Report of the unannounced inspection of Rehabilitation and Community Inpatient Healthcare Services at the Sacred Heart Hospital, Castlebar, Co Mayo.

Monitoring programme against the *National Standards for Safer Better Healthcare*

Dates of inspection: 15 January 2020
About the Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA’s mandate to date extends across a wide 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 responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Chief Inspector within HIQA is responsible for registering and inspecting services for older people and people with a disability, and children’s special care units.

- **Regulating health services** — Regulating medical exposure to ionizing radiation.

- **Monitoring services** — Monitoring the safety and quality of health services and children’s social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland’s health and social care services.

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.
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1.0 Information about this monitoring programme

Under the Health Act Section 8 (1) (c) the Health Information and Quality Authority (HIQA) has statutory responsibility for monitoring the quality and safety of healthcare among other functions.

This inspection programme monitors compliance of Rehabilitation and Community Inpatient Healthcare Services against the *National Standards for Safer Better Healthcare (2012)*. The focus of inspection is on governance and risk management structures, and measures to ensure the prevention and control of healthcare-associated infections and the safe use of medicines.

Inspection findings are grouped under the National Standards’ dimensions of:

1. **Capacity and capability**
2. **Quality and safety**
Report structure

This monitoring programme assesses Rehabilitation and Community Inpatient Healthcare Services’ capacity and capability through aspects of the theme:

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

HIQA assesses Rehabilitation and Community Inpatient Healthcare Services’ provision under the dimensions of quality and safety through aspects of the themes:

- **Person-centred Care and Support: Standard 1.1.** The planning, design and delivery of services are informed by patients’ identified needs and preferences.

- **Safe Care and Support: Standard 3.1.** Service providers protect patients from the risk of harm associated with the design and delivery of healthcare services.

Based on inspection findings, HIQA uses four categories to describe the service’s level of compliance with the National Standards monitored.

These categories included the following:

- **Compliant:** A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant National Standard.

- **Substantially compliant:** A judgment of substantially compliant means that the service met most of the requirements of the National Standard but some action is required to be fully compliant.

- **Partially compliant:** A judgment of partially compliant means that the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks which could lead to significant risks for patients over time if not addressed.

- **Non-compliant:** A judgment of non-compliant means that this inspection of the service has identified one or more findings which indicate that the relevant standard has not been met, and that this deficiency is such that it represents a significant risk to patients.
1.1 Hospital Profile

The Sacred Heart Hospital, Castlebar was a statutory hospital owned and managed by the Health Service Executive (HSE) and under the governance of Community Health Organisation (CHO) 2. The hospital campus included a Rehabilitation Unit and a Designated Centre for Older People.

The Rehabilitation Unit was inspected on this inspection. The unit comprised 31 beds; 29 rehabilitation beds and two respite beds. It was reported that only 24 rehabilitation beds were operational due to staffing levels at the time of inspection.

The Rehabilitation Unit accepted patient referrals mainly from Mayo University Hospital through the consultant geriatricians affiliated to the unit. Patients were admitted for rehabilitation for example following acute stroke and post surgery. It was reported that admission criteria to the unit included patients who were medically stable and had a plan for discharge.

1.2 Information about this inspection

This inspection report was completed following an unannounced inspection carried out by Authorised Persons, HIQA; Noreen Flannelly-Kinsella, Kathryn Hanly and Denise Lawler on 15 January 2020 between 09.30hrs and 16.00hrs.

Inspectors spoke with hospital managers, staff and patients. Inspectors also requested and reviewed documentation, data and observed the clinical environment in the Rehabilitation Unit at the hospital.

HIQA would like to acknowledge the cooperation of the hospital management team and staff in the Rehabilitation Unit who facilitated and contributed to this unannounced inspection.

* Community Health Organisation 2 area consists of Galway, Mayo and Roscommon.
2.0 Inspection Findings

2.1 Capacity and Capability

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<th>Theme 5: Leadership, Governance and Management</th>
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<tr>
<td><strong>Standard 5.2</strong></td>
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<td>Service providers have formalised governance</td>
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<td>arrangements for assuring the delivery of</td>
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<td>high quality, safe and reliable healthcare.</td>
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**Judgment: Substantially compliant**

Whilst the Rehabilitation Unit had established several oversight governance committees and membership of one committee included a consultant, it was reported that failure to progress with an additional consultant geriatrician position resulted in additional workloads which did not support regular attendance at this forum.

