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:	Belmullet Community Hospital, Rehabilitation and Community Inpatient Healthcare Service
Address of healthcare service:	Tallagh Belmullet Co. Mayo
Type of inspection:	Announced
Date(s) of inspection:	19 and 20 of September 2023
Healthcare Service ID:	OSV-005710
Fieldwork ID:	NS_0056

The following information describes the services the hospital provides.

Model of hospital and profile

Belmullet Community Hospital is a statutory hospital owned, managed by the Health

About the healthcare service

Service Executive (HSE) and under the governance of Community Health Organisation (CHO) 2.* Belmullet Community Hospital comprised 20 beds, 12 of which, at the time of inspection were open to admissions. This included 10 stepdown and or palliative beds and two respite beds.

Patients were admitted from Mayo University Hospital, Sligo University Hospital and Galway University Hospital.

A designated centre for older persons and a primary care centre were also onsite.

CHO2 and Community Healthcare West are interchangeable names for the same geographical area.

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 the Health Information and Quality Authority's (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, information submitted by the provider, unsolicited information and other publically available information.

During the inspection, inspectors:

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

* Community Health Organisation 2 area consists of the three counties of Galway, Mayo and Roscommon.
† Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare (2012)

- 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
19 September 2023 20 September 2023	09.00hrs – 17.00hrs 09.00hrs – 13.15hrs	Eileen O'Toole	Lead
		Nora O'Mahony	Support

Information about this inspection

An announced inspection of Belmullet Community Hospital was conducted on 19 and 20 September 2023.

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.**

Historically, the hospital was divided into two separate wards, a female and male side but because of bed closures both female and male patients were now cared for on one 13 bedded ward. The inspection team visited the 'Female side' which was the clinical area that contained the 12 beds that were currently open.

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

- Director of Nursing, Belmullet Community Hospital
- Acting Clinical Nurse Manager 2, Female side, Belmullet Community Hospital
- Nursing and Support staff, Female side, Belmullet Community Hospital

After the inspection, the inspection lead spoke with the General Manager, Community Health Organisation 2 (CHO2).

Acknowledgements

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

What people who use the service told inspectors and what inspectors observed in the clinical areas visited

The female side of the hospital was a 13-bedded ward (open to 12 admissions) consisting of two four-bedded rooms, one two-bedded room which was being used as a single room

‡ 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 improve 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

and four single rooms. The single rooms did not have en-suite bathroom facilities. At the time of inspection, 11 beds were occupied.

Inspectors spoke with patients accommodated on the ward and patients said that they were happy with the care they received and were very complimentary of staff and their time spent in Belmullet Community Hospital.

Inspectors observed that staff actively engaged with patients in a respectful and kind manner and ensured patients' needs were promptly met. The patients validated this observation in comments such as 'they are there for you' and 'obliging staff' and 'never met anything like here'.

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

Capacity and Capability Dimension

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

Inspectors were provided with organisational charts, setting out clear lines of accountability and responsibility in relation to reporting structures within Belmullet Community Hospital. The organisational charts also showed the governance, oversight and accountability relationship to the Head of Service for Older People in Community Healthcare West, Older People Services.

The General Manager reported to the Head of Service for Older People and the Older Peoples Service Manager reported to the General Manager. The director of nursing (DON) was responsible for the operational management of the hospital and reported directly to the Older Peoples Service manager. This position was vacant at the time of inspection and inspectors were informed that a candidate had been appointed and would be in post in October 2023. In the interim, the DON reported to the General Manager.

There were two posts for older people service managers' in CHO2. The services within CHO2 were divided by location with each manager responsible for ten of the twenty community hospitals and designated centres for older persons within CHO2. Belmullet Community Hospital was in the Mayo Roscommon area, which had three community hospitals and seven designated centres for older persons.

A quality, safety and service improvement (QSSI) organogram was submitted, as part of the pre-onsite documentation, data and information request which detailed the community health organisation (CHO)2 reporting structure from the key personnel into the Head of

Service. As part of the QSSI structure, the quality and patient safety manager, quality improvement officer, complaints manager, consultant microbiologist, principal social worker and service improvement pharmacist all reported to the Head of Service at CHO2 level.

An organisational chart was not available for reporting committees within the CHO2. The community hospitals were represented by a designated director of nursing (DON) on committees and were reported as being responsible to bring any issues from all of the community hospitals to the committee and to feedback to the DON's following committee meetings. On speaking with CHO2 management, there was an acknowledgement that this process was not functioning as anticipated. At the time of HIQA's last inspection in July, 2020, the lack of dissemination of minutes of meetings within the CHO2 was also highlighted as an area for improvement.

At the time of inspection, there was no committee dedicated to the governance and oversight of medication safety practices across primary and social care within CHO2. An audit had been completed across CHO2 with regards to medication safety practices. The report was awaited at the time of inspection. It was expected that the report would finalise the actions required to formalise the governance structure around medication management within the CHO2.

A local general practitioner (GP) was contracted by the HSE as a medical officer to provide clinical care to the patients. The medical officer visited the hospital daily Monday-Friday and was available by phone during the hours of 9am to 6pm. There was an out-of-hours medical service available by the formation of an on-call system which comprised of local GP's or the local after-hours GP service, Westdoc.[††]

The DON was supported in their role by an acting clinical nurse manager, level 2 (CNM2). Nursing and support staff within the hospital reported to the acting CNM2. The health and safety officer, administrative staff and catering chef reported directly to the DON. Allied health professionals that were provided by an agency also reported to the DON while on site in the hospital.

