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:	Lisdarn Transitional Care Centre
Address of healthcare service:	Lisdarn Cavan H12 A5D7
Type of inspection:	Announced
Date(s) of inspection:	9 and 10 October 2024
Healthcare Service ID:	OSV-0007855
Fieldwork ID:	NS_0099

About the healthcare service

Model of hospital and profile

Lisdarn Transitional Care Centre (Lisdarn Centre) is a rehabilitation and community inpatient healthcare service which is owned and managed by the Health Service Executive (HSE). It is located in the grounds of Cavan General Hospital. Until 1 October 2024 the service was under the governance of Community Health Organisation 1 (CHO 1) and at the time of inspection the centre was transitioning to the governance of the Integrated Healthcare Area Cavan Monaghan.

Lisdarn Centre has 32 inpatient beds spread across two wards, unit 1 and unit 2. Patients are admitted to the centre from acute hospitals and the community for reablement care, transitional care, pre-discharge care and palliative care. Reablement patients have access to a multidisciplinary team which includes physiotherapists, speech and language therapists and occupational therapists onsite.

Due to renovation building works taking place in unit 2, on the days of inspection inpatient bed capacity was 25 beds all accommodated in unit 1. There was a maximum of seven reablement beds, including one community bed. The remaining beds were allocated to pre-discharge care, transitional care and palliative care as required. On the days of inspection 19 beds were occupied.

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 (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

* 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

- 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 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.

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.

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 of this report. The compliance plan submitted following this inspection is included in Appendix 2.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
09 October 2024 10 October 2024	13:00 – 17.00hrs 09.00 – 15.10hrs	Sara McAvoy	Co-Lead
		Nora O' Mahony	Co-Lead
		Aedeen Burns	Support

Information about this inspection

This announced inspection of Lisdarn Centre focused on 11 national standards from five of the eight themes of the *National Standards for Safer Better Healthcare*.

This inspection focused on four key areas of known harm, these were:

- infection prevention and control
- medication safety
- deteriorating patient
- transitions of care.[†]

During this inspection inspectors visited unit 1, and spoke with the following staff:

- Assistant Director of Nursing, Lisdarn Centre
- Clinical Nurse Manager 2
- Service Manager for Older Persons Cavan Monaghan CHO 1
- A representative from each of the following areas:
  - Infection Prevention and Control Committee
  - Drugs and Therapeutics Committee
  - Transitions of Care[‡]
  - Quality and Patient Safety CHO 1.

Inspectors also spoke to hospital staff from a variety of professions and disciplines in the clinical area visited during this 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 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

Inspectors spoke with patients accommodated on the ward. Patients reported that they were happy with the care they had received and were very complimentary of their time spent in the Lisdarn Centre. They said *'all is good'* and *'I get everything I need'*. Patients

[‡] Transitions of care includes internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

who spoke with inspectors were aware of their plan of care. When asked about their care they said they had *'no complaints'* and '*we want for nothing'*, *and 'this place is 100%'*.

Inspectors observed staff engaging with patients in a kind, respectful and considerate manner. Staff were observed supporting and assisting patients with their individual needs.

Inspectors noted that signage to the centre used an incorrect name for the centre. Management informed inspectors that they planned to rectify this to avoid confusion for service users and people visiting the centre. The inspectors observed information about the HSE's complaints process and advocacy services displayed in the clinical area visited. However patients were unclear on how to make a complaint, but stated that '*I don't need to complain about anything'* and *'I've no complaints'*.

Capacity and Capability Dimension

Inspection findings in relation to the capacity and capability dimension are presented under four national standards 5.2, 5.5, 5.8, and 6.1, from the themes of leadership, governance and management and workforce. Key inspection findings leading to judgments 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.

Inspectors found that there were integrated corporate and clinical governance arrangements in place in Lisdarn Centre which were appropriate for the size, scope and complexity of the services provided.

The assistant director of nursing (ADON) was responsible for the operational management of the centre. The ADON reported to the director of nursing (DON) for CHO 1, who reported to the service manager for older persons services in Cavan Monaghan CHO 1, who in turn reported upwards to the general manager for older persons services CHO 1. Physiotherapists and occupational therapists reported within CHO 1 structures. Organisational charts detailing the reporting structures clearly depicted the direct reporting arrangements for Lisdarn Centre management, and these were consistent with the governance arrangements outlined by staff during this inspection.

