TOR, which is a crucial pathway for escalating issues at Swinford District Hospital to management at CHW level. Communication between the hospital and CHW was often informal, indicating an opportunity to enhance the formal and regular recording of important discussions and decisions. Additionally, the Quality and Safety Committee did not appear to have effective oversight of issues impacting the hospital, and there appeared to be no direct line of communication between the committee and the hospital.

However, there were positive aspects noted, such as the effective governance processes in place for infection prevention and control (IPC), the deteriorating patient and transitions of care. These measures contributed to enhancing patient safety and care

quality. Addressing the identified areas for improvement will further strengthen the hospital's ability to provide high-quality, safe healthcare services.

Judgment: Partially-compliant

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

At the time of inspection, management arrangements were in place in the hospital to support the delivery of safe and reliable healthcare in the Male Ward and the hospital in general, which inspectors found were functioning well.

The management arrangements in place at the hospital in relation to the four areas of known harm were as follows:

Infection prevention and control (IPC)

The hospital had an IPC link practitioner who provided guidance and training to hospital staff on matters concerning infection prevention and control. A poster outlining the role of the IPC link nurse and access to the CHW IPC team was displayed on the ward. Inspectors were told that the IPC link nurse for Swinford District Hospital attends bi-monthly meetings with the IPC team via an online meeting platform. Hospital management and ward staff spoke of the close links for IPC support and training between the CHW IPC team and the hospital.

Medication safety

Hospital management and staff highlighted the need for clinical pharmacy[†††] support to ensure safe and high-quality medication practices. In the absence of such support, the Acting DON assumed overall responsibility for pharmacy services. Management detailed the processes in place for medication safety, including ordering, stock checking, dispensing medications from the hospital pharmacy to the wards, medication reconciliation, staff training, and audits. However, these audits were limited to the drug administration record, drug refrigerator or opening dates on liquid medications. There were no audits of pharmacy services related to ordering, storage, usage, or types of medications being used in the hospital. Inspectors were informed that staff queries about patient medications were directed to the medical officer or addressed through informal and ad-hoc support from local pharmacists in the community, or occasionally by contacting the pharmacist at a nearby district hospital. As previously mentioned,

[†††] Clinical pharmacy - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.

medication safety was a concern at Swinford District Hospital and is discussed further in National Standards 6.1 and 3.1.

Deteriorating Patient

Management and staff outlined key measures employed for the identification and management of deteriorating patients as follows:

- Review of the pre-admission referral and clinical handover
- Monitoring for changes against baseline assessments
- Vital signs monitoring and clinical judgment
- Clinical patient reviews by either the medical officer or Westdoc out-of-hours when indicated
- Transfer via ambulance to Mayo University Hospital as appropriate.

Management and ward staff were knowledgeable about the deteriorating patient.

Transitions of care

Inspectors found that the hospital had effective management processes in place to monitor and support safe transitions of care. All admissions were planned in advance and originated from the following sources:

- Referrals from acute hospitals (Mayo University Hospital, Galway University Hospital and Sligo University Hospital)
- Referrals from the community for respite care, managed through the Respite Forum
    - Occasionally 'emergency' respite patients were admitted on a case by case basis through Public Health Nurses
- Referrals from palliative care in the community.

Admitted patients had access to a multidisciplinary team, including nursing staff, medical officers and inpatient physiotherapy services.

Inspectors reviewed documentation supporting transitions of care, including referral forms for proposed patient transfers from acute hospitals to Mayo District Hospitals in CHW. Management informed inspectors that these referrals, typically initiated three days in advance, provide the hospital with the patients' clinical details, dependency levels, multidisciplinary health and social care professionals inputs, ongoing care needs, and the proposed discharge plan post-discharge from the district hospital. This advance notice served as a screening tool to ensure the hospital had adequate resources to provide the necessary care and support to the patients being admitted to Swinford District Hospital.

At the time of inspection, the hospital did not employ either a medical social worker (MSW) or an occupational therapist (OT). This impacted its capacity to accept referrals of patients requiring ongoing MSW or OT input. Inspectors were informed that patients requiring MSW input could only be accepted by the hospital if their medical social work needs were completed (discharged from social work) by the referring hospital. For patients requiring OT input, they could be accepted only if their therapy was first completed in the discharging hospital, or could be deferred until after discharge from the district hospital, at which point OT services could be accessed in the community. This had the potential to contribute to delayed discharges in the referring hospital.

On the day of a patient's transfer to Swinford District Hospital, staff contacted the referring hospital to receive a verbal handover. This information was recorded on the '*Verbal Handover Notation for the Transfer of Patients'* form, ensuring that up-to-date details about the patient's clinical status and activities of daily living were captured. The handover included information on IPC status, medications, and discharge plans, including any required home help assessments.

Inspectors also reviewed a '*Discharge Aide Plan Memoire*' and flow chart used by staff to support the discharge of patients from the hospital to either their home or long-term care, in line with the patient's wishes. The design of the form promoted a patient-centred approach to discharge. It identified the patients aims, goals and wishes in their plan for discharge and the flowchart ensured all necessary assessments and supports were in place prior to discharge. The Acting DON's involvement in patient flow and membership of the Local Placement Forum supported safe and effective transitions of care. While all of these documents supported safe transitions of care, they lacked essential elements of document and version control, such as the author, effective date and review date.

In summary, the hospital demonstrated adequate management arrangements to support the delivery of high-quality, safe, and reliable healthcare services. Although the Acting DON had implemented management processes to oversee medication safety, the absence of clinical pharmacy support highlighted an area for improvement, and this is discussed elsewhere in this report. The hospital had effective processes in place for infection prevention and control, the management of deteriorating patients and transitions of care. However, the absence of dedicated medical social work and occupational therapy staff impacted the hospital's capacity to accept certain referrals, which had the potential to contribute to delayed discharges in the referring hospital.

Judgment: Substantially 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.

The hospital and CHW had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of the healthcare services provided, relevant to the size and scope of the hospital. The acting CNM2 in conjunction with the Acting DON had overall responsibility for matters relating to quality and patient safety in the hospital. Minutes of meetings at CHW level were reviewed and these reflected a range of clinical and quality data sources.

Monitoring service performance

The hospital, in collaboration with CHW, systematically collected data on various clinical metrics related to the quality and safety of healthcare services. This included the number of admissions and discharges, length of stay, number of transfers to acute hospitals, patient safety incidents, infection prevention and control data, workforce statistics, and risks that could potentially impact service quality and safety. The collated performance data was reviewed during the relevant committee meetings, as outlined under National Standard 5.2, and at performance meetings held between the hospital and CHW.

