Report of the unannounced inspection at St. Columcille’s Hospital, Loughlinstown, Co Dublin.

Monitoring programme undertaken against the National Standards for the prevention and control of healthcare-associated infections in acute healthcare services

Date of on-site inspection: 21 June 2018
About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent authority established to drive high-quality and safe care for people using our health and social care services in Ireland. HIQA’s role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.

HIQA aims to safeguard people and improve the safety and quality of health and social care services across its full range of functions.

HIQA’s mandate to date extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has statutory responsibility for:

- **Setting Standards for Health and Social Services** — Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.
- **Regulation** — Registering and inspecting designated centres.
- **Monitoring Children’s Services** — Monitoring and inspecting children’s social services.
- **Monitoring Healthcare Safety and Quality** — Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment** — Providing advice that enables the best outcome for people who use our health service and the best use of resources by evaluating the clinical effectiveness and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion and protection activities.
- **Health Information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information about the delivery and performance of Ireland’s health and social care services.
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1.0 Introduction

HIQA monitors the implementation of the *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services*¹ in public acute hospitals in Ireland to determine if hospitals have effective arrangements in place to protect patients from acquiring healthcare-associated infection. The *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services* will be referred to as the National Standards in this report.

In 2017, HIQA commenced a revised monitoring programme against the National Standards. The aim of this revised monitoring programme is to assess aspects of the governance, management and implementation of designated programmes to prevent and control healthcare-associated infections in hospitals. This monitoring programme comprises Phases One, Two and Three which will be described next.

The National Standards were updated in 2017 and therefore supersede the previous version. Hospitals should work towards implementing these revised National Standards.

**Phase One**

All public acute hospitals were requested to complete and return a self-assessment tool to HIQA during April and May 2017.

The hospital Chief Executive Officer or General Manager and the Health Service Executive (HSE) Hospital Group Chief Executive Officer were asked to verify that the information provided to HIQA accurately reflected the infection prevention arrangements within the hospital at that time.

**Phase Two**

Using a revised assessment methodology HIQA commenced a programme of unannounced inspections against the National Standards in public acute hospitals in May 2017.

Specific lines of enquiry were developed to facilitate monitoring in order to validate some aspects of self-assessment tools submitted by individual hospitals. The lines of enquiry which are aligned to the National Standards are included in this report in Appendix 1.

Further information can be found in the *Guide to the monitoring programme undertaken against the National Standards for the prevention and control of healthcare-associated infections*² which was published in May 2017 and is available on HIQA’s website: [www.hiqa.ie](http://www.hiqa.ie)
In October 2017, the Minister for Health activated a Public Health Emergency Plan* and convened a National Public Health Emergency Team as a public health response to the increase of Carbapenemase-Producing *Enterobacteriales* (CPE)† in Ireland. In light of the ongoing national public health emergency the focus of inspections in 2018 will be on systems to detect, prevent and respond to healthcare-associated infections and multidrug-resistant organisms in line with national guidelines.

**Phase Three**

Phase Three of this monitoring programme will focus on the reprocessing of reusable medical devices and HIQA will commence onsite inspections in this regard from quarter 3 2018 onwards.

**Information about this inspection**

This inspection report was completed following an unannounced inspection carried out at St. Columcille’s Hospital, Loughlinstown by Authorised Persons from HIQA; Noreen Flannelly-Kinsella and Kathryn Hanly. The inspection was carried out on 21 June 2018 between 09:00hrs and 14:30hrs.

Prior to this inspection, authorised persons reviewed the hospital’s completed self-assessment tool and related documentation submitted to HIQA earlier in May 2017.

Inspectors spoke with hospital managers, staff and a member of the Infection Prevention and Control Team. Inspectors requested and reviewed documentation and data and observed practice within the clinical environment in one medical ward inspected at the hospital. The medical assessment unit was also visited to assess if the national screening guidelines in relation to CPE were fully implemented.

Additionally, a central location used for reprocessing reusable floor cleaning mop heads at the hospital was visited.

The inspection team used designed monitoring tools during this inspection and focused specifically on aspects of the prevention and control of transmission of antimicrobial-resistant bacteria and healthcare-associated infections. All low level findings observed in the clinical area inspected were reported to the local ward manager to inform ongoing improvement measures.

