



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

# **Report of the unannounced inspection of University Hospital Kerry.**

Monitoring programme against the *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services* during the COVID-19 pandemic

Date of inspection: 03 December 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, Equality, Disability, Integration and Youth, 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 residential services for older people and people with a disability, and children's special care units.
- **Regulating health services** — Regulating medical exposure to ionising 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 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. In light of the ongoing COVID-19 pandemic, HIQA has developed a monitoring programme to assess compliance against the *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services* during the COVID-19 pandemic.<sup>1</sup>

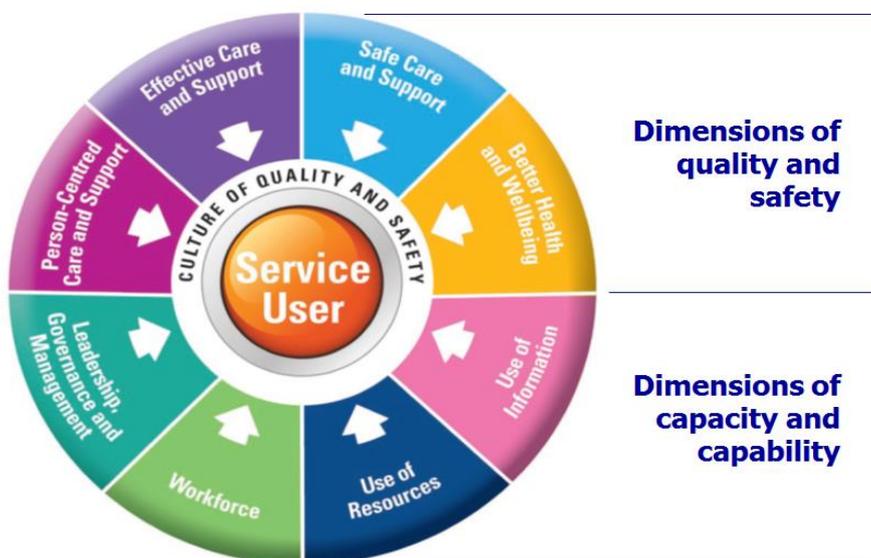
The national standards provide a framework for service providers to assess and improve the service they provide particularly during an outbreak of infection including COVID-19.

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 the prevention and control of healthcare-associated infections in acute healthcare services**



\* National Standards for the prevention and control of healthcare-associated infections in acute healthcare services

## Report structure

The lines of enquiry for this monitoring programme of infection prevention and control in acute healthcare 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 acute healthcare services’ **capacity and capability** through the following standards:

| <b>Capacity and Capability</b>                  |  |
|---|--|
| <b>Theme</b>                                    | <b>Standard</b>  |
| <b>5: Leadership, Governance and Management</b> | <b>Standard 5.3:</b> Service providers have formalised governance arrangements in place to ensure the delivery of safe and effective infection prevention and control across the service |
| <b>6: Workforce</b>                             | <b>Standard 6.1:</b> Service providers plan, organise and manage their workforce to meet the services’ infection prevention and control needs.   |

HIQA also assesses acute healthcare services’ provision under the dimensions of **quality and safety** through the following standards:

| <b>Quality and Safety</b>              |  |
|--|--|
| <b>Theme</b>                           | <b>Standard</b>  |
| <b>2: Effective Care &amp; Support</b> | <b>Standard 2.6:</b> Healthcare is provided in a clean and safe physical environment that minimises the risk of transmitting a healthcare-associated infection.<br><b>Standard 2.7</b> Equipment is cleaned and maintained to minimise the risk of transmitting a healthcare-associated infection.               |
| <b>3: Safe Care and Support</b>        | <b>Standard 3.1.</b> Service providers integrate risk management practices into daily work routine to improve the prevention and control of healthcare-associated infections.<br><b>Standard 3.8</b> Services have a system in place to manage and control infection outbreaks in a timely and effective manner. |

## Judgment Descriptors

The inspection team have used an assessment judgment framework to guide them in assessing and judging a service’s compliance with the National Standards. The assessment judgment 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**

University Hospital Kerry is a model 3 acute hospital which is owned and managed by the Health Service Executive (HSE) and is part of the South/South West Hospital Group.<sup>†</sup> The hospital provides a range of services including acute inpatient, maternity, paediatrics, outpatient and day services. The hospital has 278 inpatient beds and 55 day patient beds.