Risk management

The hospital in conjunction with CHW had risk management structures and processes in place to proactively identify, manage and minimise risks in clinical areas. The hospital's risk register relating to the four key areas of known harm was reviewed by inspectors. It was maintained by the Acting DON and included details on the date of assessment, the hazard and risk description, controls measures in place, actions required, an action owner, the risk rating and a due date. Inspectors were told that the risk register was reviewed every three months and matters of concern were escalated by the Acting DON to the manager for OPS and then on to the GM at CHW level. This reflects an improvement on the findings from the HIQA inspection in August 2020 where inspectors noted that the risk register was not being reviewed frequently enough.

Audit activity

Local medication safety audits were conducted every three months, covering the medication chart, the drug refrigerator, and the marking of opening dates on certain liquid medications. The IPC audits included environmental and equipment audits, hand hygiene, and antimicrobial resistance. Findings from these audits were disseminated to staff, and action plans were developed. These action plans were assigned to a responsible person and monitored for completion. While IPC actions were time bound, it was noted that the local medication safety audits were not time bound.

Outstanding actions outlined from a medication management audit of the service conducted by a member of the QSSI team in July 2023 included conducting a risk assessment for self-administration of medications in the hospital, developing a policy portal and standard operating procedures (SOPs) for medication management, and appointing a Senior Pharmacist. The actions were not time bound or assigned to a responsible person. While the Acting DON reported that patients do not self-administer medicines in the hospital, the other two actions remain outstanding. These steps are crucial for enhancing medication safety and ensuring compliance with best practices.

Management of patient-safety incidents

Patient-safety incidents related to the clinical area visited were reported to the National Incident Management System (NIMS),[‡‡‡] in line with the HSE's Incident Management Framework.[§§§] These were recorded by staff at the point of occurrence using a paper-based National Incident Reporting Form (NIRF). The NIRF was reviewed by the Acting DON and then entered onto the NIMS system by a clerical officer in CHW. Inspectors viewed the trending of NIMS reports provided by the hospital for 2023 and January to September 2024. 'Slips, trips and falls' were the most commonly reported incident in 2023 and 2024, with the second most common being 'virus' in 2023, and 'violence, harassment and aggression' in 2024. Incidents related to medication, although low in number, were the third most commonly reported incidents in both 2023 and 2024.

Inspectors were informed by management and reviewed documentation confirming that no Serious Reportable Events (SREs) had occurred in the hospital in the previous 12 months. The GM for OPS in CHW was listed as a member of the Serious Incident Management Team (SIMT) in its undated and unsigned Terms of Reference (TOR) reviewed by inspectors.

Incidents were discussed at CHW level at both the DON governance meetings and at the OPS Q&S committees.

Feedback from people using the service

Inspectors found that there was no process in place to collect patient feedback on the service and care received. Management informed inspectors that they were considering reintroducing a patient satisfaction survey. Inspectors were informed that patients are provided with an information leaflet on the HSE's *Your Service Your Say* only if a complaint was made that could not be resolved locally. This represents an area for attention and improvement in the hospital.

[‡‡‡] The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).
[§§§] HSE – Incident Management Framework and Guidance. 2020. Available online https://tinyurl.com/2p8k3k5m

In summary, the hospital and CHW implemented monitoring processes to enhance the quality, safety and reliability of healthcare services. Key activities included data collection on clinical performance, risk management, regular audits and incident reporting. A structured approach to audits generally ensured that findings were disseminated and action plans were monitored for completion. However, some areas for improvement were identified, such as having a process in place for patient feedback, and addressing the low level of reporting medication incidents compared to national and international norms which suggests potential underreporting. Higher incident reporting rates are seen as signs of a stronger patient safety culture. Despite these challenges, the hospital demonstrated a commitment to continuous improvement.

Judgment: Substantially Compliant

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

Staffing Levels and Recruitment

Management informed inspectors that the hospital's approved complement of staff across all grades was 39.4 whole-time equivalents (WTEs). Of these, 31.4 WTE posts were filled, leaving a variance of eight WTE vacancies, representing a 20.3% vacancy rate overall. These vacancies included 4.2 WTE nursing staff (22.8% vacancy rate) and 3.8 WTE combined healthcare assistants (HCAs) and multi-task attendants (MTAs) (20.8% vacancy rate). Of the eight vacancies, 6.8 WTE were temporary and related to maternity and sick leave across nursing and support staff. Inspectors were informed that one WTE nursing post was in recruitment at the time of inspection. Regular agency and existing staff were utilised effectively to cover staffing deficits across the disciplines. Risks related to unforeseen staff absence at the hospital were recorded on the risk register.

Inspectors reviewed ward rosters for the previous two months and found that shift patterns and staffing cover aligned with the information provided. Staff spoken with on the ward, including nursing, support and cleaning staff, stated that staffing levels were sufficient on a day-to-day basis.

The hospital's Acting DON was operationally responsible for recruitment. It was evident from meeting minutes, interviews with senior management and documentation reviewed that workforce issues were reviewed daily locally and formally at meetings at CHW level. Inspectors reviewed recent documentation of communication between hospital management, the OPS manager and the GM regarding the staffing requirements needed for the hospital to open the eight beds that were closed to admissions.

At the time of inspection, the hospital did not employ either a medical social worker post or an occupational therapist post. Management, ward staff and the medical officer informed inspectors that this impacted the hospital's capacity to deliver optimal services to patients. They indicated that patient throughput could be improved if these services were in place. Inspectors reviewed recent documentation of communication between the Acting DON and management in CHW outlining the staffing requirement to open the full complement of beds in the hospital, which included a medical social worker and an OT post.

As outlined elsewhere in this report, there was no pharmacist employed at the hospital. Due to the 'HSE Pay and Numbers Strategy', approval for this previously funded post was lost as the post was unfilled on 31 December 2023. Hospital and CHW management informed inspectors that since the lifting of the HSE staff embargo, a derogation had not been sought for approval to recruit a pharmacist at the hospital.

One WTE medical officer role was filled by three local GPs. A medical officer provided cover for the hospital from Monday to Friday, 8am to 6pm and on Saturday until 12 noon, attending daily for patient rounds. Westdoc provided out-of-hours cover. Staff informed inspectors of good collegiate and collaborative working relationships between the medical officers and hospital staff, noting that medical officers were readily available to address any queries or patient concerns raised by nursing staff. An antimicrobial pharmacist at CHW level was available for advice if required.

Staff Training and Education

Hospital staff, including nursing and health and social care professionals (HSCPs), had their attendance at mandatory and essential training monitored by the Acting DON. The Acting DON had systems in place to monitor and record attendance. Discussions with staff indicated they were up to date with training relevant to their roles, such as infection prevention and control and medication management. Mandatory training programmes included infection prevention and control, basic life support (BLS), and medication safety. Training records reviewed indicated that there was scope for improvement in attendance at mandatory and essential training for both nursing staff and HCAs.

