



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of the unannounced inspection of Rehabilitation and Community Inpatient Healthcare Services at St Mary's Hospital, Phoenix Park

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

Dates of inspection: 2 October 2019

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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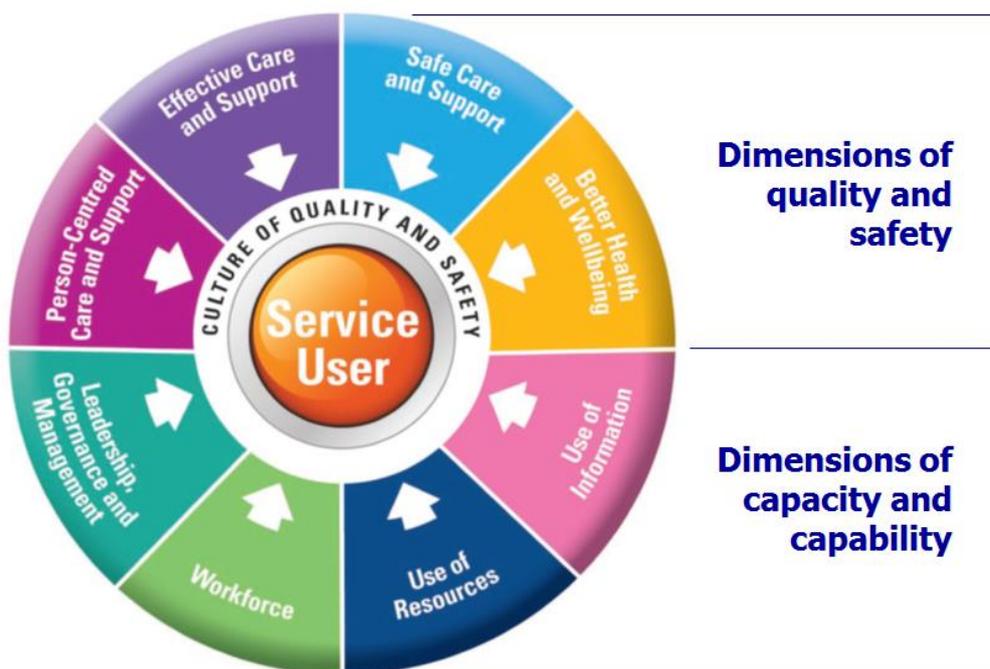
1.0 Information about this monitoring programme

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*¹ (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

St Mary's Hospital, Phoenix Park was a statutory hospital owned and managed by the Health Service Executive (HSE) and under the governance of Community Health Organisation (CHO) 9.* St Mary's Hospital comprised 75 beds. Inspectors were informed that 27 beds were closed at the time of the inspection for renovations.

The hospital accommodated 10 stroke rehabilitation beds, 22 general rehabilitation beds and 16 community response beds. Patients were admitted for rehabilitation following acute stroke, post falls, surgery, chemotherapy treatment and post heart transplant.

The community response unit admitted patients from the day hospital, directly from the community or from referring hospitals for example the administration of intravenous antibiotics, blood transfusions and rehabilitation.

1.2 Information about this inspection

This inspection report was completed following an unannounced inspection carried out by Authorised Persons, HIQA; Bairbre Moynihan, Noreen Flannelly-Kinsella and Geraldine Ryan on 2 October 2019 between 0915 hrs and 1715 hrs.

Inspectors spoke with hospital managers, staff and patients. Inspectors also requested and reviewed documentation, data and observed practice within the clinical environment in a sample of clinical areas which included:

- Rosal Community Response Unit – 16 bedded assessment unit
- Clements Unit – 22 bedded general rehabilitation unit

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

* Community Health Organisation 9 area consists of Dublin North, Dublin North Central and Dublin West.

2.0 Inspection Findings

2.1 Capacity and Capability

Theme 5: Leadership, Governance and Management

Standard 5.2

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

Judgment: Substantially compliant

There was a lack of progression with identified actions from the corporate hygiene committee meetings and no timeframes stated for the completion of identified actions.