## **1.2 Information about this inspection**

This inspection report was completed following an unannounced inspection carried out by Authorised Persons, HIQA; Siobhan Bourke, Bairbre Moynihan and Sean Egan on 03 December 2020 between 09.15hrs. and 15.10hrs.

HIQA's focus during this inspection included a detailed evaluation of how, on the day of the inspection, the hospital organised themselves to minimise the spread of healthcare-associated infections; with a particular focus on systems to prevent, detect and manage COVID-19.

Inspectors spoke with hospital managers, staff, representatives from the Infection Prevention and Control Committee and patients. Inspectors also requested and reviewed documentation, data and observed the clinical environment in a sample of clinical areas which included:

- Annagh Ward (COVID-19 pathway).
- Sceilig Ward (Non COVID-19 pathway).

Inspectors conducted a walkthrough of the Emergency Department and the Respiratory Receiving Unit (RRU). In addition, inspectors also visited the Intensive Care Unit to observe progress with the implementation of recommendations relating to infrastructural deficits identified in previous inspections.<sup>2</sup>

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

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<sup>†</sup> Hospital groups: The hospitals in Ireland are organised into seven hospital groups. 1. Ireland East Hospital Group. 2. Dublin Midlands Hospital Group. 3. South/South West Hospital Group. 4. Saolta University Health Care Group. 5. University of Limerick Hospitals Group. 6. RCSI Hospitals Group. 7. Children's Health Ireland Hospital Group

## 2.0 Inspection Findings

The following sections present the general findings of this unannounced inspection.

- Section 2.1 High risks identified during the unannounced inspection
- Section 2.2 Capacity and Capability
- Section 2.3 Quality and Safety.

### 2.1 High risks identified during the unannounced inspection

#### Lack of onsite Consultant Microbiologist

During the inspection HIQA identified that the hospital had no onsite consultant microbiologist at the hospital since September 2020. Inspectors were informed that the consultant microbiologist position had been filled by a full time locum consultant microbiologist from April 2020 to September 2020. As the hospital had been unable to fill this position since September 2020, as an interim contingency arrangement, a consultant microbiologist from the United Kingdom provided telephone advice to the infection prevention control team and clinical staff at the hospital. Hospital staff told inspectors that the off-site consultant provided valuable advice and input to the microbiology service. Nonetheless, inspectors were informed that the lack of an onsite consultant microbiologist impacted on the effectiveness of the infection prevention and control activities at the hospital. Furthermore, it was not clear to inspectors as to:

- further contingency measures should demands for microbiology services increase
- and the arrangements in place to ensure clinical governance oversight of microbiology reporting in the absence of an onsite consultant microbiologist.

These risks was escalated to the Chief Executive Officer of the South/South West Hospital Group on 7 December 2020.

#### **Response to high risks identified by HIQA**

In correspondence provided to HIQA on 22 December 2020, the Chief Executive Officer of the South/South West Hospital Group outlined that efforts to recruit a suitable replacement to fill the onsite position were ongoing. The Hospital Group received developmental funding for two permanent consultant microbiologists and one of these positions, once filled, would be allocated as a shared position between University Hospital Kerry and the Mercy University Hospital, which is in Cork city. HIQA was also informed that the covering microbiologist would attend the hospital once in a position to do so.

The CEO also provided assurances to HIQA that arrangements were in place to ensure clinical oversight of microbiology laboratory reports by the off-site consultant microbiologist.

## **2.2 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 5.3:** Service providers have formalised governance arrangements in place to ensure the delivery of safe and effective infection prevention and control across the service

**Judgment Standard 5.3: Substantially compliant**

A number of interventions for the hospital's antimicrobial stewardship programme could not be achieved due to staffing shortages.

#### Corporate and Clinical Governance

Inspectors found that there were clear lines of responsibility and accountability for the prevention and control of healthcare associated infection at the hospital.

The hospital's infection prevention and control team had day-to-day responsibility for delivering the infection prevention and control programme and met each week. This team was part of and reported to the Infection Prevention and Control Committee.

