



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

# **Report of the announced inspection of Rehabilitation Services at The Royal Hospital Donnybrook.**

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

Date of inspection: 10 September 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*.<sup>1</sup>

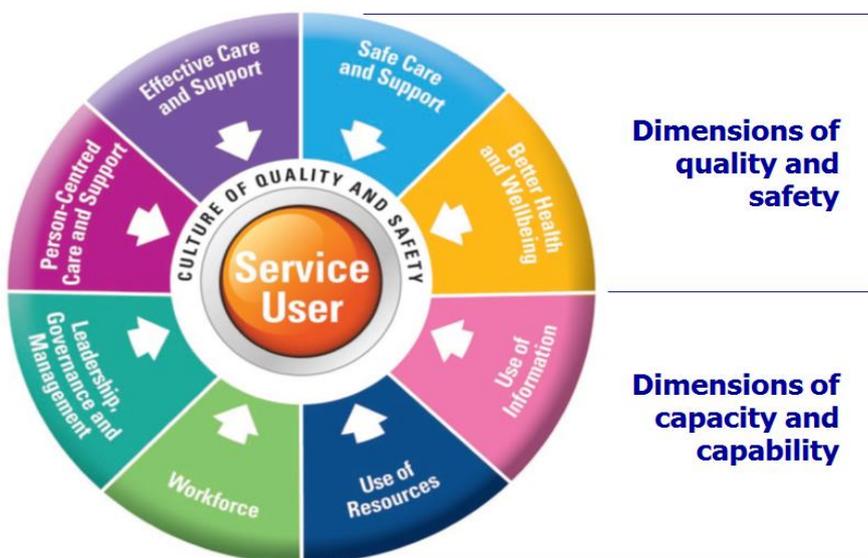
The National Standards provide a framework for service providers to assess and improve the service they provide particularly during an outbreak of infection including COVID-19.

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**



<sup>1</sup>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:

<b>Capacity and Capability</b>	
<b>Theme</b>	<b>Standard</b>
<b>5: Leadership, Governance and Management</b>	<p><b>Standard 5.1:</b> 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><b>Standard 5.2:</b> 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>
<b>6: Workforce</b>	<p><b>Standard 6.1:</b> 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:

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

## Judgment Descriptors

The inspection team have 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:

<b>Compliant</b>	<b>Substantially compliant</b>	<b>Partially compliant</b>	<b>Non-compliant</b>
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 Royal Hospital Donnybrook is an independent voluntary organisation that operates in partnership with the Health Service Executive (HSE) and is funded through Community Health Organisation (CHO) 6<sup>†</sup>

The hospital provides specialist rehabilitation and a complex continuing care service.

At the time of the inspection the specialist rehabilitation service comprised 75 inpatient rehabilitation beds split between four units. The majority of patients had been discharged from St. Vincent's University Hospital following an orthopaedic injury or medical or surgical illness. The consultant led interdisciplinary rehabilitation services include:

- Short-Term Post Acute Rehabilitative Care
- General Rehabilitation
- Stroke Rehabilitation
- Neuro-Rehabilitation.

## 1.2 Information about this inspection

This report was completed following an announced inspection of the specialist rehabilitation services carried out by Authorised Persons, HIQA; Kathryn Hanly and Geraldine Ryan on 10 September 2020 between 09:20hrs and 15:00 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:

- Short-Term Post Acute Rehabilitative Care (SPARC) unit: The SPARC service provided a consultant geriatrician-led, multidisciplinary rehabilitation programme for patients who were medically stable and fit for discharge from acute care but require a further period of multidisciplinary inpatient care.
- General Rehabilitation Ward: The General Rehabilitation unit was a consultant geriatrician-led rehabilitation service for adults over 65 years of age with complex needs requiring a long period of rehabilitation.

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

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<sup>†</sup> Community Health Organisation 6 area consists of South East Dublin, East Wicklow and Dun Laoighaire

## 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: Substantially Compliant**

- Ongoing antimicrobial stewardship activities were not evident.

