



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of the unannounced inspections at University Hospital Limerick

Monitoring programme for unannounced inspections undertaken
against the National Standards for the Prevention and Control of
Healthcare Associated Infections

Date of on-site inspections: 28 November 2014 and 13 January 2015

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is the independent Authority established to drive high quality and safe care for people using our health and social care services. HIQA's role is to promote sustainable improvements, safeguard people using health and social care services, support informed decisions on how services are delivered, and promote person-centred care for the benefit of the public.

The Authority's mandate to date extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, the Health Information and Quality Authority has statutory responsibility for:

- **Setting Standards for Health and Social Services** – Developing person-centred standards, based on evidence and best international practice, for those health and social care services in Ireland that by law are required to be regulated by the Authority.
- **Supporting Improvement** – Supporting services to implement standards by providing education in quality improvement tools and methodologies.
- **Social Services Inspectorate** – Registering and inspecting residential centres for dependent people and inspecting children detention schools, foster care services and child protection services.
- **Monitoring Healthcare Quality and Safety** – Monitoring the quality and safety of health and personal social care services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment** – Ensuring the best outcome for people who use our health services and best use of resources by evaluating the clinical and cost effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.
- **Health Information** – Advising on the efficient and secure collection and sharing of health information, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

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1. Introduction

Preventing and controlling infection in healthcare facilities is a core component of high quality, safe and effective care for patients. In order to provide quality assurance and drive quality improvement in public hospitals in this critically important element of care, the Health Information and Quality Authority (the Authority or HIQA) monitors the implementation of the *National Standards for the Prevention and Control of Healthcare Associated Infections*.¹

These Standards will be referred to in this report as the Infection Prevention and Control Standards. Monitoring against these Standards began in the last quarter of 2012. This initially focused on announced and unannounced inspections of acute hospitals' compliance with the Infection Prevention and Control Standards.¹

The Authority's monitoring programme continued in 2014, focusing on unannounced inspections. This approach, outlined in guidance available on the Authority's website, www.hiqa.ie – *Guide: Monitoring Programme for unannounced inspections undertaken against the National Standards for the Prevention and Control of Healthcare Associated Infections*² – included scope for re-inspection within six weeks where necessary.

The purpose of unannounced inspections is to assess hygiene as experienced by patients at any given time. The unannounced inspection focuses specifically on observation of the day-to-day delivery of hygiene services and in particular environment and equipment cleanliness and adherence with hand hygiene practice. Monitoring against the Infection Prevention and Control Standards¹ is assessed, with a particular focus, but not limited to, environmental and hand hygiene under the following standards:

- Standard 3: Environment and Facilities Management
- Standard 6: Hand Hygiene.

Other Infection Prevention and Control Standards¹ may be observed and reported on if concerns arise during the course of an inspection. It is important to note that the Standards may not be assessed in their entirety during an unannounced inspection and therefore findings reported are related to a criterion within a particular Standard which was observed during an inspection. The Authority uses hygiene observation tools to gather information about the cleanliness of the environment and equipment as well as monitoring hand hygiene practice in one to three clinical areas depending on the size of the hospital. Although specific clinical areas are assessed in detail using the hygiene observation tools, Authorised Persons from the Authority also observe general levels of cleanliness as they follow the patient's journey through the hospital. As part of the inspection programme for 2014, hospitals were advised that

re-inspections would be carried out in some circumstances, the aim of which was to drive rapid improvement at the hospital.

Timeline of unannounced inspections

An unannounced inspection was carried out at University Hospital Limerick (UHL) on 28 November 2014, followed by a re-inspection on 13 January 2015. The re-inspection examined the level of progress which had been made regarding environmental hygiene on one out of the two clinical areas inspected during the November inspection. In addition, two other clinical areas were inspected during the re-inspection. This report was prepared after the re-inspection and includes the findings of both inspections and any improvements observed between the first and second inspections.

A summary of these inspections is shown in Table 1.

Date of Inspection	Authorised Persons	Clinical Areas Inspected	Time of Inspection
28 November 2014	Sean Egan Katrina Sugrue Alice Doherty Leanne Crowe	High Dependency Unit 1D (Surgical)	11:00hrs-16:55hrs
13 January 2015	Sean Egan Katrina Sugrue Alice Doherty Leanne Crowe	1D (Surgical) 3C (Medical) 4A (Medical Short Stay)	10.30hrs-15.35hrs

Table 1: Summary of inspections carried out at UHL in 2014 and 2015.

The Authority would like to acknowledge the cooperation of staff with the two unannounced inspections.

2. University Hospital Limerick Profile[‡]

UHL is a large academic teaching hospital on the outskirts of Limerick City with academic links to the University of Limerick. UHL provides acute care services across to the population of Limerick, Clare, North Tipperary and surrounding counties (approx 400,000)

UHL is the Model 4 hospital, within University of Limerick (UL) Hospitals group, which comprises:-

- UHL 364 beds and 81 day beds
- Ennis Hospital (EH) 50 inpatient and 16 day beds
- Nenagh Hospital (NH) 49 inpatient and 22 day beds
- Croom Hospital (CH) 37 inpatient and 13 day beds
- University Maternity Hospital Limerick (UMHL) 83 inpatient beds and 19 cots
- St John's Hospital Limerick (SJH) (Voluntary) 89 beds

UHL is one of the 8 designated cancer centres in the country and is also a designated 24/7 Primary Percutaneous Coronary Intervention (PPCI) centre for ST-Elevation Myocardial Infarction (STEMIs, or Heart attack) and a thrombolysis centre for the management of acute stroke. UHL is the only hospital site that has a full 24/7 emergency service and critical care service in the region.

In 2013 29,259 inpatients and 20,192 day cases were treated at UHL. There were almost 60,000 attendances at the Emergency Department. Patients attending UHL have access to a full range of medical and surgical services and allied health services.

A major redevelopment project is currently underway at UHL with the Critical Care development just completed and work commenced on a new Emergency Department, Dialysis Unit, Cystic Fibrosis, Stroke Dermatology and Symptomatic Breast Units

UL Hospitals is governed by an interim Board and an Executive Management Team led by the CEO who reports to the Board. The CEO is accountable to the National Director Acute Services within the Health Service Executive (HSE). Delegated authority for the operation of the services is through the National Director Acute Services to the CEO of UL Hospitals.

[‡] The hospital profile information contained in this section has been provided to the Authority by the hospital, and has not been verified by the Authority.

3. Managing the risk associated with multidrug-resistant Gram-negative organisms at University Hospital Limerick

Resistance to antibiotics is an ongoing and evolving risk that all healthcare providers internationally need to contend with to ensure a safe environment for the treatment of their patients. In recent years, an emerging trend has seen an increase in the incidence of multidrug resistant Gram-negative bacteria in healthcare settings globally. In an Irish context, intermittent reports of cases of colonisation or infection with multidrug-resistant Gram-negative organisms have been reported in numerous hospitals across the Irish acute healthcare settings.