At Community Healthcare West/CHO2 level

Quality and Safety Committee-Community Healthcare West, Older People Services

The quality and safety committee was a multidisciplinary team who had responsibility for the development of a quality and safety programme for the older people's service supporting continuous quality improvement. The committee had responsibility to oversee risk management processes including incidents and serious reportable events (SRE), audit activity and the implementation of recommendations from investigation and audit reports. The committee was chaired by the Head of Service and the community hospitals were

[††] Westdoc is an out-of-hours urgent GP service part funded by the HSE

represented by a DON representative from one of the four community hospitals in CHO2. The DON representative was responsible for circulating minutes of meetings to colleagues and to represent the issues from all the community hospitals at this forum. At the time of inspection, it was reported to HIQA that minutes were not circulated by the DON representative but that any actions or issues would be communicated by the older people service manager. From review of the minutes of the meetings submitted to HIQA it was evident that the committee followed a set structure of discussion and that the meetings were action orientated but no timeframes were assigned to actions.

Community Healthcare West (CHO2) Older People Services - Health and Safety Committee

The health and safety committee was set up to develop and implement a health and safety governance structure to enable implementation of health and safety requirements and to promote a positive safety culture throughout CHO2. This committee was responsible for the identification of trends in relation to incidents and dangerous occurrences which were categorised into biological, behavioural and physical. The committee was chaired by the General Manager and members included the human resources representative and service managers from older people's services. At the time of inspection minutes of meetings were not being circulated to DON's of other community hospital nor were items of concern or issues sought to bring forward to this forum. Communication to and from the DON's need to be improved for this committee to be effective. The terms of reference submitted to HIQA were not dated and it was unclear as to when the review was due. The committee met quarterly and would benefit from having time-bound actions assigned to an identified person.

Community Healthcare West, Infection Prevention and Control and Antimicrobial Stewardship Committee

The Community Healthcare West infection prevention and control (IPC) and antimicrobial stewardship committee was in place to ensure the effective management of infection prevention and control. The chairperson was the Head of Service, responsible for quality, safety and service improvement. Membership comprised of representation from the IPC team, public health medicine and the antimicrobial pharmacist. The community hospitals were represented by a DON from one of the four community hospitals and the feedback mechanism was the same as for the quality and safety committee. The terms of reference was under review and was not available to view at the time of inspection. The committee met quarterly and minutes reviewed showed that the meetings followed an agenda, actions were assigned to a responsible person but it was not always clear that actions were time bound. Minutes reviewed showed that the committee received updates from each service area, IPC and antimicrobial stewardship.

CHO2 Older People Services - Serious Incident Management Team

The serious incident management team (SIMT) was responsible for ensuring that there was effective structures and oversight of all serious incidents and serious reportable events (SRE) that occurred in services within CHO2. Serious incidents and SREs were managed in line with the HSE's incident management framework. The committee met weekly, was chaired by the Head of Service for older people and membership of the committee was multidisciplinary. A representative from the service where the incident occurred attended as relevant. Minutes of meetings submitted to HIQA detailed discussion of an SRE that occurred in Belmullet Community Hospital and showed that the SIMT discussed the action plan and outcome and that learning for staff and for other community hospitals was considered.

Management Operations/Director of Nursing Meeting

A monthly meeting was chaired by the service manager for older people, with representation from CHO2 for the Mayo and Roscommon area with DON's from the three community hospitals and the seven designated centres for older persons. This forum was used for feedback from all other CHO2 committees and any relevant updates. Minutes reviewed showed safeguarding, quality and risk and health and safety (including risk register) as items discussed. It was unclear if there was an agenda or terms of reference for this committee. Every three to four months a regional meeting was scheduled which included the areas of Galway, Mayo and Roscommon and was chaired by the General Manager. The two service managers for older people attended alongside the DON's from the four community hospitals and the 16 designated centres for older persons in the region. Inspectors noted that the minutes would benefit from having clearly defined time-bound actions.

Infection Prevention and Control Link Practitioner Meeting

The IPC nursing team at CHO2 level had regular meetings with all IPC link practitioners. The acting CNM2 was the link practitioner for Belmullet Community Hospital. Link personnel could add items to the agenda as required to raise issues from their clinical area. Minutes reviewed showed that this forum was, in the main, an information sharing meeting and a forum to seek specialist IPC advice.

At hospital level

At hospital level, meetings between the DON and service managers for older people's services were not taking place due to the post being vacant but the DON liaised regularly by phone with the General Manager. These meetings should be recommenced once the new service manager for older people's service is in post.

Staff Nurse Meetings

The acting CNM2 held meetings with the staff nurse group. However, this meeting only occurred twice in the past year. Discussions at these meetings included staffing, IPC, incidents, results of audits, education and training. An unscheduled meeting was called

following a serious reportable event at the hospital where discussion around actions and learning were discussed. This is an example of good practice.

In summary, HIQA was not fully assured that Belmullet Community Hospital had corporate and clinical governance arrangements in place for assuring the delivery of high quality, safe and reliable healthcare. The feedback mechanism from community hospitals to and from committees at CHO2 level needs review and must be addressed to ensure communication is effective. There was no committee dedicated to discussing governance and oversight of medication safety practices across the CHO2. Meetings between the DON and line manager must recommence once the service managers for older people's services position is filled. All committees should have up-to-date terms of reference and committee minutes should have clearly defined, time-bound actions that are assigned to individuals.

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.

An effectively managed healthcare service ensures that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care and that there are necessary management controls, processes and functions in place.

