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:	Gorey District Hospital
Address of healthcare service:	13 McCurtain Street Gorey Co. Wexford Y25 KX86
Type of inspection:	Announced
Date(s) of inspection:	7 and 8 August 2024
Healthcare Service ID:	OSV-0007830
Fieldwork ID:	NS_0089

About the healthcare service

The following information describes the services the hospital provides.

Model of hospital and profile

Gorey District Hospital is a model 1* hospital managed by the Health Service Executive (HSE) and at the time of inspection was under the governance of Community Health Organisation (CHO) 5.†

The hospital has a total of 20 beds; 12 transitional care beds, five respite beds and three palliative care beds. Referral processes are in place for patients to access a bed in the hospital from acute and community services.

The following information outlines some additional data on the hospital.

Model of Hospital	1
Number of beds	20

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

To prepare for this inspection, the inspectors‡ reviewed information which included previous inspection findings, unsolicited information§ and other publicly available information.

* Model 1 hospitals are community and or district hospitals and do not have surgery, emergency care, acute medicine (other than for a select group of low risk patients) or critical care, as outlined in *Securing the Future of Smaller Hospitals: A Framework for Development,* 2013. Available online: https://assets.gov.ie/12170/91124d282ee84248b929698e050dedc5.pdf

† Community Health Organisation area 5 consists of South Tipperary, Carlow, Kilkenny, Waterford and Wexford

‡ 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.*

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

During the inspection, inspectors:

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

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 and caring one that is both person-centred and safe. It also includes information about the environment where people receive care.

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
7 August 2024	13.30 – 17.35hrs	Danielle Bracken	Lead
8 August 2024	08.50 – 17.00hrs	Mary Flavin	Support

Information about this inspection

An announced two-day inspection of Gorey District Hospital was conducted on 7 and 8 August 2024.

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

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

The inspection team visited the clinical area within the hospital, which consisted of a number of multi-occupancy and single rooms.

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

- Clinical nurse manager grade 2 (CNM 2) who was the interim manager of the hospital
- Manager of older persons' services, Waterford Wexford community nursing units, CHO 5
- General manager older persons' services, community nursing units and Integrated Care Programme for Older People (ICPOP), CHO 5 (quality and patient-safety representative)
- A general practitioner (GP) — one of the hospital's medical officers
- An infection prevention and control link nurse
- A senior medical social worker (transitions of care representative)

[**] The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improves recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.

[††] 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. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

- An acting CNM 2 (deteriorating patient and medication safety representative)
- Staff working in the clinical areas visited.

During this inspection, inspectors reviewed documentation and data on site and requested additional documentation and data from hospital management which was reviewed following the inspection.

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 service who spoke with inspectors about their experience of the service.

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

On day one of inspection there were 15 patients and on day two there were 14 patients present in the hospital, which had capacity for 20 patients.

Patients informed inspectors their experience of care received in the hospital. When describing staff one patient told inspectors "everyone is lovely", with another stating that staff as "fantastic". A patient who had used the service regularly said that "they (staff) are excellent, I have been here many times, it (the experience) is always good". When describing their experience of the hospital, patients stated "it couldn't be any better" and "I love it here", "it is very comfortable". Two patients who spoke with inspectors remarked on the cleanliness of the hospital, telling inspectors that they saw the cleaners in every day. Inspectors observed that the clinical area was clean and free from clutter.

Inspectors observed that staff responded promptly to patients requiring assistance. All patients stated that they got assistance when required. One patient described staff as "very helpful, they come when I ring the call bell". Another patient said that "staff listen to me" and "I have a call bell and if I need anything, staff come straight away, staff are very busy". Inspectors observed staff assisting patients to mobilise up and down the corridor and the majority of patients were dressed and up and out of bed.

When asked about making a complaint if needed, patients stated that they would be comfortable speaking with staff, with one patient saying they "couldn't fault anything" and another telling inspectors "it would be very difficult to fault anything". All patients expressed satisfaction with the food provided, describing it as "very

good", "great" and "lovely". A day room was available in the hospital, as a quiet place for patients to sit and relax. Inspectors observed this room in use during the inspection. Inspectors also observed a communal dining space in place for patients who wished to eat meals together. A garden was available for patient use, where patients could partake in gardening activities. Inspectors observed a patient being assisted to access the garden by a staff member.