#### Corporate and clinical governance

The Royal Hospital Donnybrook was a voluntary organisation governed by a Board of Management with a Chief Executive Officer (CEO) appointed by the Board to manage hospital services. Overall accountability, responsibility and authority for infection prevention and control and antimicrobial stewardship within the service rested with the CEO.<sup>1</sup>

The Medical Director provided overall clinical leadership for clinical services within the hospital. Patient care was delivered by a Consultant Geriatrician or by a Rehabilitation Consultant, supported by a wide range of multidisciplinary professionals. Patients received medical, nursing, physiotherapy and occupational therapy input and were referred to medical social work, speech and language therapy, dietician, tissue viability, pastoral care etc. according to their clinical needs. Ward rounds were held by consultants and the interdisciplinary team members on a weekly basis.

## Committee structures

Hospital management had established several hospital committees through which to govern services and address quality and safety issues. Governance arrangements and organisational structures were outlined in an organogram provided to HIQA. (Appendix 1).

The Hygiene and Infection Prevention and Control Committee reported to the Clinical Governance Steering Group who in turn reported to the Clinical Governance Committee. Inspectors were informed that infection prevention and control was a standing agenda item on both Clinical Governance Steering Group meetings and Clinical Governance Committee meetings. The Clinical Governance Committee reported to the Board of Management.

The hospital operated in partnership with the Health Service Executive. Inspectors were informed that there was support and coordination during the outbreak on behalf of CHO 6, through assigned public health representatives.

The Infection Prevention and Control Committee was chaired by the assistant director of nursing. Inspectors were informed that quarterly Infection Prevention and Control Committee meetings had been temporarily replaced by a COVID-19 response team meetings at the onset of the COVID-19 pandemic. This group was tasked with overseeing the management of COVID-19 outbreaks and for making recommendations for the prevention of future outbreaks. Outbreak management will be further discussed in section 2.2 of this report.

## Coordination of care within and between services

Hospital management informed inspectors that the majority of patients were transferred from St Vincent's University Hospital following an episode of care for an acute illness. The nursing and support staff were provided by the Royal Hospital Donnybrook while consultants had shared appointment St Vincent's Hospital and Royal Hospital Donnybrook, creating a cohesive link between a patient's care in St Vincent's University Hospital and Royal Hospital Donnybrook.

Nursing and medical staff had electronic access to laboratory and radiology reports from St Vincent's University Hospital.

## **Monitoring, Audit and Quality assurance arrangements**

### Incident reporting

The monitoring of adverse incidents including of healthcare-associated infection was a function of the incident review forum. Hospital management informed inspectors that it was hospital policy to report incidents of healthcare-associated infection on

the hospital incident management system.<sup>‡</sup> These were tracked through the incident committee. However incidents of healthcare associated infection reported were not trended.

### Environmental and equipment hygiene

The hospital had a number of assurance processes in place in relation to the standard of hospital hygiene.

Prior to the COVID-19 pandemic regular senior management walkabouts were undertaken. Issues identified were brought to the attention of the clinical nurse managers to be addressed.

An audit schedule was in place whereby environmental hygiene was monitored by contract cleaning provider and clinical nurse managers in all rehabilitation units each month. Action plans were developed and agreed with clinical nurse managers. Results of these audits were discussed at Hygiene and Infection Control Committee meetings. However results were not tracked and trended to identify and address any deficiencies or continued non-compliance.

Findings in regard to environmental and equipment hygiene will be discussed in section 2.2 of this report.

### Hand hygiene and personal protective equipment (PPE) compliance

Hand hygiene audits were carried out quarterly by an independent external auditor. Audits of hand hygiene compliance undertaken the rehabilitation services in May 2020 found 100% compliance.

Audit of compliance with the correct use of PPE found that 47% staff observed adhered to the correct sequence for removing PPE. This should be a continued focus for staff education.

### Antimicrobial stewardship

Local antimicrobial guidelines had been adapted from St Vincent's University Hospital guidelines. Inspectors were informed at the time of the inspection that there were no specific ongoing antimicrobial stewardship<sup>§</sup> activities within the rehabilitation services, for example audit of compliance against the prescribing guidelines or antimicrobial stewardship education. Whilst there may be barriers to implementing antimicrobial stewardship programs in rehabilitation and community inpatient

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<sup>‡</sup> 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

<sup>§</sup> Antimicrobial stewardship is a suite of coordinated strategies which together aim to promote the appropriate use of antimicrobial agents to maximise their benefit while causing the least harm.

healthcare services, antimicrobial stewardship activities that are tailored to this setting can be very effective.<sup>2</sup> This should be reviewed following this inspection.