Infection, prevention and control

The hospital had an IPC link nurse who provided guidance and training on matters concerning infection prevention and control to staff. The IPC link nurse joined the monthly meeting with the IPC team from CHO2 which provided the link nurse with updates and education and an opportunity to seek advice and direction in relation to any clinical matters. Advice and direction was also available as needed outside of these meeting times. The IPC team were also available to provide education sessions to staff at the hospital if required. Out-of-hours, staff nurses could access IPC advice from the acute hospital in the area.

The hospital had an antimicrobial stewardship link nurse in the hospital who attended relevant education sessions available and was responsible for the provision of feedback of relevant information to staff in the hospital. The link nurse was also responsible for collecting and inputting data, requested by the antimicrobial pharmacist, on a set of questions to provide a snapshot of antibiotic usage in the hospital. The hospital then receives a monthly point prevalence report from the antimicrobial pharmacist. Staff had access to an antimicrobial pharmacist if required but the antimicrobial pharmacist did not visit the hospital routinely except to deliver education. Nursing staff would discuss any

issues in relation to antibiotic usage with either the medical officer or the antimicrobial pharmacist.

Staff did not have access to a microbiologist but laboratory reports from the acute hospital would contain microbiologist advice.

Medication safety

CHO2 staff had access to two pharmacists, a service improvement pharmacist that joined the CHO2 in April 2023 and an antimicrobial pharmacist.

The hospital had a formal arrangement with an external pharmacy supplier who supplied patient specific medication over a six day service. Stock medications were supplied by two external pharmacies. Belmullet Community Hospital had a process in place to ensure that patients received correct medication for patients that were transferred in from another hospital, emergency admission from home and patients admitted for respite. Nursing staff undertook the checking of prescriptions against what the patient had been prescribed on discharge from the hospital. On discharge from Belmullet Community Hospital, the patient's GP received a discharge letter detailing the patient's medication requirements and the GP was then responsible for prescribing medication for home use from the time of discharge.

Deteriorating patient

Staff were aware of how to manage and care for a patient whose health status was deteriorating. In the event of a patient becoming acutely unwell and requiring transfer to an acute hospital, the nursing team, in consultation with the medical officer, or out-of-hours-service, arranged the patient's transfer by emergency ambulance to the accepting hospital. The hospital did not however, have a formal documented process in place to guide staff. Hospital management should ensure that the process to be followed in such instances is documented and subject to regular review.

Transitions of care

A local general practitioner (GP) was contracted by the HSE as a medical officer to provide clinical care to the patients. The medical officer visited the hospital daily Monday-Friday and was available by phone during the hours of 9am to 6pm. There was an out-of-hours medical service available by the formation of an on-call system which comprised of local GP's or the local after-hours GP service.

The DON and acting CNM2 were the first point of contact in relation to patient admissions and liaised with the medical officer in relation to all transitions of care. A member of the nursing staff was identified as the person responsible for decisions in relation to transitions of care out-of-hours. The hospital did not have formalised admission criteria. CHO2 identified a manager on-call as a senior person for staff to contact out of hours. The hospital, along with the other community hospitals in the area, had a weekly meeting

with the acute hospital to discuss plan of care for patients from their geographical area. Hospital management could liaise with the integrated discharge coordinator at CHO2 level if ongoing issues with discharge of patients. Hospital management should have agreed and documented admission and discharge criteria in place which clearly sets out the roles and responsibilities of the various staff disciplines involved in these processes.

In summary, HIQA was not fully assured that the hospital had management structures and monitoring in place for medication safety, the deteriorating patient or transitions of care. While staff demonstrated their knowledge and ability at the hospital, management should ensure that all processes are formalised, for example, admission criteria and staff have a reference point to underpin their decision making.

Judgment: Partially 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.

HIQA was not fully assured that the hospital, within the CHO2 structure, had monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Monitoring service performance

The hospital collected data on a range of measurements related to the quality and safety of healthcare services. Data was collected by the DON on the number of admissions and discharges, average length of stay, number of respite admissions, patient-safety incidents and workforce. Bimonthly, the DON sent the number of occupied beds to the service manager for older people which is the only metric reported into the CHO on a regular basis.

On the days of inspection, inspectors were informed that there were two patients with delayed transfers of care. Hospital management reported the lack of home help in the community as the greatest barrier to discharging patients.

Risk management

The hospital had risk management structures and processes in place to proactively identify, manage and minimise risks in clinical areas. The hospital's risk register was prepared by the DON and reviewed with the service manager for older people but there was no formal process outlined for this review process. The hospital had undergone a health and safety audit, after which, the quality and patient safety manager visited the site and reviewed the risk register with the DON. The outcome of the audit report and review of risk register was not finalised at the time of inspection. HIQA were informed

that the quality and patient safety manager at CHO2 level is currently reviewing the possibility of holding a separate risk register that would detail the complete escalated risks associated with the 20 community hospitals and designated centres for older persons.

Audit and monitoring activity

The hospital had a monthly audit plan that was, in the main, carried out by the acting clinical nurse manager 2 with oversight by DON. Audit and monitoring activity was not overseen or reported at a governance forum to ensure that opportunities for improvement were identified and actioned.

Management of serious reportable events and patient-safety incidents

The SIMT for older people had oversight of the management of serious reportable events (SRE) and serious incidents which occurred in all services under the remit of the CHO2. The SIMT were responsible for ensuring that all SRE incidents were managed in line with the HSE's Incident Management Framework. The SIMT was chaired by the Head of Service for older people, had representative membership and met weekly or more frequently if required. A service representative from where the incident occurred was required to attend.

Patient-safety incidents and serious reportable events were reported to the National Incident Management System (NIMS). Staff recorded incidents on paper which were escalated to the acting clinical nurse manager 2 and DON for review. Incidents were inputted according to administrative staff availability and hospital management could not confirm if the percentage of incidents inputted to NIMS within 30 days of date of notification was within the HSE's national target of 90%. Patient-safety incidents are discussed further under national standard 3.3.