Capacity and Capability Dimension

Inspection findings related to the capacity and capability dimension are presented under four national standards from the themes of leadership, governance and management and workforce. Two national standards (5.5 and 5.8) assessed on the inspection were found to be compliant, one national standard (6.1) was substantially compliant and one national standard (5.2) was partially compliant. Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

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

As part of this inspection, organisational charts setting out corporate and clinical reporting structures within the hospital were provided to inspectors. At the time of inspection, the director of nursing position was vacant and had been for some time. Although no impact was identified with this arrangement on the day of inspection, the ongoing vacancy is not sustainable. The unfilled position will be discussed further under national standard 6.1. Organisational charts reviewed outlined that the clinical nurse manager grade 2 (CNM 2) was the person with overall responsibility for the day-to-day management of the hospital.

The CNM 2 reported upwards to the manager of older persons' services, Waterford, Wexford community nursing units, (CHO5). This manager in turn reported upwards to the general manager for community nursing units and ICPOP (CHO 5). Both of these managers, along with the CNM 2, met with inspectors on day two of inspection and described the governance arrangements with CHO 5. Health and Social Care Professionals (HSCPs) that worked in the hospital, for example, physiotherapists, reported to line managers within CHO 5. The arrangements described were in keeping with the organisational charts provided to inspectors. Additionally, the hospital's mission statement was clearly displayed on entering the building.

A standard operating procedure was in place for admission to the hospital. This document outlined the criteria for admission and admission procedures. There were documented guidelines for medical cover in place at the hospital. Medical cover was provided by GPs across three local GP practices. GPs attended the hospital daily Monday to Friday. Outside of this, GPs were contactable by phone with medical cover provided from 9am to 6pm. Medical cover was also provided on Saturdays from 9am to 1pm. Outside of these hours, if a doctor was required, an out-of-hours service was contacted.

A chart outlining committee reporting structures for the hospital was provided to inspectors. This chart outlined the Gorey District Hospital governance committee and the local committees and meetings in place at the hospital, for example nurse management meetings, and linkages with committees at CHO 5 level.

The Gorey District Hospital — Hospital Governance meeting between management at the hospital and the older persons manager Waterford Wexford, CHO 5 took place each quarter according to the terms of reference. From a review of meeting minutes, inspectors observed that this meeting had taken place in quarter two and three of 2024. Meeting minutes documented discussions in relation to infection prevention and control, the occupancy of the hospital, the risk register, quality improvements and updates from local committees. Discussions in relation to oversight of medication safety and the deteriorating patient were not an agenda item and did not take place routinely at these meetings. There was evidence that both medication safety and the deteriorating patient were discussed locally at nurse management meetings in the hospital.

A quarterly Director of Nursing Governance Group for Community Nursing Units, Older Persons, South-East Community Healthcare (SECH) was attended by a management representative from the hospital. Minutes of this meeting showed that discussions in relation to recruitment, delayed transfers of care and patient-safety incidents took place.

A regional Quality and Safety SECH Waterford Wexford Community Units meeting was attended by representatives from the hospital. Meetings had taken place quarterly to the date of inspection, in line with the terms of reference which were in draft format and were due to be signed off at the next meeting. Meeting minutes reviewed by inspectors showed that infection prevention and control, service user experience, patient-safety incidents and quality improvement initiatives were discussed at this meeting. Oversight of medication safety and recognising and responding to deteriorating patients were not agenda items at these meetings. Inspectors were told by the manager of older persons' services, Waterford Wexford community nursing units (CHO 5) that early discussions in relation to setting up either a Gorey District Hospital or combined district hospital's drugs and therapeutics committee were

underway. This plan was also documented in the minutes of the Quality and Safety SECH Waterford Wexford Community Units meetings.

Gorey District Hospital — Supporting Transitions of Care, a multidisciplinary committee had recently been established with the first meeting taking place in August 2024. This committee was accountable to manager of older persons' services, Waterford Wexford community nursing units, CHO 5. The minutes of this committee reviewed by inspectors showed actions arising from this meeting which were required to aid patient discharge were assigned to a named person.