### Patient assessment

Good communication and information sharing underpins safe and effective transfers of care. All patients received a pre-admission assessment by a medical and nursing team to assess their suitability for rehabilitation. Patients were required to have a non-detected Covid-19 test 48-72 hours prior to admission. Results were received before a decision to admit was made. A prevention and control of infection assessment was undertaken for all patients on admission. However this did not detail patient's COVID-19 status.

**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 risk in relation to the prevention and control of healthcare-associated infections.

### Risk registers

Clinical nurse managers were responsible for developing risk registers in their own clinical areas. Inspectors were informed by management that high risks were escalated in line with HSE risk management processes.<sup>3</sup> Risks identified in clinical areas were addressed at clinical area level or were documented and escalated to the next level of management for action as required. Where risks identified had significant potential to impact on the objectives of the organisation they were added to the organisation's risk register.

A number of infection prevention and control risks had been escalated to the hospital corporate risk register and included for example:

- Inadequate physical environment and infrastructure
- Risk of outbreak of COVID-19 infection affecting patients/residents/staff.

The findings in this report would indicate that although risks in relation to infrastructure and maintenance issues had been escalated through established governance structures, they had not been addressed. These risks were of particular concern in the context of an ongoing pandemic.

The corporate risk register was subject to ongoing monitoring by the Hospital Management Team and was updated quarterly to ensure that actions identified as

required were completed. Risk Management was a standard item on the agenda for every Board meeting.

### Infection prevention and control policies

The hospital had a suite of infection prevention and control policies which covered aspects of standard precautions, transmission-based precautions and outbreak management. A number of COVID-19 specific infection control and outbreak management policies had also been developed.

### Influenza vaccination

The director of nursing co-ordinated the annual influenza vaccination programme. Uptake had improved in recent years and it was reported that uptake rates for influenza vaccine amongst staff had reached the national uptake target of 60% in the last influenza season.<sup>4</sup> This was commendable. Initiatives to increase uptake included peer to peer vaccinations, visual feedback in communications and incentives e.g. hospital branded fleece.

Achieving a high uptake of influenza vaccination among healthcare workers is recognised as a vital infection control measure to reduce the risk of dual outbreaks of influenza and Covid-19. Improved uptake of flu vaccination may also ease pressure on Covid-19 testing, due to similarity of the symptoms of both infections.

Management informed inspectors that local peer vaccinators had been trained to administer flu vaccinations to staff. Influenza information sessions had also been planned. The hospital should continue with measures to promote healthcare worker uptake of seasonal influenza vaccine to meet the 2020/ 2021 target of 75%.

## **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: Substantially Compliant**

- The hospital did not have infection prevention and control nurse onsite at the hospital or formalised links with the infection prevention and control team from CHO6.

### Access to specialist staff with expertise in infection prevention and control

The hospital did not have infection prevention and control nurse onsite at the hospital or regular input from the CHO infection prevention and control team. Recent recruitment efforts made in to employ experienced infection prevention and control nurse with the requisite post-graduate training at the hospital had not been successful. The hospital had planned to address this issue.

In the interim outbreak management advice was sought from the HSE's public health department as required. The hospital also had access to infection prevention and control advice from the St Vincent's University Hospital, however this arrangement was not formalised.

Microbiology advice was available from St. Vincent's University Hospital during core working hours. Consultant to consultant support was available outside these hours. During the COVID-19 outbreak at the hospital, management reported that onsite infection prevention and control support was also provided by a Consultant in Infectious Diseases based at St Vincent's University Hospital.

Staff demonstrated awareness and understanding of their roles and responsibilities in working to prevent and control infection during discussions with inspectors. Staff in the clinical areas inspected reported positive and supportive engagement from and with Senior Management during the ongoing COVID-19 pandemic.

#### Infection prevention and control education

The assistant director of nursing and the Quality Nurse Manager provided a range of both formal and informal ongoing educational sessions to staff on infection prevention and control procedures and practices.

Hand hygiene training was mandatory for staff at induction and every two years thereafter. The figures showed that the majority of nursing staff and healthcare assistants in the wards inspected had attended hand hygiene training. However the overall up-to-date attendance levels and compliance rate of other staff member groups with hand hygiene training could not be determined.