The Lisdarn Transitional Integrated Governance Committee had a remit to provide governance and accountability for the integrated post-acute service at Lisdarn Centre and was chaired by the ADON. This committee met at a frequency aligned with its terms of reference and was operationally accountable to the service manager for older persons

services in Cavan Monaghan CHO 1. Committee membership included the service manager for older persons Cavan Monaghan CHO 1, the DON for Integrated Care Cavan Monaghan CHO 1, the director of operations for Cavan Monaghan Hospital and the infection prevention and control (IPC) clinical nurse specialist CHO 1. The pharmacy executive manager for Cavan General Hospital was a committee member but had only attended one of the last three meetings. However, inspectors were told that the pharmacy executive manager had received invitations and would be attending meetings regularly going forward.

Cavan Monaghan CHO 1 Services for Older Persons Quality and Safety Committee was chaired by the service manager for older persons services Cavan Monaghan CHO1 and attended by the ADON from the Lisdarn Centre. This committee's remit was to oversee quality and safety across Cavan Monaghan Older Persons Services including the Lisdarn Centre. The committee provided assurance of the governance of CHO 1 Cavan Monaghan Older Persons Services upwards to the head of service. The terms of reference for this committee indicated four-weekly meetings but from minutes of the last three meeting viewed by inspectors, meetings had taken place approximately every two months.

The CHO 1 Older Persons Services Quality and Safety Review Committee was chaired by the head of service for social care CHO 1. The function of the committee was to provide assurance of the governance of CHO 1 older persons services to the chief officer CHO 1. This committee met at a frequency aligned with its terms of reference. The service manager for older persons services CHO 1 Cavan Monaghan was a member of this committee and submitted a monthly Quality and Patient Safety Assurance Report for the Lisdarn Centre to this committee. This report included incidents, medication errors and IPC issues.

The Lisdarn Local Infection Prevention and Control Committee was chaired by a clinical nurse manager (CNM) 2 and membership included representation from IPC link nurses in Lisdarn Centre, catering staff and healthcare assistants. The function of this committee was to highlight IPC concerns, to liaise with and escalate issues to the IPC team in CHO 1. This committee provided assurance on IPC to the Services for Older Persons Quality and Safety Committee, and IPC was a standing agenda item and discussed at Integrated Governance Committee meetings. The committee was meeting at a frequency aligned with its terms of reference and inspectors viewed IPC quality improvement plans which included time-bound actions, action owners and depicted appropriate progress on action items.

The Cavan Monaghan Hospital Drugs and Therapeutics Committee was chaired by a hospital consultant and the committee reported to the hospital's Quality and Safety Executive Committee. Inspectors reviewed the three most recent sets of minutes available for this committee and it was clear that the committee was meeting at a frequency aligned with its terms of reference. The ADON in the Lisdarn Centre was a member of this committee with responsibility to report from and to Older Persons Services and provide input from frontline nursing staff in Lisdarn Centre. However, there were no reports from

the Lisdarn Centre in the minutes of the Drugs and Therapeutics Committee reviewed by inspectors. As mentioned previously the pharmacy executive manager was also a member of the centre's Integrated Governance Committee.

Patients transferred from Cavan Monaghan Hospital to the service were administratively discharged from the hospital and admitted under the clinical governance of a Cavan Monaghan Hospital medical consultant in Lisdarn Centre. The ADON for Lisdarn Centre was a member of the Cavan Monaghan Hospital Deteriorating Patient Committee.

Overall, it was evident from documents reviewed by inspectors and meetings with relevant staff that Lisdarn Centre had governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare relevant to the size and scope of this centre. However:

- Cavan Monaghan CHO 1 Services for Older Persons Quality and Safety Committee was not meeting at a frequency aligned with its terms of reference.
- The Lisdarn Centre representative at the Cavan Monaghan Hospital Drugs and Therapeutics Committee was not reporting to this committee as per the terms of reference.

Judgment: Substantially compliant

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

Management arrangements were in place to support the delivery of safe and reliable healthcare in the hospital. The ADON in Lisdarn Centre was responsible for the operational management of the unit, and minutes of two recent management 'site visits'[§] were action-oriented and showed good support from the general manager, the service manager for older persons services and the DON. A named medical consultant had overall clinical responsibility for the care of the patients admitted to the centre. The consultant was onsite one day per week and attended the weekly multidisciplinary team meeting. A medical registrar assigned to the centre was onsite Monday to Friday. Out of hours medical cover was provided by the on-call medical registrar in Cavan Monaghan Hospital. There was access to the palliative care team for patients receiving end-of-life care. Nursing support out of hours was available through the site manager in Cavan Monaghan Hospital, and staff were familiar with those supports. There was also an on-call nurse manager available through the office of the service manager for older persons services

[§] Site visits at Lisdarn Centre aimed to review current practice and procedures against the Safer Better Healthcare Judgement Framework.

