



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of the announced inspection of Rehabilitation and Community Inpatient Healthcare Services at the Rehabilitation Unit: St. Joseph's Hospital, Ennis.

Monitoring programme against the *National Standards for
Infection Prevention and Control in Community Services* during
the COVID-19 pandemic

Date of inspection: 30 July 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. In light of the ongoing global pandemic of COVID-19 and its impact on the quality and safety of care for patients admitted to rehabilitation and community inpatient healthcare services, HIQA has developed a monitoring programme to assess compliance with the *National Standards for Infection Prevention and Control in Community Services*.

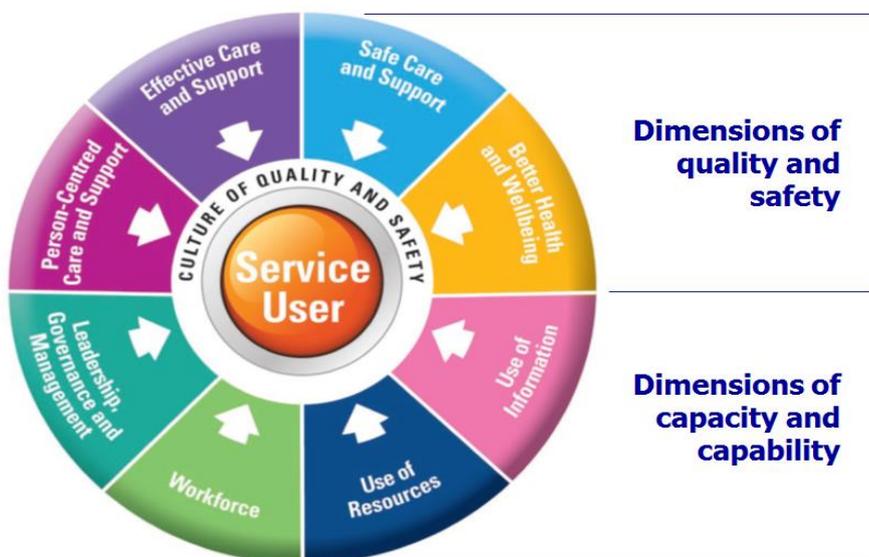
The National Standards provide a framework for service providers to assess and improve the service they provide particularly during an outbreak of infection including COVID-19.

Inspection findings are grouped under the National Standards dimensions of:

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

Under each of these dimensions, the standards* are organised for ease of reporting.

Figure 1: National Standards for infection prevention and control in community services



National Standards for infection prevention and control in community services

Report structure

The lines of enquiry for this monitoring programme of infection prevention and control in community services will focus on six specific national standards within four of the eight themes of the standards, spanning both the capacity and capability and quality and safety dimensions.

This monitoring programme assesses Rehabilitation and Community Inpatient Healthcare Services' **capacity and capability** through aspects of the themes:

Capacity and Capability	
Theme	Standard
5: Leadership, Governance and Management	<p>Standard 5.1: The service has clear governance arrangements in place to ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship.</p> <p>Standard 5.2: There are clear management arrangements in place to ensure the delivery of safe and effective infection prevention and control and antimicrobial stewardship within the service.</p>
6: Workforce	<p>Standard 6.1: Service providers plan, organise and manage their workforce to meet the services' infection prevention and control needs.</p>

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

Quality and Safety	
Theme	Standard
2: Effective Care & Support	<p>Standard 2.2: Care is provided in a clean and safe environment that minimises the risk of transmitting a healthcare-associated infection.</p> <p>Standard 2.3: Equipment is decontaminated and maintained to minimise the risk of transmitting a healthcare-associated infection.</p>
3: Safe Care and Support	<p>Standard 3.4: Outbreaks of infection are identified, managed, controlled and documented in a timely and effective manner</p>

Judgment Descriptors

The inspection team used an assessment judgement framework to guide them in assessing and judging a service's compliance with the National Standards. The assessment judgement framework guides service providers in their preparation for inspection and support inspectors to gather evidence when monitoring or assessing a service and to make judgments on compliance.