There was no governance and oversight of locally created policies, procedures, protocols and guidelines (PPPG), with no evidence that these were discussed at hospital governance meetings or CHO5 governance structures. Some PPPGs had not been formally approved, this is discussed further in national standard 3.1. This was also a finding on a previous inspection of the service in September 2020. Inspectors were told by the manager of older persons' services, Waterford Wexford community nursing units (CHO 5) that there was a plan to create a PPPG sub-committee of the Quality and Safety SECH Waterford Wexford community units. The sub-committee would focus on the creation of regional documents and how these could be adapted for local use.

In summary although some governance arrangements for assuring the delivery of high quality, safe and reliable healthcare were in place in the hospital, areas for action were identified:

- a CNM 2 was acting in an interim capacity as the person with overall accountability for the service due to a vacant director of nursing position
- medication safety and the deteriorating patient were not agenda items at the hospital governance meeting
- no governance and oversight arrangements for locally created policies, procedures, protocols and guidelines (PPPG) were in place, with some PPPGs not formally approved.

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.

There were management arrangements in place at the hospital to support and promote the delivery of high quality, safe and reliable healthcare.

The hospital had two infection prevention and control link practitioners. Their role was to support staff to implement infection prevention and control policies, procedures and guidelines, to deliver training and undertake audit. An advisor for infection prevention and control from CHO 5 was assigned to the hospital, who was onsite twice in 2024 having recently met with the hospital's link practitioners and management in April 2024. Access to a microbiologist in University Hospital Waterford was available for advice when required and staff had access to the laboratory system to check results.

The hospital had no onsite pharmacy presence. Inspectors were informed that controls in place to reduce this risk included a weekly check on stock, medication orders by nursing staff and telephone support provided by the pharmacy department, Wexford General Hospital was available when required. This was validated by a review of the risk register. Notwithstanding this, no impact of this risk was evident on inspection. The risk register indicated that as an action, pharmacy support from within the region would be sought by the manager of older persons' services, Waterford, Wexford community nursing units with a timeline of 21 August 2024 for completion.

Patients' vital signs were monitored where appropriate, and this system was audited. This will be discussed further under national standard 2.8.

An admission and discharge policy was in place at the hospital. Daily multidisciplinary meetings took place each morning where the anticipated date of discharge for patients were discussed and recorded. A patient handover tool was used at the hospital to aid effective communication during clinical handover and between members of the multidisciplinary team.

In summary, management arrangements were in place in relation to infection prevention and control and transitions of care in the hospital, and evidence provided on inspection indicated that pharmacy arrangements were under review. At the time of inspection, telephone support was provided by the pharmacy in Wexford General Hospital.

Judgment: Compliant

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

Performance data in relation to hospital activity such as bed occupancy rate, delayed transfers of care, infection prevention and control and patient-safety incidents were discussed at Gorey District Hospital — Hospital Governance meetings. These topics were also discussed at Quality and Safety SECH Waterford Wexford Community Units.

Findings from the previous inspection in 2020 identified that infection prevention and control auditing, monitoring and assurance arrangements were not comprehensive. At that time, there was scope to expand monitoring to include antimicrobial stewardship and standard and transmission-based precaution practice. During this inspection, inspectors found that data on antimicrobial stewardship and rates of infection were now being captured. SECH Infection Prevention and Control Link Practitioner meetings, held every one to two months were attended by infection prevention and control link practitioner nurses from the hospital. From a review of minutes of this meeting, inspectors identified that data on local and national healthcare associated infections, audit activity and training was discussed and was fed back to management and staff at the hospital.

Nursing quality care-metrics were in the process of being implemented in the hospital. Discussions were underway at the time of inspection regarding a suitable electronic platform to capture care metrics. Local audit was in place in relation to infection prevention and control, medication management and vital signs monitoring.

The hospital's risk register was reviewed quarterly by hospital management and the manager of older persons' services, Waterford Wexford community nursing units, (CHO 5). The risk register was last updated in May 2024 with documented evidence of controls and actions in place to minimise risks at the hospital. During a previous inspection of the service in 2020, infrastructural issues had not been recorded on the hospital's risk register. This had been remedied and are now documented on the risk register. Inspectors were informed that risks that could not be managed locally were escalated to risk registers held at CHO 5 level.