Cavan Monaghan CHO 1. However staff on the ward were unfamiliar with this CHO 1 on-call nursing management arrangement.

The CHO 1 Infection Prevention and Control team were responsible for support and training for infection prevention and control in Lisdarn Centre, and this was provided by two whole-time equivalent[**] (WTE) IPC clinical nurse specialists. There were IPC link practitioners on site who provided support and training on matters concerning infection prevention and control. The IPC link practitioners undertook environmental audits and attended CHO 1 IPC Link Practitioner Forum meetings. The link nurses were allocated time to carry out their duties.

Patients requiring isolation were cohorted in accordance with a standard operating procedure (SOP) for prioritisation of single rooms. However the scope of this SOP was for Cavan Monaghan Hospital, and did not specifically include Lisdarn Centre. The centre had identified the need for IPC advice for patients with intravascular devices which required expertise which was not available through the CHO 1 IPC team. An informal arrangement was in place with Cavan Monaghan Hospital for IPC nurses from the hospital to provide the required support for the Lisdarn Centre nursing staff. Management of the centre were working to formalise this arrangement.

Medicines were supplied to Lisdarn Centre from Cavan Monaghan Hospital. There was a 0.5 WTE pharmacist allocated to Lisdarn Centre. They provided a clinical pharmacy service[††] for patients at the centre. There was access to antimicrobial pharmacy advice and support from Cavan Monaghan Hospital as required.

There was a process in place at the centre for the management and transfer of a deteriorating patient. Contact details for required services were displayed clearly on the ward. Staff who spoke with inspectors were knowledgeable about the management of a deteriorating patient and the processes for escalation and transfer of care when required.

Inspectors were informed that patients for reablement, pre-discharge care and palliative care were transferred principally from Cavan General Hospital as a planned admission for an average two to three weeks duration under the care of a consultant in medicine for the elderly. There was one community bed which was used infrequently, but which was also under the medical governance of the same consultant. Inspectors were told that a discharge co-ordinator role was filled at the time of inspection and there was a director of nursing for integrated care in post who attended the Lisdarn Transitional Integrated Governance Committee meetings to whom issues regarding transfers from Cavan Monaghan Hospital were escalated. The CNM 2 provided a daily capacity report to Cavan

[**] Whole-time equivalent - allows part-time workers' working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to a full-time worker, 0.5 refers to an employee that works half full-time hours.

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

Monaghan Hospital. Nursing transfer and discharge letters were generated electronically from the patient information management system in use in the centre. Discharge planning commenced at admission and the average length of stay was monitored and discussed at the Integrated Governance Committee meetings.

Overall, the management arrangements were effective to support and promote the delivery of high quality, safe and reliable healthcare services relevant to the size and scope of the unit. However:

- Staff were unaware of CHO 1 on-call nursing management arrangements.
- The standard operating procedure (SOP) for prioritisation of single rooms in use at the Lisdarn Centre did not specifically include Lisdarn Centre in its scope.
- The arrangement with Cavan Monaghan Hospital for IPC nurses to provide support to Lisdarn Centre nursing staff in relation to patients with intravascular devices was not formalised.

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.

Lisdarn Centre had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of services provided at the unit with oversight at CHO 1 level.

The centre had risk management structures and processes in place to proactively identify, monitor, analyse and manage identified risks. Documentation submitted to HIQA showed that key risks were recorded on the centre's corporate risk register. Existing controls and additional actions required to mitigate these risks were documented. The corporate risk register was reviewed annually by the ADON with oversight by the service manager for older persons services Cavan Monaghan CHO 1. Risks which required additional supports were escalated to the CHO 1. Risks related to the four key areas which were the focus of this inspection, such as infection prevention and control, are discussed under section 2.7 and 3.1.

Cavan Monaghan CHO 1 Services for Older Persons Quality and Safety Committee had responsibility of the development and delivery of the quality and safety programme with associated structures and policies to promote a culture of quality improvement across Cavan Monaghan Older Persons Services including the Lisdarn Centre.