This section describes arrangements for the leadership, governance and management of the rehabilitation service at this hospital, and HIQA’s evaluation of how effective these were in ensuring that a high-quality, safe service was being provided.

**Corporate and clinical governance**

Inspectors found that there was defined leadership and management arrangements with clear lines of accountability and responsibility at the hospital.

The director of nursing was the person with overall responsibility for the hospital campus, both the Rehabilitation Unit and Designated Centre for Older People. The director of nursing reported to the manager for older persons, who in turn reported to the general manager for social care, and upwards to the chief officer of CHO 2. An organisational chart was viewed by inspectors. This outlined responsibility, accountability and authority arrangements, and reporting relationships of staff within the Rehabilitation Unit.

Whilst the Rehabilitation Unit had established several oversight governance committees and membership of one committee included a consultant, it was reported that failure to progress with an additional consultant geriatrician position resulted in additional workloads which did not support regular attendance at this forum. Therefore a review at corporate level so as to ensure that consultants are enabled to actively participate at oversight governance committees meetings held at the hospital is recommended.1,2
Clinical governance arrangements

Day-to-day operations of the unit was the responsibility of two clinical nurse managers who along with nursing, support staff and the assistant director of nursing reported to the director of nursing at the hospital. A designated clinical nurse manager had responsibility for the hospital at weekends and outside of core working hours.†

Two consultant geriatricians from Mayo University Hospital had clinical responsibility for patients admitted for rehabilitation to the unit. The consultants attended for approximately three to four hours one day each week. Each consultant undertook a ward round and attended a multidisciplinary (medical, nursing and allied health professionals) team meeting in relation to patients under their care. If patients needed medical review, they were reviewed by either a consultant geriatrician or an SHO during their onsite visit. A third consultant geriatrician had clinical responsibility for patients allocated to two respite beds in the unit.

Medical cover was available 24/7, seven days a week to the unit. Inspectors were informed that a senior house officer (SHO) from Mayo University Hospital attended the unit from Monday to Friday during core working hours. Nursing staff had access to medical advice from the on call medical team at Mayo University Hospital outside of these hours and at weekends. Staff had electronic access to laboratory and radiology reports at Mayo University Hospital which enabled clinical staff to access results, if required, in a timely manner.

There were three physiotherapists (whole-time equivalent positions (WTE))‡ assigned to the unit and reported to the physiotherapy manager, of which all were employed by and based at the hospital. Other allied health professionals such as occupational therapists and speech and language therapists were employed by the hospital and reported through respective line managers based in the community. Inspectors were told that access to a community-based dietician was available, as required.¹

Reporting arrangements in relation to committees

Hospital management had established several hospital committees to govern rehabilitation services and address quality and safety issues, for example, rehabilitation, governance and health and safety committees. It was reported that these committees facilitated the exchange of information and sharing of learning in

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¹ For the purpose of this monitoring programme core working hours are considered to be 09.00am-05.00pm.

² Whole-time equivalent (WTE): one whole-time equivalent employee is an employee who works the total number of hours possible for their grade. WTEs are not the same as staff numbers as many staff work reduced hours.
relation to quality and safety issues. The health and safety and governance committees met monthly and bimonthly respectively, and both committees had defined terms of reference and reporting structures to the director of nursing.

Whilst minutes of committee meetings reviewed clearly outlined actions arising from meetings and identified persons responsible for implementing the actions, time frames for the actions were not identified.

The director nursing attended monthly CHO quality and safety and director of nursing meetings and quarterly CHO health and safety meetings. It was evident from documentation reviewed that feedback from these meetings was provided to staff at the hospital.

**Arrangements with other facilities including transfer when a patient become acutely unwell**

The hospital had an up-to-date transfer and discharge procedure in place. In the event of a patient becoming acutely unwell or a deterioration in clinical condition outside of these hours, the nursing staff liaised with the medical on call team at Mayo University Hospital. The transfer policy incorporated the ISBAR (Identify, Situation, Background, Assessment, and Recommendation)\(^3\) structured communication tool and was used to guide and inform staff when transferring patients. The nursing staff arranged the patient’s transfer by ambulance to Mayo University Hospital.

**Risk management**

The Rehabilitation Unit had formalised systems in place to identify and manage risk in relation to the prevention and control of healthcare-associated infections and safe use of medicines. The hospital had a comprehensive risk register\(^5\) in both hard and electronic format.