An audit action plan for 2024 was available for review with oversight provided by hospital management. This document, which was reviewed by inspectors, detailed audits that had been carried out in the hospital in 2024. Included in this document were findings from environmental hygiene, equipment and medication safety audits. Actions that had taken place in response to these findings were documented. However, findings from hand hygiene and patient vital sign monitoring audits that had taken place in February 2024 had not been included in the action plan. Findings in relation to hand hygiene audits are discussed further in national standard 2.8.

A local patient satisfaction survey was carried out in quarter one 2024 with an action plan in place to address findings; such as ensuring that posters and information leaflets on how to make a complaint were displayed. Service user experience was discussed at Gorey District Hospital — Hospital Governance meetings and Quality and Safety SECH Waterford Wexford Community Units meetings.

When incidents requiring discussion occurred in the hospital, evidence was provided that a serious incident management team (SIMT) meeting took place. The last incidents requiring review had occurred in 2023 and 2021. These incidents had been

discussed at SIMT meetings and followed up in line with the HSE's incident management framework 2020 according to documentation provided to inspectors.

Judgment: Compliant

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

The hospital had workforce arrangements in place to support and promote the delivery of quality, safe and reliable healthcare. However, areas for action identified on this inspection included compliance with infection prevention and control training.

As discussed under national standard 5.2, the director of nursing position was vacant. At the time of inspection, the position had been vacant for a period of two years, since August 2022. In the interim, a CNM 2 was the person with overall responsibility for the day-to-day management of the hospital. An acting 0.5 whole-time equivalent (WTE)[§§] CNM 2 was in place to backfill this post, leaving 0.5 WTE unfilled CNM 2 position. Inspectors were told by the manager of older persons' services, Waterford Wexford community nursing units (CHO 5) that the replacement post was at the final stages of approval from the HSE.

The hospital had an approved complement of 11.5 WTE staff nurses. At the time of inspection, 1.5 of these positions were vacant and a further 1.5 positions were unfilled due to long term leave, with these being filled by shift changes, staff taking on extra shifts and the use of agency staff. On the day of inspection the hospital was fully staffed with 1.5 WTE agency nurses in place as backfill for the vacancies. Inspectors were informed that approval to recruit for these posts had been sought by hospital management and was awaited.

The risk posed by vacant posts and the use of agency staff to fill positions was recorded on the hospital's risk register. There were unfilled multi-task assistant (MTA) positions, with 2.0 WTE positions vacant out of an approved complement of 9.25 WTEs, which were filled by agency staff. On the day of inspection, the hospital was fully staffed with one MTA position filled by agency staff. The hospital had two cleaners, 8am to 5pm Monday to Friday and outside of these hours cleaning was carried out by the MTAs.

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

There were systems in place to monitor and record staff attendance at mandatory and essential training and this was overseen by the CNM 2. Staff attendance at training on for example, hand hygiene was 100% for nurses and MTAs and medication safety training was 100% for nurses. Compliance with basic life support, 100% for nurses and 91% for MTAs. Training in transmission-based precautions required action with compliance at 67% for nurses and 63% for MTAs. Additionally, outbreak management training compliance was low, at 20% for nurses.

The hospital had workforce arrangements in place to support and promote the delivery of quality, safe and reliable healthcare, however:

- poor compliance levels were identified in staff training in transmission-based precautions and outbreak management.

Judgment: Substantially compliant

Quality and Safety Dimension

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

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

Overall, inspectors observed that the dignity, privacy and autonomy of those using the service were respected and promoted.

Patients were observed out of bed, dressed and sitting out in chairs and mobilising along the corridors with assistance. Inspectors observed a communal dining room with four tables where patients could sit and eat together. There were numerous information leaflets available in the library to help inform patients about local services such as 'Age Friendly Ireland' and about the 'Get Up, Get Dressed, Get Moving' campaign.

The privacy and dignity of patients was protected through the use of single rooms and curtains in multi-occupancy areas. Patient files were stored appropriately in a locked nurses' office.