The emergence of this issue prompted the development and publication of *National Guidelines for the Prevention and Control of Multi Drug Resistant Organisms (MDRO) excluding MRSA in the Healthcare Settings*³ in 2012 by the Health Protection Surveillance Centre. These guidelines, which were further updated in 2014, provide guidance for hospitals on how best to manage the risk associated with numerous different types of resistant bacteria in hospitals, including multidrug resistant Gram-negative organisms.

University Hospital Limerick was among the first hospitals in Ireland to report the identification of carbapenem producing Enterobacteriaceae (CPE), which are especially resistant Gram-negative bacteria that can cause infection in patients. Historically, the hospital has experienced outbreaks with bacteria that contain this antibiotic resistance mechanism. It has been explained to the Authority by the hospital that a certain small proportion of the patient population in the hospitals catchment area are chronically colonised with organisms which contain this resistance mechanism. The hospital must therefore continually ensure that patients who are colonised with CPE who present for treatment are rapidly identified and appropriately managed to ensure that they do not become infected with CPE during treatment, and that the risk of spread to other patients is managed effectively.

In monitoring the hospitals measures to manage this issue, the Authority has identified that the hospital has implemented a number of strategies to mitigate this ongoing risk. This has included, but is not limited to;

- An effective programme of targeted patient screening on admission to hospital for CPE, which is in excess of national guidelines
- A comprehensive staff education programme which has led to a high level of awareness in relation to the management of this issue across the hospital
- The conduction of a detailed process mapping exercise to identify the route each patient who presents with known or suspected CPE follows on entry to the hospital. This has enabled the hospital to better manage the patient isolation process and in doing so reduce the risk of organism transmission

- Ensuring the dedicated use of patient equipment for all patients who are known or suspected as being colonised or infected with CPE

The management of this risk by the hospital has required them to conduct detailed root cause analyses to identify the possible causes of CPE transmission and infection. While much work has been done at the hospital to implement mitigation measures identified from such exercises to manage this risk to date, the hospital has continued to try to further address this issue in a progressive way. Ongoing work includes the development of a single patient identifier number for the University of Limerick Hospital Group which will, amongst other benefits, allow more seamless CPE patient identification on transfer between hospitals within the group. In addition, preliminary efforts to better understand the epidemiology of this issue across healthcare settings in the region have also commenced.

As with the control of all potentially transmissible infectious diseases in healthcare settings, hospital adherence to best practice in relation to environmental hygiene and hand hygiene are absolutely critical to protect patients and staff from colonisation and infection from such organisms. While CPE are relatively novel in an Irish context, the principles of best practice in relation to infection control, especially in relation to hand hygiene remains as relevant as ever in mitigating their risk. The Authority, in conducting its inspection of the hospital therefore focused on environmental hygiene and hand hygiene as the foundation for its approach to monitoring, in common with all other hospitals inspected throughout 2014. This report outlines the findings in relation to environmental hygiene and hand hygiene, with further consideration of the implications for management of the CPE risk alongside other infection control related risks.

4. Findings

This section of the report outlines the findings of the unannounced inspections at UHL on 28 November 2014 and 13 January 2015.

Overview of areas inspected

The **High Dependency Unit** is an eight-bedded ward comprising all single rooms with neutral air pressure settings. Six rooms were occupied at the time of the November inspection with three patients requiring isolation.

Ward 1D is a 32-bedded ward which consists of one 17-bedded ward, one five-bedded ward, one four-bedded ward, one two-bedded ward and four single rooms with ensuite facilities. During both unannounced inspections, there was an extra bed situated in the main 17-bedded ward. The Authority was informed that the extra accommodation of a patient in this way was a constant occurrence, that has been in place since reconfiguration of the UL Hospitals Group over three years ago. Two patients that were accommodated in a two-bedded ward were cohorted together for infection control purposes, and three patients were isolated in single rooms at the time of the November inspection. During the re-inspection in January, four single rooms had isolated patients, and three patients who required isolation precautions were accommodated together in a five-bedded ward – the remaining two beds were unoccupied for isolation purposes. An extra patient on a trolley was also placed on the main corridor of the ward, which was in response to the hospital's escalation policy.

Ward 3C is a 32-bedded ward which consists of one 15-bedded ward, one five-bedded ward, one four-bedded ward, two two-bedded wards and four single rooms with ensuite facilities. On the day of the January inspection, there was an extra bed on the 15-bedded ward. It was explained that the extra accommodation of a patient in this way was a regular occurrence on the ward. Two of the single rooms on the ward were allocated for exclusive use by immunocompromised patients being treated at the hospital. On the day of the re-inspection, two patients were isolated in the other two single rooms and another three patients requiring isolation with contact precautions were accommodated in the multi-bedded wards, including one patient who was accommodated in a bed in the corner of the 15-bedded ward.

Ward 4A is a 17-bedded medical short-stay ward. It consists of two two-bedded-wards, one three-bedded ward, a nine-bedded observation area and one single room. At the time of the re-inspection the single room was occupied by a patient requiring isolation and a second patient requiring isolation was accommodated in the main nine-bedded area adjacent to a hand hygiene sink. In addition, an extra

patient was accommodated on a trolley in the hallway leading into the nine-bedded area in response to the hospital's escalation policy.

Structure of this report

The structure of the remainder of this report is as follows:

- **Section 4.1** of the report outlines the **immediate high risks** and **mitigating measures** implemented by UHL between the November and January inspections in relation to environmental hygiene and hand hygiene, with a particular focus on Ward 1D. Copies of communications from the Authority and ULH regarding these findings are shown in **Appendices 1** and **2** respectively.
- **Section 4.2** presents the **key findings** from inspection of Wards 3D and 4A during the January re-inspection.
- **Section 4.3** presents the findings relating to hand hygiene at University Hospital Limerick under the headings of the five key elements of a multimodal hand hygiene improvement strategy.
- **Section 4.4** outlines findings, and associated actions by the Authority in relation to the management of multidrug-resistant Gram-negative organisms at ULH
- **Section 5** provides an overall summary of all findings.

4.1 Immediate high risk findings

Introduction

During the unannounced inspection on 28 November 2014, a number of immediate high risk findings were identified on Ward 1D. Details of these risks were communicated to UHL and escalated nationally (see Appendix 1). In response (see Appendix 2), UHL prepared a Quality Improvement Plan (QIP) to address the findings of the inspection. The level of progress which had been made regarding the immediate high risks was assessed during the re-inspection on 13 January 2015. The sections below describe these findings and the mitigating measures implemented by UHL in response to these findings. In addition, another immediate high risk was identified on Ward 4A during the January re-inspection. This was addressed at the time of the inspection and is described below.