The centre had a schedule of audits for medication safety and infection prevention and control. Information from monitoring was used to improve the quality of services and

evidence of implementation of quality improvement plans related to audit findings was seen by inspectors.

Incidents were managed by the CHO 1 quality and safety lead with oversight by the Cavan Monaghan CHO 1 Services for Older Persons Quality and Safety Committee. The centre proactively identified, documented and monitored patient-safety incidents. All incidents were uploaded onto the National Incident Management System[‡‡] (NIMS). Learning from incidents was shared at safety pauses and at nursing handover. Information from compliments and complaints from people who used the service was shared at safety pauses.

The Lisdarn Centre collected data on a range of different measurements related to the quality and safety of healthcare services for example, patients who required readmission to the acute hospital, patient-safety incidents and complaints. It was evident that performance data was reviewed at Integrated Governance Committee meetings and at CHO 1 level.

Overall Lisdarn Centre had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of services provided relevant to the size and scope of the centre.

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.

Lisdarn Centre had effective workforce arrangements in place to support the delivery of high-quality, safe and reliable healthcare.

There were 24.2 approved WTE nursing posts including management grades. There were four vacant staff nurse posts at the time of inspection (16.5% variance). Management has sought approval to recruit the vacant posts but approval had not be received to progress to interview stage. Management reported that current staffing levels were adequate for the existing bed capacity while unit 2 remained closed for refurbishment. The risk associated with staffing both units when fully open was included on the centre's risk register. Vacant shifts were covered by the centre's own staff or from within CHO 1. Care was supported by 28.7 approved WTE healthcare assistant posts, of which 2.7 WTE were vacant (9.4% variance). There was also one approved WTE multi-task assistant post, which was filled at the time of inspection. IPC advice and support was provided by two

[‡‡] 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).

WTE IPC clinical nurse specialists in CHO 1, and these posts were filled at the time of inspection.

There was one WTE medical registrar onsite Monday to Friday in Lisdarn Centre. There was an approved 0.5 WTE pharmacist post. However, inspectors were told the pharmacist visited the centre one or two times per week as pharmacy resources allowed. Management reported that this level of pharmacy services was adequate at current bed capacity.

The centre also had one approved WTE physiotherapist and one approved WTE physiotherapist assistant, of which 0.5 WTE of the physiotherapist post was vacant. There was one approved WTE occupational therapist post and one approved WTE occupational therapist assistant post, both of which were filled at the time of inspection. Speech and language therapy and medical social worker resources were provided by Cavan Monaghan Hospital as required.

The ADON had oversight of staff training, and it was evident from staff training records reviewed and from speaking with staff that they were up to date with training appropriate to their scope of practice. For example, nursing compliance with training in infection outbreak management (97%), hand hygiene (100%) and Irish National Early Warning System training (98%) was high. Full compliance rates were identified in standard and transmission based precautions with nurses and healthcare assistants achieving 100% compliance.

Staff had access to expertise and training in IPC from CHO 1 community-based infection prevention and control clinical nurse specialists, and there were strong links with the IPC team in Cavan Monaghan Hospital in the form of training opportunities and advice if required. IPC link practitioners facilitated staff training on hand hygiene and donning and doffing of personal protective equipment. Staff in the Lisdarn Centre were invited to and attended Cavan Monaghan Hospital IPC education and training sessions.

Overall, workforce arrangements in the unit were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare and staff shortfalls across the different disciplines were being managed. Notwithstanding this, there were nursing, healthcare assistant, pharmacist and physiotherapy staffing shortfalls, which if left unfilled could impact on the delivery of care when the centre reopens fully.

Judgment: Substantially compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred.

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

Overall inspectors found that patients' dignity, privacy and autonomy were respected and promoted. Inspectors observed staff communicating with patients in a manner that respected their dignity and privacy, and seeking consent when providing patient care.

Patients were accommodated in six multi-occupancy rooms and three single rooms. Privacy curtains and screens were available and utilised for patients receiving personal care and patients were supported to dress in their own clothes. Patients that inspectors spoke with were aware of their plan of care and knew their predicted length of stay. Patients' personal information and healthcare records were stored appropriately on the ward visited. There were posters on the ward encouraging patients to seek clarity on their care if needed stating 'if you don't understand, ask'. The single rooms were prioritised for patients receiving end-of-life care.