The hospital's Infection Prevention and Control Committee reported to the Quality and Patient Safety Committee who in turn reported to the hospital's Executive Management Board. The General Manager chaired the Infection Prevention and Control Committee. The Terms of Reference outlined that the Committee was due to meet every three months. Minutes provided to inspectors indicated that the Committee did not meet for the first six months of 2020 due to the ongoing COVID-

19 pandemic but that the Committee had reconvened in July 2020 and had met twice since July 2020.

In response to the COVID-19 pandemic the hospital had instead established a multidisciplinary COVID-19 Group to plan and manage the hospital's services. This Group had met each Monday and Friday since the onset of the pandemic. A sample of minutes reviewed by inspectors noted that a member of the executive management team of the South/Southwest Hospital Group also participated in these meetings via teleconference.

In addition, the general manager represented the hospital at the South/South West Hospital Group's Healthcare Associated Infections and Antimicrobial Stewardship Steering Committee that were held every three months.

#### Antimicrobial Stewardship Programme

The hospital had an antimicrobial stewardship programme in place. The hospital's antimicrobial stewardship committee was multidisciplinary and met each quarter in 2019 and 2020. Inspectors reviewed minutes and noted that antimicrobial consumption rates, audits to monitor antimicrobial interventions were reported through the committee structures. Inspectors found that a number of the programmes interventions were limited due to lack of resources such as:

- availability of an onsite consultant microbiologist to undertake antimicrobial stewardship ward rounds
- the lack of a surveillance scientist to assist with surveillance activities and development of local antibiograms
- insufficient microbiology laboratory scientists to provide clinical staff with antimicrobial sensitivity reading at weekends and bank holidays.

Hospital-associated *Clostridioides difficile* levels in 2020 remained above the national performance indicator of less than 2.0 per 10,000 bed days for the majority of the year.<sup>3</sup> The necessity of a resourced antimicrobial stewardship programme is of specific importance in the context of significant *Clostridioides difficile* rates at the hospital. Overall, the antimicrobial stewardship programme needed to be further resourced and supported in order to progress and should be a focus for improvement following this inspection.

#### Emergency Department and Hospital Capacity

University Hospital Kerry had implemented separate pathways for the assessment care and management of patients presenting with suspected and confirmed COVID-19 and non COVID concerns to the Emergency Department.<sup>4</sup> In response to the COVID-19 pandemic, the hospital had renovated and reconfigured a section of the

Emergency Department, named the Respiratory Receiving Unit. This unit had five single rooms assigned for patients presenting with suspect and confirmed COVID-19. Separate designated waiting areas and triage areas for patients presenting with suspected and confirmed COVID-19 had been reconfigured in the Emergency Department.

In addition to the existing Emergency Department, access to the Acute Medical Assessment Unit was used to assess patients should the Emergency Department reach capacity. Patients were required to wear a surgical mask in the waiting rooms. Waiting areas allowed for minimum physical spacing (1m+).<sup>5</sup>

### Monitoring, Audit and Quality assurance arrangements

The infection prevention and control surveillance programme included surveillance of 'alert' organisms<sup>‡</sup>, 'alert' conditions<sup>§</sup> and Notifiable Diseases.<sup>6</sup>

The infection prevention and control team gathered and provided assurance to the hospital management team through the reporting of nationally mandated key performance indicators against the 2020 HSE service plan targets.<sup>7</sup> Antimicrobial Stewardship performance indicators were reported through the hospital's governance structures.

The infection prevention and control team used an information and communication technology system that assisted in the prompt identification of patients that needed to be isolated. This was communicated daily to hospital managers to guide with appropriate placement of patients who required transmission-based precautions.

Assurance as to the effectiveness of the infection prevention and control systems and processes were provided through audit and monitoring of multiple elements of the infection prevention and control programme. These included but were not limited to the following:

- Environmental and patient equipment monthly audits.
- Audits of donning and doffing personal protective equipment (PPE) were undertaken by the infection prevention and control team since the onset of the COVID-19 pandemic.
- Audits to assess compliance with transmission based precautions.