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*A National Public Health Emergency Plan was activated on 25 October 2017 by the Minister for Health in response to the increase and spread of Carbapenemase-Producing *Enterobacteriales* (CPE) in Ireland. As a result a National Public Health Emergency Team was convened and they have been meeting on a weekly basis since 02 November 2017. Please refer to the Department of Health webpage for further details: http://health.gov.ie/national-patient-safety-office/patient-safety-surveillance/antimicrobial-resistance-amr-2/public-health-emergency-plan-to-tackle-cpe/nphet-press-releases-minutes-of-meetings/*

†*Carbapenemase-Producing *Enterobacteriales* (CPE), are Gram-negative bacteria that have acquired resistance to nearly all of the antibiotics that would have historically worked against them. They are therefore much more difficult to treat.*
HIQA would like to acknowledge the cooperation of the hospital management team and all staff who facilitated and contributed to this unannounced inspection.

2.0 Findings at St. Columcille’s Hospital, Loughlinstown

Inspection findings showed that the hospital had actively endeavoured to address the issues identified in HIQA’s previous unannounced inspection in 2016. Notwithstanding that dated infrastructure posed many challenges for staff and patients at the hospital, it was evident that the hospital’s interior was maintained to an acceptable standard to facilitate effective cleaning and compliance with infection prevention and control best practice in the clinical area inspected.

In light of the focus of this inspection and the public health emergency in relation to CPE, HIQA found that the hospital had not ensured full implementation of the latest national screening guidelines in relation to CPE.

The following section of this report outlines the main findings of the inspection. The report is structured as follows:

- Section 2.1 outlines a risk identified during this unannounced inspection.
- Sections 2.2 to 2.4 present the general findings of this unannounced inspection which are aligned to the lines of inquiry.

2.1 Risk identified during this unannounced inspection

HIQA acknowledge that hospital management had identified that they had not fully implemented the latest screening guidelines in relation to CPE and had entered this risk on the hospital risk register. Considering this in the context of the activation of the National Public Health Emergency Plan to address CPE in our health system, HIQA sought assurance regarding arrangements in place to ensure compliance with the national guidelines on screening for CPE at the hospital.

In response, the general manager outlined key actions implemented to manage this risk. A copy of the letter issued by HIQA to the general manager seeking further assurance regarding the risk previously identified by the hospital and a copy of the response and associated action plan received from the general manager are shown in Appendices 2 and 3 respectively.

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1 Performing active surveillance cultures, active screening tests or contact screening of at-risk patients to detect colonisation with Carbapenemase-Producing Enterobacteriales.
2.2 Governance and risk management

Governance arrangements

St. Columcille’s Hospital, Loughlinstown is a statutory public hospital owned and managed by the Health Service Executive (HSE). The hospital is a member of the Ireland East Hospital Group.\(^5\)

The general manager at the hospital held overall accountability and responsibility for the prevention and control of healthcare-associated infection. Inspectors found that there were clear lines of accountability and responsibility at the hospital in relation to governance and management arrangements for the prevention and control of healthcare-associated infection.

The infection prevention and control service was delivered by a specialist Infection Prevention and Control Team (IPCT) who reported to the Infection Prevention and Control Committee (IPCC). The IPCC was chaired by the deputy general manager and membership included the IPCT, executive management team representation, clinical nurse managers, the quality, safety and risk manager, and representatives from the medical board and public health.

The IPCC presented a quarterly report to the Quality Safety and Risk Committee. In addition the IPCC reported to the Clinical Governance Committee meeting held monthly. Infection prevention and control was a discussion item at these meetings.

The Infection Prevention and Control Team

The team led by a consultant microbiologist monitored the implementation of the infection prevention and control programme by conducting ongoing surveillance and audits in relation to many components of the programme. The consultant microbiologist had a joint whole-time equivalent (WTE)\(^*\) position based at St. Vincent’s University Hospital inclusive of an eight hour onsite weekly commitment at St. Columcille’s Hospital. The consultant microbiologist attended the IPCC, Quality Safety and Risk Committee, Clinical Governance Committee meetings and antimicrobial stewardship ward rounds held at the hospital.