A clinical nurse manager in charge at night was responsible for ongoing review, and management of the hospital’s risk register. The director of nursing as the person in charge in turn reported to and presented monthly status updates in relation to the risk register to the manager of older persons in CHO 2. Risks that could not be effectively mitigated at a local hospital level were escalated through the quality and patient safety structures of CHO 2 in line with HSE integrated risk management policy.\(^4\)

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\(^3\) ISBAR is a structured communication tool used to guide and inform staff when transferring patients.

\(^4\) HSE integrated risk management policy

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\(^5\) 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 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.
Inspectors were told that risks identified in the Rehabilitation Unit were risk assessed and risks that could not be effectively managed were entered on a local risk register and escalated to the person in charge. Inspectors viewed a sample of completed risk assessments on the day of inspection. Risks entered on the hospital’s risk register relating to infection prevention and control included inadequate infrastructure in the unit. To mitigate this risk plans to relocate to another ward or unit in the hospital were underway. The absence of an onsite pharmacist was identified as one risk in relation to the safe use of medicines and had been escalated through appropriate governance structures in community services. Inspectors noted that a number of existing and additional controls to manage each risk were recorded and a risk rating entered. However an action owner and a date by which these actions were to be completed was not always recorded.5

The risk register was a standing agenda item on staff and clinical nurse manager meetings and at health and safety committee meetings. Quality and risk also featured as a standing agenda item in minutes of governance group committee meetings. Documentation reviewed showed that all nursing managers had undertaken a risk management and patient safety programme at the hospital.

**Monitoring, audit and quality assurance arrangements**

Staff told inspectors that incidents in relation to infection prevention and control and safe use of medicines were reported and logged on the National Incident Management System (NIMS).** An incident log received following this inspection showed that 20 medicine incidents were reported in 2019.

It was evident that incidents were tracked at the hospital and featured as an agenda item on monthly clinical nurse managers’ meetings to promote learning. Staff told inspectors that falls-related incidents were reviewed at a Falls Steering Committee and learning from reviews were shared at ward and nurse manager meetings. Serious reportable events,6 if applicable, were presented weekly by the director of nursing and reviewed with a senior management team which included a risk manager in CHO 2.

Minutes of a staff ward meeting viewed by inspectors showed that staff had received online training in relation to the National Incident Management System. The hospital had a HSE safety incident management policy available on the day of inspection however it was not in line with the latest guidance.6

Hospital management had an agreed audit plan in place for 2020 which included safe use of medicines, patient satisfaction, the risk register and alerts and key

**The State Claims Agency National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation.**
performance indicators. A review by inspectors showed that key performance indicator measurement centered primarily on monitoring numbers of completed assessments and other documentation more than on clinical outcomes. The hospital should also act to define clinical outcomes so that performance can be measured against set standards and targets. Infection prevention and control audits and safe use of medicines audits are discussed further in this report under Theme 3: Safe Care and Support.

Documentation reviewed by inspectors during and after inspection showed that the Rehabilitation Unit held monthly educational sessions on hospital policies (for example infection control, hand hygiene, medication management and risk management) at staff meetings which is good practice.

Other process measures monitored included environmental and patient equipment hygiene and findings in this regard will be presented under Section 2.2 Safe Care and Support.

Taking feedback from patients and staff

The director of nursing was responsible for managing complaints under the HSE’s ‘Your Service, Your Say’ policy. Comment cards to provide feedback on the service were available for patients, relatives, carers, and visitors to make a comment, compliment or complaint. Comment boxes were also located at the reception area.

It was evident from documentation reviewed by inspectors that complaints and compliments were discussed at staff ward and clinical nurse manager meetings held at the hospital. Hospital management stated that no patient complaint had been recorded over the last year.

Hospital management told inspectors that a staff survey as a forum for staff to provide feedback to hospital management was undertaken on an annual basis at the hospital.
2.2 Quality and safety

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<th>Theme 1: Person-Centred Care and Support</th>
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<td>Standard 1.1</td>
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The planning, design and delivery of services are informed by patients’ identified needs and preferences. |
| Judgment: Compliant                     |

Person-centred care and support places service users at the centre of all that the service does. It does this by advocating for the needs of patients users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care.

Staff had devised a patient information booklet which included infection control advice, medication requirements and information in relation to providing feedback. In addition a comprehensive suite of generic patient information leaflets was available in relation to the safe use of medicine and infection prevention and control. Samples included warfarin therapy, and anti-blood clotting treatment for atrial fibrillation and hand hygiene information for residents and visitors.