There were three single rooms with en-suite toilet and bathroom facilities in the hospital that were designated for those requiring palliative care, including those at end of life. A kitchenette and space to sit down were available nearby for families of patients in these single rooms to use. End-of-life information leaflets were available.

Judgment: Compliant

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

A culture of kindness, consideration and respect was evident in the hospital. Inspectors observed many kind interactions between staff and patients. Staff were observed being friendly and attentive towards patients and assisting them with their needs. This included assistance to mobilise, and assistance with eating meals. Headphones were available for patients to assist them to hear the television, if required.

Efforts were made to provide a homely environment in the hospital. Historic photos of Gorey were on display in the day room and along the corridors in the hospital. These served as a talking point for patients. A number of communal areas were available in the hospital where patients could relax; this included a bright and spacious day room with chairs and a library, a quiet lounge and the garden. Much time and consideration had been given to the garden in particular, which was extensively planted with shrubs and flowers. A work area in the garden was available for planting pots and inspectors were told that patients could partake in this activity. There was also a hairdressers' room. A hairdresser visited regularly.

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 interim manager of the hospital (CNM 2) was the designated complaints officer. Hospital management followed the HSE's complaints policy, '*Your Service Your Say'.*[***] '*Your Service Your Say'* leaflets, posters and a comment box were on display at the entrance to the hospital. An information leaflet about the hospital included information about the complaints process. Information on independent advocacy services to facilitate patients in making complaints was also clearly displayed.

Staff at the hospital focused on resolving complaints locally. Staff who spoke with inspectors were knowledgeable about the complaints process. Local complaints were filed in a complaints folder which was shown to inspectors. A point of contact complaints form was used to document complaints, with actions taken to resolve the complaint documented on the form. No formal written complaints were received by the service to the date of inspection in 2024. Inspectors were informed by the manager of older persons' services, Waterford Wexford community nursing units, CHO 5, that formal complaints were escalated when required. From a review of meeting minutes, inspectors found that complaints, if any, were discussed at the hospital governance meeting as a standing item and at local management meetings.

Patients who spoke with inspectors did not have any complaints and told inspectors that they would speak to staff if they had any concerns.

Judgment: Compliant

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

Despite the dated infrastructure, inspectors noted that the hospital's physical environment was clean and generally well maintained.

There were six single rooms, three had en-suite toilet and shower facilities. For those patients accommodated in single rooms with no en-suite toilet or shower facilities that required transmission-based precautions, a toilet and shower was designated for their use. On the day of inspection there was clear signage in place to outline the transmission-based precautions for those requiring these. Personal protective equipment (PPE), was readily available.

Inspectors noted that alcohol-based hand sanitiser was available in numerous locations along corridors and in patient rooms. Hand hygiene signage was clearly displayed. The clinical hand-wash sinks throughout the hospital did not conform to

[***] 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.

requirements.[†††] This was a finding on a previous inspection of the service in 2020 and was recorded on the hospital's risk register. Inspectors were informed and minutes of management meetings confirmed that works to replace sinks were due to commence shortly.

Multi-occupancy rooms were large and bright with good spacing between beds. There was a lack of storage facilities to store commodes. These were stored in a patient toilet as the dirty utility was too small. Hazardous waste and linen were segregated and stored appropriately.

A system was in place to identify equipment that was cleaned through the use of a tagging system. A cleaning checklist was in place and this was provided to inspectors by a cleaner who was knowledgeable in relation to the cleaning practices in place at the hospital. CNMs had oversight of cleaning.

In general, the physical environment at the hospital supported the delivery of high quality, safe, reliable care, with action required in relation to the following:

- sinks in the hospital did not conform to requirements
- patient equipment was inappropriately stored in patient areas.

Judgment: Substantially compliant

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

While hospital management had assurance systems in place to monitor, evaluate and continuously improve the service, some areas for improvement were identified. For example; Assurances included analysing information from a variety of sources such as incident reporting, complaints and audits. As discussed under national standard 5.8, nursing quality care-metrics were in the process of being introduced at the hospital.

Audits completed by staff in the hospital in relation to the four areas of focus of this inspection included infection prevention and control, medication management and monitoring of patients' vital signs.