\(^5\) Hospital groups: The hospitals in Ireland are organised into seven hospital groups: 1. Ireland East Hospital Group. 2. Dublin Midlands Hospital Group. 3. South/South West Hospital Group. 4. Saolta University Health Care Group. 5. University Limerick Hospitals Group. 6. RCSI Hospitals Group. 7. National Children’s Hospital Group.

\(^*\)Whole-time equivalent (WTE): 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.
Microbiological laboratory services were provided by St. Vincent’s University Hospital with clinical microbiology expert advice available to clinical staff at St. Columcille’s Hospital on a 24-hour basis seven-days-a-week in line with National Standards.

The IPCT also included one WTE infection prevention and control clinical nurse specialist (IPC CNS). Inspectors were told by hospital management that the IPC CNS liaised closely with the consultant microbiologist, undertook daily ward rounds and held a face-to-face meeting with the consultant microbiologist on a weekly basis. Infection prevention and control surveillance data was collated by the IPC CNS and consultant microbiologist at the hospital.

Infection prevention and control link nurses†† were available on each ward and department at the hospital to support the work of the IPCT. In the absence of a dedicated antimicrobial stewardship pharmacist, the pharmacists at the hospital contributed to the delivery of the hospital’s antimicrobial stewardship programme.

Policies and procedures

The hospital had a comprehensive suite of infection prevention and control policies, procedures and guidelines which covered aspects of standard precautions, transmission-based precautions and multidrug-resistant organisms including outbreak management. Hospital policies relevant to infection prevention and control were in hard copies format, up-to-date and approved by the hospital’s IPCC, Quality, Safety and Risk Committee and Clinical Governance Committees. The hospital should ensure that electronic formats of these documents are also reviewed.

Infection prevention and control education

The IPCT provided a range of education sessions to personnel on the infection prevention and control programme, procedures and practices. These included formal and informal lectures, ward and department-based education sessions and hands-on training and up-dates.

Staff at the hospital were required to attend mandatory hand hygiene training at induction and on an annual basis thereafter which was greater than the national hand hygiene training guidance of every two years. Mandatory practical training was given at induction and every two years thereafter; staff could avail of the HSE eLearning programmes for annual updates.

At the time of the inspection, 68% of hospital staff had attended hand hygiene training in the previous two year period. Staff attendance by staff discipline was recorded centrally which facilitated tracking and trending of attendance by each staff

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††Link practitioners are hospital staff who in addition to performing their own job support the Infection Prevention and Control Team to promote good practice in relation to infection prevention and control.
discipline. Data breakdown showed that 84% of nursing, 71% of patient and client care personnel and 56% of medical staff were up-to-date with hand hygiene training at the time of inspection. Hospital staff told inspectors that figures in respect of uptake of hand hygiene training for medical staff may not be accurate; medical staff jointly appointed with St. Vincent’s University Hospital may have also attended training at this site. It is recommended that a system to accurately capture this information is developed between both hospitals so that hospital management have oversight and can be assured that training uptake by medical staff is up-to-date.

Inspectors were informed that 100% of relevant staff in the medical ward inspected had attended face-to-face hand hygiene training in the previous two year period.

A general infection prevention and control education programme was also mandatory for relevant hospital staff at induction with refresher courses every two years thereafter. Documentation reviewed by inspectors indicated that training and education sessions included, but was not limited to:

- standard and transmission-based precautions
- patient equipment decontamination
- multidrug-resistant updates
- antimicrobial stewardship
- Legionella control measures and Aspergillus precautions.

It was reported that additional sessions were provided in response to identified training needs, outbreaks of infection and transmissible infections, such as CPE. Infection prevention and control education was also provided to medical staff at induction and at weekly education sessions.

All staff at the hospital had access to advice from the IPCT, the clinical pharmacist and clinical microbiologist as required.

**Risk management**

The hospital had systems in place to identify and manage risk in relation to the prevention and control of healthcare-associated infection. An infection prevention and control risk assessment was completed by the hospital in 2017 outlining specific risks. Some high rated risks included inadequate environment and lack of isolation rooms.

A corporate risk register‡‡ was maintained by hospital management which included infection prevention and control risks and included some of the following:

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‡‡ A risk register is a database of assessed risks that face any organisation at any one time. Always changing to reflect the dynamic nature of risks and the organisation’s management of them, its purpose is to help hospital managers prioritise available resources to minimise risk and target improvements to best effect. The risk register
- lack of single rooms and en-suite facilities
- non-compliance with best practice for CPE screening
- risk of slips, trips or falls due to equipment when patients were cohorted for infection prevention and control purposes
- unclear governance of point of care testing.