Following a review of the evidence gathered during the inspection a judgment has been made on how the service performed. The following judgment descriptors have been used:

Compliant	Substantially compliant	Partially compliant	Non-compliant
A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant National Standards.	A judgment of substantially compliant means that the service met most of the requirements of the National Standards but some action is required to be fully 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.	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 Rehabilitation Unit known as the Cherry Unit is located within St. Joseph's Hospital, Ennis. St. Joseph's Hospital Ennis, is a statutory hospital owned and managed by the Health Service Executive (HSE) and under the governance of the HSE Mid- West Community Healthcare Organisation (CHO) 3.[†] The 12 bedded Rehabilitation Unit comprised the in-patient ward located in the Cherry Unit and the occupational and physiotherapy departments.

Patients were provided with gymnasium and ward-based physiotherapy. The hospital had recently renovated the physiotherapy gymnasiums and occupational therapy room where patients attended for assessment and treatments.

The Rehabilitation Unit provided a multi-disciplinary in-patient service to patients who have experienced deterioration in function following recent illness or surgery. This could include falls, decreased mobility, stroke, neurological conditions or amputation. Referral to the Rehabilitation Unit was by the Consultant Geriatrician or General Practitioner (GP).

The Medical team consisted of a consultant geriatrician and a medical registrar. On arrival to the Rehabilitation Unit patients were admitted by the registrar who then referred patients to other services as appropriate.

1.2 Information about this inspection

This inspection report was completed following an announced inspection carried out by Authorised Persons, HIQA; Kathryn Hanly and Siobhan Bourke on 30 July 2020 between 10:00 hrs. and 15:30 hrs. Inspectors informed the hospital manager of the inspection 48 hours prior to the onsite inspection.

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

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

[†] Community Health Organisation (CHO) 3 consists of Limerick, Clare and North Tipperary.

2.0 Inspection Findings

2.1 Capacity and Capability

This section describes arrangements for the leadership, governance and management of the service at this hospital, and HIQA's evaluation of how effective these were in ensuring that a high quality safe service was being provided. It includes how the service provider is assured that there are effective governance structures and oversight arrangements in place for clear accountability, decision-making, risk management and performance assurance. This includes how responsibility and accountability for infection prevention and control is integrated at all levels of the service. This is underpinned by effective communication among staff. Inspectors also reviewed how service providers plan, manage and organise their workforce to ensure enough staff are available at the right time with the right skills and expertise and have the necessary resources to meet the service's infection prevention and control needs.

Theme 5: Leadership, Governance and Management

Standard 5.1: The service has clear governance arrangements in place to ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship.

Judgment Standard 5.1: Compliant

Corporate and Clinical Governance

Inspectors were informed that the General Manager for Residential Services for Older Persons had overall responsibility, responsibility and authority for infection prevention and control and antimicrobial stewardship within St. Joseph's Hospital. The Director of Nursing was responsible for operational management of the hospital and reported directly to the General Manager for Older Persons Services.

The organisational chart viewed by inspectors clearly outlined responsibility, accountability and authority arrangements and reporting relationships for staff within the organisation.

A consultant geriatrician from University of Limerick Hospitals Group was responsible for the medical care of patients admitted to the Rehabilitation Unit. The Consultant Geriatrician reported within the governance structures of University of Limerick Hospitals Group.

A full time medical registrar was designated to the rehabilitation unit to provide medical care as required for patients. It was reported that this doctor was onsite Monday to Friday during normal working hours (9am-5pm).

If a patient in the rehabilitation unit required medical review outside of normal working hours, nursing staff contacted the local on call general practitioner services (SHANNONDOC) to review patients.

At the time of the announced inspection it was explained that the hospital's Infection Prevention and Control Committee was not operational. However documentation reviewed indicated that this committee was in the process of being re-established.

Documentation reviewed indicated that infection prevention and control was a standing agenda item on both the older persons residential service's management team meetings and the clinical nurse manager meetings.

Prompt establishment of an outbreak control team coupled with early communication and the rapid institution of early control measures are the most effective ways of limiting the extent of outbreaks in hospitals.¹ Discussion with staff and review of documentation showed that an Emergency Management Team was convened to advise and oversee the management of outbreaks of infection at the hospital. It was confirmed at interview, and verified in the documentation which was reviewed, that the Emergency Management Team meetings were well attended with a structured agenda and schedule. Outbreak management will be presented in section 2.2 of this report.