Standard precautions training was also mandatory for all staff every two years. This was delivered by the assistant director of nursing. At the time of this inspection it was reported to inspectors that 77% of staff had attended this training in the preceding 24 months.

Additional training in transmission based precautions including the appropriate use of personal protective equipment (PPE) had been provided to clinical staff since the onset of the COVID-19 pandemic. Attendance was monitored by the Quality Nurse Manager.

Nursing staff attended training in the administration of intravenous\*\* medicines. However nursing staff had not received any antimicrobial stewardship education as part of this training.

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\*\* Intravenous is a way of administering medicines directly into the vein via an injection or infusion

## 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 and antimicrobial stewardship 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 number of infrastructural and maintenance issues which had the potential to impact on infection prevention and control measures were identified.

#### Environment and infrastructure

Inspectors visited the General Rehabilitation Unit and the Short Term Post Acute Rehabilitation Care Unit. Overall the general environment in both areas inspected was clean with few exceptions.

The recent HSE physical distancing directive outlining one metre as the minimum distance required between patients in all clinical areas had been implemented in the context of a comprehensive infection prevention and control approach.

Refurbishment works were ongoing Short Term Post Acute Rehabilitation Care Unit on the day of inspection. However a number of infrastructural and maintenance issues which had the potential to impact on infection prevention and control measures were identified in the clinical areas during the course of the inspection. For example,

- Several of the surfaces and finishes including wall paintwork, wood finishes and flooring were worn and poorly maintained in both units inspected and as such did not facilitate effective cleaning.
- Storage space was quite limited in the General Rehabilitation Unit with inappropriate storage of equipment and supplies within vacant bed spaces and patient toilets.

- Consumables and clinical supplies were stored in a number of mobile closed cabinets within patient rooms in the General Rehabilitation Unit.
- Single rooms the General Rehabilitation Unit did not have clinical hand wash sinks.
- The cleaners room the General Rehabilitation Unit did not have a hand hygiene sink.
- The design of clinical hand wash sinks in the units inspected did not conform to Health Building Note 00-10 Part C: Sanitary assemblies.<sup>5</sup>

It was reported that maintenance and infrastructural issues impacted on the overall compliance rate in environmental hygiene audits undertaken within the units inspected.

There was good local ownership in relation to infection prevention and control in the both units despite the challenging circumstances posed by the unit infrastructure in Respiratory Unit. Inspectors were informed that there were sufficient cleaning resources to meet the needs of the units inspected.

Antimicrobial soaps containing chlorhexidine gluconate were available at a number of hand hygiene sinks in the wards inspected. When alcohol-based hand rub is available in the healthcare facility for hand hygiene, the use of antimicrobial soap is not recommended.<sup>2</sup> Antimicrobial soap is associated with skin care issues and it is not necessary for use in everyday clinical practices.

### 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 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.

Patient admissions from acute hospitals were managed in line with HSE/ HPSC COVID-19 guidelines.<sup>6</sup> Patients admitted to the rehabilitation services from acute hospitals were routinely tested for COVID-19 within the three days before admission.

Protective personal equipment was readily available outside isolation rooms however appropriate infection prevention and control signage was not visible on the doors of isolation rooms or cohort rooms.

## Discussion with patients

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 and the care provided within the units inspected.

**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 both units inspected appeared clean and well maintained with few exceptions. Inspectors viewed daily and weekly equipment cleaning checklists and schedules and noted they were consistently completed and were monitored by Clinical Nurse Managers on an ongoing basis. However the equipment cleaning checklist in the General Rehabilitation Unit was not comprehensive and did not include a portable fan observed in the clinical area.

In so far as possible, facilities should avoid the use of fans that re-circulate air. It may be necessary to use mobile fans and/dehumidifiers during very warm weather to keep patients cool, in such instances these items should be cleaned regularly and maintained according to the manufacturer's instructions.

Intravenous sharps trays used for taking blood samples were stocked with consumables and trays were not decanted after use. It is recommended that only the equipment required for a single procedure on an individual patient should be brought to a patient bedside.

## **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**

The hospital had systems in place to manage and control infection outbreaks in a timely and effective manner. Discussion with staff and review of documentation showed that outbreak control teams were convened to advise and oversee the management of outbreaks of infection at the hospital. The hospital's outbreak management policy defined the arrangements to be instigated in the event of an outbreak of hospital infection.