To address significant risks identified, a number of existing control measures to mitigate or manage infection prevention and control related risks had been implemented. For example, the risk in relation to incomplete implementation of the national CPE screening guidelines had been escalated by the IPCC to the Clinical Governance Committee and the Ireland East Hospital Group. As previously presented in section 2.1 of this report, HIQA sought assurance regarding arrangements put in place by the hospital to actively manage and mitigate this high risk.

To manage the lack of single isolation rooms at the hospital, the IPCT worked closely with the Bed Management Team and local ward managers in relation to isolation prioritisation at the hospital. The hospital had introduced a number of process improvement management tools to help streamline processes in the hospital, for example, in relation to the management of storage and waste. A number of control measures had been put in place in relation to point-of-care testing and concerns in this regard had been escalated by the hospital to the Ireland East Hospital Group.

A review of the risk register showed that a risk in relation to a lack of a chemical pathologist position at the hospital had been identified. While a number of existing controls were in place to mitigate this risk inspectors noted that actions, the owners of actions and due dates were not documented. This needs to be addressed by the hospital.

Clinical risk forms completed at a local level were escalated to nursing administration and the quality, safety and risk manager at the hospital. The quality, safety and risk manager reported on risks and incident management at IPCC, the Quality Safety and Risk Committee and the Clinical Governance committee meetings held at the hospital. The hospital’s risk register was formally reviewed by a Risk Register Committee on a six-week basis.

The general manager and the quality, safety and risk manager reported on clinical risk and incident management issues at monthly performance meetings with the

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provides management with a high level overview of the hospital’s risk status at a particular point in time and becomes an active tool for the monitoring of actions to be taken to mitigate risk.

Point-of-care testing is defined as medical diagnostic testing at or near the point of care. This contrasts with the historical pattern in which testing was wholly or mostly confined to the medical laboratory, which entailed sending off specimens away from the point of care and then waiting hours or days to learn the results, during which time care must continue without the desired information.
CEO of the hospital group. Inspectors were informed that relevant incidents were also recorded in the National Incident Management System.***

2.3 Infection surveillance

The infection associated surveillance programmes at St. Columcille’s Hospital included surveillance of:

- ‘alert’ organisms and ‘alert’ conditions†††
- multidrug-resistant organisms and healthcare-associated infection
- clusters or outbreaks of infection
- bloodstream infections
- number of patients not isolated within 24 hours.

Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-associated infection; in line with HSE’s national reporting requirements5 and Business Information Unit.6

Data reviewed by inspectors showed that the number of new cases of hospital-acquired Staphylococcus aureus bloodstream infection was in line with the national HSE performance indicator from January to May 2018. Sporadic isolated cases of Clostridium difficile infection were reported for the same period. The team performed enhanced Clostridium difficile infection surveillance and molecular typing of isolates was undertaken for hospital-acquired cases. As part of the hospital’s ongoing surveillance programme, the hospital undertook a root cause analysis of all cases of Clostridium difficile infection and Staphylococcus aureus bloodstream infection in line with national guidance. The hospital had introduced an evidenced-based care bundle for the management of patients with a Clostridium difficile infection.

The hospital introduced an expanded set of 15 infection prevention and control key indicators in 2017; such as the number of new cases of hospital-acquired Vancomycin-resistant enterococci (VRE) bloodstream infection and the rate of acquisition of new cases of extended spectrum β-lactamase producing Gram-negative organisms (ESBL). Monthly and quarterly breakdown of cases was provided by the IPCT. It was reported to inspectors that surveillance reports were disseminated to clinical departments, consultants and the IPCC and Clinical Governance committees at the hospital. Surveillance and key indicator data was tracked and trended and well presented with colour shading highlighting areas of

*** The State Claims Agency National Incident Management System is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation.

††† Alert conditions include physical symptoms such as skin rashes, vomiting, diarrhoea, respiratory illness that could be due to an infectious illness.
concern. Performance data was shared with staff, patients and visitors on a notice board in a main public corridor at the hospital.