Face-to-face training in hand hygiene and donning and doffing of Personal Protective Equipment (PPE) was provided by the IPC link nurse, supplemented by educational posters in clinical areas. Theoretical components of IPC and medication management were delivered on HSELanD.[****] An antimicrobial pharmacist delivered training on antimicrobial stewardship.

Employee Supports

[****] HSeLanD is the Irish Health Service's national online learning and development portal.

Staff were knowledgeable about the supports available, including access to the Employee Assistance Programme (EAP) and occupational health. Signage was observed in the clinical area with information on the resources available from the EAP and how to access it. Staff across various disciplines expressed that the hospital was a positive work environment and that they were satisfied with their employment there.

In summary, the hospital demonstrated a structured approach to workforce planning, organisation, and management, with systems in place to monitor and address staffing levels and training needs, with some areas for improvement identified. While day-to-day staffing levels are reported as sufficient, significant vacancies in key roles and the absence of certain approved positions were impacting on the hospital's capacity to deliver optimal services. Staff were well-informed about available support programmes, which contributed to a supportive work environment.

Judgment: Substantially compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. Key inspection findings leading to these judgments are described in the following sections.

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

During the inspection, several measures were observed that ensured the dignity, privacy, and autonomy of service users were respected and promoted, consistent with the human rights-based approach to care promoted by HIQA. Nurses and HCAs were observed engaging meaningfully with patients in a kind, caring, and respectful manner. They ensured clear communication and confirmed patients' understanding and consent before proceeding with any care activities.

Family members were observed visiting patients in the day room, which provided a private setting for their interactions. Additionally, other patients and family members were seen using the outside garden enclosure, offering a serene and peaceful environment. Curtains were used effectively to protect patients' dignity and privacy during personal care activities.

Patients' charts were kept in a locked room, and a whiteboard with patient details was located in an office behind the nurses' station. The whiteboard had a flap that closed over to cover patient names when not in use, ensuring confidentiality. While patient names were

displayed over beds, patients who spoke with inspectors said they were comfortable with this practice.

Call-bells were available for patients to alert staff if they needed attention, and staff were observed to be responsive when patients utilised this. Although a single call-bell was noted to be missing from a patient bay, this was brought to the attention of management and remedied promptly on the day.

A patient receiving end-of-life care was being cared for in a single room, providing privacy and dignity during this sensitive time.

All of the single rooms had en-suite toilet and shower facilities and the multiple occupancy rooms each had separate toilets and shower rooms.

Overall, there was evidence that hospital management and staff were committed to ensuring that patients' dignity, privacy and autonomy were respected and promoted in the hospital. This commitment was evident through respectful communication, secure handling of patient information, and provision of private spaces for patients and their families.

Judgment: Compliant

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

The inspection highlighted the hospital's commitment to fostering a culture of kindness, consideration, and respect. This was validated by patients who expressed their satisfaction with the care provided by the staff and commended the staff for their kindness.

Nurses and healthcare assistants (HCAs) were consistently observed interacting with patients in a kind and respectful manner, ensuring that patients felt valued and cared for. Staff were attentive to patients' needs, assisting with mobility and promoting safety through the use of anti-slip socks.

The hospital facilitated family visits in private and comfortable settings, such as the day room and garden enclosure, promoting a welcoming environment for patients and their families. Food menus with ample choices were observed in patient rooms, and patients reported that the food quality was very good. Staff also informed inspectors that additional choices beyond the menu could be provided if patients preferred, demonstrating a commitment to patient satisfaction and personalised care. While signage promoting protected mealtimes were on display in the hospital, patients requiring assistance with meals could be supported by a family member if they preferred.

The hospital provided an oratory where patients could spend quiet time, promoting a peaceful environment for reflection or prayer.

While only one poster promoting the HSE *Your Service Your Say* was displayed near the hospital entrance, patient advocacy posters were prominently on display throughout the hospital. All patients spoken with indicated they would speak with a nurse if they needed to make a complaint.

Overall, it was evident that hospital management and staff promoted a culture of kindness, consideration, and respect for people accessing and receiving care at the hospital. This was demonstrated through respectful interactions, patient-centred care, and efforts to accommodate patient preferences.

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 Acting DON was the designated Complaints Officer, responsible for managing complaints and implementing recommendations arising from reviews of complaints. There was a culture of local complaints resolution within the hospital.

The Acting DON reported on complaints to the manager for OPS and the GM as needed. Formal written complaints that could not be resolved locally were managed by the Complaints Manager for CHW. The hospital had access to the HSE complaints management system (CMS) for complaints at stage 2 and higher through this channel in CHW.

Inspectors were informed that the hospital had no complaints recorded in 2023 and five complaints recorded year-to-date in 2024. Four (80%) of these were resolved within 30 days, exceeding the HSE target of resolving 75% of complaints within 30 days.

The hospital used the HSE's complaints management policy *Your Service Your Say*. The Acting DON maintained a local database to track and trend the types of complaints recorded. Staff on the ward were knowledgeable about supporting patients in making a complaint, local resolution of complaints, and escalating a complaint.

Inspectors observed a single HSE *Your Service Your Say* poster inside the entrance to the hospital, which provides information on how to make a complaint, and several patient advocacy service posters in the corridors. While the hospital had a supply of *Your Service Your Say* leaflets, these were kept in staff areas and not readily available in public areas. It would be beneficial to have these leaflets freely accessible to patients in leaflet stands, ensuring proactive rather than reactive access.

Quality improvement plans were developed in response to patient complaints when applicable, and shared learning from complaints was provided to staff informally at handover and ward meetings. Inspectors were informed of specific training being organised for staff in response to a patient complaint related to information and interventions for patient falls.

In summary, it was evident from the documentation reviewed, and from speaking with staff and management, that complaints were broadly managed in line with the HSE's complaints management policy. However, the limited visibility and accessibility of *Your Service Your Say* materials for patients and families suggests there is room for improvement. Ensuring these materials are readily available in public areas would enhance transparency and proactive engagement, aligning more closely with best practices for patient feedback and complaints management.

Judgment: Substantially 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, the hospital, situated in a newly built extension constructed in 2011, was observed to be generally clean, spacious, and well-maintained. Inspectors visited the Male ward, which consisted of two single rooms with ensuite facilities and three six-bedded rooms, each with separate shower and toilet facilities. One of the single rooms was equipped with a ceiling hoist. None of the single rooms had ante rooms.[††††] Single rooms were available for patients who required transmission-based precautions and for patients needing palliative care at end of life. Patients requiring transmission-based precautions are identified on the Integrated Patient Management System (iPMS) prior to admission by clerical staff and notified to the nursing staff.

The layout of the ward promoted safety, with patients who had higher levels of dependency or requiring closer observations, accommodated in the rooms closest to the

[††††] An ante-room is a small intermediate space leading to a main room, designed to control air pressure and airflow. It enhances the effectiveness of single patient rooms by reducing the escape of airborne infectious particles into the corridor.

nurses' station. The wards nearest to the nurses' station were equipped with ceiling hoists, while patients with more independence were placed in rooms further away.