## COVID-19 Outbreak Preparedness

The CEO was the designated lead for COVID -19 preparedness and response within the hospital. A COVID-19 response team was established early in the pandemic to oversee plans to minimise the impact of COVID-19 on services and ensure the safety and wellbeing of patients and staff. A review of minutes of these meetings confirmed that meetings were well attended with a structured agenda and schedule.

Plans were in place for the management of patients who developed symptoms during their admission to the rehabilitation services. Contingency plans were also in place in the event of a shortfall in staffing levels including redeployment of Health and Social Care Professionals to inpatient wards.

Operation bed plans reflected the implementation of the one meter physical distancing directive<sup>2</sup> within rehabilitation services. For example;

- The rehabilitation wards had reduced occupancy multiple occupancy bedrooms.
- 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 breaks.

The hospital had also put measures in place to eliminate crossover of staff between the designated centre for older people and the Rehabilitation Wards. Wards operated as far as possible as discrete units. Installation of swipe access doors had commenced. When patients left the rehabilitation unit for occupational therapy and physiotherapy they did not mix with residents from other areas of the hospital.

The physiotherapy department had developed a standard operating procedure to ensure that therapy was delivered in line with current public health advice and best practice.

Issues were identified in the early phase of the COVID-19 pandemic with the turnaround times for testing and contact tracing. In response testing capacity was increased by training a number of staff members to perform the sampling for COVID-19 testing. Inspectors were informed that patient tests were processed in St Vincent's University Hospital. These actions significantly reduced turnaround time of tests which at the time of the inspection had an average turnaround time of 24 hours.

Staff spoken with on the day demonstrated their knowledge of the management of COVID-19. Patients were monitored for symptoms compatible with COVID-19 on a daily basis. Information about atypical presentation of COVID-19 infection had been highlighted. COVID-19 signage on preventing the spread of infection was prominently displayed throughout the units inspected.

#### COVID-19 Management

Rehabilitation services experienced an outbreak of COVID -19 in May 2020.

The early detection of this outbreak during routine patient and staff testing ensured prompt action was taken to isolate infectious patients and commence containment measures to successfully limit the spread of infection.

A local outbreak control team (a subgroup of the COVID-19 response team) was convened to advise and oversee the management the COVID-19 outbreak and the local Public Health Department was informed. Teleconferences were held with Public Health early in the outbreak.

Multimodal infection prevention and control strategies were implemented to effectively manage and control the outbreak in a timely manner. These included but were not limited to:

- implementation of transmission based precautions for patients where required
- allocation of dedicated staff to care for patients with confirmed COVID-19
- increased cleaning and disinfection of all clinical areas.

Inspectors were informed that patient occupancy levels had remained low throughout the outbreak and that staffing levels remained sufficient to meet the needs of the patients within the unit.

This outbreak was declared over by Public Health following 28 days (two incubation periods) without identifying any new cases on 30 May 2020. There were no patients with confirmed COVID-19 in the rehabilitation services on the day of the inspection.

Outbreak investigation is one of the key components of outbreak management that feeds into quality care and prevention of disease transmission. The outbreak control group prepared an outbreak report at the conclusion of the outbreak which included learnings and recommendations for the management of future potential outbreaks.

### **3.0 Conclusion**

Overall this inspection identified that The Royal Hospital Donnybrook was compliant with three of the six of the *National Standards for infection prevention and control in community services* assessed. A judgment of substantially complaint was made against the remaining three standards. Findings from the inspection were therefore positive overall.

#### Leadership, Governance and Management

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

Regular performance updates in relation to infection prevention and control were reported through the established hospital governance structures.

Systems were in place to identify and manage risk in relation to the prevention and control of healthcare-associated infections. A comprehensive risk management framework was in place to ensure that information-related risks were identified, managed and effectively controlled on an ongoing basis. Overall, senior management had good oversight of the infection prevention and control risks on the corporate risk register

The overall antimicrobial stewardship programme needs to be considerably developed, strengthened and supported in order to progress.

The hospital had a number of effective assurance processes in place in relation to the standard of hospital hygiene. 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. Results of these audits should be tracked and trended by management.