Surveillance reports showed a 14% decrease in number of VRE cases diagnosed at the hospital in 2017 compared with 2016. Since the last HIQA inspection in 2015, the hospital had commenced surveillance of ESBL as recommended. The number of reported new cases of hospital-acquired ESBL had substantially decreased from January to April 2018 compared with the same period in 2017. There were no reported cases of hospital-acquired Carbapenem-resistant Enterobacteriaceae (CRE) at the hospital in 2017.

National guidelines recommend healthcare-associated infection surveillance in relation to surgical site infection, central venous access device-related infection, and urinary catheter-associated urinary tract infection. Surveillance of peripheral vascular catheter (PVC)-related bloodstream infections (BSI) and hospital-acquired urinary catheter-related BSI was routinely performed at the hospital. No case of PVC-related SA BSI was reported in 2017.

There was no reported outbreak of infection in 2017. To date the hospital reported two outbreaks of infection in 2018 relating to influenza and methicillin-resistant Staphylococcus aureus (MRSA). Following this outbreak, the hospital had implemented pre-emptive MRSA monthly screening for patients with length of stay greater than 30 days. Outbreak reports reviewed by inspectors showed that dated hospital infrastructure and inadequate number of single rooms at the hospital were highlighted as potential contributory factors. Consequently there had been a slight increase in the number of patients not isolated within 24 hours during 2017 compared to 2016.

A formal legionella hospital site risk assessment had been performed at the hospital in 2018. Hospital management told inspectors that a copper silver ionisation system had been installed at the hospital in 2017. On foot of findings from HIQA’s inspection undertaken in 2015, control measures in relation to water-borne infections were in place. Governance and oversight in relation to water management was provided by the hospital’s Environmental Monitoring Committee, the IPCC and the Quality Safety and Risk Committees. The consultant microbiologist was a member of the Water Monitoring Committee.
Care bundles

Care bundles‡‡‡ for peripheral vascular catheter (PVC) and urinary catheter (UC) care had been implemented at the hospital in line with national guidelines. Monthly nursing metrics also recorded limited elements of invasive device management.

The hospital intermittently audited care bundle implementation. There should be ongoing audit in relation to care bundle implementation at the hospital as full implementation of all evidenced-based components of care bundles have shown improved patient outcomes.

2.4 Prevention and control of healthcare-associated infections and multidrug-resistant bacteria

As with the control of all potentially transmissible infectious diseases in healthcare settings, hospital adherence to best practice in relation to transmission-based precautions is critical to protect patients and staff from colonisation and infection from such organisms. The inspection team focused on measures to prevent the spread of antimicrobial-resistant organisms and implementation of aspects of transmission-based precautions.

Evidence of good practice

Examples of measures implemented to prevent and control healthcare-associated infections and multidrug-resistant bacteria at the hospital included but were not limited to:

Antimicrobial stewardship

The hospital had a proactive antimicrobial stewardship team, programme and annual plan coordinated by a multidisciplinary antimicrobial stewardship team. The team consisted of clinical pharmacists and the consultant microbiologist; team members participated in a quality improvement project held at the Royal College of Physicians in relation to antimicrobial prescribing. Weekly review of antimicrobial stewardship activities was undertaken. The hospital had:

- restricted antimicrobial prescribing rights for the broad-spectrum carbapenem antibiotic meropenem in line with national guidelines
- antimicrobial prescribing process indicator reports prepared and presented quarterly at the hospital’s IPCC and Drugs and Therapeutic Committee meetings.

‡‡‡ A care bundle consists of a number of evidence-based practices which when consistently implemented together reduce the risk of device-related infection.
Hand hygiene

- implementation of the essential components of the World Health Organization (WHO) multimodal improvement strategy to minimise the risk of acquiring or transmitting infection was evident
- since 2016, the hospital consistently achieved a compliance rate well above the current required compliance target of 90% set by the HSE in national hand hygiene audits
- a local hand hygiene compliance audit report reviewed by inspectors showed that 15 clinical areas and departments achieved between 90-100% compliance in quarter four 2017
- the design of clinical hand wash sinks in the clinical area inspected was compliant with relevant guidance.