Environmental hygiene

Environmental hygiene on Ward 1D was noted to be particularly poor during the November inspection with widespread unacceptable levels of dust observed in patient areas, sanitary facilities, storage facilities and the linen storeroom. Heavy dust was present on high ledges. Deficits were also observed in the management of environmental hygiene in sanitary facilities which was of particular concern given the high demand placed on these facilities. Staining was observed on curtains around some patient beds and it was noted that some labels showing the date on which the curtains were next due to be changed were not completed.

Unacceptable levels of dust were also identified in regional audits conducted by a team of representatives of the UL Hospital Group. The widespread nature of dust throughout the ward indicated to inspectors that the systems in place to manage and maintain environmental hygiene were not as effective as they should be. The lack of reciprocal action to this issue when identified through internal audit was also of concern to the Authority.

Since the November inspection, significant improvements in environmental hygiene were observed on the Ward 1D during re-inspection. A deep clean of the ward took place after the first inspection, which was repeated at the request of the Ward Manager because the first clean was deemed to be insufficient. The Authority acknowledges a noticeable improvement with regard to the storage facilities in the clean utility room between the initial inspection and re-inspection, as a result of this deep clean. Resources for cleaning have increased from eight hours per day to sixteen hours per day on five days a week. A further increase to seventeen and a half hours per day, six days a week is planned, with an intention to also introduce cleaning on the seventh day for between eight to ten and a half hours on that day. In addition, a three-day training programme had been organised for both existing

and new employees with cleaning responsibilities. High-level dusting was carried out twice after the November inspection although a light layer of dust was still observed on some high ledges during the re-inspection. Spot-checks of the sanitary facilities are now conducted more frequently throughout the day since the November inspection to ensure the facilities are clean, or to identify if cleaning is required.

Members of the Executive Management Team (EMT) have conducted regular structured walkabouts of all wards within the hospital, and a process for managing and executing action plans is being developed. Action plans developed following EMT walkabouts were viewed by the Authority during the re-inspection. The Authority was also informed that an Executive Council is in the process of being established with a view to developing improved practices around environmental hygiene. At the time of the re-inspection, this Council was not yet in place.

The general maintenance of the facilities and clinical environment on Ward 1D

Maintenance of the patient environment on Ward 1D was of concern to the Authority. There was a crack in a window on the 17-bedded ward on Ward 1D during the November inspection. The Authority was informed that this had been logged on the maintenance system for several months. A patient whose bed was adjacent to the window had covered the crack with newspaper and tape in order to block the draught coming through the window. In addition, the macerator on Ward 1D was not working for the three days prior to the inspection. The Authority was informed that the matter had been logged with the maintenance system each day due to the fact that the Ward Manager was unable to automatically check the priority status of maintenance issues. The matter was also logged with the Assistant Director of Nursing. Repairs to the macerator were carried out during the inspection.

A Group-wide Buildings and Maintenance Manager was appointed after the November inspection. The Authority was informed on Ward 1D that the rapidity of the resolution of maintenance issues had improved. Hygiene related maintenance issues are given priority and are checked three times each day. Weekly meetings are held to discuss outstanding maintenance issues which the Ward Manager on Ward 1D attends. Further changes to the maintenance system are planned which will assign a timeframe of completion to each request and allow Ward Managers to check the status of maintenance requests. A review to identify all outstanding maintenance works on the hospital site is planned, with the objective of resolving any issues found. A preventative maintenance plan is also being developed. The broken window on Ward 1D was repaired at the time of the re-inspection and further work to improve the environment and facilities of Ward 1D was on-going.

Infrastructure on Ward 1D

An extra patient was accommodated on the 17-bedded ward at the time of the November inspection. The extra bed and three other beds on the ward did not have access to oxygen and suction apparatus at the point of care. The Authority was informed that the ward has been used to accommodate an extra patient for the last 3-4 years indicating permanent escalation. Due to restricted space, the extra patient did not have a bedside locker and was observed using another patient zone to take a meal. In addition, it was noted that the curtains around the adjacent bed were touching the bed of the extra patient when pulled. This posed an increased risk of transmission of Healthcare Associated Infections and does not comply with the minimal space requirements between patient beds. The Authority was informed that the ward was due to be refurbished some time ago but resources for the refurbishment had to be directed elsewhere in the hospital at the time.

There was an extra patient on the 17-bedded ward during the re-inspection. Additionally, a patient was accommodated on a trolley in the main corridor of the ward. Following the November inspection, a risk assessment of the extra patient bed was carried out with the Chief Clinical Director, and both the extra patient bed and trolley are being managed in line with the hospital's escalation policy. A review of the Escalation Plan by the Executive Management Team was ongoing at the time of the re-inspection.

The cleanliness of patient equipment

Opportunities for improvement were noted in the management of patient equipment on Ward 1D during the November inspection. Unacceptable varying levels of dust were present on several items of patient equipment including the resuscitation trolley, the base of a hoist, suction apparatus and blood pressure monitoring equipment. Sticky residue and staining were also present on blood pressure monitoring equipment and on the surface of a resuscitation trolley. Several pieces of equipment inspected were unclean, including the interior of a nebuliser, the basket on blood pressure monitoring equipment and the surface of an intravenous pump. Several temperature probe holders were also observed to be unclean. For example, debris was visible in one temperature probe holder, and two holders contained used probe covers which indicated that the equipment had not been cleaned after each patient use. Staining was observed on four out of six commodes inspected, splash stains were visible on one seat cover and three seat covers were torn. Rust-coloured staining was also visible on the wheel areas of two commodes, and tissue was stuck to the wheel of one commode. Red staining was visible on the surface of a blood glucose monitor, and a small amount of debris was observed in the case used to hold the blood glucose monitor. A charging unit for a blood glucose monitor was dusty and unclean, with residue observed in the interior of the charging unit. Red

staining was also visible on a curtain around a patient bed, on the surface of a drug trolley and on a sharps box attached to the trolley.

The Authority was informed that a daily cleaning checklist is in operation for patient equipment. However, it was explained that the role of healthcare attendants had expanded to include additional tasks including patient care and other off-ward duties. Despite this, the number of healthcare attendants assigned to the ward had not increased. It was reported that this had impacted on the time required for cleaning patient equipment, and so the cleaning checklists were completed infrequently. Instead, it was explained that staff prioritised cleaning of the most frequently-used patient equipment and attended to remaining equipment if time permitted. Records viewed by the Authority indicated that patient equipment such as suction apparatus, intravenous stands and pumps had not been signed as being cleaned in several days prior to the inspection. Further discussion also indicated that relief staff often failed to complete the cleaning records, which prevented ward staff from accurately identifying what equipment required cleaning. These deficits were reflected in the findings by the Authority during the course of the inspection. The Authority was informed that a proposal has been made to place attendants on the ward to address the deficit in the cleaning of patient equipment, and this is due to be trialled in January 2015.