There was evidence of collaboration regarding infection prevention and control at CHO3 level. For example the Director of Nursing attended quarterly quality and patient safety committee meetings for CHO 3 Social Care Division. Inspectors were informed that infection prevention and control was a standing agenda item at these meetings.

Inspectors were also informed that weekly Outbreak Crisis Team teleconferences were held to discuss planning for and management of COVID-19 within CHO 3. The CHO3 Senior Management Team, General Manager, Head of Service, business manager, infection prevention and control nurse, risk advisor and the nine Directors of Nursing from the CHO attended these teleconferences.

CHO 3 had established a Regional Cleaning Committee. This committee aimed to review and standardise hygiene audit practices, frequencies and processes across the Community Healthcare Organisation. A review of this committee was outside the scope of this inspection. However, the formation of this committee demonstrated progression towards a coordinated approach to hygiene standards in the region.

Monitoring, Audit and Quality assurance arrangements

The hospital had a number of effective assurance processes in place in relation to the standard of hospital hygiene. An audit schedule was in place whereby environmental and patient equipment hygiene was monitored on the Rehabilitation Unit each month. Results of these audits were tracked and trended by management and time-bound quality improvement plans were developed following audits. In addition, the community infection prevention and control nurse performed validity audits in relation to the environment and patient equipment hygiene at the hospital. An environmental hygiene audit carried out by the community infection prevention and control nurse in July 2020 demonstrated 94% compliance with desired standards. This high level of compliance was evident on the day of inspection. Findings in relation to the standards of hygiene in the clinical areas visited on this inspection will be presented in section 2.2 of this report.

Compliance with the appropriate use of surgical facemasks by staff for personal protection and source control was also monitored. A recent audit confirmed high levels of compliance with the use of surgical facemasks within the Rehabilitation Unit.

High levels of antimicrobial usage increases the number of patients who are colonised or infected with resistant organisms, both in healthcare facilities and in the community.² The volume of antimicrobial use was monitored. However there were no other ongoing antimicrobial stewardship activities[‡] within the unit, for example audit of compliance against the prescribing guidelines. This should be reviewed.

Coordination of care within and between services

It was reported that the majority of patients were admitted from acute hospitals within the University of Limerick Hospitals Group. Admissions to the Rehabilitation Unit were managed in line with HSE/ HPSC COVID-19 guidelines.³ Prior to admission to the Rehabilitation Unit, an infection prevention and control assessment was undertaken and documented on the HSE mid-west community interfacility infection prevention and control transfer form. This was an example of good practice.

[‡] Antimicrobial stewardship refers to coordinated interventions designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration.

Standard 5.2: There are clear management arrangements in place to ensure the delivery of safe and effective infection prevention and control and antimicrobial stewardship within the service.

Judgment Standard 5.2: Compliant

The hospital had systems in place to identify and manage risks in relation to the prevention and control of healthcare-associated infection. Nursing management had undertaken local risk assessments in relation to infection prevention and control of COVID-19 in the rehabilitation unit.

An infection prevention and control risk register was in place and regularly monitored. The risk register was managed by the Director of Nursing. Inspectors also viewed the hospital risk register and noted that risks were identified, existing controls to manage risks were in place and a person assigned to address the risk.

Inspectors were informed that risks identified in clinical areas were addressed at clinical area level or were documented and escalated as required. A number of infection prevention and control risks were escalated to the hospital corporate risk register. Additionally, decisions made were communicated appropriately, and actions were implemented within defined timelines.

Hospital management informed inspectors that it was hospital policy to report incidents of healthcare-associated infection on the National Incident Management System (NIMs).[§] It was noted that there were no infection prevention and control related incidents reported in the Rehabilitation Unit in the 12 months prior to the date of inspection.

Staff communicated information about patient safety issues including infection prevention and control at a daily safety pause⁴ at shift handover. Recent discussions included the Covid-19 preparedness plan, the importance of social distancing, appropriate use of personal protective equipment (PPE)** and hand hygiene.

Management informed inspectors that peer vaccinators delivered flu vaccinations to staff. However it was reported that uptake rates for influenza vaccine amongst staff did not reach the national uptake target of 65% in 2019/2020 influenza season.⁵ Uptake of the seasonal influenza vaccine in the 2020/ 2021 influenza season needs to be a focus for improvement to meet the 2020/ 2021 target of 75%.