### Workforce

Access to specialist staff with expertise in infection prevention and control was available at the time of the inspection through the public health department and St Vincent's University Hospital, however this arrangement was not formalised. Management within CHO 6 should be assured that access to specialist infection prevention and control advice is maintained within the hospital going forward in line with National Standards.<sup>1</sup>

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 mandatory infection prevention and control education and training. Uptake of hand hygiene training should be a focus for improvement going forward.

### Effective Care and Support

Overall, the general environment and equipment in the areas inspected were clean and well maintained with some exceptions.

HIQA notes that the fabric and infrastructure of the hospital presents ongoing challenges to the maintenance and upkeep of the building. Notwithstanding this, it is essential that hospital environments are maintained at a high standard to ensure the effectiveness of infection control practices and prevent the transmission of infection.

### Safe Care and Support

The hospital had systems in place to manage and control infection outbreaks in a timely and effective manner. Management had effectively accelerated and streamlined the hospital's COVID-19 testing and tracing processes with onsite testing and contact tracing teams.

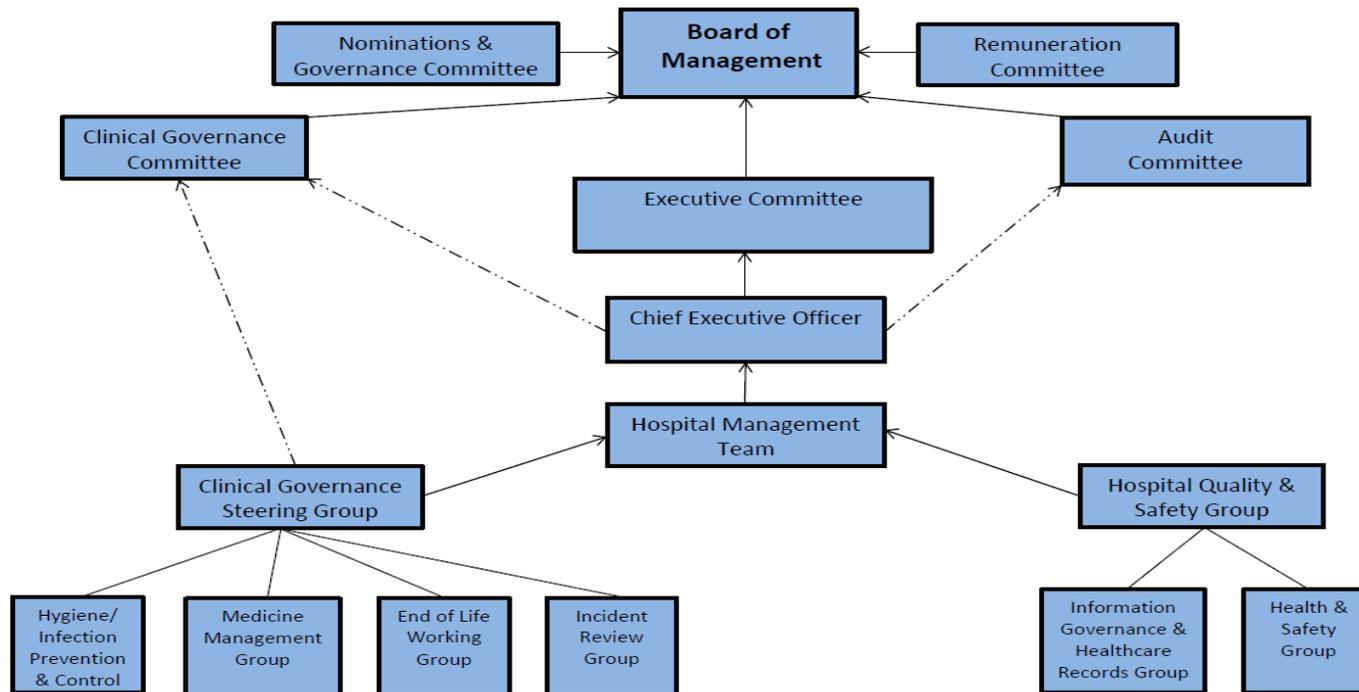
The hospital declared a COVID-19 outbreak within rehabilitation services in May 2020. Outbreak control teams were convened to oversee the timely management of the outbreak and public health departments were notified.<sup>7</sup> Inspectors identified many examples of good practice in the management of COVID-19.

## 4.0 References

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## 5.0 Appendix 1: Governance organogram

### The Royal Hospital Donnybrook Governance Structure



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