Inspectors were informed that staff on the Rehabilitation Unit were participating in a pilot quality improvement project that began in 2019. The project was aimed at working with health and social care staff to support patients in self-management support strategies to maximise the quality of service provision, patient experience and satisfaction. Staff had attended workshops and training. The project was in the early stages of implementation and had not been evaluated at the time of inspection.

**Coordination of care within and between services**

The Rehabilitation Unit had an admission policy that was in draft form at the time of inspection. Patients were assessed as able to participate in the rehabilitation programme by a consultant geriatrician prior to admission. A nurse manager liaised with the bed manager at Mayo University Hospital in relation to planned transfers and admissions.

A sample of nursing and medical pre-assessment, transfer and discharge documentation was reviewed. Although prompts in relation to infection prevention and control information was evident in pre-assessment and nursing discharge documentation, it was not in medical discharge documentation. A review of this document is recommended so as to be assured that hospital correspondence informs healthcare workers if a person is colonised or infected with a transmissible infection,^9,10^
**Evaluation of services**

Staff informed inspectors that setting of individual patient goals were agreed with patients on admission and monitored at weekly multidisciplinary team meetings. Family members also participated at meetings if and when required.

A patient satisfaction survey conducted in September 2019 showed that patients surveyed were very satisfied with the care received. However, it was not evident that an action plan to address any suggestions and recommendations made was put in place. Documentation reviewed showed that a re-audit was planned for 2020.

Inspectors spoke with some patients who voiced satisfaction about the care they received and was aware of the discharge plan and name of consultant responsible for the care received.

<table>
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<th>Theme 3: Safe Care and Support</th>
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<td><strong>Standard 3.1</strong></td>
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<td>Service providers protect patients from the risk of harm associated with the design and delivery of healthcare services.</td>
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<td><strong>Judgment: Substantially compliant</strong></td>
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<tr>
<td>- Environmental and patient equipment hygiene needs to be improved.</td>
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<td>- The infrastructure was poorly maintained.</td>
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**Prevention and control of healthcare-associated infections**

Overall responsibility for infection prevention and control and implementation of National Standards rested with the director of nursing. It was evident that infection prevention and control featured as an agenda item on staff meetings and health and safety committee meetings held at the hospital.

Inspectors were informed that screening for Methicillin-resistant *Staphylococcus aureus* (MRSA) and multidrug-resistant organisms such as Carbapenemase Producing *Enterobacteriales* (CPE)\(^\text{††}\) was undertaken prior to patient transfer by staff at Mayo University Hospital.

\(^{††}\) 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.
Access to specialist staff with expertise in infection prevention and control

Staff had access to advice from specialist staff with expertise in infection prevention and control such as a consultant microbiologist and infection prevention and control nurse at Mayo University Hospital. There was no dedicated infection prevention and control nurse position at CHO2 level.

An infection prevention and control link nurse,‡‡ with training in infection prevention and control, was available for consultation to the unit.

Outbreak management

Hospital management told inspectors that there had been no known outbreak of infection in the unit for the previous few years. There was one single room with an en-suite facility which was prioritised for patients with a suspected or confirmed transmissible infection. On the day of inspection signage to communicate isolation precautions was observed and personal protective equipment was available outside the isolation room.

Alcohol gel was available outside six-bedded patient care rooms however not readily accessible at point of care;¹¹ this needs review. Hand hygiene sinks located in patient rooms were compliant with HBN 00-10 Part C: Sanitary assemblies¹² and hand hygiene information signage was observed.

Hospital management told inspectors that the unit was actively promoting the influenza vaccine. A clinical nurse manager in community services had provided information to staff and peer vaccinators had been appointed to support staff to access the flu vaccine. The unit had a process for ensuring patients received the flu vaccine during their stay at the hospital. However December 2019 records showed that the uptake by staff was well below the HSE’s target of 75% for 2019/2020 influenza season: this needs to be reviewed.

Infrastructure, maintenance and storage

Overall the infrastructure of the Rehabilitation Unit was dated and poorly maintained. Surfaces were damaged on flooring, plasterwork and paintwork (doors, window ledges and skirting) in many areas. The number of toilet and shower facilities were insufficient and spatial separation between some beds in six-bedded rooms was limited.¹³ A door to an anteroom leading into the single isolation room was missing.

There was a lack of appropriate storage facilities and inappropriate storage was observed for example three mattresses were stored on floor surfaces and cleaned equipment was stored in a wet room (with a toilet and shower facility).