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

** Personal protective equipment (PPE) refers to a variety of barriers, used alone or in combination, to protect mucous membranes, airways, skin and clothing from contact with infectious agents. PPE used as part of standard precautions includes aprons, gowns, gloves, surgical masks, protective eyewear and face shields.

Policies, procedures and guidelines

The hospital had an up-to-date suite of infection prevention and control policies, procedures and guidelines which covered aspects of standard precautions, transmission-based precautions.

Management had developed procedures for the management of patients with suspected and confirmed COVID-19 infection, including appropriate infection control precautions to protect staff and patients.

A COVID-19 resource folder was available within the Rehabilitation Unit. This contained up-to-date national guidelines, local terminal cleaning and decontamination protocols and local COVID-19 infection prevention and control policy and procedures. Individual staff members were also provided with a COVID-19 information sheet and a copy of the St Joseph's Hospital Preparedness Plan.

Theme 6: Workforce

Standard 6.1: Service providers plan, organise and manage their workforce to meet the services' infection prevention and control needs.

Judgment Standard 6.1: Compliant

Access to specialist staff with expertise in infection prevention and control

A community infection prevention and control nurse advised on all aspects of infection prevention and control and provided education and assistance in outbreak management as required.⁶ The community infection prevention and control nurse attended onsite periodically and as required.

An infection prevention and control link nurse was available on the Rehabilitation Unit to promote and support good practice in relation to infection prevention and control.

Discussions with staff working in the service confirmed that they had a clear understanding of their roles and responsibilities in working to prevent and control infection.

The hospital's COVID-19 preparedness plan identified the minimum staffing needs and prioritised critical and non-essential services based on patients' health status, functional limitations, disabilities, and essential facility operations.

Infection Prevention and Control Education

Infection prevention and control training was delivered to all staff, inclusive of agency staff, by an onsite training facilitator. Inspectors were informed that all staff had received training on standard infection prevention and control precautions,

transmission-based precautions, outbreak prevention and management and COVID-19 including appropriate use of PPE for patients with suspected or confirmed Covid-19.

Documentation reviewed indicated that 100% of staff had completed hand hygiene training within the previous two years. Hand hygiene observation audits were also undertaken. Staff achieved a hand hygiene compliance rate of 95% in May 2020.

Management reported that nursing staff had recently undergone training in the administration of intravenous^{††} medicines delivered by the Centre of Nursing and Midwifery Education in University Hospital Limerick. However nursing staff had not received any antimicrobial stewardship education as part of this training.

2.2 Quality and Safety

This section looks at how rehabilitation and community inpatient healthcare services ensure that infection prevention and control outbreak/s including COVID-19, are managed to protect people using the healthcare service. This includes how the services identify any work practice, equipment and environmental risks and put in place protective measures to address the risk, particularly during a pandemic.

It also focuses on how these services ensure that staff adhere to infection prevention control best practice^{††} to achieve best possible outcomes for people during the ongoing COVID-19 pandemic.

Theme 2: Effective Care and Support

Standard 2.2: Care is provided in a clean and safe environment that minimises the risk of transmitting a healthcare-associated infection.

Judgment Standard 2.2: Substantially- Compliant

- A need for improvement noted with the infrastructure of the Rehabilitation Unit.

Environment and infrastructure

Overall, the general environment in the unit was clean with few exceptions.

Patient rooms were spacious with surfaces, finishes and furnishings that readily facilitated cleaning.

However a number of infrastructural issues which had the potential to impact on infection prevention and control measures were identified during the course of the

^{††} Intravenous is a way of administering medicines directly into the vein via an injection or infusion

inspection. For example, the clinical room was small in size and did not facilitate effective infection prevention and control measures including the preparation of intravenous medicines. There was only one single en-suite patient room available. Multi-occupancy rooms did not have ensuite toilet/shower facilities. Shower and sanitary facilities in the unit required upgrading.

Hospital management was working to mitigate risks in respect of hospital infrastructure through refurbishment of existing facilities. Inspectors were informed that the Rehabilitation Unit was due to be relocated to a new area within the hospital in approximately eight weeks. This should address the concerns identified relating to infrastructure outlined within this report. Furthermore, inspectors were informed that the expertise of the community infection prevention and control team was sought regarding the refurbishment of the new unit.