None of the rooms in the unit had ensuite bathroom facilities, but staff reported that patients in multi-occupancy rooms who needed to use a commode were brought to the bathroom in order to promote dignity and protect privacy. However, patients requiring isolation who were cared for in single rooms were required to use a commode and did not have access to shower facilities which impacted on patients dignity and respect.

Overall, staff and management in the unit made every effort to ensure that patients' dignity, privacy and autonomy were respected and promoted. However, this was challenging in an environment with no toilet or shower ensuite facilities for patients requiring isolation.

Judgment: Substantially compliant

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

Overall it was evident that a culture of kindness, consideration and respect was actively promoted in Lisdarn Centre. Kind interactions between staff and patients were observed by inspectors, and staff were observed providing individualised assistance with respect and consideration.

Inspectors observed that patients were communicated with in a respectful manner. Patients outlined how their preferences and needs were taken into account, including with regard to meal choices. One patient described the care by staff as '*unreal*'. Patient experience surveys were sent to all patients on discharge and the patients' survey results were displayed in the ward demonstrating positive feedback.

Patient information leaflets and posters were accessible, including advice on the different services provided at the centre, advocacy services and information on how to make a complaint. Overall, staff and management of the centre promoted a culture of kindness, consideration and respect.

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.

Lisdarn Centre had systems in place to ensure that complaints and concerns were responded to promptly, openly and effectively.

The ADON was the designated complaints officer for the centre and the HSE's complaints management policy '*Your Service, Your Say*'[§§] was used. The management of complaints was guided by a local policy. The complaints process, as described to inspectors on the day of inspection by management and staff, aligned with the local policy. '*Your service Your Say*' leaflets were on display in the ward. Information about how to make a complaint was also included in the patient information booklet for the centre.

Management and staff reported that verbal complaints were managed locally by staff with a focus on local resolution. This was validated on review of the complaints log which described resolution of a complaint related to food choice. The service manager for older persons services CHO 1 Cavan Monaghan submitted a monthly Quality and Patient Safety Assurance Report for Lisdarn Centre to the CHO 1 Older Persons Services Quality and Safety Review Committee, which captured complaints and compliments. Complaints management training was mandatory for the ADON and CNM 2 in the centre, and these staff were up to date in this training. Compliments were also tracked by the centre, and the number of compliments received far exceeded complaints.

[§§] Health Service Executive. Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints. Dublin: Health Service Executive. 2017.

Overall there was evidence that the hospital had systems and processes in place to respond effectively to complaints and concerns raised by people using the service.

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.

Unit 1 was a 25-bedded ward comprising two three-bedded rooms, four four-bedded rooms and three single rooms. There were no ensuite toilet and shower facilities but toilets and shower facilities were located across the corridor from the bedrooms. Single rooms were prioritised for patients at end of life and for patients who required transmission based precautions.

Unit 2 was closed at the time of inspection while undergoing refurbishment works. The physical environment of unit 1 in Lisdarn Centre showed signs of significant wear and tear including chipped paint and damaged flooring which impeded thorough cleaning. Inspectors noted that some recent refurbishment work had been undertaken in bathrooms on the ward. Inspectors were told that refurbishment of unit 1 to include lighting, flooring and painting was scheduled after completion of unit 2 refurbishment works.

Wall-mounted alcohol based hand sanitiser dispensers were located strategically throughout the unit and hand hygiene signage was clearly displayed. There was personal protective equipment and hand-hygiene facilities available for staff and inspectors noted that clinical hand-wash basins conformed to HBN 00-10 part C Sanitary Assemblies or equivalent standards.[***]

Environmental cleaning was undertaken by contract cleaners and staff told inspectors that they were satisfied with the cleaning resources allocated to the centre. The ADON undertook supervision and checking of cleaning undertaken. However, there was no documented oversight in place with regard to the checking of cleaning undertaken at the centre. Staff outlined that the condition of the physical environment was challenging in terms of effective cleaning. A potential IPC risk related to mould on a ceiling was identified by inspectors in a store room and staff acted to mitigate the risk when made aware. A risk assessment was submitted to HIQA after the inspection with a due date for full mitigation of actions to be completed by 24 October 2024.