‡‡ The role of the infection prevention and control link nurse was to increase awareness of infection control issues in their ward and motivate staff to improve practice.
Maintenance issues featured as an agenda item on team meetings and health and safety meetings however the maintenance team did not appear to be represented. It was not evident from minutes reviewed that updates on actions required were given.

**Environment and equipment hygiene**

During this inspection opportunities for improvement were identified in relation to environmental hygiene and oversight of same. For example, in some areas there was:

- dust visible on undercarriages of beds, floors surfaces and storage systems and behind radiator covers on the corridor
- dusty ventilation extract grilles and stained window frames
- staining on under surfaces of armchairs and bin lids and on some privacy curtains at bed spaces.

The surfaces of some furnishings such as beside tables and armchairs were damaged and sticky residue was evident on many bedside wardrobes and bins which did not facilitate effective cleaning. Staff told inspectors that some bedside furnishings were due to be replaced shortly. The base of some non-clinical waste bins were missing and unsuitable temporary measures to address this deficiency had been put in place which is not in line with current best practice guidelines.\(^\text{14}\)

The need for improvement in the management of patient equipment was also identified. Staining and or dust was observed on some items such as manual handling equipment, a medication trolley and medication fridge. Some blood pressure cuffs were either worn and or single-use and should have been replaced. During this inspection mattress and pillow covers inspected appeared intact.

Patient equipment cleaning schedules did not identify all items of equipment requiring cleaning for example wheelchairs and therefore needs review. Additionally there was no clearly defined process in place for identifying cleaned items as a green labelling system used to identify cleaned items was inconsistently applied. Furthermore environmental hygiene daily check-clean lists reviewed did not always identify if and when cleaning had taken place.

Documentation provided by the hospital showed that a hygiene audit was last performed in March 2019. The audit also identified deficiencies however it was unclear if an action plan had been put in place and re-audit carried out. The results of and learning from measurement data should be used to improve the safety and quality of the care provided.

Minutes of a Rehabilitation Unit staff ward meeting viewed identified issues in relation to hygiene standards in October 2019. Furthermore, minutes of health and
safety and nurse manager meetings held in December 2019 and January 2020 identified the need to follow-up on hygiene audits.

In light of the findings of this inspection cleaning specifications including cleaning methods, frequency, training, and oversight of hygiene service delivery need to be revised and improved upon. Auditing procedures should form part of the ongoing management and supervision of cleaning services.

Policies, procedures and guidelines

The hospital had an up-to-date guideline for the management of infection prevention and control at the hospital which included standard and transmission-based precautions and outbreak management.

It was reported that a group with responsibility for providing oversight and standardisation of policies, procedures and guidelines across the community health organisation had been recently established at CHO 2 level.

Staff training

Management told inspectors that a HSElanD online training programme in relation to hand hygiene was mandatory for staff every two years. Documentation reviewed showed that 100% of staff were up to date with this online training. Inspectors were told that two staff members had undertaken a ‘train the trainer’ programme and assessed staff competence in relation to hand hygiene practices in the unit.

Staff had also attended infection prevention and control training in relation to standard and transmission-based precautions at the Centre of Nurse and Midwifery Education Mayo. At the time of inspection 82% of staff had completed this training.

Hospital management told inspectors that training in relation to safe cleaning systems was provided to staff with responsibility for hospital cleaning on an annual basis.

Safe use of medicines

The hospital had processes in place for the safe use of medicines and practices were reviewed and monitored regularly. Medication management and medication errors were a standing agenda item on health and safety committee meetings and discussed at clinical nurse managers meetings.

Pharmacy arrangements

A formalised agreement for provision of dispensing services was in place with Mayo University Hospital. Staff reported that access to advice from a pharmacist was also available.
Audit

Medication management audits in relation to administration, reconciliation, and prescribing of psychotropics, analgesics and antibiotics was undertaken in October and November 2019 in the unit. Documentation reviewed showed that results were shared at local staff meetings held in the unit and the hospital’s nursing management meetings.

As a safety initiative staff nurses wore red aprons during medication administration rounds indicating that they were not to be disturbed when administering medications. However, the effectiveness of this initiative had not been formally evaluated.

Medicine reconciliation

The unit had a formalised medication reconciliation procedure to guide and inform nursing staff on medication reconciliation during admission, transfer and discharge of patients. The hospital had a ‘medication prescription and administration record’ which included a reconciliation record for checking medication lists on admission and discharge, and for recording and acting on any discrepancies identified. It was reported that discrepancies were reported to the nurse manager, doctor and or pharmacist at Mayo University Hospital.