Hand hygiene audit results viewed by inspectors for February 2024 showed 86.7% compliance. This is below the HSE's target of 90%, there was no documented quality improvement plan in place to address this. There was evidence in minutes of nurse meetings from May 2024 that hand hygiene audits and hand hygiene training had been discussed. An audit of hand hygiene facilities in July 2024 showed compliance of

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

78% and noted that clinical hand-wash sinks did not conform to requirements, an action to address this was that replacement sinks were ordered. As discussed under national standard 2.7 this was also a finding on the day of inspection.

Environmental hygiene audits reviewed by inspectors for January, April and July 2024, had action plans in place to address issues. No percentage compliance was calculated for these audits and this was a finding on a previous inspection in 2020. However, action plans to address findings were in place.

Medication management audits were carried out in February and August 2024, although areas for action were documented such as completion of staff signatures, there was no percentage compliance completed.

Audits of measurement of patients' vital signs, which inspectors were informed should be completed every six months had been completed in February 2024 and last completed a year prior in February 2023. In line with other audits, actions were recorded but percentage compliance was not.

Overall, there were processes in place at the hospital to systematically monitor, evaluate, and continuously improve the service, however;

- there was no documented quality improvement plan in place to improve practice with hand hygiene
- audits did not always have percentage compliance calculated to facilitate benchmarking of performance.

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.

Systems were in place to identify, evaluate and manage risks to people being cared for there.

As discussed under national standard 5.8, a hospital risk register was reviewed with management from CHO 5 on a quarterly basis. Risks recorded on the risk register which related to the four areas of focus included infrastructure, medication management, acutely deteriorating patients and transitions of care. None of these risks had a high risk rating and controls were in place to minimise these risks. These risks were also monitored and overseen by the manager of older persons' services, Waterford Wexford community nursing units, CHO 5. Action updates and due date in relation to risks in Gorey District Hospital were recorded on the risk register. For example, one action was to introduce a modified early warning system into the hospital to help detect deteriorating patients. Inspectors requested the date of the

last legionella risk assessment carried out at the hospital, however, this was not available at the time of inspection.

Inspectors were told that patients were screened for multi-drug resistant organisms if clinically indicated or advised by the GP but not as standard. Patient referrals to the service were managed through a bed request form and this included the documentation of known infections. An infection prevention and control link practitioner folder which was available for all staff to refer to. An infection outbreak folder contained previous outbreak reports as well as a list of who to contact in the event of an outbreak. The last outbreak of infection was COVID-19 in December 2023. An outbreak report was completed and provided to inspectors. The report identified the source of COVID-19 and documented that patients were isolated within 24 hours of onset of symptoms. The report also noted good practice in relation to outbreak control and identified learning arising out of the management of the outbreak, which was available for staff to view in the infection outbreak folder.

A list of high-risk medicines in the form of APINCH[‡‡‡] and sound-alike, look-alike drugs (SALADS) was on display in the treatment room of the hospital. Medication trolleys were stored securely, and locked. As discussed earlier in the report, under national standard 5.5, no clinical pharmacy service was provided to the hospital. Medication reconciliation[§§§] was carried out by nursing staff at the hospital. A sample of medication prescribing and administration records were reviewed which confirmed that medication reconciliation was completed. To reduce the risk of incorrect patient identification, there was a patient identification photograph on the front of medication prescribing and administration records. A process was in place to obtain consent for these photographs.

The risk of patients deteriorating acutely was recorded on the hospital risk register. Staff outlined to inspectors and documentation provided identified a number of controls in place at the hospital to minimise this risk. For example, a documented guideline was in place which outlined the process for recording patient observations and vital signs on admission and then at the required interval. Management informed inspectors that consideration was given to implementing an early warning system in the hospital such as the Irish National Early Warning System version 2 (INEWS). A standard operating procedure was in place for admissions to the hospital. Patients accessing transitional care beds were required to be medically stable for admission to the hospital. For patients needing urgent medical care an ambulance was called. These arrangements were documented in medical cover guidelines for the hospital. Patients at risk of deteriorating were discussed at handover and at daily safety

‡‡‡ APINCH is an acronym used to identify high risk medicines and includes anti-infective agents, potassium, insulin, narcotics and sedatives, chemotherapy and heparin and other anti-coagulants.
§§§ 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

pauses. An Automated External Defibrillator (AED) was available onsite in the hospital for use if required.