[***] National Clinical Effectiveness Committee. Infection Prevention and Control (IPC) National Clinical Guideline No. 30. May 2023. Available online https://www.gov.ie/

Inspectors were informed that the cleaning of patient equipment was the responsibility of the staff member who used it. There were additional routine equipment cleaning schedules for completion by multi-task attendants and health care assistants with oversight by the CNM. Terminal cleaning[†††] was undertaken by a multi-task attendant. However checks of these schedules were not documented. Equipment was observed to be clean and the hospital had a label system in place to identify cleaned equipment. However there was inconsistent use of this labelling system to identify equipment that had been cleaned.

Multi-occupancy rooms were spacious and there was adequate spacing of greater than one metre between beds. The centre was secure, requiring a staff member to permit access.

In summary, there was evidence that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care with some exceptions which were highlighted to the ADON on the day of inspection and included the following:

- The unit had no single room with ensuite bathroom facilities for patients with a suspected or confirmed infection that required transmission-based precautions.
- There was significant wear and tear to the physical environment which impeded effective cleaning.
- There was no formalised oversight for checking of cleaning.
- There was ceiling mould in a store room.
- There was inconsistent use of the labelling system to identify equipment that had been cleaned.

Judgment: Partially compliant

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

Hospital management were systematically monitoring, evaluating and responding to information in order to identify opportunities for improvement and provide assurance to CHO 1 on the effectiveness of healthcare services delivered at Lisdarn Centre.

Inspectors viewed evidence that environmental, hand hygiene, medication safety, and patient care plans audits were carried out monthly. Quality improvement plans were

[†††] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

developed which included time-bound actions assigned to responsible persons. However, patient care plan audits did not provide overall compliance scores to facilitate tracking and trending of results.

Environmental audits were undertaken by the IPC link nurse. Inspectors were told that link nurse training on the use of the environmental audit tool had improved the quality of auditing in recent months. Inspectors reviewed a rolling quality improvement plan for this area which showed completed items and some action items which remained outstanding. Staff and management indicated that audit results were discussed at the Local Infection Prevention and Control Committee and meeting minutes seen by inspectors confirmed this. Minutes of the Cavan Monaghan CHO 1 Services for Older Persons Quality and Safety Committee confirmed that environmental audit completion and audit training were discussed. However, audit results were not highlighted in the minutes of meetings reviewed to identify areas for improvement.

Hand-hygiene audits were undertaken monthly and inspectors saw associated quality improvement plans (QIPs). Audits provided to HIQA for June and July 2024 did not included overall collated compliance scores to facilitate on going trending. An audit provided for September 2024 did have overall compliance calculated at 85.7%.

Inspectors reviewed monthly medication safety audits undertaken by the CNM 2. Compliance levels were good at 86.1%, 85.9% and 84.7% in July, August and September 2024 respectively. QIPs developed for areas requiring improvement showed evidence of the implementation of required actions.

Management were tracking average length of stay and incidence of patients requiring transfer to the emergency department or a hospital admission. Minutes of meetings reviewed showed that length of stay was discussed at Lisdarn Integrated Governance Committee meetings. Management reported that the target length of stay key performance indicator was 21 days and this target was met in August 2024 according to data submitted to HIQA.

Inspectors reviewed the 2023 incident management analysis report for Lisdarn Centre which included data on medication errors and common causes of harm. Four concise reviews had been commissioned in 2023 and all recommended actions had been completed. CHO 1 quality and patient safety advisor provided an update at CHO 1 Older Persons Services Quality and Safety Review Committee which included an update on incidents, medication errors and implementation of recommendations.

Irish National Early Warning System (INEWS) had been implemented in the centre two years previously, underpinned by the Cavan Monaghan Hospital policy. Management reported that this was working well, however audit of INEWS had not been undertaken but was planned.

Lisdarn Centre sought feedback from patients on discharge to ascertain their experience of care in the unit, and had recently commenced posting this survey to patients, however

response rates were low. Feedback results were displayed on the ward but were not trended to facilitate improvement.

Overall, the hospital were systematically monitoring and evaluating the service. However it was noted that:

- overall scores were not calculated for all audits to facilitate tracking and trending
- audit of INEWS had not been undertaken.

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 centre had systems in place to proactively identify and manage risks. Risks in relation to the service were recorded on a risk register and there was evidence of appropriate review of the risk register and risk assessments by the ADON. Risk assessments reviewed had owners assigned and outlined existing controls in place and additional actions required to manage and reduce recorded risks. Meeting minutes confirmed that risk was an agenda item at local and CHO 1 meetings and inspectors were informed by the management team that risks that could not be managed at local level were escalated to the service manager for older persons services. A scheduled daily safety pause was observed by inspectors which included discussion of risks associated with patients' clinical deterioration, medication safety and IPC issues.