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.

Inspectors found that there were clear lines of accountability and responsibility in relation to corporate and clinical governance arrangements at St Mary's hospital.

Corporate and Clinical Governance

The hospital manager reported to the general manager for older persons, CHO 9 who reported to the chief officer of CHO 9. The director of nursing and consultant geriatricians reported to the hospital manager. Medical cover was available twenty-four hours a day, seven days a week. Two consultant geriatricians had an on-call rota of one month on and one month off.

Management informed inspectors that a number of health and social care professional managers including dietetic manager, physiotherapy manager and speech and language therapy manager had dual reporting relationships to the hospital manager and to CHO 9. Inspectors were informed that physiotherapy and occupational therapy services were restricted in Rosal Community Response Unit as some of the posts were vacant and as a consequence patients with a higher level of complexity were not admitted to this unit. Inspectors were informed that inpatients requiring physiotherapy or occupational therapy input were referred and reviewed by the relevant health and social care professional from another unit.

Reporting arrangements in relation to committees

Hospital management had established several hospital committees through which to govern services and address quality and safety issues. The drugs and therapeutics committee, infection prevention and control committee reported to the clinical

quality and safety committee. The corporate hygiene committee reported to the hospital management committee.

The clinical quality and safety committee was chaired by the Consultant Geriatrician and met every six weeks. Membership of this committee included a consultant geriatrician, the director of nursing and the quality and safety manager. Items discussed by this committee included, compliments and complaints, audit, key performance quality indicators and outcomes and staff training.

The clinical quality and safety committee in turn reported to the hospital manager and hospital management committee. Quality and safety was a standing agenda item. The multidisciplinary hospital management committee was chaired by the hospital manager.

The hospital management committee reported to the general manager for older persons' services, CHO 9. A strategic committee meeting was held quarterly with designated HSE Senior Managers from CHO 9. Representation from St Mary's included the hospital manager, the director of nursing, a consultant geriatrician and the quality and safety manager.

Inspectors also reviewed minutes of hospital committees and identified a number of issues for example:

- Inspectors noted a lack of progression with identified actions from the corporate hygiene committee with no timeframe for the actions.
- It was not evident from the agenda or a sample of clinical quality and safety committee minutes reviewed by the inspectors that the infection prevention and control and drugs and therapeutics committee provided regular updates at this meeting. The risk register was also a standing agenda item at the clinical quality and safety committee although it had not been reviewed in the meeting minutes viewed by an inspector.

Minutes from meetings must clearly outline actions arising from the meetings, persons responsible and timeframes afforded to actions identified. The clinical quality and safety committee should have a reporting schedule for the committees reporting into it in line with guidance.²

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

St Mary's hospital accepted patient referrals from the Mater Misericordiae University hospital and Connolly hospital Blanchardstown. In the event of a patient becoming acutely unwell and requiring transfer to an acute hospital, the medical team

arranged the patient's transfer by ambulance to the accepting hospital. The hospital had a transfer policy in place which was under review at the time of inspection.

Risk management

The hospital had systems in place to identify and manage risk in relation to the prevention and control of healthcare-associated infections and safe use of medicines. Two infection prevention and control risks were identified on the risk register however the infrastructure challenges and lack of isolation facilities were not included on the risk register. Management informed inspectors that they were in the process of updating the risk register in line with HSE risk register template³ and that training in relation to the new risk register was ongoing at the time of inspection.

Monitoring, Audit and Quality assurance arrangements

Inspectors were informed that incidents were reported on a paper-based system. These incidents were logged on the National Incident Management System (NIMs).[†] Management stated that the trending of incidents had recently commenced. Clinical incident review meetings were held every two weeks. This was attended by the director of nursing, a consultant geriatrician, assistant directors of nursing and members of health and social care professionals. The purpose of this meeting was to have a multidisciplinary review of clinical incidents from the previous two weeks and follow up on actions arising from the previous meeting. Staff informed inspectors that they attended the meeting and provided a reflection on a clinical incident. Staff were able to discuss the learning following the incident. This is an example of good practice.