There were no patients requiring isolation facilities at the time of inspection. However, staff demonstrated knowledge of the indications for patient isolation and outlined the practices in place if isolation rooms were unavailable. This was supported by the HSE prioritisation policy, which was referred to by staff and seen by inspectors. Physical distancing of one metre was observed between beds in multi-occupancy rooms.

Waste management and storage were in line with hospital policy. Used or soiled linen was managed and stored appropriately, with a poster displaying information on the colour coding of alginate bags. Hand hygiene signage, including the '5 Moments for Hand Hygiene', was prominently displayed, and alcohol-based hand sanitiser dispensers were plentiful throughout the ward. All hand hygiene sinks in clinical areas observed were compliant with Health Building Note (HBN) requirements.[‡‡‡‡]

Some wear and tear was noted on recliner chairs and in a few areas where plaster was exposed or wood was chipped. These issues were brought to the attention of the ward manager. Although some equipment for example, chairs, wheelchairs, weighing scales, and sit-to-stand hoists were stored in a corridor, the corridor was extra wide and the equipment did not obstruct egress or access. Emergency exits were observed to be unobstructed.

Contract cleaners were employed in the hospital and were responsible for environmental cleaning. Cleaning schedules were seen by inspectors and cleaning checklists were up to date. Changing of curtains was on a schedule, which was seen by inspectors, and as part of a terminal clean. The date of the last curtain change was documented on the curtains. A previous HIQA inspection in August 2020 noted that there was no evidence that cleaning schedules or checklists were monitored by the ward manager, which remained the case on this inspection and is an area of focus for the hospital.

There was no tagging system to identify if equipment had been cleaned. Inspectors were informed that clinical equipment was either cleaned immediately after use by the nurse or HCA before returning it for storage, or as per the cleaning schedule. HCAs maintained a checklist for cleaning patients' immediate environment, including bedside tables and chairs, and a nightly schedule was in place for cleaning the patient and staff kitchenette and linen room. There were no gaps in the cleaning checklists seen by inspectors.

The clean utility room had a code lock entry system. Sterile products were stored above floor level. Dressing trolleys, drip stands, and other equipment including blood glucose monitoring equipment and an ultraviolet system (used to check on compliance with hand

[‡‡‡‡] An HBN compliant sink is a sink that meets the standards outlined in Health Building Note (HBN) 00-10 Part C. These standards ensure the sink supports hygiene and infection control in healthcare settings through features like non-touch operation, integrated splashbacks, smooth surfaces, and efficient drainage.

hygiene as part of training) were observed to be free of visible dirt or dust. Lids on sharps trays with integrated sharps bins were appropriately set in the temporary closed position and not overfilled. The ward manager informed inspectors that the clinical room underwent a deep clean once per week, in line with the cleaning schedule seen by inspectors. Some improvement was noted from the previous HIQA inspection in 2020. The hospital now uses single-use blood pressure cuffs and bedpans, replacing the previously used reusable ones.

Various signage was observed, including appropriately placed signage for 'How to put on and take off PPE' and 'Cover-up' posters encouraging appropriate cough and sneeze etiquette, and IPC Point Of Care Risk Assessment (PCRA) posters prominently displayed outside each ward. These posters outlined point of care risk assessments that healthcare professionals should carry out before each interaction with a patient to accurately assess the risk of exposure to infectious agents. The posters contained QR codes[§§§§] that staff could scan for additional guidance and information. Additional signs promoting the HSE 'We're talking climate action' strategy to reduce the carbon footprint in healthcare work environments were also on display.

While there was no maintenance department onsite, the hospital had access to offsite maintenance services. Items requiring attention were recorded in a maintenance book by staff and the clerical officer reported it to the offsite maintenance department. Urgent requests were communicated by phone. Staff reported that they had no difficulty in accessing maintenance support. In addition, staff reported access to out-of-hours maintenance services by telephone including electrical, plumbing and general maintenance.

The dirty utility room had a macerator with an in-date service tag. There was no inappropriate storage of clean or sterile items in the sluice room. A guide to *Segregation and packaging of healthcare risk and non-risk waste Edition 2014* was available in the dirty utility room, along with a guide to the management of blood and body fluid spillages.

Overall, the hospital demonstrated a strong commitment to maintaining a clean and safe environment, with effective infection prevention and control measures in place. The ward was well-maintained, and staff were knowledgeable about isolation protocols and the use of personal protective equipment. Minor issues related to equipment storage and the monitoring of cleaning schedules were noted. These areas require ongoing attention to ensure continuous improvement.

Judgment: Substantially Compliant

[§§§§] A QR code is a type of barcode that you can scan with your smartphone to quickly access information like websites or contact details.

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

Hospital management were proactively and systematically monitoring, evaluating, and responding to information from multiple sources to inform improvement and provide assurances on the quality and safety of the service provided to patients.

IPC and AMS practices were monitored and reported to CHW. The CNM of the ward spoke about the use of antibiotics for urinary tract infections (UTIs) and highlighted the impact of the national *'Skip the Dip'*[*****] campaign. This quality improvement (QI) initiative supports best practices in managing UTIs in older persons and has significantly reduced antibiotic prescribing. Anecdotally, staff reported a decrease in the number of antibiotics being ordered and prescribed to manage urinary tract infections. Staff reported how the campaign had increased both nursing and medical officer awareness of judicious use of antibiotics. This was verified in minutes of IPC meetings seen by inspectors, which reported that the 'Skip the Dip' initiative resulted in a change in practice with 0% of HSE OPS using routine dipstick urine testing in patients aged over 65 years old, resulting in a considerable reduction in antibiotic prescribing.

Staff reported that antibiotic use was reported to the CHW IPC team on the last Friday of every month, in addition to outbreak data and cases of CPE, Clostridium difficile (C. diff) or COVID-19. Minutes of IPC meetings reviewed confirmed 100% compliance for HSE OPS returning data on monthly metrics.

Inspectors reviewed IPC AMS reports titled '*Community Operations Monthly monitoring of a Healthcare-Associated Infection/Antimicrobial Resistance (HCAI/AMR)'* and *'Antimicrobial Consumption minimum dataset HSE Older Persons Residential Care Facilities'*. These reports included quarterly data for the hospital for 2023 and for Q1, Q2 and Q3 in 2024. The data indicated significant improvements in antibiotic stewardship at the hospital. The hospital demonstrated a commitment to reducing unnecessary antibiotic use, setting a positive example within the CHW area and nationally.