Referral and admission processes for patients wishing to access care in the hospital were documented and staff were knowledgeable about these processes. A number of forms were available at the hospital to ensure that important information was shared between staff at transitions and transfers of care. For example, referral forms, transfer of patient forms, and discharge to community support forms.

Staff could access relevant policies, procedures, protocols and guidelines (PPPGs) through hospital computers and demonstrated this to inspectors. Most local PPPGs reviewed had been updated in 2024 with some exceptions. The discharge policy was due for review in March 2023, the standard operating procedure (SOP) for admissions and the local outbreak management SOP were not dated and had not been formally approved.

Systems were in place at the hospital to identify, evaluate and manage risks to people being cared for there, however, the following is identified for action:

- the date of the last legionella risk assessment was not available at the time of inspection.

Judgment: Substantially compliant

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

Systems were in place at the hospital to identify, manage, respond to and report on patient-safety incidents. Staff who spoke with inspectors were knowledgeable about how to report patient-safety incidents. Completed incident forms were sent to the risk advisor in CHO 5 for input on to the National Incident Management System (NIMS).[****] Feedback on patient-safety incidents was provided to staff at safety pauses. Inspectors attended a safety pause where a recent patient-safety incident, and the response to this was discussed.

Hospital management and management within CHO 5 had oversight in relation to patient-safety incidents reported at the hospital. Inspectors found evidence of discussion of patient-safety incidents in minutes of meetings of Gorey District Hospital – Hospital Governance meetings and Older Persons Services South-East Community Healthcare (SECH) Directors of Nursing Governance Group meetings. A summary report of incidents occurring in the hospital was produced each year. Inspectors

[****] 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).

reviewed the summary report for 2023 which outlined the number, location and type of patient-safety incidents that had occurred in the hospital. This information was compared against previous years for trending purposes.

Judgment: Compliant

Conclusion

Capacity and Capability

Lines of reporting and accountability at the hospital were clear. At the time of inspection, the director of nursing position was vacant for two years. While no impact of this was observed on the days of inspection this ongoing vacancy had the potential to impact on the overall governance and oversight of the hospital. Medication safety and the deteriorating patient were not agenda items at the hospital governance meeting. However, audit results in relation to these areas were discussed locally. The management arrangements in the hospital in relation to the four key areas of focus of this inspection were clear. Data from a variety of sources were used to improve services at the hospital. In addition, nursing quality-care metrics were in the process of being implemented.

Quality and Safety

Staff at the hospital promoted and respected the dignity, privacy and autonomy of those being cared for there. Patients who spoke with inspectors were complimentary of staff and spoke positively of their experiences of care. Although the infrastructure of the hospital was dated, in general it was well maintained and clean. Performance was being measured in the hospital in relation to the quality and safety of services provided. Control measures were in place to manage identified risks. The processes in place in relation to the reporting and management of patient-safety incidents at the hospital were clear and understood by staff.

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

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

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	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.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	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.	Compliant
Theme 2: Effective Care and Support	

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

Appendix 2 – Compliance Plan, Service Provider's Response

Compliance Plan for Gorey District Hospital OSV-0007830

Inspection ID: NS_0089

Date of inspection: 07 and 08 August 2024

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

- A permanent Director of Nursing has commenced at Gorey District Hospital as of December 2024. In conjunction with our permanent CNM2 and CNM1, all nurse management posts at Gorey District Hospital are now filled. Complete.
- Both medication safety and management of the deteriorating patient have been added to the standing agenda for the hospital's governance meetings, monthly MDT meetings and staff meetings. Complete.
- A PPPG sub-committee has been established across CHO5/SECH Older Persons Services. A regional policy for the development of policies, procedures and guidelines has been put in place and there is now a defined pathway from local development group through to hospital governance through to the PPPG sub-committee for final approval, ratification and cataloguing. Complete.
- A retrospective project to review existing local policies and bring them within this process is underway with expected completion by Dec 2025.

Timescale: Immediate Actions – Complete

Retrospective Project re local PPPGs - Dec 2025.