It was reported that incidents noted by the external pharmacist were reported to the hospital. However it was not clear if or who recorded such incidents in the hospital. The hospital needs to review this practice, implement a formal procedure and communicate this to hospital staff.⁴

The hospital used the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) to categorise drug variances. It was evident that variances were identified, trended, categorised, discussed and actioned at the drug and therapeutics committee.

An audit plan was in place for both nursing and health and social care professionals. Inspectors viewed an audit undertaken by the medical team on medicine prescribing of doctors in August and September 2019. The audit outlined the overall results since the previous audit with areas for immediate action and associated action plans

[†] 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

outlined. However no dates for the completion of the actions were evident in the audit.

Infection prevention and control audits and safe use of medicines audits were completed and discussed under Theme 3: Safe Care and Support.

Taking feedback from patients and staff

St Mary's hospital had a complaint's officer onsite. Inspectors were informed that complaints were managed under "your service, your say"⁵ with the majority of complaints dealt with informally under Stage 1 of "your service, your say". A compliments and complaints policy was in place but it did not identify the date the policy was signed off or a review date.⁶ Management stated that they planned to train staff in de-escalation of complaints. Compliments and complaints were a standing agenda item on the clinical quality and safety committee and hospital management committee.

The HSE 'Values in Action' was in place in the hospital. 'Values in Action' is about delivering better experiences to those who use the services, and creating better workplaces for staff.⁶ The hospital had identified staff who were champions of this initiative. Meeting minutes reviewed by inspectors showed that this initiative was discussed at the hospital management committee. Management stated that staff were invited to join different committees for example staff were involved in a 'green team' committee to look at conservation and recycling. Management stated that staff could provide feedback and comments through the line management structure. However, staff in Rosal Community Response Unit advised an inspector that they were not aware of the staff feedback mechanism within the hospital. Management need to ensure that frontline staff are aware of the forums in place for providing feedback within the hospital.

2.2 Quality and Safety

Theme 1: Person-Centred Care and Support

Standard 1.1

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 service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care.¹

Overall, patients who spoke with inspectors stated that they were happy with their care received. Patients were assessed prior to admission and provided with written patient information. The hospital had recently completed a patient satisfaction survey.

Staff identification badges were worn by hospital staff in the clinical area inspected and by members of the executive management team.

A comprehensive suite of patient information leaflets was available and clearly displayed in Clements unit. Samples of patient information leaflets were available on Rosal Community Response Unit on safe use of medicines but were not displayed in a public area. Hospital-specific leaflets included information about services provided on the hospital and integrated discharge planning processes and generic leaflets relating to infection prevention and control and medicines information.

An inspector observed an activities co-ordinator on Rosal Community Response Unit and a number of patients engaging with the activity.

Coordination of care within and between services

The hospital had defined criteria for patient referral and or admission to the rehabilitation service. Patients were assessed prior to admission.

A sample of nursing and medical admission, transfer and discharge documentation was reviewed. Patient-specific infection prevention and control information was evident in the nursing admission notes. However the medical admission form and nursing transfer and discharge documentation did not capture this information. Hospital documentation should inform healthcare workers if a person is colonised or infected with a transmissible infection.⁷ A review of patient documentation by the hospital is recommended.

Evaluation of services

A patient satisfaction survey was conducted at the end of September. Management informed inspectors that results had been collated and an action plan would be devised following identification of the issues from the satisfaction survey.

Inspectors spoke with patients who voiced satisfaction about the care they received. While patients were aware of their discharge plan not all were aware of the name of the consultant responsible for their care. Patients had participated in the recent patient satisfaction survey undertaken at the hospital and reported that patient information leaflets were accessible. Inspectors noted that service user feedback forms were available in a physiotherapy room located on Clements unit.

Improvements brought about as a result of general feedback included upgrade of the entrance lobby and installation of automatic double doors.

Theme 3: 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.

Judgment: Substantially compliant

There was a lack of local and managerial oversight of environmental and equipment hygiene.