Upon re-inspection of Ward 1D, the Authority found considerable improvement in the management of patient equipment. Aside from a small number of non-compliances, patient equipment was clean.

The hospital had taken a number of steps to improve the management of patient equipment since the initial inspection. The arrangements regarding staff's responsibility for the cleaning of patient equipment are currently under review. The generic cleaning checklist was still in use during the re-inspection. However the ward was in the process of assessing all patient equipment to determine the frequency of cleaning they require, and a new cleaning checklist will be created accordingly. Since the initial inspection, all equipment is now tagged after it has been cleaned, and this practice will remain when the new cleaning checklist is introduced.

Waste management

During the November inspection, there was an accumulation of waste on the floor in the 'dirty'[±] utility room on Ward 1D. The Authority was informed that there were two waste collections from the area each day but the Ward Manager had requested more frequent collections. Similarly, there was an accumulation of waste in the 'dirty' utility rooms on both Wards 3C and 4A in January and the Authority was informed

[±] A 'dirty' utility room is a temporary holding area for soiled/contaminated equipment, materials or waste prior to their disposal, cleaning or treatment.

on Ward 4A that the number of collections each day was insufficient. The Authority was informed by the hospital that the frequency of collection of clinical waste had increased in the time period between inspections. However arrangements for the management of waste remain under review.

Hand hygiene

Hand hygiene compliance observed by the Authority on Ward 1D at the time of the inspection was 33% (six out of 18 opportunities were taken). The Authority was informed during the re-inspection that most of the ward staff at the hospital had completed hand hygiene training, and a plan for all staff to complete hand hygiene training was in progress. Additional education sessions were carried out on the ward by the Link Infection Control Nurse. Hand hygiene audits are carried out by members of the EMT and hand hygiene reports are a standing agenda item at Peri-Operative Directorate Management Team meetings.

Risk associated with intravenous fluid administration

During the November inspection, a needleless syringe attached to a saline container was sitting on a bedside locker on Ward 1D and a second syringe was lying on the floor at a patient bedside. The Authority was informed that it was normal practice on the ward to leave syringes at the patient bedside to flush intravenous access following intravenous medication. This practice raised a significant concern for the Authority as it poses an increased risk of patients acquiring a blood stream infection through contamination of the intravenous cannula, and is not in line with evidenced-based practice. The Authority was informed during the re-inspection that it was not a widespread practice in the Peri-op Directorate and it ceased on Ward 1D immediately after the November inspection. The Authority recommends that the hospital assures itself that the risk observed in 1D is not practiced in any clinical area within the hospital.

Isolation rooms

During the re-inspection in January, a patient requiring contact precautions was accommodated in the 15-bedded nightingale ward* on Ward 3C. While there was access to appropriate personal protective equipment, waste disposal facilities and appropriate signage at the point of care with this patient, the generally cramped conditions in the room meant that this arrangement for isolation was not optimal in preventing the risk of transmission of multidrug resistant organisms to other patients. Similarly, a patient requiring isolation was accommodated in the main nine-bedded area on Ward 4A. There was no precautionary signage to indicate that the patient required contact precautions. It was explained to the Authorised Person that

* A nightingale ward consists of one long room with a large number of beds arranged along the sides, without subdivision of the room into bays.

staff were informed of the requirement for contact precautions when caring for the patient. However, practices observed by the Authority indicated that all staff members were not aware of the isolation precautions, which has the potential to significantly increase the risk of transmission of infectious pathogens.

These concerns were raised with Senior Management who highlighted that there is an awareness at a senior level as to the risk represented due to the relative lack of isolation rooms on these and similar wards. It was explained to the Authority that the hospital is currently exploring the relative merits of the creation of a dedicated ward for the accommodation of patients requiring isolation due to the shortage of single room accommodation available.

4.2 Additional key findings

During both inspections, the Authority identified additional non-compliance with standards which, although not deemed to represent an immediate high risk to patients, still warranted improvement. An overview of these findings is contained in the following section.

In general terms, the High Dependency Unit was generally clean and well maintained. Some improvements were required in the management of waste and isolation precautionary signage.

Whilst patient equipment was generally clean on ward 3C, there were varying levels of improvement required with respect to environmental hygiene and maintenance. Improved practice in relation to waste management was also warranted.

Overall, Ward 4A was generally clean and well maintained. An immediate high risk was identified relating to the isolation of patients. This has been previously discussed in this report and was addressed at the time of the inspection. Some improvements were also required in the management of domestic waste collection and the cleanliness of some patient equipment.

Patient equipment

During the re-inspection, some non-compliances with the Standards in relation to patient equipment were observed on Ward 4A. A nebuliser mask beside a patient bed was visibly unclean. The Authority was informed that nebulisers masks and chambers were not changed in accordance with the hospital policy as there was insufficient supply. This finding can potentially increase the risk of transmission of *Legionella sp.*⁴ Small red stains were also visible inside a blood glucose monitor holder. It was explained to the Authority that it was the normal practice to take the glucose monitor and the holder to the patient's bedside. This practice is not recommended as it has the potential to increase the risk of transmission of blood borne viruses. The Authority recommends that the hospital review the current practices relating to blood glucose monitoring to ensure that best practice is adhered to.

A mattress cover was visibly compromised on both sides. It was explained that beds are moved regularly between different wards and it is difficult to provide assurance at ward level that mattresses and covers are in a good state; as audit on one day may not be reflective of what is on the ward the following day.

Ward infrastructure

During the re-inspection, it was observed that water outlets on several of the hand hygiene sinks were visibly unclean on Ward 4A, which can potentially pose an

increased risk of transmission of water borne pathogens. This was also identified as an issue in the High Dependency Unit during the initial inspection in November 2014 and again during the re-visit in January 2015. The Authority recommends that the hospital review its procedure and policy relating to the cleaning of all components of hand hygiene sinks in the context of the potential risks.

In addition, it was identified on Ward 3C that bathroom facilities on the ward were limited, and hindered on the day in question in the 15-bedded ward as the lock on the door of one of the two bathrooms was broken. This meant that the room was operating with only one bathroom for all of the patients accommodated in this area. This issue was raised with the Ward Manager for immediate maintenance. In general terms, it was also noted that storage facilities on Ward 3C were limited, which resulted in a relatively cramped environment which was harder to keep clean as a result.

Waste management

During the November inspection, a sharp used at a patient bedside was not disposed of at the point of care on Ward 1D thus increasing the risk of a sharps injury. Splash stains were observed on the interior of a non-clinical waste disposal bin in the 17-bedded ward, and used temperature probe covers were present inside the frame of the bin. A ledge inside the bin was also unclean. The lid on the non-clinical waste disposal bin in the clean utility room was damaged and rust-coloured staining was observed on the foot pedal. The clinical waste bin in the 'dirty' utility room was overflowing and the non-clinical waste bin was also over two-thirds full, which is not in line with best practice. Peeling paint and rust-coloured staining was also visible on the non-clinical waste bin.