Overall, inspectors were not assured that hospital management were identifying and acting on all opportunities to continually improve the quality and safety of healthcare services at the hospital. Hospital management should ensure that they have oversight and control of submission of incident data as per HSE target of 90% within 30 days. Opportunities for improvement were identified in relation to establishing formalised structures between the hospital and CHO2 to ensure that performance data is reviewed and overseen, the risk register is reviewed formally and audit is centrally controlled in order to promote quality management.

Judgment: Partially 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 high-quality, safe and reliable healthcare.

A local general practitioner (GP) was contracted by the HSE as a medical officer to provide clinical care to the patients. The medical officer visited the hospital daily Monday-Friday and was available by phone during the hours of 9am to 6pm. There was an out-of-hours medical service available by the formation of an on-call system which comprised of local GP's or the local after-hours GP service.

The director of nursing (DON) also had responsibility for the designated centre for older persons that was on the same site and so this was a shared post. The hospital's approved complement of nursing staff was 14.49 whole-time equivalent[‡‡] (WTE), including one clinical nurse manager 2. At the time of inspection, for the 12 beds open, the actual nursing staff complement and available to work was 10.79 WTE. There was a total of 0.9 WTE vacant position. Recruitment for this post was being processed by the Health Service Executive (HSE) recruitment process. Shortfalls in nursing rosters were covered with staff overtime and or on occasions the use of agency staff. There were no shortfalls in the nursing roster for the following week at the time of inspection.

The hospital were approved for 9.8 WTE support staff comprising 7.8 WTE healthcare assistants and two WTE multi-task attendants. From the 7.8 WTE healthcare assistants, 3.8 WTE were seconded to the designated centre for older persons. The decision for secondment was taken at CHO2 level and was not impacting on the community hospital based on the number of beds open at the time of inspection. The HCA's and multi-task attendants were assigned duties per shift, cleaning, caring or catering. Once assigned that role there was no cross-over of duties on that shift. A porter was on duty daily from 9am to 5pm or 6pm. A night porter, a position shared with the designated centre for older persons, covered duties related to laundry, waste disposal and security for two to three hours per night.

The palliative care team from CHO2 assisted with medication administration and advice, a tissue viability nurse from CHO2 visited as required and offered advice over the phone. Physiotherapy services were provided through an agency on a twice weekly basis and this was a shared service with the designated centre for older persons. Speech and language therapy was also accessed through an agency as required. There was no permanent funding available for these posts.

The hospital did not have any access to a dietetic service since September 2022 as the post was vacant and recruitment was ongoing. There were only two referrals to an agency for dietetic input from September 2022 to time of inspection and so deemed the impact to patient cohort to be minimal. Social worker services was accessed through different teams

‡‡ 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.

such as safeguarding team or psychiatric team but this service was not available to all patients in the hospital.

CHO2 management reported that they recognised the deficit to patients caused by the lack of permanent health and social care professionals. They report that they have sought funding for these roles in the past, were not successful and will continue to seek funding as funding streams become available to them. The deficit of dietetic input and social worker availability were on the hospital's risk register.

Staff training

It was evident from staff training records reviewed by inspectors that staff undertook multidisciplinary team training appropriate to their scope of practice every two years.

Training records provided to inspectors for the hospital demonstrated that improvements are required relating to compliance with staff training among nurses across a number of areas, in particular medication safety education (14% compliance) and outbreak management (33% compliance). Records also showed that just 60% of nursing staff had undertaken their standard based precaution and transmission based precaution training (HSE target is 90%).

Records provided showed that HCA's compliance for hand hygiene (75%) was also below the HSE target of 90%, improvements are required in all areas of training for this cohort of staff with the exception of basic life support.

Compliance with infection prevention and control training for housekeeping and cleaning staff was 50%. Records provided showed that the medical officer and physiotherapist (agency) were 100% compliant with all mandatory training.

Nurse management informed inspectors that their current system for recording the uptake of key and essential training at the hospital did not facilitate effective oversight of staff training compliance and needed review.

It is essential that hospital management ensure that all clinical staff have undertaken key and essential training appropriate to their scope of practice and at the required frequency, in line with national standards. This issue should represent a key focus for early improvement efforts following HIQA's inspection. The hospital should continue to review health and social care professional resourcing, in particular dietetic support to ensure the service meets the needs of patients.

Judgment: Partially compliant

Quality and Safety Dimension

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

Staff promoted a person-centred approach to care and were observed by inspectors to be respectful and caring towards patients whilst also maintaining their dignity and privacy.

Inspectors noted that staff actively engaged with people using the service throughout the inspection and they were observed being kind and caring in those interactions. Inspectors heard staff communicating with people using the service in relation to their needs and preference, ensuring that patients had all they required. Patients who spoke with inspectors reported that staff immediately responded to their needs and requests.

At the time of inspection there was no gender mix observed and hospital management informed inspectors that mixed-gender bays were not permitted.

The infrastructure layout did not fully support dignity and privacy as the communal sitting area, and a single room had to be accessed through one or other of the four-bedded bays. The single room opened out directly into this communal area and a toilet and showers facility had to be accessed through the communal area. This is further discussed in standard 2.7.

There were no en-suite facilities in any of the single or multi-occupancy rooms. Patients that required isolation for infection prevention and control reasons did not have en-suite facilities and so toileting and personal hygiene was undertaken by the bedside.