Policies, procedures and guidelines and other information

The hospital had an up-to-date medication management policy which included guidance in relation to ordering, receipt, storage, administration, and disposal of medicines for the Designated Centre for Older People at the hospital. It is recommended that this policy is reviewed to ensure of its applicability to the Rehabilitation Unit.

The 10 rights of medication administration was included on the ‘medication prescription and administration record’ and displayed on drug trolleys as reminders to staff. Labels to identify sound-alike-look-alike-drugs (SALADS) were placed on medications when applicable. Staff had access to information sources for example the ‘Monthly Index of Medical Specialities’ (MIMS) prescribing guide. Other information displayed at the point of use included a reference guide in relation to transdermal opioid patches.

The hospital did not have an official list of high-risk medication however, double checking of high risk medications such as insulin’s, anticoagulants and controlled drugs was included in the medication management policy. Medicine safety alerts

The 10 rights of drug administration include right patient, right reason, right drug, right route, right time, right dose, right form, right action, right documentation and right response.
such as from the Irish Medication Safety Network were received via the pharmacy department and from CHO 2. Alerts were stored in a folder on the medication trolley and discussed at local ward meetings.

Nursing staff undertook a pain assessment on patients prior to and following the administration of analgesics.

**Storage of medicines**

All medicines were stored in a secure manner. Controlled drugs*** were locked in a separate cupboard from other medicinal products in line with Misuse of Drugs legislation.**16** A designated fridge for medicines requiring storage at a required temperature was available and temperature was recorded nightly.

**Staff training**

The HSElanD medication management online training programme**17** was mandatory for registered nurses annually. 100% of nursing staff were up to date with training at the time of inspection.

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*** Substances, products or preparations, including certain medicines, that are either known to be, or have the potential to be, dangerous or harmful to human health, including being liable to misuse or cause social harm, are subject to control under the Misuse of Drugs Acts 1977 to 2016. They are known as "controlled drugs".
3.0 Conclusion

Overall inspectors found that the Rehabilitation Unit was endeavouring to fully implement the *National Standards for Safer Better Healthcare*.

**Leadership, Governance and Management**

Inspectors found that there were clear lines of accountability, responsibility and management arrangements in place at the unit. Hospital management had put several oversight committees in place in which to govern service provision. Notwithstanding this a review at corporate level to ensure that the necessary resources are available to enable, and support integration of corporate and clinical governance arrangements is recommended.

The hospital had defined systems in place to identify and manage risk and for reporting of clinical incidents. Performance data such as, service user feedback, medication management audits and patient safety incidents, to provide assurance on the safety of the service were monitored.

All staff were up-to-date with mandatory hand hygiene and nursing staff with medication management online training. The hospital had an up-to-date suite of policies, procedures and guidelines to guide and support staff in relation to infection prevention and control and safe use of medicines.

**Person-centred care and support**

The hospital had completed a satisfaction survey in 2019 and had plans to repeat the audit in 2020. In the interim an action plan to address the findings of this survey should be implemented.

A suite of generic patient information leaflets in relation to the safe use of medicines and infection prevention and control and specific information leaflets about the Rehabilitation Unit were available. Furthermore patients who spoke with inspectors voiced satisfaction about the care they received.

**Safe care and support**

**Prevention and control of healthcare-associated infections**

Staff has access by phone to specialist advice at Mayo University Hospital. However in light of some inspection findings specialist staff with expertise in infection prevention and control should be made available to help community services identify local needs in order to improve infection prevention and control.9 There was no dedicated infection prevention and control nurse position at CHO2 level.

While inspectors were informed that plans to relocate to another unit in the hospital were underway, environmental and patient equipment hygiene service delivery and
ongoing preventative maintenance programmes needed to be improved upon to facilitate compliance with national standards and recommended practices.

Safe use of medicines

The Rehabilitation Unit had a formalised agreement for provision of dispensing services with Mayo University Hospital. Notwithstanding this arrangements should be formally reviewed by both parties on a regular basis.

Inspectors found that the safe use of medicines agenda was being actively progressed at the Rehabilitation Unit. The hospital had processes in place for the safe use of medicines and practices were reviewed and monitored regularly. A medicine reconciliation programme was in place.

Following this inspection the hospital needs to address the areas for improvement identified in this report and requires the support of the CHO to effectively address issues highlighted in order to facilitate compliance with the National Standards for Safer Better Healthcare and other existing national healthcare standards.
4.0 References


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