Hand hygiene facilities

The design of clinical hand wash sinks in the unit conformed to Health Building Note 00-10 Part C: Sanitary assemblies.⁷ The availability of moisturiser at hand hygiene sinks throughout the ward and in the dirty utility room should be reviewed. Hand hygiene compliance and the appropriate use of hand hygiene products are very dependent on appropriate product placement. In addition the underside of several alcohol gel dispensers were unclean.

Patient placement

Transmission-based precautions were applied to patients suspected or confirmed to be infected with agents transmitted by the contact, droplet or airborne routes. Patients colonised with multidrug resistant organisms such as meticillin-resistant *Staphylococcus aureus* (MRSA) were barrier nursed in multi-occupancy rooms. Such an approach is not ideal as the preference is for colonized or infected patients to be managed in single rooms where possible – however in the absence of appropriate facilities it may be considered as a short-term control measure. Signage was positioned prominently outside the rooms of patients requiring transmission-based precautions.

Inspectors spoke with a number of patients. Patients were very positive in their feedback to inspectors and expressed satisfaction about the standard of environmental hygiene within the unit and the care provided.

Cleaning resources

Cleaning and hygiene duties were undertaken by household staff and specialised cleaning teams within the hospital. Inspectors were informed that there were sufficient cleaning resources to meet the needs of the unit. A member of the deep cleaning team had been allocated to the unit. This staff member had completed a nationally accredited training programme in environmental and equipment cleaning.

The recently updated hospital cleaning policy and procedure provided guidance on cleaning techniques and best practice advice on defining responsibilities, scheduling work, measuring outcomes, reporting and driving improvements in environmental hygiene. A regular cleaning checklist, deep clean checklist and additional cleaning checklist for nurses/healthcare assistants/ multi-task attendants were in use and were monitored by the clinical nurse manager on the unit.

It was noted that the cleaning checklist was not comprehensive. For example in the sterile supplies storage unit in the clinical room was not included. Unacceptable levels of dust were present in the shelves of this unit.

Standard 2.3: Equipment is decontaminated and maintained to minimise the risk of transmitting a healthcare-associated infection.

Judgment Standard 2.3: Compliant

Equipment hygiene

Overall, equipment in the Rehabilitation Unit was clean and well maintained with few exceptions. Where there were exceptions, these were brought to the attention of the ward manager for resolution.

Inspectors were informed that patient wash bowls were rinsed in the clinical hand hygiene sinks and occasionally decontaminated in the bedpan washer. This practice should be reviewed. Hand hygiene sinks should be dedicated for hand hygiene only. There is also a potential for recontamination of washbowls as soon as it is removed from the bedpan washer if procedures are inadequate.

Designated care equipment including blood pressure monitors and hoist slings were available for patients in the rehabilitation unit, which is good practice.

Inspectors viewed daily equipment cleaning checklists and schedules and noted they were consistently completed and were monitored by the Clinical Nurse Manager on an ongoing basis.

Theme 3: Safe Care and Support

Standard 3.4: Outbreaks of infection are identified, managed, controlled and documented in a timely and effective manner

Judgment Standard 3.4: Compliant

COVID-19 Preparedness

There were no patients confirmed or suspected to have COVID-19 in the Rehabilitation Unit on the day of the inspection.

The Director of Nursing was the designated lead for COVID-19 preparedness and response within the hospital. COVID-19 preparedness plans were in place and included planning for cohorting of patients (COVID-19 separate from non-COVID-19), enhanced infection prevention and control, resource and consumables management, visiting restrictions, staff and workflow management (including staff training), establishing surge capacity and promoting patient and family communication.

Local guidelines on infection prevention and control measures for the management of possible and confirmed cases of COVID-19 infection had also been developed based on national guidance from the Health Service Executive (HSE) and the Health Protection Surveillance Centre³ (HPSC).

A risk assessment of admissions to the rehabilitation unit had been undertaken and measures to manage the risk of COVID-19 transmission from patients admitted from the acute settings. Patients admitted to the unit from acute hospitals were routinely tested for COVID-19 within the three days before admission. Patients admitted from the community were isolated and tested on admission in line with national guidelines.