Curtains were supplied around each bed and were drawn appropriately. Patients' personal information in the clinical areas visited, during the inspection, was observed to be protected and stored appropriately.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital and this is consistent with the human rights-based approach to care promoted by HIQA.[§§]

Judgment: Substantially compliant

[§§] Health Information and Quality Authority. *Guidance on a Human Rights-based Approach in Health and Social Care Services*. Dublin: Health Information and Quality Authority. 2019. Available online from: https://www.hiqa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services

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

Overall, it was evident that a culture of kindness and consideration was actively promoted by all staff. This was validated by patients who spoke with inspectors. Staff were described by patients as 'extraordinarily good' and 'first class'.

Patients were communicated with in a kind sensitive manner in line with their expressed needs and preferences. Inspectors, whilst speaking to patients found that most patients mentioned their satisfaction with the individualised care they were receiving saying that staff 'will stand and listen to you' and 'they are there for you'.

The hospital had arrangements in place to facilitate access for patients to independent advocacy services where required and leaflets on these independent services were on display.

Overall, HIQA were assured that hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital.

Judgment: Compliant

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

The DON was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. There was a culture of local complaints resolution in the clinical area visited. There was a complaints manager within the CHO2 QSSI structure who the DON could access for support if required.

All written and verbal complaints were recorded, and a log was maintained by the DON. In 2023, year to date, the hospital received one written complaint and three verbal complaints. The written complaint was in relation to accessing the service. When staff receive verbal complaints they attempt to resolve locally and escalate to the acting clinical nurse manager 2 and DON.

Inspectors were informed that management had a programme in place for all staff to attend training on how to assist people in making a complaint. At the time of inspection 42% of nursing staff, 25% of HCA's and 50% of housekeeping/cleaning staff had attended the training. Leaflets on 'Your Service Your Say' and advocacy services were observed in the hospital.

Hospital management described and gave examples of good practice of initiating actions from complaints, updating the complainant and sharing the learning from the complaint with staff. Minutes from staff meetings that were reviewed by inspectors showed quality and safety as a standing agenda item but there was no evidence of discussion or learning shared with regards complaints received which is an opportunity for improvement. There was no evidence that complaints or compliments were reported to or shared with CHO2. This presents an opportunity for improvement following this inspection.

Overall, HIQA were assured that the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service.

Judgment: Substantially Compliant

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

On the days of inspection, inspectors visited the clinical area and observed that overall the hospital's physical environment was clean and tidy with few exceptions. There was evidence of general wear and tear which did not facilitate effective cleaning. Exposed wood was seen on doors, some sink surrounds were in need of refurbishment and there was damaged paintwork in store rooms and verbal complaints received by staff are escalated immediately to the DON and acting in the cleaner's room.

Following the last HIQA inspection in July 2020, inspectors were informed that a maintenance plan was put in place for all the identified infrastructure improvements required and that these issues were not completed at time of this inspection. Inspectors were informed that some improvements were completed, for example, the flooring on the female side of the hospital, was replaced and now intact. There was evidence of on-going maintenance work and painters were on site on the last day of inspection.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the clinical areas. Inspectors noted that not all hand hygiene sinks throughout the unit conformed to national requirements.[***] At the time of the last inspection in July 2020, there was one sink that conformed to national requirements and this had improved to five sinks in 2023.

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

Inspectors were informed that the maintenance team were slowly progressing the further replacements required. There was no hand hygiene sink in the 'pharmacy' room or treatment room which was used for medication preparation.

Physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms. Infection prevention and control signage in relation to transmission based precautions was observed in the clinical area visited.

Environmental and equipment cleaning was carried out by dedicated cleaners and multi-task attendants. Equipment was observed to be clean and there was a green tagging system in place to identify equipment that had been cleaned. Checklists and lists of cleaning duties were observed by inspectors.

Hazardous material and waste was safely and securely stored in each clinical area visited. Appropriate segregation of clean and used linen was observed. Used linen was stored appropriately.

The hospitals infrastructure and layout required improvement. The communal sitting area and a single room had to be accessed through one or other of the two four-bedded bays. A single room opened out directly into the communal area, and one of the two showers had to be accessed from this communal area. There were no en-suite facilities for single rooms or multi-occupancy rooms. The communal area was reported to have minimal usage due to its layout and inspectors noted that it was being used for storage of some patient equipment.

One of the single rooms was noted to be small in size which may limit access to a patient for an emergency intervention should it be required. Inspectors were informed that this room was used infrequently and hospital management were advised to carry out a risk assessment prior to using the room for patient care.

Patients who required isolation for transmission-based precautions were accommodated in a single room. If there were no single rooms available within the 13 bedded female side the patient would then be accommodated on the 'male' side of the hospital in the most suitable room. The nursing staff had risk assessed the suitability of placing patients away from the main clinical area but this process was not formalised. Hospital management need to ensure that risk assessments are documented and retained.

All patients were assessed on admission for safety of environment and if confused or unable to maintain their own safety then a wrist transmitter was placed on their wrist. This system triggered alarms and locked monitored doors to safeguard patients at risk of wandering.

In summary, HIQA was not fully assured that the physical environment comprehensively supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care. There were limited toilets, showering and en-suite facilities for patients. The medication management room did not contain a hand-hygiene

sink and not all not all hand hygiene sinks throughout the unit conformed to national requirements. There were ongoing refurbishment requirements, use of clinical area as a thoroughfare and suboptimal location of the communal area.

Judgment: Partially compliant

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

HIQA was not fully satisfied that the hospital management had systems and processes in place to monitor, analyse, evaluate and respond to information from multiple sources in order to inform continuous improvement of services. There was no evidence that the audit plan or audit results were reviewed or evaluated at any governance forum.