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<sup>‡</sup> Alert organisms are identified in the microbiology laboratory and include organisms such as CPE and other antibiotic resistant organisms

<sup>§</sup> Alert conditions include physical symptoms such as skin rashes, vomiting, diarrhoea, respiratory illness that could be due to an infectious illness

- Monthly audits to assess compliance with Carbapenemase-Producing *Enterobacteriales* \*\* (CPE) the hospital's screening for CPE guidelines.<sup>8</sup>
- Quarterly Hand hygiene audits in all clinical areas. The hospital also participated in national hand hygiene audits, the results of which are published twice a year. The hospital's overall compliance in the national hand hygiene audits completed in 2019 and 2020 were above the HSE's national target of 90%.
- Audits to assess compliance with care bundles<sup>††</sup> including peripheral vascular cannula and urinary catheter care bundles.

The hospital had a number of 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 and infection control guidance.

Inspectors were informed that the hospital was trialling an electronic system ward assessment process for the monitoring of environmental and equipment hygiene, hand hygiene, sharps management, waste disposal and linen management since November 2020. Hospital staff who spoke with inspectors reported that they found the tool was time saving and easy to use. Inspectors viewed audit reports generated from the tool where results were trended and clearly presented to facilitate the identification of areas for improvement.

Inspectors were informed that members of the hospital's Executive Management Board commenced quality walkabouts to check on infection prevention and control compliance in November 2020.

### Policies, Procedures and Guidelines

The hospital had a suite of infection prevention and control guidelines which covered aspects of standard precautions, transmission-based precautions and outbreak management. In response to the COVID-19 pandemic the hospital had developed clinical guidelines and patient care pathways to guide staff on the management of patients with suspected or confirmed COVID-19. The hospital had updated its outbreak management policy in 2020 in response to the COVID-19 pandemic. Inspectors were informed that medical staff at the hospital had developed a clinical decision tool for assessment of patients with suspected COVID-19. This tool was adapted into national guidance.<sup>9</sup>

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\*\* Carbapenemase-Producing *Enterobacteriaceae* (CPE), are a family of bacteria which can cause infections that are difficult to treat because they are resistant to most antimicrobials, including a class of antimicrobials called carbapenems which have typically been used as a reliable last line treatment option for serious infection. Bloodstream infection with CPE has resulted in patient death in 50% of cases in some published studies internationally.

†† A care bundle consists of a number of evidence based practices which when consistently implemented together reduce the risk of device related infection.

### Influenza Vaccination

It has been acknowledged that the health system and wider society should prepare for the potential for co-epidemics of COVID-19 and seasonal influenza in 2020/2021.

Uptake rates for influenza vaccine amongst staff failed to reach the national uptake target of 60% in the 2019/2020 influenza season.<sup>10</sup>

By the time of the onsite inspection, the hospital's influenza vaccination programme was underway with the aim of improving the uptake among staff in line with the 2020 national target.<sup>7</sup> Documentation reviewed indicated that 843 staff which equated to over 60% of all staff at the hospital had already been vaccinated by the end of November 2020. Vaccination clinics were still in progress at the hospital to ensure that the 2020 target of over 75% was reached at the hospital.

### Quality Improvement Plan (QIP)

Inspectors reviewed the quality improvement plan (QIP) developed following the HIQA inspection on 15 June 2017.<sup>2</sup> Actions required for the 17 items identified on the QIP were listed and viewed. Ten items on the list were documented as complete at the time of the inspection. The remaining seven issues were in progress.

The hospital's Intensive Care Unit (ICU) infrastructure had undergone significant renovations since the previous HIQA inspection. An inspector visited the ICU and noted that ancillary rooms such as a designated clean utility room, designated dirty utility room, linen room and cleaners' store room space were now in place. There were two single rooms in the Intensive Care Unit. However, neither of these rooms had pressurised controlled ventilation systems installed.

## **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: Non-Compliant**

- The hospital did not have a consultant microbiologist onsite.
- The hospital did not have a surveillance scientist in position at the time of the inspection.
- There were insufficient microbiology laboratory scientists to provide antimicrobial sensitivity reading at weekends.
- Uptake of attendance at hand hygiene training required improvement.

The infection prevention and control team at the hospital were responsible for implementing the hospital's infection prevention and control programme. While the infection prevention and control team's resources had increased since the previous inspection, it remained under resourced.