Prevention and control of healthcare-associated infections

Access to specialist staff with expertise in infection prevention and control

The hospital had access to specialist microbiologist expertise from Cherry Orchard Public Health Laboratory. Subsequent to the inspection management reported that this arrangement was a long standing arrangement; however a formal arrangement was not in place in line with National Standards.⁷ The post of infection prevention and control nurse had been vacant since May 2019. Inspectors were informed that a staff member with specialist infection prevention and control experience onsite was available for advice if required. Staff informed inspectors that they could also access advice from the community infection prevention and control nurse. An infection prevention and control link nurses[†] programme was in place. Link nurses attended the hospital's infection prevention and control committee meetings.

Communication

Signage to communicate infection prevention and control precautions was in place where required on Clements and Rosal Community Response unit.

St Mary's hospital had developed a risk assessment tool for staff to assess when to implement standard precautions or contact precautions for patients colonised with a multidrug resistant organism.

A staff communication board on both units identified patients colonised with a transmissible infection. Hand hygiene information signage was observed on both units.

[†] The role of the infection prevention and control nurse was to increase awareness of infection control issues in their ward and motivate staff to improve practice.

Infrastructure

The infrastructure was outdated. Inspectors observed issues in relation to general maintenance in both units inspected, for example damage to plasterwork, paintwork on walls, doors, skirting boards and flooring were poorly maintained and as such did not facilitate effective cleaning.

Although bed-spacing appeared adequate there were insufficient toilet and shower facilities on both units. The multi-occupancy patient care areas did not have en-suite facilities. Hand hygiene sinks located in patient rooms were not compliant with HBN 00-10 Part C: Sanitary assemblies.⁸

The single rooms in Clements unit did not have en-suite facilities but patients were assigned a designated toilet located adjacent to the single rooms on a main corridor. No single rooms for isolation were available in Rosal Community Response Unit. Inspectors were informed that the interim measure was to designate a four-bedded room and a toilet for isolation if required. However this meant that access to toilet facilities on both units for the remaining patients was restricted.

Environmental hygiene

Inspectors found that improvements were required in the management of environmental hygiene and oversight of same at ward level and hospital level, for example:

- Excess dust and staining were observed on and under surfaces of some furnishings, gaps in the flooring and on doors.
- Exposed pipe work and radiator design throughout the two units inspected did not facilitate effective cleaning.
- Inappropriate storage of supplies in both units for example administration folders, used linen, commodes and wheelchairs were stored in a wet room in Rosal Community Response unit and staff lockers were stored in the linen room.

Inspectors were informed that cleaning schedules were in place and that hygiene audits were carried out monthly by a member of St Mary's hospital staff and by the external cleaning contractor. Two recent sets of minutes from the corporate hygiene committee reviewed by inspectors documented that following the vacating of the infection prevention and control post no staff member was available to do the audits with the external cleaning company. Management need to identify a person to progress this.

Local monthly environmental hygiene audit results showed that hygiene audit scores ranged between 34% to 74% compliance from February 2018 to September 2019 in

Clements unit. It was unclear if an action plan was put in place following these audits.

Environmental hygiene audit findings were discussed at the corporate hygiene committee chaired by the hospital manager. However action plans were not consistently developed to address issues identified. In addition, inspectors noted that there appeared to be a lack of ownership relating to environmental hygiene audits results at unit level. The results of and learning from measurement data should be used to improve the safety and quality of the care provided.⁷

Equipment hygiene

Both units had a number of cleaning checklists in relation to patient equipment, general equipment, mattresses and the sluice room.

Equipment in Rosal Community Response Unit was generally clean with few exceptions. However opportunities for improvement included:

- Dust and or surface damage was observed on example a resuscitation trolley and a wheeled chair weighing scales.
- Some items of equipment were not captured in cleaning schedules reviewed for example wall-mounted privacy screens and raised toilet seats.
- There was lack of clarity relating to the responsible person for each item of patient equipment cleaning.
- No defined process in place for identifying cleaned patient equipment. Two sets of minutes from the corporate hygiene committee reviewed by inspectors showed that there was going to be a trial of the tagging system. This had yet to be actioned at the time of inspection.