Infection prevention and control monitoring

Assurance as to the effectiveness of the infection prevention and control systems and processes were provided through audit of hand hygiene compliance, environmental audit, commode audit, mattress audit, furniture audit and staff flu vaccination levels.

Environmental audits were carried out twice a year by the acting CNM2. While there were areas for potential improvement noted, there were no time bound action plans developed or responsible persons identified. Hospital management need to ensure completion of the audit cycle to ensure that improvement to practice and services occur. At the last HIQA inspection in July, 2020 the deficit of comprehensive auditing with the lack of appropriate action plans in place was also highlighted as a concern. The IPC clinical nurse specialist from CHO2 had carried out an environmental audit in June 2022 and reported a number of incidental findings that the audit tool did not identify. Inspectors were informed that feedback on standardising the audit tool was yet to be received by the hospital from the IPC team. The hospital management should pursue the feedback following this inspection.

Hand hygiene compliance was carried out every three months. Audit findings did not demonstrate any improvement in compliance with limited action plans or interventions to improve compliance.

Furniture and mattress audits were carried out yearly with replacements of equipment as necessary. Commode audits were carried out twice a year and actions were identified but were not time bound or assigned to an individual.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital. Medication chart audits which included audit of drug fridge temperature monitoring were carried out twice or three times a year. Audit results were again noted

to have actions which were not time bound or assigned to an individual and no evidence of implementation of actions to improve practice was seen by inspectors.

The quality improvement pharmacist had undertaken an audit of medication practices in the hospital in May 2023. This audit was part of a CHO2 wide audit and the hospital had not yet received any action plan related to that audit at the time of inspection. This should be followed up by the hospital management to progress.

Deteriorating patient monitoring

Staff were aware of the process to follow for the management and escalation of patients who deteriorated and required transfer to an acute care facility. This process was not formally documented and available to staff in the clinical areas. There was no audit or evaluation of the process of escalation.

Transitions of care monitoring

The DON collected data on the number of admissions, patient discharges and length of patient stay, data which was not shared with CHO2. The hospital did not have documented admission criteria but hospital management and staff spoken to clearly identified the patient cohort that was accepted in the hospital.

Discharge documentation audit was carried out twice a year which included auditing of six discharges over the previous two months. Audit of the discharge date identified on admission and on the integrated discharge plan completed on admission were part of the audit process. While there were areas for potential improvement noted, there were no time-bound action plans developed or responsible persons identified and no evidence of implementation of actions to improve practice was seen by inspectors.

Overall, HIQA acknowledged that hospital management had some systems in place to monitor and evaluate healthcare services and were working hard to ensure that the patients received good quality care. Inspectors were not fully assured that the audit cycle was effective in demonstrating how audits were supporting changes or improvements. Many of these deficits were already highlighted in a previous inspection and have yet to be fully addressed. Hospital management needs to ensure that recommendations and areas for improvement identified by all audit and monitoring activity have time-bound action plans in place with re-audit plans to ensure improvement in practice occurs.

Judgment: Partially compliant

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

The hospital had some systems in place to identify and manage risks. Risks in relation to the service were recorded on a risk register and reviewed regularly by the DON with the service manager for older people.

Inspectors reviewed the hospital's risk register of which there was a total of 10 risks actively open on the register. Risks reviewed had owners assigned and controls and actions in place to manage and reduce recorded risks. There was evidence that risks and associated controls were being regularly updated.

Infection prevention and control

There was a risk on the risk register relating to risk of infection as areas were difficult to clean due to damaged paintwork and flooring. The surrounds on some sinks were water stained and there was damaged tiles in bathrooms.

Additionally, there was limited number of staff in the hospital that could access patients' laboratory results via laboratory web enquiry. This posed a risk to the patients as not all key clinical staff could access information in relation to their patients' blood and microbiology results, blood transfusion, histopathology and point of care. This issue was highlighted as a risk to hospital management at the time of inspection. Hospital management need to ensure that sufficient relevant personnel have access and are competent in retrieval of laboratory results as required for safe patient care at all times.

The hospital had a process in place to prevent legionella. While annual testing was undertaken in the hospital, records of preventative actions including flushing were not overseen or signed by hospital management. This needs to be addressed by hospital management.

Inspectors were informed that prior to transferring to the hospital, patients' infection status was assessed as part of the referral process and nursing referral letters viewed confirmed this. At the time of transfer, the patients' infection status was again assessed at handover and patients were assessed for signs of respiratory symptoms.

The hospital recently experienced two confirmed outbreaks of COVID-19 in April and May 2023. The IPC team were alerted immediately and advice sought. Outbreak management teams were convened in response to these outbreaks and outbreak reports were completed in line with national guidelines. Outbreak reports reviewed by inspectors outlined control measures implemented, key learnings and specific recommendations made by the IPC team.

Medication safety

A risk related to medication safety following a patient's transfer from an acute hospital was on the risk register. This risk related to the potential delays or omission of medication when the patients prescription was not sent to the community hospital in a timely manner prior to transfer. Hospital management were discussing their issues with the hospitals

concerned, involving staff in the process to ensure patients receive their medication on time and tracking the incidence of issues.

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

Inspectors were informed that formalised medication reconciliation [†††] was not routinely carried out in the unit. Nursing staff undertook a process of cross checking what the medical officer prescribed against the prescription from the acute hospital. The lack of medication reconciliation was not recorded on the risk register.