The infection control status of patients was assessed on admission. However, this information was not consistently documented in the patients' healthcare records viewed by inspectors. Inspectors were told that this information was accessible either from the patients' referral form or on the electronic patient information management system. There was no single room with ensuite bathroom facilities available for patients requiring isolation. This risk was not recorded on the risk register, but the centre had controls in place to minimise associated risks. The hospital had an outbreak of COVID-19 in September 2024, and evidence of outbreak management in line with national guidance and the completion of an outbreak report was provided to inspectors.

Medication safety in Lisdarn Centre was supported by a medication management policy. There were lists of sound-alike look-alike medications (SALADs) and high-risk medications, in the A-PINCH[‡‡‡] format, available on the ward. There were forcing functions in place for example, high-risk medications were not stored as stock items to

[‡‡‡] A-PINCH 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.

reduce the risk of high-risk medication error. Two-person checks were required for high-risk medications such as insulin and other injectable medicines. Medicines were stored in a secure manner. Staff could access information about medication using an approved application and through the Cavan Monaghan Hospital intranet, and the information was available electronically at the point of medicines preparation.

A pharmacist from Cavan General Hospital came onsite one to two times per week and staff informed inspectors that they could contact the pharmacy department in the hospital if they had any queries. Medication reconciliation[§§§] was undertaken on admission by the pharmacist and medical registrar for patients who did not have medication reconciliation undertaken in Cavan Monaghan Hospital. Cross checking of prescribed medication against the patients' discharge prescription was undertaken by nurses for patients admitted out of hours. However this process was not formalised or included in medication guidelines or policies viewed by inspectors. Arrangements were in place for accessing medications out of hours and staff were knowledgeable about that process. Cross checking of prescribed medicines was also undertaken prior to discharge by the medical registrar, which was confirmed by staff members.

The centre had introduced the INEWS in 2022, with a clear escalation process in place for a deteriorating patient. Both medical and nursing staff who spoke with inspectors were knowledgeable on the escalation processes in place for the deteriorating patient. A patient's sudden deterioration or medical emergency was managed through emergency ambulance calls. Contact details for required services were observed clearly displayed on the ward. Staff spoken with were able to describe the procedures in place. Anaphylaxis training was not included in the mandatory training schedule and was identified by inspectors as a potential area for improvement since intravenous medication was administered in the centre. Hospital management told inspectors that this would be reviewed following this inspection.

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services such as the use of a standardised referral form. Inspectors observed evidence that discharge summaries were completed and sent to the patients' general practitioner. Inspectors reviewed evidence that the escalation of a deteriorating patient was supported by the use of the Identify, Situation, Background, Assessment, Recommendation (ISBAR) communication tool and that patients' early warning scores were discussed at safety pauses. Clinical handover was undertaken using the ISBAR format, and inspectors saw evidence of this in use. Staff had access to radiology and laboratory results electronically.

Management reported that referrals were reviewed in advance of admission to ensure all admissions aligned with the centre's admission criteria. Predicted discharge dates were

[§§§] 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.

determined and reviewed at the weekly multidisciplinary team meetings. Transfer and discharge letters were electronically generated from the electronic patient information management system.

Overall, the service provider protected service users from the risk of harm associated with the design and delivery of healthcare services relevant to the size and scope of the services provided in the unit. However:

- The infection control status of patients on admission was not consistently recorded in the healthcare records viewed by inspectors.
- The process of cross checking prescribed medications against the patients' discharge prescription on admission out of hours was not included in medication policies viewed by inspectors.
- Anaphylaxis training was not included in the mandatory training schedule.

Judgment: Substantially compliant

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

Lisdarn Centre had systems in place to identify, manage, respond to and report on patient-safety incidents, in line with national legislation, standards, policy and guidelines.

Staff who spoke with the inspectors could clearly outline how to report and manage patient-safety incidents. Inspectors saw evidence of clear reporting pathways for medication errors in Lisdarn Centre. Staff were knowledgeable about patient-safety incident reporting pathways. All patient-safety incidents were uploaded onto the National Incident Management System (NIMS), with 99% of 2024 incidents year to date uploaded within 30 days, compliant with the HSE target.[****] There was evidence that local and CHO 1 management had oversight of the management of incidents. Reports and meeting minutes reviewed showed evidence that reported incidents were tracked and trended by the quality and patient safety advisor for CHO 1.