Patient placement

- processes were in place to facilitate identification of patients who required screening and transmission-based precautions
- the IPCT advised staff in relation to screening and isolation requirements for in-patients colonised or infected with a transmissible organism
- dedicated equipment was available in single rooms designated for isolation.

Communication

- an infection prevention and control alert system was available on existing hospital information systems which identified patients previously colonised or infected with a transmissible infection
- a communication board for staff clearly identified patients requiring transmission-based precautions on the clinical area inspected
- signage to communicate isolation precautions was in place in the clinical area inspected; doors to single rooms accommodating patients who required transmission-based precautions were closed
- patient information leaflets were available for patients diagnosed with a multidrug-resistant organism including CPE
- nursing admission documentation reviewed by inspectors included an infection status section in respect of all patients admitted or transferred from healthcare facilities; as the hospital is reviewing and updating nursing documentation, a more comprehensive assessment with triggers to support an assessment of risk for CPE contact and colonisation should be considered going forward

Colonisation is the presence of bacteria on a body surface (like on the skin, mouth, intestines or airway) without causing disease in the person. Infection is the invasion of a person's bodily tissues by disease-causing organisms.
- colour-coded signage was available as guidance for staff and contained instructions in relation to essential elements of the infection prevention and control programme for example: hand hygiene, spillages, single use items, colour codes for cleaning cloths, cleaning products, linen and waste
- a comprehensive infection prevention and control information sheet was available in relation to best practice guidance pertaining to many elements of the infection prevention and control programme including transmission-based precautions; information in relation to screening for multidrug-resistant organisms needs to be updated to include the latest guidance for CPE.

**Hospital hygiene**

- overall the clinical environment and patient equipment inspected was generally clean with very few exceptions
- the clinical area inspected was well maintained; surfaces and finishes facilitated effective cleaning
- the hospital had comprehensive specifications for hospital hygiene in line with national guidelines\(^{11,12}\)
- environmental hygiene audit reports were completed regularly
- audit findings were tracked and trended; analysis of audit results and communication of issues that required action were communicated to staff and escalated to the hospital management team
- quality improvement action plans were implemented if areas for improvement were identified; actions taken to address areas for improvement were documented
- a dedicated hygiene team was assigned to terminal cleaning of isolation rooms; included use of steam cleaning technology for commodes
- clear separation of clean and dirty functions was evident in the central area for reprocessing reusable floor cleaning mop heads
- an environmental hygiene audit done in the clinical area inspected in April and May 2018 showed 95% compliance
- a staff member with responsibility for cleaning in the clinical area inspected had undertaken a recognised course in cleaning.

**Patient equipment hygiene**

- a patient equipment hygiene audit report reviewed by inspectors showed incremental progress had been achieved year on year in relation to compliance with desirable standards across the hospital: the hospital should continue to audit practices regularly so that the hospital target of 85% is achieved and sustained
action plans had been put in place to address areas of deficiencies; disinfectant wipes had been introduced in response to audit findings
guidance posters on cleaning of point-of-care equipment were introduced in 2017 and visible in the clinical area inspected.

Opportunities for improvement

Hospital management had identified a number of deficiencies in effective infection prevention and control prior to this inspection. These included:

Hospital infrastructure

- dated infrastructure was not in line with recommended specifications of a modern healthcare facility\textsuperscript{13,14,15}
- insufficient number of single rooms with en-suite facilities (8 single rooms for 109 patient beds) to accommodate all patients requiring single room isolation in line with national and best practice guidelines\textsuperscript{15,16,17}
- on the day of inspection single room isolation was indicated for 14 patients, of which five patients were isolated in single rooms; the remainder of inpatients, where transmission-based precautions were indicated, were cohorted with patients who were colonised or infected with a similar strain of multidrug-resistant organism.

Screening

- as previously highlighted screening in relation to CPE, was not fully in line with the latest national screening guidelines.