Issues relating to waste segregation were identified in the High Dependency Unit during the November inspection. For example, two medication vials were not disposed of in the correct waste stream, a clinical waste bag was inserted into a domestic waste bin and there was no waste segregation signage in the waste sub-collection area. Access to a rigid sharps bin was restricted due to two blue trays stored on top of the lid and the temporary closing mechanism on one bin was not activated. The lid on a clinical waste disposal bin in the clean utility room was missing. During the re-inspection, the Authority was informed that additional waste management audits had been carried out on the unit as part of monthly hygiene audits to drive improvements, and non-compliances were being addressed at shift hand over times.

On Ward 4A, a sharps bin in an integrated sharps tray in the clean utility room was overfilled with intravenous tubing protruding through the opening. A non-clinical waste disposal bin in the 'dirty' utility room was also overfilled. Assembly details were not completed on a wall mounted sharps bin in the clean utility room.

Isolation rooms

During the November inspection, precautionary signage was not present on the doors of all isolation rooms on the High Dependency Unit. This was addressed at the time of the re-inspection. It was also noted that the automatic sensors on the doors from the corridor to the ante room and from the ante room to the isolation room were not functioning and these doors were open during the inspection. The Authority was informed during the re-inspection that this matter was under being addressed.

4.3 Hand Hygiene

Assessment of performance in the promotion of hand hygiene best practice occurred using the Infection, Prevention and Control Standards¹ and the World Health Organization (WHO) multimodal improvement strategy.⁵ Findings are therefore presented under each multimodal strategy component, with the relevant Standard and criterion also listed.

WHO Multimodal Hand Hygiene Improvement Strategy

4.3.1 System change⁵: *ensuring that the necessary infrastructure is in place to allow healthcare workers to practice hand hygiene.*

Standard 6. Hand Hygiene

Hand hygiene practices that prevent, control and reduce the risk of the spread of Healthcare Associated Infections are in place.

Criterion 6.1. There are evidence-based best practice policies, procedures and systems for hand hygiene practices to reduce the risk of the spread of Healthcare Associated Infections. These include but are not limited to the following:

- the implementation of the *Guidelines for Hand Hygiene in Irish Health Care Settings, Health Protection Surveillance Centre, 2005*
 - the number and location of hand-washing sinks
 - hand hygiene frequency and technique
 - the use of effective hand hygiene products for the level of decontamination needed
 - readily accessible hand-washing products in all areas with clear information circulated around the service
 - service users, their relatives, carers, and visitors are informed of the importance of practising hand hygiene.
-
- The design of some clinical hand wash sinks in Ward 1D and Ward 3C did not conform to Health Building Note 00-10 Part C: Sanitary assemblies.⁶

4.3.2 Training/education⁵: *providing regular training on the importance of hand hygiene, based on the 'My 5 Moments for Hand Hygiene' approach, and the correct procedures for handrubbing and handwashing, to all healthcare workers.*

Standard 4. Human Resource Management

Human resources are effectively and efficiently managed in order to prevent and control the spread of Healthcare Associated Infections.

Criterion 4.5. All staff receive mandatory theoretical and practical training in the prevention and control of Healthcare Associated Infections. This training is delivered during orientation/induction, with regular updates, is job/role specific and attendance is audited. There is a system in place to flag non-attendees.

Hospital training

- Staff at University Hospital Limerick are required to attend hand hygiene training on a yearly basis. Training records are logged on an electronic system and regular reports are sent to each of the Directorates. The Authority viewed documentation during the November 2014 inspection showing that 62% of staff attended hand hygiene training up to the November 2014 inspection. It was explained to the Authority that Ebola Virus Disease training, being undertaken as a response to the outbreak of Ebola in Africa in 2014, had impacted on the hospital's hand hygiene training programme. The Ebola Virus Disease Training became a priority for health services in 2014, and while the hospital's hand hygiene training would have normally been completed by the time of the inspection, this could not have been achieved due to these other training requirements. However, the hospital had recently initiated a 'train the trainer' programme, which it was hoped would better facilitate staff to be trained at ward level and therefore increase the levels of staff that are trained.
- During the re-inspection, the Authority was informed that the number of staff that had attended hand hygiene training had increased to 70%. Education had been provided to staff outside the canteen by the Infection Prevention and Control Team. It was also intended to improve the level of training amongst medical staff through dedicated hand hygiene training during an impending medical induction programme.

Local area training

- Documentation viewed by the Authority for all areas inspected indicated that the majority of staff had attended hand hygiene training within a rolling year.

4.3.3 Evaluation and feedback⁵: *monitoring hand hygiene practices and infrastructure, along with related perceptions and knowledge among health-care workers, while providing performance and results feedback to staff.*

Criterion 6.3. Hand hygiene practices and policies are regularly monitored and audited. The results of any audit are fed back to the relevant front-line staff and are used to improve the service provided.

The following sections outline audit results for hand hygiene.

National hand hygiene audit results

University Hospital Limerick participates in the national hand hygiene audits which are published twice a year.⁷ University Hospital Limerick, together with five other hospitals, is a member of the University of Limerick Hospitals Group (UL Hospitals Group). Since October/November 2013, the UL Hospitals Group commenced reporting data as a group in the national hand hygiene audits and submits under three Directorates. The results below, taken from publically available data from the Health Protection Surveillance Centre's website, demonstrate that University Hospital Limerick did not achieve compliance with the national targets for 2012 or 2013, although results have generally improved since 2011.⁸ Results for periods 6 and 7 which are presented below by directorate likewise failed to achieve national targets.

Period 1-7		Result
Period 1 March/April 2011	Mid Western Regional Hospital Dooradoyle	78.1%
Period 2 October/November 2011	Mid Western Regional Hospital Dooradoyle	83.8%
Period 3 May/June 2012	Mid Western Regional Hospital Dooradoyle	77.6%
Period 4 October/November 2012	Mid Western Regional Hospital Dooradoyle	82.4%
Period 5 May/June 2013	Mid Western Regional Hospital Dooradoyle	83.8%
Period 6 October/November 2013	Peri-Operative Directorate	88.6%
	Medicine Directorate	86.2%
	Maternal and Child Health Directorate	88.6%
Period 7 May/June 2014	Peri-Operative Directorate	87.6%
	Medicine Directorate	85.2%
	Maternal and Child Health Directorate	88.1%

Source: Health Protection Surveillance Centre – national hand hygiene audit results.⁷

Hospital hand hygiene audit results

- The Authority was informed during the November 2014 inspection that there were five lead auditors at the hospital. The Authority viewed hand hygiene audit results which were carried out across the Peri-Operative Directorate, the Medicine Directorate and the Maternal and Child Health Directorate from September 2013 to October 2014. The records demonstrated that regular hand hygiene audits are carried out across the group. A total of 126 hand hygiene audits were completed within that period; however only 33% of the areas audited achieved 90% compliance.
- The Authority was informed that areas that do not achieve the targeted compliance of 90% are re-audited. For example, areas achieving less than 75% should be re-audited within a month and areas achieving between 75-90% should be re-audited within two months. It was explained to the Authority that re-auditing is not always completed due to other priorities. Evidence of re-auditing was not strongly demonstrated in the documentation viewed, which

suggests that there is room for improvement in hand hygiene practices in order to achieve and sustain good compliances at all levels within the ward.