The Senior Incident Management Team for Older Persons Services CHO 1 reviewed and managed all category 1 incidents[††††] and serious reportable events. Meeting minutes and reports reviewed by inspectors evidenced that concise reviews commissioned for Lisdarn Centre were closed within appropriate timelines.

[****] HSE target that 70% of reported incidents are entered onto NIMS within 30 days of notification of the incident.
[††††] Category 1 incident - clinical and non-clinical incidents rated as major or extreme as per the HSE's Risk Impact Table.

Inspectors reviewed the incident management analysis reports for Lisdarn Centre for 2023 and 2024 year-to-date which provided detailed analysis of incident categories and sub hazard types, including data on medication errors and pressure ulcer stages. Overall, the centre effectively identified, managed, responded to patient-safety incidents relevant to the size and scope of the centre.

Judgment: Compliant

Conclusion

An announced inspection of Lisdarn Centre was carried out to assess compliance with 11 national standards from the National Standards for Safer Better Health. Overall, the inspectors found good levels of compliance with the national standards assessed.

Capacity and Capability

The Lisdarn Centre had governance arrangements in place for assuring the delivery of high quality, safe and reliable healthcare which were appropriate for the size, scope and complexity of the centre. Terms of references reviewed for some committees did not accurately reflect the practical operation of those committees. There were effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services. There were opportunities to formalise and ensure staff were aware of arrangements in place with regard to support from both Cavan Monaghan Hospital and CHO 1. There were systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of services provided. Workforce arrangements in the unit were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare

Quality and Safety

Staff and management in the unit made every effort to ensure their patients dignity, privacy and autonomy were respected and promoted. However, this was challenging in an environment with no ensuite facilities for patients requiring isolation. Management and staff promoted a culture of kindness, consideration and respect. The hospital had systems and processes in place to respond effectively to complaints and concerns raised by people using the service. The physical environment did not fully support the delivery of high-quality, safe, reliable care and opportunities to improve oversight of cleaning were highlighted to management on the days of inspection. The centre protected service users from the risk of harm associated with the design and delivery of healthcare services with some opportunity for improvement identified and outlined in this report. The centre effectively identified, managed, responded to patient-safety incidents relevant to the size and scope of the service.

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	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	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.	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.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	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 1 – Compliance Plan

Service Provider's Response

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

Outline how you are going to improve compliance with this 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.

- The unit had no single room with ensuite bathroom facilities for patients with a suspected or confirmed infection that required transmission-based precautions.

  -A comprehensive assessment is carried out on each patient prior to admission. Patients who have a suspected or confirmed infection that require transmission based precautions are not deemed suitable for admission.
  -In the event of a patient developing an infection that requires transmission based precautions, individual equipment is supplied to the patient, for example commodes.
  -There are three single rooms available and their use is prioritised for patients who require transmission based precautions.
  A local Standard Operating Procedure has been developed in the Centre outlining this process.
  - Two Community Infection Prevention & Control Clinical Nurse Specialists and the Acute Infection Control Clinical Nurse Specialist Teams are available to support and advise the Centre's Management Team and staff in relation to any IPC issues / concerns / outbreaks etc. There are also two Infection Control Link Nurses working in the Centre who provide additional support and guidance to their colleagues and to patients in the Centre.

- There was significant wear and tear to the physical environment which impeded effective cleaning.
  Planned repair and décor works will commence in the Centre in January 2025. These works will be carried out in a two phased approach, commencing in Unit 2 and finishing in Unit 1. Works are due for completion in June 2025. This will ensure that the physical environment is conducive to effective cleaning.

- There was no formalised oversight for checking of cleaning.

  A new daily cleaning checklist commenced in the Centre on the 12th November 2024. This checklist is signed off by one of the Centre's Management Team or the most senior nurse on duty. This ensures Governance and oversight of the cleaning processes and practices in the Centre.

- There was ceiling mould in a store room.

The maintenance team have cleaned and painted the ceiling and tiles in this store room. The room was ready for use on the 7th November 2024.

- There was inconsistent use of the labelling system to identify equipment had been cleaned.
  A review has been carried out of the process for the labelling system in the Centre to identify equipment which has been cleaned. After each use equipment is cleaned and a green label applied which is signed and dated by the staff member who has cleaned the equipment and left ready for use.