The hospital had access to an antimicrobial pharmacist and IPC team at CHO2 level if required. The hospital did not have access to any out-of-hours pharmacy service but did not accept admissions on Sundays or out-of-hours in the main. Staff spoken to were knowledgeable about the process of managing patient own medications in the event of an emergency admission out-of-hours. However, no formalised policy was in place for use of patient own medications and this presents an opportunity for improvement.

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

Deteriorating patient

As outlined in national standard 2.8, staff were aware of the process to follow for the management and escalation of patients who deteriorated and required transfer to an acute care facility. This process was not formally documented to guide staff in the clinical areas. The risk of harm to patients due to deterioration in clinical condition was identified as a risk on the risk register. Actions associated with this risk included staff undertaking training in relation to use early warning systems[‡‡‡] and clinical handover tool ISBAR$_3$.[§§§] The HSE Early Warning Systems used in acute care were not designed for and currently do not apply to the rehabilitation and community inpatient healthcare services.

Safe transitions of care

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services and support safe and effective

[†††] 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.
[‡‡‡] Early Warning Systems include: Irish National Early Warning System (INEWS) (adults), Irish Maternity Early Warning Systems (IMEWS) for use on all women who are currently pregnant or who have given birth or had a miscarriage within the previous 42 days and the Paediatric Early Warning systems (PEWS) (children).

[§§§] ISBAR3 Communication Tool for Inter-departmental Handover- Identify, Situation, Background, Assessment, Recommendation

discharge planning. The unit had transfer and discharge templates to facilitate and strengthen safe transitions of care. Discharge dates were identified on admission and an integrated discharge plan was initiated at time of admission. Discharge documentation also included a checklist 24 hours prior to discharge and a day of discharge checklist. A risk assessment was undertaken by hospital management in relation to risk of harm to patients during transition of care which listed the existing controls in place, no additional actions were identified.

Policies, procedures and guidelines

The hospital, in the main, utilised the national HSE community infection, prevention and control manual to guide their staff on standard and transmission based precautions and equipment decontamination.

The hospital utilised the CHO2 medication management policies which included guidelines on prescribing and administration of medication, high alert medicines and 'sound alike, look alike' drugs. The Irish Medicines Formulary (IMF) could be accessed by staff at the point of care. Intravenous medication was not administered in the hospital. On occasions, intramuscular antimicrobial therapy was given to patients receiving a palliative care**** approach to prevent admission to an acute hospital. The antimicrobial pharmacist was aware of this practice.

All policies, procedures, protocols and guidelines were accessible to staff via hard copy.

In summary, HIQA was not satisfied that the hospital had systems in place to identify and manage potential risk of harm. Hospital management should ensure that the risk register contains all risks that require monitoring and further action. Hospital management need to ensure that sufficient relevant personnel have access and are competent in retrieval of laboratory results as required for safe patient care at all times. This must be a key priority for hospital management following this inspection. Hospital management must oversee all risks and ensure compliance with agreed course of action as in the case of prevention of legionella. Hospital management need to ensure that formalised policies are in place for staff to support their decision making.

Judgment: Partially compliant

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

**** Palliative care is an approach that improves the quality of life of people facing the problems associated with life-limiting illness. The palliative care approach focuses on the prevention and relief of suffering by means of assessing and treating pain and other physical, psychosocial or spiritual problems.

The hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. Clinical incidents were reported on a paper-based system and then discussed with the acting CNM2 and or DON. Clerical officers were then responsible for inputting these on the National Incident Management System (NIMS). Inspectors were informed that if the incident resulted in patient harm the clerical officer then prioritised inputting. Other incidents were inputted according to the availability of the clerical officer and hospital management could not articulate if the percentage of incidents created within 30 days of date of notification was within the HSE's national target of 90%. Incidents were also escalated to the serious incident management team (SIMT) if required and a multidisciplinary team met weekly to discuss the action plan and outcome.

The hospital tracked and trended patient-safety incidents for the hospital since the start of 2023. Prior to 2023, incidents from the community hospital and the designated centre for older persons were combined. A total of 32 incidents was reported in the first six months in 2023, 37% were related to falls while 34% were related to IPC issues, in the main, COVID-19 related. Hospital management outlined quality improvement initiatives introduced in relation to the tracking and trending of falls incidents. There were no medication management incidents reported in the first six months of 2023. Hospital management should consider the possibility of under reporting and the potential for the requirement of further education for staff.

Staff who spoke with HIQA were knowledgeable about how to report a patient-safety incident and were aware of the most common patient-safety incident reported — falls. Staff meeting minutes reviewed evidenced that patient-safety incidents were tracked and trended and discussed at hospital level. Hospital management also reported that incidents were also discussed at handover time with nursing staff. There was no evidence that incidents that occurred in Belmullet Community Hospital were discussed at any management level meetings except those that were escalated to SIMT.

Overall, HIQA was satisfied that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents. Hospital management should however, ensure that they have oversight and control of inputting of incidents as per HSE target of 90% within 30 days. It is important that hospital management continue to track and trend incidents in relation to the community hospital as a separate entity in order to identify the emerging themes. An absence of medication error is not in itself an assurance of safety and hospital management need to consider the possibility of under-reporting and actions required to ensure all incidents are reported in a timely manner. There was evidence that the Senior Incident Management Team had oversight of serious incidents and reportable events.

Judgment: Substantially compliant

Conclusion

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

Capacity and Capability

HIQA was not fully assured that Belmullet Community Hospital had corporate and clinical governance arrangements in place for assuring the delivery of high quality, safe and reliable healthcare. The feedback mechanism from community hospitals to and from committees at CHO2 level needs review for effective communication. There was no committee dedicated to discussing governance and oversight of medication safety practices across the CHO2. A number of committee's minutes would benefit from having clearly defined, time-bound actions that are assigned to individuals.