Patient equipment hygiene audits were submitted post inspection. The hospital needs to ensure that there is clarity relating to responsible persons and managerial oversight of patient equipment hygiene to provide assurance that cleaning specification are implemented.

Outbreak management

The hospital experienced an outbreak of influenza in January 2018. Inspectors were informed that this outbreak was identified, reported and managed in line with advice from the infection prevention and control team. Staff told inspectors that the learning from this outbreak related to hand hygiene and ensuring that staff received the flu vaccine. Inspectors viewed an outbreak report from 2018. The report identified the units affected, the number of patients affected and control measures put in place. However learning and recommendations were not detailed in the outbreak report viewed.

Policies, procedures and guidelines

The hospital had a suite of infection prevention and control policies including standard and transmission-based precautions from CHO 9. Inspectors found that these policies were due for revision at the time of the inspection.

Inspectors noted that the policy on outbreak management was limited to outbreaks of influenza. All facilities where care is delivered should have a documented outbreak management plan appropriate to the services provided, detailing the action to be taken in the event of an outbreak of infection, in line with relevant national guidelines where they exist.⁷

Staff Training

Staff training included 'Breaking the chain of infection' was mandatory for staff on an annual basis.

Hand hygiene training was also mandatory for staff yearly. Hand hygiene training records viewed by inspectors showed uptake of training by health and social care professionals ranged from 70% to 100%, medical staff 92%. However, nursing, health care assistants and catering assistants hand hygiene results was only 60% for 2018-2019. Hand hygiene training needs to be a focus in the infection prevention and control programme going forward.

Safe use of medicines

The hospital had processes in place for the safe use of medicines and practices were reviewed and monitored regularly. A medicine safety strategy 2019-2022 had been devised for the hospital campus. The hospital had eight nurse prescribers.

Information for patients, posters and learning notices in relation to the safe use of medicines were noted on Clements unit. However these initiatives were not evident on Rosal Community Response Unit.

Pharmacy arrangements

The hospital had a formal arrangement with an external pharmacy supplier who was onsite one day per week. There was evidence that regular audit of this arrangement was undertaken. Management outlined and staff confirmed the arrangements in place for access to the external service out of hours. Management and staff stated that if patients were transferred late at night from the acute hospital, an overnight supply of medicines was sent with the patient.

The hospital accessed controlled drugs from St Mary's hospital campus onsite pharmacist and staff confirmed this arrangement.

Drugs and Therapeutics committee

The hospital had a drugs and therapeutics committee and the terms of reference viewed by an inspector outlined its functions. The external pharmacy supplier was also a member of this committee. The committee reported to the clinical quality and safety committee.

Sample meeting minutes were reviewed and these reflected that the agenda included for example medicine variances and nurse prescribing. It was clear that issues were discussed, associated actions put in place where required with persons assigned to address actions. For example, memos were circulated to nursing staff outlining contact details for external pharmacy, a procedure to follow in the event of non-delivery of a prescribed medicine and these were noted on the unit inspected.

Audit

Safety initiatives included staff nurses wearing a red apron indicating that they were not to be disturbed while administering medicines. In addition, management had undertaken an audit of this practice and findings included that interruptions to administration of medicines was primarily caused by other staff on the unit. This finding was communicated to and confirmed by staff.

It was apparent that issues identified by the hospital in January 2019 concerning medicines management were addressed, for example increased audit by the external pharmacy supplier, development of a policy on self-administration of medicines and a guide for staff on medicines that 'sound alike and look alike'.

Nursing and midwifery quality care metrics[§] had been implemented by the hospital and a sample viewed by inspectors was recorded between June and September 2019.

Audit of both onsite and offsite pharmacy services was evident and learning from audit shared with actions put in place to address learnings. For example, the provision of new books for recording controlled drugs and new mobile medicine storage cabinets.

An inspector spoke with the pharmacist who confirmed that six-monthly audits were undertaken on all units and a monthly clinical pharmacy review on medicine documentation was undertaken.