From Q1 2023 to Q3 2024, the hospital demonstrated effective infection control, with no new cases of C. diff reported throughout the period. However, there were three cases of CPE, occurring sporadically in Q2 2023, Q1 2024 and Q2 2024. The hospital also managed five outbreaks of infection, including COVID-19 in Q3 2023 and Q3 2024, and an Influenza outbreak in Q1 2024. The IPC link nurse reported close communication and support from the CHW IPC AMS team. The summary report from the COVID-19 outbreak in October 2024 was reviewed by inspectors and included learnings shared with staff in the hospital. These outbreaks highlighted the need for continued vigilance, particularly

[*****] The "Skip the Dip" campaign promotes best practices for assessing UTIs in people aged 65+ in care facilities. It highlights that not using antibiotics for bacteria in urine without symptoms is safe and helps prevent antibiotic resistance, based on best-practice guidelines and evidence.

during peak respiratory infection seasons. Despite these challenges, the absence of C. diff cases suggests strong infection control measures, which could be leveraged to address other infections effectively.

An audit schedule submitted for 2023 and 2024 included medication management and IPC covering AMS, hand hygiene, as well as various environmental and equipment audits. IPC audits were completed by an IPC Clinical Nurse Specialist (CNS) from CHW. Medication safety audits were completed by nursing staff in the hospital.

The hospital regularly audited IPC practices, including the environment, equipment, and hand hygiene. QIPs were developed for deficits, with actions assigned to responsible persons. They were time bound and there was evidence of completion. The audits showed improvements in compliance with cleanliness issues, particularly in areas that initially performed below expectations. For example, cleanliness in certain wards improved significantly upon re-audit. However, some areas still require ongoing attention, and areas with lower compliance should be re-audited earlier to ensure timely improvements.

Equipment audits highlighted the need to update and maintain items, and demonstrated consistent improvement in re-audit results. For example, a patient care equipment audit found 78% compliance in May 2024 with improvement to 83% on re-audit in August 2024. A cleaning chemical in the spillage kit was found to be out of date on each of those audits, but inspectors found it to be in-date on the day of inspection. A clinic room and combined environment and equipment audit showed further improvement to 100% in September 2024. Other audits demonstrated good compliance in areas such as waste management and PPE both at 100% in August 2024. Significant improvements were demonstrated in hand hygiene, with compliance increasing from 86% in August 2024 to 100% in October 2024.

Three medication safety audits conducted in May, August and November 2024, each auditing 10 medication charts, identified several compliance issues. Common findings included allergy status not always being documented, legibility issues, signatures missing, and opening dates not being recorded on eye drops. Additionally, the August audit noted that drug fridge temperatures were not always monitored in line with hospital policy. Corrective and preventative actions were listed for these issues, but they were not time bound.

The medication management audit report for the hospital, conducted in July 2023 as part of a wider CHW audit, identified several actions across various topics. The Acting DON provided a summary of the findings, which included nine items completed, such as the co-signing of Westdoc prescriptions by two nurses and the Medical Officer (MO), and daily checks of the pharmacy fridge temperature. One item was listed as a work in progress, involving the inclusion of a box on the drug kardex explaining the use of PRN

medications.[†††††] Five items were documented as outstanding, including the development of a Policy Portal for Medication Management and the appointment of a Senior Pharmacist. These outstanding items require external input from CHW.

Overall, the hospital demonstrated a strong commitment to systematically monitoring and evaluating healthcare services. The hospital's proactive approach to auditing and quality improvement initiatives, such as participation in the national 'Skip the Dip' campaign, highlighted their dedication to enhancing patient safety and care quality. Significant improvements were noted in IPC practices, with re-audits showing marked progress in areas such as cleanliness and hand hygiene compliance. However, some areas, such as consistency in re-auditing, and the time-bound nature of corrective actions in medication safety audits, require ongoing attention to ensure continuous improvement.

Judgment: Substantially Compliant

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

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the hospital. Risks at ward level were managed where appropriate, or escalated by the acting CNM to the Acting DON, who had oversight of the process. Inspectors found that knowledge of staff in the clinical area in relation to the presence and use of risk registers could be improved. There was a central risk register for the hospital which was reviewed quarterly by the Acting DON. Risks related to the four areas of harm were recorded on the risk register. Risks not manageable at hospital level were escalated to CHW via the OPS manager and upwards to the GM if necessary. However, inspectors found that there was no direct communication link between the hospital or a district hospital representative and the CHW OPS QSC where matters related to risk are discussed.

IPC

Patients being admitted to the hospital were not routinely tested for multi-drug resistant organisms (MDRO) or transmissible infections. However, a screening process was in place. This process involved the collection of the patient IPC status from the discharging facility on a handover form, access to the IPC patient alerts on the IPMS systems, and isolating patients with any symptoms or history of a MDRO until laboratory testing was complete. The hospital adhered to the HSE prioritisation policy when there were not enough single rooms to meet the demand for isolating patients.

The hospital had an IPC link practitioner who was available to staff for IPC advice. An IPC link practitioner poster was on display in the clinical area identifying the link

[†††††] PRN medication stands for "pro re nata" medication, which means "as needed." It refers to medicines that are taken only when necessary, rather than on a regular schedule.

practitioner and outlining the resources available to staff in the hospital. The IPC link practitioner provided hand hygiene training locally, and reported having close links with and support from the CHW IPC AMS team.

Ward staff reported that AMS training was provided on-site by an antimicrobial pharmacist who was a member of the CHW IPC AMS team. This was confirmed in the minutes of the CHW IPC AMS meeting in June 2024, which noted that AMS training had been delivered to all 20 sites across OPS. The lack of AMS training was identified as a deficit during the HIQA inspection in August 2020. This training demonstrates a commitment to improving the quality and safety of patient care in the hospital. Additionally, a poster promoting the appropriate use of antibiotics in the community was observed in the clinical area.

Staff reported having no issues with access to appropriate PPE stock as needed, and a separate storage room for PPE stock was seen by inspectors. Although there were no patients requiring isolation at the time of inspection, both cleaning and nursing staff clearly articulated examples of appropriate IPC practices employed when caring for a patient with transmission-based precautions. These examples included the management and cleaning of the environment, patient equipment, and the donning and doffing of PPE.

Inspectors found that not all of the cleaning staff were aware of the correct hospital policy and manufacturer instructions regarding the recommended concentration of decontamination agents. This was brought to the attention of the cleaning staff on the day of inspection.

Medication safety

As previously discussed under National Standard 5.2, the hospital or CHW did not employ a pharmacist for oversight and support of medication management. This posed a risk to the quality and safety of medication management in the hospital. Inspectors reviewed the hospital's risk register and noted that this issue had been escalated to CHW level.

Inspectors observed the clinical area and reviewed documentation, and management and staff outlined practices employed in the hospital to protect patients from harm with risks associated with medication safety and medication management.