Patients were monitored for symptoms compatible with COVID-19 on a daily basis. Information about atypical presentation of COVID-19 infection had been highlighted.

Routine weekly sampling of all staff for detection of COVID-19 in the unit had been implemented over the previous month. A number of registered nurses within the unit had been trained to perform the sampling for COVID-19. Inspectors were informed that tests were processed in University Hospital Limerick and had an average turnaround time of 24 hours. Medical and nursing staff had access to laboratory reports from University of Limerick Hospitals Group on ward based computers.

The hospital had put measures in place to eliminate crossover of staff between the designated centre for older people and the Rehabilitation Unit. Due to the likelihood of SARS-CoV-2 transmission by persons with few or no symptoms, the hospital had implemented measures to ensure that physical distancing measures are implemented by staff, visitors and patients. For example group meetings and social interaction among staff were restricted or held in a room where physical distancing could be maintained. Staff members were also required to adopt social distancing measures during their break and meal times. When patients left the rehabilitation unit for occupational therapy and physiotherapy they did not mix with residents from other areas of the hospital.

Occupational health supports including psycho-social supports were available to staff.

Outbreak management

Hospital management reported that systems were in place to manage and control infection outbreaks in a timely and effective manner. All outbreaks in the hospital were reported to the regional Medical Officer of Health (MOH) at the Department of Public Health.

Inspectors were informed that there had been no outbreaks of infection within the rehabilitation unit in the past year. A review of documentation showed that the emergency management team was convened to advise and oversee the management of an outbreak in the onsite residential care service. Appropriate infection control measures had been implemented and the outbreak was contained. There was no evidence of cross infection to patients within the rehabilitation unit.

3.0 Conclusion

Overall, this inspection identified that the Rehabilitation Unit was compliant with five of the six of the *National Standards for infection prevention and control in community services* assessed.

Leadership, Governance and Management

Effective leadership, governance and management arrangements were evident around the prevention and control of healthcare-associated infection at the hospital.

The Infection Prevention and Control Committee was in the process of being re-established at the time of the inspection. Infection prevention and control was a standing agenda item on both older persons residential services management team meetings and clinical nurse manager meetings. An Emergency Management Team was convened to advise and oversee the management of outbreaks of infection at the hospital.

The Director of Nursing reported positive and supportive engagement from and within CHO3. Regular performance updates in relation to infection prevention and control were consistently reported through the established hospital governance structure. The hospital had systems in place to identify and manage risks in relation to the prevention and control of healthcare-associated infection. Infection prevention and control was discussed at daily safety pauses within the unit.

A variety of systems were used to ensure that environmental and equipment cleaning standards were met. These included cleaning specifications and checklists, colour coding to reduce the chance of cross infection, infection control guidance, and audits of equipment and environmental cleanliness.

Up-to-date infection prevention and control policies and procedures were in place and based on national guidelines. Efforts to integrate infection prevention and control guidelines into practice were underpinned by education and training.

Workforce

Established communication pathways were in place including access to external expertise in infection prevention and control. A link-nurse program supported infection prevention and control practices within the unit. The roles and responsibilities of staff were clearly defined in COVID-19 preparedness plans and the service supervised, monitored and reviewed the provision of care to ensure all members of the workforce understand their responsibilities.

Effective Care and Support

A number of infrastructural issues which had the potential to impact on infection prevention and control measures were identified during the course of the inspection. Hospital management was working address the issues with the existing infrastructure in the unit through the planned move to the newly refurbished unit.

Overall, the general environment and equipment in ward inspected were clean and well maintained with few exceptions. Staff undertaking environmental and equipment decontamination processes had the necessary training and competencies to do so. The responsibilities for staff were clearly defined and documented.

Safe care and support

Hospital management reported that systems were in place to manage and control outbreaks of infection in a timely and effective manner. The hospital had developed COVID-19 preparedness plans. COVID-19 preparedness plans in the Rehabilitation Unit were based on contingency planning, early recognition, isolation, care and prevention of onward spread.

Following this inspection the hospital needs to address the remaining areas for improvement identified in this report to effectively address issues highlighted in order to facilitate continued compliance with the *National Standards for infection prevention and control in community services* and other existing national healthcare standards.

4.0 References

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