Additionally, inspectors noted the following which require review by management:

Hospital hygiene

- patient equipment hygiene audits were not routinely carried out; hospital management told inspectors that plans were underway to address this
- an overview hospital environmental hygiene audit report for 2018 showed that a high risk area was not audited in line with recommended auditing frequencies for higher risk areas\textsuperscript{11,12}
- local ward managers should form part of regular technical auditing schedules. In addition multidisciplinary managerial audits should form part of the ongoing management and supervision of cleaning services.\textsuperscript{11,12}
3.0 Conclusion

HIQA found that St. Columcille’s Hospital was actively working to improving infection prevention and control practices and endeavouring to fully implement the *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services*. The hospital dates back to 1840’s and therefore was not aligned to modern healthcare facility requirements. HIQA notes that the older fabric and infrastructure of the hospital continued to present ongoing challenges. Despite these challenges HIQA found that maintenance deficiencies identified in previous inspections were being actively managed by hospital management. A new endoscopy unit was opened at the hospital in 2015. A proposal for minor capital funding had been submitted to the hospital group and discussions regarding a new hospital block had been instigated.

In light of the National Public Health Emergency Plan in response to the increase and spread of CPE in Ireland, the HSE introduced screening guidelines in relation to CPE. The hospital had identified a high risk in relation to the incomplete implementation of CPE national screening guidelines and had entered this risk on the hospital risk register and escalated accordingly. In response to HIQA’s seek assurance letter, the general manager provided assurances regarding arrangements put in place to actively manage this risk. However it is imperative that the hospital is fully supported both at group and national level in their endeavours to fully mitigate this risk.

The hospital had many elements of an infection prevention and control programme which included some of the following:

- clear lines of accountability and responsibility in relation to governance and management arrangements
- systems in place to identify and manage risk pertaining to the prevention and control of healthcare-associated infections
- ongoing monitoring of infection prevention and control process and outcome measures
- a structured antimicrobial stewardship programme
- compliance with the HSE national performance indicator for hand hygiene.

The hospital environment in the clinical area inspected was maintained to a high standard and overall the patient environment and equipment was clean. The hospital should continue to build upon the improved compliance in relation to infection prevention and control audits including patient care equipment hygiene audits across the hospital. Similarly the hospital should continue to build on the progress to date to fully embed infection prevention care bundles audit into routine practice.
4.0 References


### 5.0 Appendices

**Appendix 1: Lines of enquiry for the monitoring programme undertaken against the National Standards for the prevention and control of healthcare-associated infections in acute healthcare services**

<table>
<thead>
<tr>
<th>Number</th>
<th>Line of enquiry</th>
<th>Relevant National Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>The hospital has formalised governance arrangements with clear lines of accountability and responsibility around the prevention and control of healthcare-associated infections.</td>
<td>2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 5.2, 5.3, 5.4, 6.1, 7.1</td>
</tr>
<tr>
<td>1.2</td>
<td>Risks in relation to the prevention and control of infection are identified and managed.</td>
<td>2.1, 2.3, 2.5, 3.1, 3.6, 3.7, 3.8</td>
</tr>
<tr>
<td>2</td>
<td>The hospital has policies, procedures and guidelines in relation to the prevention and control of infection and hospital hygiene.</td>
<td>2.1, 2.5, 3.1, 3.6, 3.8, 5.4, 7.2</td>
</tr>
<tr>
<td>3</td>
<td>Hospital personnel are trained and in relation to the prevention and control of healthcare-associated infection</td>
<td>2.1, 2.8, 3.1, 3.2, 3.3, 3.6, 6.1, 6.2</td>
</tr>
<tr>
<td>4.1</td>
<td>The hospital has implemented evidence-based best practice to prevent intravascular device-related infection and urinary catheter-associated infection, ventilator-associated pneumonia and surgical site infection.</td>
<td>1.1, 2.1, 2.3, 3.5</td>
</tr>
<tr>
<td>4.2</td>
<td>The hospital has systems in place to detect, prevent, and respond to healthcare-associated infections and multidrug-resistant organisms in line with national guidelines.</td>
<td>2.1, 2.3, 2.5, 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.8</td>
</tr>
</tbody>
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Appendix 2: Copy of the letter issued to St. Columcille’s Hospital regarding the high risk identified during HIQA’s inspection at St. Columcille’s Hospital

Linda O’Leary
General Manager
St Columcille’s Hospital
Loughlinstown
Co Dublin
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22 June 2018

Ref: PCHCAI 2018/62

Dear Linda

National Standards for the prevention and control of healthcare-associated infections in acute healthcare services - monitoring programme

The Health Information and Quality Authority (HIQA) carried out an unannounced inspection at St Columcille’s Hospital, Loughlinstown, Dublin against the National Standards for the prevention and control of healthcare-associated infections in acute healthcare services on 21 June 2018.