Medications were stored in a secure manner. An up-to-date version of the Irish Medicines Formulary was available providing staff with access to details for all medicines licensed and marketed in Ireland. There was no SALAD or high-risk medication list or posters displayed in the clinic room. Nursing staff outlined appropriate risk reduction strategies in use for high-risk medications such as insulin and opioids where specific labelling, storage, and two-nurse checks with co-signing safety measures were employed. On the day of inspection, inspectors found that the medication fridge was not

functioning as it should be. This was brought to the attention of management in the hospital and a replacement fridge was installed on the same day.

Medication reconciliation[‡‡‡‡‡] was performed by the Acting DON, acting CNM2 or staff nurses for patients transferring from acute services. Management described a triple check process for transfers of patients from MUH which involved reconciling the prescription against three sources. Initially, once a patient is accepted for admission to the hospital, nursing staff contact MUH by telephone and use a transfer form to gather the patient details including their list of medications on discharge. On admission to the hospital, the discharge prescription from MUH is compared against the medication list gathered on the transfer form and against the hospital kardex in the patient medical records which accompanies patients from MUH. For patients from other hospitals, the first two steps are performed.

Nursing staff told inspectors that the medical officer was contacted and relied upon for reviewing medication discrepancies or identifying potential adverse drug-to-drug interactions. As previously highlighted under National Standard 5.2, the policy submitted to HIQA in relation to medication reconciliation was in draft form and undergoing revision. Sections of the policy in its unrevised form did not align with practices occurring in the hospital, particularly in relation to medication reconciliation and the audit of pharmacy services. In addition, as previously outlined, the SALADs and high-risk medication policies in the hospital's PPPG folder were developed by and for another district hospital, and made no reference to Swinford District Hospital.

Patient admissions for respite brought in their own medications and staff outlined the process for accessing medications out of hours. Staff had access to an antimicrobial pharmacist who was part of the CHW IPC AMS team, who had also delivered the AMS education sessions to staff in the hospital.

Deteriorating Patient

Nursing staff outlined the process for recognising and managing a deteriorating patient. All patients had their baseline observations recorded on admission. Staff explained that if there was clinical judgment or suspicion of deterioration from a patient's baseline, the frequency of vital signs monitoring was increased, and the medical officer was contacted to review the patient. Out of hours, Westdoc was contacted, or if nursing staff were concerned about the patient's status, they would call an ambulance directly. Inspectors noted that the hospital used the National Clinical Guideline (NCG) for Sepsis Management for Adults as part of its suite of PPPGs. Additionally, the '*Sepsis Form – Adult*' from the NCG was on display at the nurses' station to support staff in recognising sepsis. The Acting DON recorded and reviewed data in relation to the nature and frequency of patients who had been transferred back to the acute hospital.

[‡‡‡‡‡] 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.

Transitions of care

The hospital had implemented systems to mitigate the risk of harm during patient transfers within and between healthcare services, as well as to support safe discharge planning. A review of documentation by inspectors found that discharge and transfer forms included the patient's personal details, medical history, current medications and infection status.

Inspectors observed that the hospital had recently introduced a handover transfer form to facilitate the systematic collection of information for patients being admitted to the hospital. Nursing staff reported their involvement in developing and trialling this form, which at the time of inspection was under review, based on their feedback. Clinical handovers occurred twice daily at shift changes.

Inspectors were informed by staff that the majority of patients admitted to the hospital were transferred from MUH, and their full MUH medical chart and notes accompanied them. For all admissions from any hospital, a verbal nurse-to-nurse handover was conducted and documented on the transfer form on the day of transfer. Staff also used an aide-memoire to ensure all discharge elements were completed for patients being discharged home or to a long-term care facility.

Policies, Procedures, Protocols and Guidelines (PPPGs)

Inspectors viewed a suite of PPPGs to support staff in the hospital. Folders containing the PPPGs were indexed and accessible to staff. Nursing staff were able to easily identify specific PPPGs requested by inspectors. As noted elsewhere, PPPGs related to medication management in the hospital require attention. National policies were used where available, such as for IPC, complaints, and risk management. The Acting DON monitored PPPGs due for revision. Inspectors were informed that efforts were underway at the CHW level to develop a region-wide database for centralising the development and management of PPPGs.

Staff Training

Training records from the clinical areas visited on the day of inspection were reviewed. There were good compliance rates for mandatory training, with 95% of nursing staff and 88.88% of HCAs having completed hand hygiene training. Additionally, 100% of nursing staff had completed BLS training.

Attendance at all components of IPC training could be improved. Compliance rates were as follows: 75% of nursing staff and 77.77% of HCAs attended standard and transmission-based precautions training. Donning and doffing PPE training was attended by 80% of nursing staff and 77.77% of HCAs. Outbreak management training was attended by 75% of nursing staff and 66.66% of HCAs.

Additionally, 85% of nursing staff had attended medication management training. For complaints training, 55% of nurses and 77.77% of HCAs had attended. Open disclosure training was completed by 35% of nurses and 27.77% of HCAs, while communication training was completed by 40% of nurses and 61.11% of HCAs.

While compliance levels varied, maintaining high compliance with mandatory and essential training is crucial for ensuring patient safety and maintaining the overall quality of care.

In summary, the hospital had systems to manage risks and support IPC practices, with screening in place for MDROs. Processes for managing deteriorating patients and transitions of care appeared to be effective, though training compliance varied and was an area identified for improvement. Medication management and reconciliation, which are core elements of medication safety, should be conducted by an interdisciplinary team that includes nurses, doctors, and pharmacists, and supported by up-to-date relevant PPPGs. Pharmacists, with their specialised knowledge of adverse drug reactions (ADRs), and drug interactions, play a crucial role in ensuring optimal medication regimens and accurate communication.[§§§§§]

Judgment: Partially 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. Clinical incidents were reported on a paper-based system and then discussed with the acting CNM2 and Acting DON. Inspectors were informed that the hospital contacts the clerical officer to input the reports onto NIMS.

Inspectors spoke with staff who were knowledgeable about how to report a patient safety incident and were aware that falls were the most commonly occurring patient safety incidents reported. The hospital tracked and trended patient safety incidents and was provided with a trending report at the end of the year from CHW.

In 2023, the hospital recorded a total of 60 incidents on NIMS, with 16.66% (10 incidents) recorded within 30 days. The majority of these incidents (53%) were related to 'slips, trips, and falls', followed by 'virus' (25%) and 'self-injurious behaviour' (8.33%). Less than 0.5% (2 incidents) were related to medications.

[§§§§§] Ravi, Padma, et al. "Nurse-pharmacist collaborations for promoting medication safety among community-dwelling adults: A scoping review." International Journal of Nursing Studies Advances 4 (2022): 100079.

In 2024, there were 54 incidents recorded, with a significant improvement in timely recording on NIMS, as 50% (27 incidents) were recorded within 30 days. The majority of incidents in 2024 (76%) were related to 'slips, trips, and falls', followed by 'violence, harassment, and aggression' (9.26%) and medication (5.56%).