Medicine reconciliation

The hospital had a policy to guide and inform staff on medicine reconciliation.

[§] Metrics are parameters or measures of quantitative assessment used for measurement and comparison or to track performance

Documentation reviewed and staff spoken with by inspectors indicated that medicine reconciliation was in place and staff were knowledgeable about the process. A medicine reconciliation admission, transfer, discharge checklist viewed included an up-to-date medicine list for patients admitted to the service and this was checked by the medical team. The pharmacist also reviewed prescriptions and checked medicine administration documentation at dispensing. Any discrepancies noted were reported to the unit manager and or doctor.

Policies, procedures and guidelines and other information

The hospital had a policy for the safe storage of medicines which included unused and or out-of-date medicines.

Staff had access to information sources for example the British National Formulary (BNF). Other information to guide staff was available at the point where intravenous drugs were prepared, for example Guidelines on Antimicrobial Prescribing, drug calculation formulae and drug ampoule concentration. However the hospital needs to ensure that all information is regularly reviewed and dated as some information was not dated or reviewed.

Storage of medicines

All medicines were stored in a secure manner. Designated fridges for medicines requiring storage at a required temperature were available. Fridge temperatures were recorded however management need to ensure that the temperature is recorded on a daily basis in line with their guidance as some gaps in recording were noted during September 2019 on both units.

Staff training

Training for staff on the safe use of medicines was part of the induction programme for staff nurses.

The clinical nurse manager in Clements unit confirmed completion of the HSE online medicine management training programme. Inspectors viewed a plan for inhouse education sessions scheduled for October and or November 2019. However not all staff on both units were aware of planned education sessions.

Management stated and staff confirmed that training for staff on intravenous administration (IV) of medicine and anaphylaxis was provided. Anaphylaxis training was mandatory for staff and staff had access to an anaphylaxis kit on both units. A staff competency assessment programme for IV administration was in place and staff confirmed they maintained this form. It is recommended that management ensure that the hospital maintains a record of each staff's competency assessment.

3.0 Conclusion

Leadership, governance and management arrangements were evident around the prevention and control of healthcare-associated infection and safe use of medicines in St Mary's Hospital Phoenix Park.

Leadership, Governance and Management

Inspectors found that there were clear lines of accountability and responsibility in relation to corporate and clinical governance arrangements at St Mary's hospital.

The hospital had good oversight of incident management, was in the process of reviewing the risk register and had planned risk register training for staff.

However, minutes from corporate and hygiene committee meetings did not clearly outline actions arising from the meetings, persons responsible and timeframes afforded to actions identified.

Person-centred care and support

The hospital had recently completed a satisfaction survey and was analysing the results with a view to forming an action plan. This was a good initiative and management should re-evaluate the service following implementation of the action plan.

A suite of patient information leaflets about the rehabilitation and assessment units were available in both areas inspected.

Safe care and support

Prevention and control of healthcare-associated infections

Overall HIQA found that the hospital was endeavouring to improve infection prevention and control practices and were striving to implement the National Standards for infection prevention and control in community services.

Notwithstanding the many good practices that HIQA identified during the inspection, areas for further improvement included:

- environmental hygiene and oversight of same
- oversight of equipment hygiene
- infection prevention and control discharge communication
- general maintenance
- compliance with mandatory hand hygiene training among all staff groups
- review and update of infection prevention and control policies, procedures and guidelines.

Safe use of medicines

Inspectors found that the safe use of medicines agenda was being actively progressed in the hospital by the drugs and therapeutic committee. The hospital had processes in place for the safe use of medicines and practices were reviewed and monitored regularly. A medicine safety strategy 2019-2022 had been devised for the hospital campus.

The hospital had a formal arrangement with an external pharmacy to supply medicines and it was evident that this arrangement was reviewed on a regular basis by both parties. A medicine reconciliation programme was in place.

Areas for improvement:

- Incidents noted by the external pharmacist were reported to the hospital. It was not clear if or who recorded such incidents in the hospital as no formal procedure was in place.
- Communication of staff education sessions.
- Some medicine information available to staff had no date of review.

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.

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