HIQA was not fully assured that the hospital had management structures and monitoring in place. Hospital management should ensure that all processes are formalised to ensure that staff are supported in their decision making.

The hospital did not have systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality and safety of all services. Hospital management should ensure that they have oversight and control of inputting of incidents as per HSE target of 90% within 30 days. Opportunities for improvement were identified in relation to establishing formalised structures between the hospital and CHO2 to ensure that performance data is reviewed and overseen, the risk register is reviewed formally and audit is centrally controlled in order to promote quality management.

The hospital had workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. Staff attendance at and uptake of mandatory and essential training was identified as an opportunity for improvement particularly in relation to medication safety and outbreak prevention.

Quality and Safety

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

The hospital's physical environment did not fully support the delivery of high-quality, safe, reliable care to protect people using the service. There was no en-suite facilities for patients. Infrastructural issues identified at a previous inspection conducted by HIQA in

July 2020 continued to have the potential to impact on IPC measures and were still being progressed by hospital management.

HIQA acknowledged that hospital management had some systems in place to monitor and evaluate healthcare services and were working hard to ensure that the patients received good quality care. HIQA were not assured that there was effective oversight of the monitoring of the quality and safety of service provided to patients. The hospital should ensure that all staff can access laboratory results and have the ability to access relevant timely patient information to support the delivery of safe and effective care.

HIQA was satisfied that there was a system in place at the hospital to identify, report, manage and respond to patient-safety incidents in relation to the four key areas of known harm.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in relation to compliance with key and essential training and improvements of the physical environment at the hospital.

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

Compliance classifications

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

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

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

Capacity and Capability Dimension	
Overall Governance	
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.	Partially 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.	Partially Compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially Compliant

Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	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.	Substantially Compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially Compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant

Compliance Plan for Belmullet Community Hospital

Rehabilitation and Community Inpatient Healthcare Service

Inspection ID: NS_0056

Date of inspection: 19 and 20 of September 2023

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 standard. This should clearly outline:

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

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

1. Organisational chart for reporting committees within the CHO2 to be devised and made available to DONS within CHO2.
2. Health and Safety, Quality and Safety and Infection Prevention and control committees to share minutes of the meetings with DONS directly in CHO2 from December 2023.Circulars and updates are sent routinely to DONs at present on these matters.
3. Health and Safety, Quality and Safety, Infection Prevention and control, Management Operations/Director of Nursing meeting minutes to implement clearly defined time bound actions for completion as well as terms of reference.
4. 1:1 Meeting with DON and Manager Older peoples now scheduled monthly from December 2023 as new Manager of OPS in post.
5. CHO 2 West will review the recommendation on the creation of a Medication Management Committee in the context of existing committees and supports. A decision will be made by end of February 2024.

Timescale:

29th February 2024

National Standard	Judgment
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially Compliant
Outline how you are going to improve compliance with this standard. This should clearly outline: (a) details of interim actions and measures to mitigate risks associated with non-compliance with standards. (b) where applicable, long-term plans requiring investment to come into compliance with the standard 1. We are developing a Deteriorating Patient Algorithm. This will be made available to staff to formally guide staff in actions to take when a patient's condition changes. 2. Admission and discharge criteria are now in use to assist staff in decision making for admission.	
Timescale: 31st January2024	
National Standard	**Judgment**
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.	Partially Compliant
Outline how you are going to improve compliance with this standard. This should clearly outline: (a) details of interim actions and measures to mitigate risks associated with non-compliance with standards. (b) where applicable, long-term plans requiring investment to come into compliance with the standard 1. Revised arrangements in place to Monitor and Audit Incident reports to ensure upload to NIMS within 30 days. 2. Audit results and actions arising to be highlighted and on Agendas of Governance and Staff meetings to ensure improvement opportunities are actioned.	
Timescale: 31st December 2023	

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

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

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

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

1. Staff training Matrix in place and reviewed monthly to bring all staff into compliance with training requirements with the unit.
2. Sourcing dietetic advice from suppliers of food supplements in the interim while awaiting CHO2 allocation of named dietician to location.

Timescale:

28th February, 2024

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

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

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

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

1. Hand hygiene sinks on order and awaiting delivery. Once delivered maintenance will install hand hygiene sink in pharmacy area and replace existing sinks in patient clinical areas.
2. Risk assessment in place in the event a patient was placed away from the main clinical area such as the palliative care room on male ward.
3. The communal area on female ward is not used as sitting area.

4. There is ongoing planning with estates and management to upgrade and renovate the existing Belmullet District Hospital. At present, CHO 2 West is unable to confirm an exact timeline for same.

Timescale:
31st March 2024

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

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

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

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

1. Audits in future to be carried out using audit cycle with time bound improvement plans and evaluation closing the audit loop. We will allocate responsibility for actions. Re-auditing, both internal and external will be undertaken to ensure improvements and compliance.
2. Audit results and actions identified to be highlighted in Governance and Staff meetings to ensure awareness of improvement opportunities. Results and actions will be circulated to staff.

Timescale:
31st December 2023

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

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

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

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

1. Nursing staff will be provided with laboratory access.

2. Lack of medication reconciliation is now recorded on our risk register. 3. Current medication chart is being revised to include a medication reconciliation checklist. 4. Patients own medication standard operating procedure to be developed for use in the event of out of hour's emergency admission. 5. Legionella preventative action i.e. weekly flushing to be on put on porter schedule formally to ensure consistency and continuity. Flushing records to be countersigned by person in charge and reviewed by management.
Timescale: 29th February 2024