Local area hand hygiene audit results

- Regular local hand hygiene audits were carried out on 1D, 3C and the High Dependency Unit. However local hand hygiene audit had not been conducted in 4A since it opened six months previously. Following the re-inspection, the results of a hand hygiene audit carried out on Ward 1D in December 2014 showed that hand hygiene compliance had increased to 93%, with 100% hand hygiene compliance amongst nurses.

Observation of hand hygiene opportunities

Authorised Persons observed hand hygiene opportunities using a small sample of staff in the inspected areas. This is intended to replicate the experience at the individual patient level over a short period of time. It is important to note that the results of the small sample observed is not statistically significant and therefore results on hand hygiene compliance do not represent all groups of staff across the hospital as a whole. In addition results derived should not be used for the purpose of external benchmarking.

The underlying principles of observation during inspections are based on guidelines promoted by the WHO⁹ and the HSE.¹⁰ In addition, Authorised Persons may observe other important components of hand hygiene practices which are not reported in national hand hygiene audits but may be recorded as optional data. These include the duration, technique^r and recognised barriers to good hand hygiene practice. These components of hand hygiene are only documented when they are clearly observed (uninterrupted and unobstructed) during an inspection. Such an approach aims to highlight areas where practice could be further enhanced beyond the dataset reported nationally.

- The Authority observed 65 hand hygiene opportunities in total during the inspection and re-inspection. Hand hygiene opportunities observed comprised of the following:
 - Thirteen before touching a patient
 - Seven before clean/aseptic procedure
 - Eleven after touching a patient
 - Thirty four after touching patient surroundings

^r The inspectors observe if all areas of hands are washed or alcohol hand rub applied to cover all areas of hands.

- Forty of the 65 hand hygiene opportunities were taken. The 25 opportunities which were not taken comprised of the following:
 - Six before touching a patient
 - Three before clean/aseptic procedure
 - Two after touching a patient
 - Fourteen after touching patient surroundings
- Of the 40 opportunities which were taken, the hand hygiene technique was observed (uninterrupted and unobstructed) by the Authorised Persons for 34 opportunities. Of these, the correct technique was observed in 27 hand hygiene actions.
- In addition the Authorised Persons observed:
 - Twenty nine hand hygiene actions that lasted greater than or equal to (\geq) 15 seconds as recommended.
 - Four hand hygiene actions where there was a barrier to the correct technique, such as wearing a wrist watch or wearing sleeves to the wrist.
 - A member of staff was observed wearing a ring with multiple stones in the clinical area.

4.3.4 Reminders in the workplace⁵: *prompting and reminding healthcare workers about the importance of hand hygiene and about the appropriate indications and procedures for performing it.*

- Hand hygiene advisory posters were available, up-to-date, clean and appropriately displayed in the areas inspected in the University of Limerick Hospital.

4.3.5 Institutional safety climate⁵: *creating an environment and the perceptions that facilitate awareness-raising about patient safety issues while guaranteeing consideration of hand hygiene improvement as a high priority at all levels.*

- The three Directorates for the UL Hospitals Group achieved a combined compliance of 87% in Period 7 (May/June 2014) which is below the HSE's national target of 90%.⁷
- The Authority notes that the hospital has adopted a multimodal strategy in improving hand hygiene practices which was evident in the hand hygiene improvement strategy for University Hospital Limerick 2014. However, the Authority's observations during the initial inspection, combined with discussions in meetings with hospital staff, suggested that a culture of hand hygiene best practice is not yet embedded at all levels. While regular internal hand hygiene

audits are carried out across the three Directorates with the UL Hospital Group, there is room for improvement in the compliance achieved throughout the group.

- The Authority observed several staff members wearing wrist watches, long sleeves and stoned rings in the clinical areas during the course of the two inspections which have the potential to impact on hand hygiene best practice. Inappropriate use of gloves was also seen which contributed to non-compliances in hand hygiene.
- The Authority's observations of hand hygiene compliance increased from 54% to 62% during the re-inspection. Through increased training and the involvement by senior management in monitoring compliance and executing action plans, the hospital has demonstrated a commitment to improving hand hygiene practices and promoting a culture of hand hygiene best practice. However, the hospital needs to continue to build on hand hygiene compliances achieved to date to ensure that good hand hygiene practice is improved and maintained, and that national targets are achieved.

4.4 Findings, and associated action by the Authority relating to the management of multidrug-resistant Gram-negative organisms at University Hospital Limerick

The ongoing need to manage and mitigate the risk associated with carbapenemase producing Enterobacteriaceae (CPE) at University Hospital Limerick has been previously outlined in this report. In monitoring the hospital's approach to this issue, the Authority notes that a significant body of work has been conducted by the hospital to mitigate this risk. In particular, the Authority is satisfied that the hospital has implemented an effective system of patient screening, which provides it with a good understanding of the overall incidence of CPE colonisation in patients who present to the hospital and allows for appropriate management of each patient.

However the ongoing limited number of isolation rooms present on a number of wards and the need to prioritise the management of this risk relative to other infection risks, means that the hospital faces particular challenges at the current time in matching the demand for isolation facilities with the availability of single rooms. Persistent overcrowding at the hospital, especially in the hospital's Emergency Department, contributes to the difficulty in managing this risk, and has been previously highlighted as a problem by the Authority¹¹. The Authority notes that a new Emergency Department is currently under construction and is due to open in 2016, and that a new ward block building with 96 single rooms is also being constructed and should be available to patients by 2017. However in the interim period, it is vital that the hospital ensures that all measures are in place to manage the risk from multidrug resistance Gram-negative organisms, and other potentially transmissible infectious diseases, within current accommodation constraints. Full implementation of the findings of this report with respect to environmental hygiene and hand hygiene will aid in this effort.