During the course of the inspection inspectors identified that the hospital had not ensured the full and consistent implementation of the national screening guidelines in relation to CPE.

We consider this to be a high risk in light of the ongoing National Public Health Emergency Plan to address CPE in our health system which was activated by the Minister for Health on 25 October 2018.
Please outline how the hospital intends to address this high risk following this inspection. Details of the risk identified, and proposed mitigating actions will be included in the report of this inspection.

Please provide this information to HIQA by close on 29 June 2018 to qualityandsafety@hiqa.ie. Should you have any queries, please do not hesitate to contact me at qualityandsafety@hiqa.ie.

Yours sincerely

Noreen Flannelly-Kinella
Authorised Person

CC: Mary Dunnion, Director of Regulation, Health Information and Quality Authority
Mary Day, CEO, Ireland East Hospital Group
Liam Woods, National Director of Acute Services, Health Service Executive
Appendix 3: Copy of the response letter received from St. Columcille’s Hospital regarding the high risk identified during the HIQA inspection of St. Columcille’s Hospital

Ms. Noreen Flannelly-Kinsella,
Authorised Person,
HIQA,
Head Office,
Unit 1301,
City Gate,
Mahon,
Cork.

28th June 2018

Ref: PCHCAI 2018/62

Dear Ms. Flannelly-Kinsella,

Thank you for your letter of 22nd June 2018 in relation to the recent unannounced inspection carried out by HIQA at St. Columcille’s Hospital (SCH) on 21st June 2018.

I wish to assure you that the incomplete implementation to date of the national CPE screening guidelines has been recognised as a significant issue by SCH which has been highlighted at the hospital’s Clinical Governance meeting in March 2018 and the Ireland East Hospital Group (IEHG) HCAI Committee meetings in September 2017, January and April 2018 and was placed on the hospital’s Risk Register on 20th March 2018. In addition, your correspondence and the requirement for an additional medical laboratory scientist to allow full implementation of the national CPE screening guidelines was again discussed at the IEHG/SCH monthly performance review meeting on Monday 25th June 2018.

Currently, the hospital screens the following patient groups for CPE, as recommended by the national CPE screening guidelines:

- All contacts of a patient with CPE (weekly for a minimum of 4 weeks)
- All patients transferred from another hospital (in Ireland or elsewhere).

SCH does not have a critical care unit, a haematology/oncology ward or dialysis unit so screening of patients in those categories is not applicable.

In addition, the microbiology laboratory completes a full work-up (identification and antimicrobial susceptibility testing) on enterobacteriales from in-patient clinical samples to ensure that any CPE isolates are detected.

The patient groups in whom consistent CPE screening has not yet been fully implemented in line with the national CPE screening guidelines are patients who have been an in-patient in any hospital in preceding 12
months, patients who have received cancer chemotherapy in the preceding 12 months and patients who normally reside in a long term care facility.

All microbiology samples from SCH are processed in the microbiology laboratory in St. Vincent's University Hospital (SVUH) who have estimated that approximately 10,000 additional screening samples annually will need to be processed if there is full implementation of the national CPE screening guidelines in the hospitals for which the laboratory provides microbiology services. It is not possible to process this number of extra samples without an additional laboratory medical scientist. A business case for the appointment of a medical laboratory scientist to the SVUH microbiology laboratory was submitted, I understand, by SVUH to IEHG in November 2017.

The infection and prevention team at SCH do daily rounds on all wards in the hospital and if patients are identified as coming from any long term care facilities in whom CPE outbreaks have been notified or as having a previous admission to any hospital in whom there have been ongoing CPE outbreaks, then CPE screening is recommended.

SCH considers the appointment of the laboratory scientist as critical in enabling us to fully implement the national CPE screening guidelines. We are currently awaiting the decision of the IEHG in respect of the business case submitted by SVUH. Once this scientist is in place, the additional screening will be implemented, along with the required education at ward level.

Yours sincerely,

Linda O'Leary,
General Manager.

cc Mary Dunnion, Director of Regulation, Health Information and Quality Authority,
Mary Day, CEO, Ireland East Hospital Group,
Liam Woods, National Director of Acute Services, Health Service Executive.