Despite the significant improvement in reporting time from 2023 to 2024, this is still outside the HSE target of recording at least 70% of incidents onto NIMS within 30 days of notification of the incident. It was noted as an action in the minutes of the April 2024 DON meeting that incidents should be recorded on NIMS within the 30-day national key performance indicator (KPI).

Hospital management and staff outlined quality improvement initiatives introduced in relation to the tracking and trending of falls incidents. One example observed by inspectors was the hospital's new falls detection system. This was a wireless alarm system that alerts staff who carry a receiver in their pocket if a patient is detected to be at risk of falling. Staff were observed being responsive to the alarm system during the inspection.

Staff on the ward and management reported that feedback on incidents is shared at staff handover and at ward meetings. The ward manager meets with both the night and day staff each morning where any incidents that may have occurred during either shift are discussed.

In summary, the hospital had effective patient-safety incident management systems in place, with significant improvements in timely incident reporting and proactive quality improvement initiatives. The hospital demonstrated responsiveness to incidents by developing and implementing QIPs. However, further efforts are needed to meet the HSE target for incident reporting within 30 days.

Judgment: Substantially compliant

Conclusion

HIQA carried out an announced inspection of Swinford District Hospital to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care.

Overall, the hospital was judged to be:

- Compliant with two national standards (1.6, 1.7)
- Substantially compliant with seven national standards (5.5, 5.8, 6.1, 1.8, 2.7, 2.8, 3.3)
- Partially compliant with two national standards (5.2, 3.1).

Capacity and Capability

The hospital demonstrated a structured approach to governance, management, monitoring, and workforce planning, with several areas identified for improvement. While there were formalised corporate and clinical governance arrangements in place at CHW level, some gaps were noted, particularly in medication safety governance. The absence of a specific forum to escalate and manage medication safety issues, coupled with a long-standing vacancy in the pharmacist post, highlighted areas needing timely action. Additionally, inconsistencies in committee meetings and documentation, as well as informal communication practices, indicated opportunities for more robust governance structures. Despite these challenges, effective governance processes were noted in IPC, the deteriorating patient, and transitions of care, contributing positively to patient safety and care quality.

The hospital demonstrated effective management arrangements supporting high-quality, safe, and reliable healthcare services. However, the absence of a dedicated medical social worker and occupational therapy staff impacted the hospital's capacity to accept certain referrals, potentially leading to delayed discharges.

Systematic monitoring processes were implemented to enhance service quality, safety, and reliability. While the structured approach to audits and incident reporting demonstrated a commitment to continuous improvement, areas such as patient feedback processes and the low number of reported medication incidents indicated potential underreporting.

The hospital demonstrated a structured approach to workforce planning, organisation, and management, with systems in place to monitor and address staffing levels and training needs. However, significant vacancies in key roles and the absence of certain approved positions impacted the hospital's capacity to deliver optimal services. Despite these challenges, staff were well-informed about available support programmes, contributing to a supportive work environment.

Quality and Safety

The hospital demonstrated a strong commitment to ensuring the quality and safety of healthcare services, with several areas identified for improvement. Hospital management and staff were dedicated to respecting and promoting patients' dignity, privacy, and autonomy, as well as fostering a culture of kindness, consideration, and respect. Complaints were broadly managed in line with the HSE's complaints management policy, ensuring that service users' concerns were addressed.

The hospital maintained a clean and safe environment, with effective infection prevention and control measures in place. While minor issues related to equipment storage and cleaning schedule monitoring were noted, these areas require ongoing attention to ensure continuous improvement. The hospital's proactive approach to auditing and quality improvement initiatives, such as the 'Skip the Dip' campaign, highlighted their dedication to enhancing patient safety and care quality. However, consistency in re-auditing and the time-bound nature of corrective actions in medication safety audits require ongoing attention.

Systems were in place to manage risks and support IPC practices, including screening for MDROs. Processes for managing deteriorating patients and transitions of care appeared to be effective, though training compliance varied and was identified as an area for improvement. Medication management and reconciliation should involve an interdisciplinary team, including pharmacists, to ensure optimal medication regimens and accurate communication.

The hospital had effective patient-safety incident management systems, with significant improvements in timely incident reporting and proactive quality improvement initiatives. However, further efforts are needed to meet the HSE target for incident reporting within 30 days.

Overall, Swinford District Hospital demonstrated a structured approach to governance, management, monitoring, and workforce planning, with several areas identified for improvement. While there were strengths in infection prevention and control, the management of deteriorating patients, and transitions of care, some gaps in medication safety governance and interdisciplinary collaboration were noted. The hospital's commitment to continuous improvement was evident through proactive auditing and quality improvement initiatives, though consistency in re-auditing and training compliance requires ongoing attention. Addressing these gaps is essential to further enhance the quality, safety, and reliability of healthcare services provided.

Following the receipt of an initial compliance plan, HIQA convened a meeting with management at the hospital and CHW to seek further details on the hospital's strategy for achieving compliance with national standards as they relate to medication safety. Subsequently, HIQA received an updated compliance plan which is included as an appendix to this report (See appendix 2). HIQA will continue to monitor the progress in implementing the actions set out in the compliance plan submitted.

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 national standards is identified, a compliance plan was issued by HIQA to the service provider. In the compliance plan, 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 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	Partially-compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially 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.	Substantially 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	Substantially 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.	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.	Substantially 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.	Substantially compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially 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.	Partially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially compliant

Appendix 2 - Compliance Plan - Service Provider's Response

Compliance Plan for Swinford District Hospital

OSV-0005693

Inspection ID: NS_0102

Date of inspection: 13 and 14 November 2024

Compliance Plan

Service Provider's Response

National Standard	Judgment
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Partially-compliant

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

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

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

1. **Medication Safety:**

- Agreement in principle has been reached with a Community Pharmacist to provide a service to Swinford District to commence on 9th June 2025. This will include supervision, audit and oversight of medication in the hospital on a part time basis.

- Drugs and Therapeutics committee met 20th November 2024 to agree the terms of reference and membership of the group. It met again on 30th Jnauary 2025.
  This group along with the Quality and Safety group will monitor the progress of the CHW medication management audit. The Chairperson of the current Saolta group has been approached to ask for CHW representation on this existing Drugs and therapeutic committee.

  Medication safety concerns from District Hospitals in Mayo were reviewed at the CHW Quality and Safety meeting on the 18th December 2024. An action arose from this meeting to circulate a learning notice to complement the

learning notice issued from Mayo University Hospital. A Medicine Reconciliation Meeting was held on 17/01/25 where A/DON from Swinford District Hospital was also in attendance. Following the meeting, a Learning Notice was issued on 22/01/25.