Notwithstanding the measures that are within the control of the hospital themselves to mitigate this risk, following discussion with the hospital the Authority had concerns that the hospital had to date been acting to mitigate the risk presented by CPE in relative isolation, within the considerable constraints of legacy infrastructure in some wards, and relative overcrowding across the hospital in general. In addition, effective management of this risk represents a significant additional financial burden to the hospital. To this end, the Authority therefore acted to escalate the risks associated with Gram-negative resistance at the hospital to senior management within the Health Service Executive (HSE) so that the hospital may be afforded all necessary supports to ensure that the risk associated with Gram-negative resistance are managed as comprehensively as they can be from a system-wide perspective.

5. Summary

The risk of the spread of Healthcare Associated Infections is reduced when the physical environment and equipment can be readily cleaned and decontaminated. It is therefore important that the physical environment and equipment is planned, provided and maintained to maximise patient safety.

The Authority found that the maintenance of the patient environment and patient equipment was of significant concern on 1D during the November 2014 inspection. Follow up re-inspection of the ward in January revealed improvements in relation to environmental hygiene on Ward 1D. This was aided by an increase in the number of allocated cleaning hours, greater clarity in relation to role allocation for cleaning tasks, more effective systems for the cleaning of patient equipment and greater awareness and ownership of appropriate ward hygiene levels both at local and senior management level in the hospital.

While environmental hygiene had improved on Ward 1D, the senior management team highlighted to the Authority during the re-inspection that a number of other wards in the hospital might also benefit from applying the lessons learned from Ward 1D during this process. It was explained that Ward 1D was being used as a pilot ward to implement change in order to identify the effectiveness of new cleaning measures prior to further implementation on other similar wards. It is important that any measures identified as part of such an approach are rapidly applied across all relevant clinical areas to ensure an optimally clean environment for all patients. The introduction of executive management team walkabouts to rapidly identify and action improvement in the physical environment of the hospital have been demonstrated in many hospitals to improve the environment for patients and engender a culture of improved corporate assurance and leadership in relation to environmental hygiene. Their introduction to University Hospital Limerick following the initial inspection in November is a potentially beneficial initiative for the hospital, although it was too early to determine their overall impact at the time of the re-inspection.

While there was reported improvement in the speed at which maintenance requests were dealt with between inspections, the system in place for the prioritisation of maintenance works and the communication and feedback to the clinical areas remains a concern following re-inspection. The measures currently implemented do not provide the assurances that the process for the escalation of maintenance issues at clinical area level to the Technical Services Department and subsequent prioritisation and management of the maintenance works is as effective as the hospital has claimed or as evidenced at the time of the inspection. The hospital has indicated that measures will be implemented to address the findings relating to the

management of maintenance requests and subsequent communication of progress in addressing issues relating to maintenance.

The Authority found that improvements regarding the management of hazardous waste are required particularly in relation to the unsecured storage of clinical waste and activation of the safety locking mechanisms on sharps waste disposal boxes. In addition, build up of waste was observed on a number of the wards inspected both in November and January, indicating scope for improvement of the systems currently in place to prevent this from occurring.

The Authority found that while the hospital has adopted a multimodal approach to improving hand hygiene performance, more needs to be done to fully embed a culture of hand hygiene at the Hospital. Measures to improve the hospitals capacity in relation to hand hygiene training through a 'train the trainer' programme have been a recent successful initiative. However there is scope for a more comprehensive system for routine education of non-nursing staff. In addition, more routine audit and feedback across all clinical areas in relation to compliance with the five moments of hand hygiene, with resources further targeted towards areas achieving poor compliance is warranted.

Over the past number of years, a significant amount of construction work has been completed or is currently ongoing at University Hospital Limerick to improve the physical infrastructure of clinical areas. In those areas which have been completed and are open to patients, the environment has been designed and completed to a high standard which is more amenable to effective environmental cleaning, is more spacious, and is better equipped to enable appropriate isolation of patients due to a higher number of single rooms. This was noted as part of the Authority's inspection process in the HDU which has only recently been opened and has 100% single rooms. However a significant portion of University Hospital Limerick is comprised of much older wards. While this in itself is not unusual for an Irish hospital, the number of nightingale type wards which have a high number of patients in one room as found on wards 1D and 3C, is relatively unusual in an Irish context as observed by the Authority. Both wards have had extra beds placed into each nightingale ward which led to suboptimal spacing between beds. This increases the risk of transmission of infection. This approach to patient accommodation was in response to the hospitals escalation policy activated due to overcrowding in the hospital's emergency department. Staff on both wards explained that such overcrowding on the wards in question was a near permanent situation due to overcrowding throughout the hospital.

The issue of accommodating patients who require isolation in large multi-bedded wards is a concern for the Authority. Bed spacing should be sufficient enough to

provide assurances that the risk of spread of healthcare associated infections are minimised^{1, 12-14} and opportunities for patients who are colonized or infected with infectious pathogens to inadvertently share items with other patients are reduced¹⁵. In addition, the right of the patient to their dignity and privacy should be protected at all times in all areas of a healthcare facility in line with national Standards¹⁵. The Authority recommends that the hospital reviews how it prioritises and determines the accommodation of extra patients, particularly those requiring isolation to assure itself that the dignity and privacy of patients is protected and to minimise the risk of transmission of infection.

University Hospital Limerick has implemented risk mitigation measures between the two unannounced inspections which demonstrated a commitment to addressing the immediate high risks identified at the time of the first inspection. Overall, the Authority found that there were significant improvements observed during the re-inspection in January which indicated that the hospital is working toward addressing the findings of both inspections. The Authority recommends that the hospital continue to build on its progress to date to ensure that the prevention and control of healthcare associated infections is effectively and efficiently managed to minimise the risks to service users, staff and visitors. In addition, the Authority have also acted to escalate the risk associated with multidrug resistant Gram-negative organism colonisation in the hospitals patient population to senior management within the Health Service Executive so that all available measures are provided to the hospital to best address this issue.

University Hospital Limerick must now revise and amend its quality improvement plan (QIP) that prioritises the improvements necessary to fully comply with the Infection, Prevention and Control Standards. This QIP must be approved by the service provider's identified individual who has overall executive accountability, responsibility and authority for the delivery of high quality, safe and reliable services. The QIP must be published by the Hospital on its website within six weeks of the date of publication of this report and at that time, provide the Authority with details of the web link to the QIP.

It is the responsibility of University Hospital Limerick to formulate, resource and execute its QIP to completion. The Authority will continue to monitor the hospital's progress in implementing its QIP, as well as relevant outcome measurements and key performance indicators. Such an approach intends to assure the public that the Hospital is implementing and meeting the Infection Prevention and Control Standards and is making quality and safety improvements that safeguard patients.