An external company is being engaged to update the medication policy suite. This update would incorporate observations and recommendations from the recent audit to ensure comprehensive policy enhancement.

2. Governance and Oversight

OPS Managers and Directors of Nursing Governance Committee at CHW:

- Following correspondence with the Chair of this committee, it has been agreed that the Terms of Reference (TOR) will be reviewed and amended to include a formal approval mechanism.
- The meeting schedule will be revised to align with the TOR, ensuring meetings occur as prescribed.
- Action points within meeting minutes will now include time-bound targets to ensure accountability and follow-through.

Quality and Safety Committee:

- Following correspondence with the Chair, it has been agreed that the TOR will be reviewed, amended, and formally approved.
- The frequency of meetings will be revisited, and a definitive schedule will be implemented to ensure consistency.
- Since September 2024, the Director of Nursing (DON) from Ballina District Hospital (BDH) has been sitting on this committee. Following meeting, minutes are now shared with Swinford District Hospital which ensures there is a two-way communication. It was also seen as an area for improvement to ensure effective communication and feedback mechanism during HIQA inspection at Swinford District Hospital.
- Following Quality and Safety Committee meeting in February 2025 ,it has now been agreed that dedicated updates under the heading "District Hospital Updates" will form part of the monthly Quality and Patient Safety Report, covering:
  - Infection Prevention and Control (IPC)
  - Medication Safety
  - The Deteriorating Patient
  - Transitions of Care

Infection Prevention and Control Committee:

- The TOR were agreed on the 15th of November 2021. A commitment has been secured to review and sign off the TOR for this committee once the changes in the RHA structures have been confirmed. HIQA

viewed the draft of the new TOR's during the inspection. The 2021 TOR's stand at present.
- Since the HIQA visit, the DON from BDH now represents Older Persons Services (OPS) on this committee, ensuring direct input and oversight.

Serious Incident Management Team (SIMT):

- It has been agreed that the TOR will be finalised and signed off by Q1 2025, providing a more robust framework for managing Category 1 incidents and Serious Reportable Events (SREs).

The revised TOR for the OPS Managers and Directors of Nursing Governance Committee, Quality and Safety Committee, IPC Committee, and SIMT will define clearer governance structures and align their functioning with national standards. Continued investment in training and administrative support will be crucial to sustain these improvements.

Ensuring consistent representation of district hospitals, including Swinford District Hospital, on key committees will require ongoing investment in staff resources and operational support.

The actions outlined are designed to address the deficiencies identified by HIQA during their inspection, strengthen governance and oversight structures, and ensure compliance with national standards. These steps, including enhanced representation, formalising processes, and ensuring consistent committee activity, demonstrate a commitment to improving the quality and safety of care at Swinford District Hospital and across Mayo IHA (was Community Healthcare West at time of inspection). By capitalising on these opportunities for improvement, along with appropriate resource allocation and monitoring, a more robust and sustainable compliance framework will be achieved. It is acknowledged that changes are expected as we transition to IHA, Mayo fully. Governance arrangements and committees may be realigned but core purpose will remain the same.

Timescale:

30/06/2025:

- Finalisation and approval of the revised TOR for governance committees.

- **Ongoing through 2025:**
  - Continuous monitoring of medication safety improvements.
  - Regular reviews and updates to the TOR for key committees.

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.	Partially compliant

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

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

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

1. **IPC**

- Cleaning staff are now aware of the hospital cleaning policy and manufacturer instructions regarding the recommended concentration of decontamination agents. Any queries/doubts raised by the cleaning staff is addressed by liaising with the Infection Prevention and Control Team locally and at regional level.

2. **Medication Safety**

- Agreement in principle has been reached with a Community Pharmacist to provide a service to Swinford District to commence on 9th June 2025. This will include supervision, audit and oversight of medication in the hospital on a part time basis.

- Drugs and Therapeutics committee met 20th November 2024 to agree the terms of reference and membership of the group. It met again on 30th Jnauary 2025.
  This group along with the Quality and Safety group will monitor the progress of the CHW medication management audit. The Chairperson of the current Saolta group has been approached to ask for CHW representation on this existing Drugs and therapeutic committee.

  Medication safety concerns from District Hospitals in Mayo were reviewed at the CHW Quality and Safety meeting on the 18th December 2024. An action arose from this meeting to circulate a learning notice to complement the learning notice issued from Mayo University Hospital. A Medicine Reconciliation Meeting was held on 17/01/25 where A/DON from Swinford District Hospital was also in attendance. Following the meeting, a Learning Notice was issued on 22/01/25.

An external company is being engaged to update the medication policy suite. This update would incorporate observations and recommendations from the recent audit to ensure comprehensive policy enhancement.

- Following the inspection feedback , SALAD and High Risk Medication Posters are displayed in the Nursing Station.

- Medication Fridge which was not functioning within the recommended temperature range was replaced with a new one on the day of inspection.

3. **Policies, Procedures, Protocols, and Guidelines (PPPGs):**

A meeting has been scheduled to review the Older Persons Services (OPS) approach to PPPGs and to develop a strategy for 2025. Key considerations include the implementation of a CHO-wide database for PPPGs and the introduction of version control to ensure staff access the most up-to-date guidance.

4. **Staff Training**

Mandatory training attendance for hand hygiene has shown marked improvement, now standing at 100% for clinical staff. 100% of Nursing Staff are compliant with Medication Management Training. Efforts are ongoing to achieve and maintain the HSE target of 90%

b) Long-Term Plans Requiring Investment to Achieve Compliance

1. **Mandatory Training Compliance:**
    - Hospital management is committed to improving mandatory training compliance across all staff categories, particularly in hand hygiene and standard and transmission-based precautions (SBP and TBP). Hand hygiene training compliance is at 100% in February of 2025.
    - A dedicated schedule of training sessions, facilitated by the IPC Link Practitioner has been implemented to facilitate uptake, and progress will be monitored monthly.
2. **Governance of PPPGs:**
    - Investment in a CHO-wide PPPG approach will ensure consistent access to current policies and guidelines. The introduction of version control as part of this initiative will eliminate ambiguity and enhance compliance.
3. **Medication Safety Governance:**
    - To address sustainability concerns, a CHO-wide process for managing medication safety issues is being established.

Summary

The actions outlined aim to address the findings identified during the HIQA inspection. Key improvements include strengthened governance processes for PPPG's and a clear

strategy to improve compliance with mandatory training. These measures, coupled with ongoing investment and a structured approach to governance, will ensure that the hospital continues to align with national standards and prioritise the safety of service users and maintain/improve the overall quality of care provided in Swinford District Hospital.

Timescale:

- **30/06/2025:**
  - Finalisation of the CHO-wide PPPG strategy, including version control.
  - Establishment of the CHO-wide medication safety governance framework.
  - Continued improvements in hand hygiene compliance through enhanced training and support by the IPC Link Practitioner.