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7. **Appendix 1 - Copy of letter issued to University Hospital Limerick following the unannounced inspection carried out on 28 November 2014.**



Health
Information
and Quality
Authority
An tÚdairis um Fhaisnéis
agus Cáilocht Sláinte

Colette Cowan
Group Chief Executive Officer
University Hospital Limerick
Dooradoyle
Limerick
CEOULHospitals@hse.ie

03 December 2014

Ref: PCHCAI/351


Dear Colette


I am writing as an authorised person under Section 70 of the Health Act 2007 (the Act) for the purpose of monitoring against the ***National Standards for the Prevention and Control of Healthcare Associated Infections*** (Infection Prevention and Control Standards) pursuant to Section 8(1)(c) of the Act. Under section 8(1)(c) of the Act, Authorised Persons of the Health Information and Quality Authority (the Authority) carried out an unannounced inspection at **University Hospital Limerick** on 28 November 2014.

During the course of the inspection at **University Hospital Limerick**, the authorised persons identified specific issues that they believe present a high risk to the health or welfare of patients and measures need to be put in place to mitigate these risks. The findings identified were such that a second unannounced re-inspection will be conducted at the hospital within six weeks.

The risks identified at **University Hospital Limerick**, which related to findings on Ward 1D included, but were not limited to:

- Especially poor standards of environmental hygiene.
- The Authority was not assured that arrangements to ensure a timely response to maintenance requests are effective, for example, the macerator on the ward had remained out of action and unrepaired for 3 days prior to the inspection, despite daily requests for repair from ward management. The

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macerator was repaired at the time of the inspection. In addition, there was a crack in a window on the 17-bedded ward on Ward 1D which the Authority was informed had been logged with the maintenance system for several months. At the time of the inspection, a patient had covered the crack with newspaper and tape in order to block the draught coming through the window.

- Longstanding extra bed placement on the ward, resulting in inappropriate bed spacing, and a subsequent increased risk of transmission of infection between patients. In addition, a lack of access to oxygen and suction apparatus at the point of care for four bed spaces was also observed.
- Unclean patient equipment.
- Waste collection is not being managed in a timely effective way resulting in an accumulation of waste on the ward.
- Hand hygiene compliance observed by the Authority on Ward 1D at the time of the inspection was 33% (six out of 18 opportunities were taken).

While these issues and this correspondence will be referred to in the report of the inspection on its conclusion, the Authority believes it is important that these risks are brought to your attention now, in advance of this. This is being done so that you may act to mitigate and manage the identified risks as a matter of urgency and in preparation for a re-inspection by the Authority within six weeks.

Given the level of potential risk associated with these findings, and the urgent requirement for the mitigation of such risks, please formally report back to the Authority by **2pm on 10 December 2014** to qualityandsafety@hiqua.ie, outlining the measures that have been enacted to mitigate the identified risks. Details of the risks identified will be included in the report of the inspection. This will include copies of the Authority's notification of high risks and the service provider's response.

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Should you have any queries, please do not hesitate to contact me at qualityandsafety@higa.ie. Please confirm receipt of this letter by email (qualityandsafety@higa.ie).


Yours sincerely



SEAN EGAN
Authorised Person

CC: Mary Dunnion, Acting Director of Regulation, Health Information and Quality Authority
Tony O'Connell, National Director of Acute Services, Health Service Executive
Philip Crowley, National Director of Quality and Patient Safety, Health Service Executive

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8. **Appendix 2 - Copy of letter received from University Hospital Limerick following the unannounced inspection carried out on 28 November 2014.**



Ospidéal na hOllscoile, Luimneach
University Hospital Limerick
Office of the Group Chief Executive
Dooradoyle, Limerick.
Tel: 061 482598

10th December 2014

Mr. Sean Egan,
Authorised Person,
HIQA,
Unit 1301,
City Gate,
Mahon,
Cork.

Your Ref: PCHCAI/351

Dear Mr. Egan,

Further to your letter of 3rd December 2014, I wish to advise that the following measures have been put in place to address the specific issues which the Authority believe present a high risk to the health and welfare of patients.

From Monday 15th December I have introduced Executive Management Team walkabouts to designated areas. Each member of the Executive have been assigned a cohort of wards which will be visited on a weekly basis to review hygiene audits, environmental cleaning, sanitary facilities, patient equipment, waste management, linen management, hand hygiene, ward kitchenettes, outstanding maintenance issues. Each member of the Executive will be teamed with a Directorate Manager or ADON. This will be expanded to the other sites in January.

Especially poor standards of environmental hygiene and unclean patient equipment

Four additional Multitask Attendants have been recruited following a recent competition. From Monday 15th December a pilot will run on Ward 1D for two weeks. Additional hours and new cleaning arrangements will be introduced and following evaluation will be expanded to other wards. Cleaning of patient equipment will be part of the role of the Multitask Attendant.

Response to Maintenance Requests

Interviews for a new Group-wide Buildings and Maintenance Manager were held on Wednesday 3rd December 2014. A suitable candidate was recommended and is currently being processed.

With immediate effect faulty hygiene related equipment e.g. macerator will be prioritised by the Maintenance Department.

The cracked window on the Ward was identified as a priority, however, replacement of same required the hire of a cherry picker. The Maintenance Department was in the process of identifying similar jobs to ensure effective utilisation of the hire equipment. This work has now been scheduled.

Challenges in relation to maintenance request have been continuously reviewed throughout 2014. A priority maintenance list has been developed per Directorate and this is in progress. The Maintenance Manager is reviewing outstanding work in all wards and will examine ways of progressing these works to completion.

The new Group Buildings and Maintenance Manager will review communication and feedback mechanisms between the wards and the Maintenance Department workflow within the department will also be reviewed to eliminate any inefficiencies.





Ospidéal na hOllscoile, Luimneach
University Hospital Limerick
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Extra bed on Ward 1D

Due to our challenges with capacity, this bed was placed on the ward to facilitate the transfer of patients from an over-crowded Emergency Department. Our Escalation Plan for the management of capacity challenges is currently under review and will include this risk assessment.

Waste Collection

An additional resource is currently being processed from the support staff panel and will be dedicated to the collection of clinical waste.

Hand Hygiene

Hand hygiene remains a top priority for UL Hospitals and will be included in the Executive Management Team walkabouts scheduled to commence on Monday 15th December. Hand hygiene training is currently being delivered.

To address the hand hygiene non-compliance, a programme of hand hygiene education has commenced. The 42 hand hygiene trainers, with the Infection Prevention & Control Team, are providing regular drop-in education sessions for all staff. Non-trained staff have been flagged to their respective directorates to attend the training.

The area in question will be re-audited as per the local quality improvement plans. The local management and directorate teams will be informed of the results and any resulting actions needed.

Programmes of training and observational audits continue within UL Hospitals.

UL Hospitals welcomes the feedback from the Authority and expresses significant disappointment at the recent feedback session following the unannounced inspection on 28th November 2014.

I would like to assure the Authority that high quality safe care remains a priority for the Group.

Yours sincerely

Professor Colette Cowan
Group Chief Executive
University of Limerick Hospitals Group

Published by the Health Information and Quality Authority.

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