Since the previous HIQA inspection in 2017, a permanent consultant microbiologist, shared between University Hospital Kerry and the Mercy University Hospital, provided microbiology services until January 2020 when the post holder took up a position at another hospital.

Inspectors were informed that the vacated post was filled by a locum position off site until the end of March 2020 when a full time onsite temporary consultant microbiologist was appointed. This post holder had left the position in September 2020 and the hospital was unable to find a replacement.

To access clinical advice and input from a consultant microbiologist, as a contingency arrangement the hospital had recruited a consultant microbiologist from the United Kingdom who provided off-site cover for the hospital since September 2020. As outlined in Section 2.1 of this report, assurances were provided to HIQA that this position had oversight of laboratory microbiology reports at the hospital.

Inspectors were informed that 1.88 whole time equivalent (WTE) <sup>##</sup> consultant microbiologist positions had been approved for funding at the hospital and recruitment to fill these positions were ongoing.

The onsite infection prevention and control team comprised three WTE clinical nurse specialists in infection prevention and control and one antimicrobial pharmacist

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<sup>##</sup> Whole-time equivalent (WTE): allows part-time workers' working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to a full-time worker. 0.5 refers to an employee that works half full-time hours.

onsite. In response to the COVID-19 pandemic, one WTE administrative support person had been appointed to support the clinical nurse specialists in infection prevention and control.

The hospital did not have a surveillance scientist or access to this resource. This has been on the hospital's risk register for a number of years. The absence of this position limited surveillance activities and the implementation of surgical site infection surveillance at the hospital. Inspectors were informed on the day of inspection that a surveillance scientist had been recently recruited to fill this vacancy but had yet to take up the position. Inspectors were informed that the South/South West Hospital Group had approved funding to recruit a second surveillance scientist position for the hospital but this position had yet to be recruited.

The hospital also had an insufficient number of microbiology laboratory scientists to facilitate antimicrobial sensitivity reading at weekends resulting in delays in appropriate antimicrobial management for patients at these times. This needs to be addressed following this inspection.

The hospital had a dedicated occupational health service onsite.

#### Infection Prevention and Control Education

Hand hygiene training was mandatory for staff at induction and every year thereafter. The Infection prevention and control team provided hand hygiene training sessions to facilitate staff each month. Training on standard based precautions, transmission based precautions and the management of patients with healthcare associated infections was also provided.

Additional training on COVID-19 and the appropriate use of personal protective equipment (PPE) had also been provided in 2020. Inspectors reviewed training records for attendance at this training which showed that 991 staff at the hospital had attended PPE training since the onset of the COVID-19 pandemic.

Fit testing<sup>§§</sup> for FFP2 and FFP3 facemasks<sup>\*\*\*</sup> to avoid COVID-19 transmission had been provided to 344 clinical staff likely to undertake procedures that involve or may involve the generation of aerosols (aerosol generating procedures or AGPs).

Records reviewed by inspectors indicated that hand hygiene training uptake was 57% for nursing staff, 27% for medical staff and 44% for health and social care

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<sup>§§</sup> Tight-fitting facemasks rely on having a good seal with the wearer's face. In order to be effective the mask must fit tightly to the wearers face, fit testing should be undertaken by a trained professional.

<sup>\*\*\*</sup> An FFP2 facemask is recommended for patients with respiratory symptoms or suspected or confirmed COVID-19 who require an aerosol generating procedure.

professionals in 2019 with similar rates for 2020. This low uptake of hand hygiene training should be a focus for improvement following this inspection.

## 2.3 Quality and Safety

This section looks at how acute 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 2.6:** Healthcare is provided in a clean and safe physical environment that minimises the risk of transmitting a healthcare-associated infection.

#### **Judgment Standard 2.6: Partially compliant**

- A number of infrastructural and maintenance issues were identified in the wards inspected that did not facilitate effective cleaning.
- There were no single rooms with specialised ventilation systems in the inpatient wards or critical care units at the hospital
- Insufficient number of showering and toilet facilities on Sceilig Ward
- The function of the day ward on Sceilig ward required review.
- It was observed that staff were not physical distancing in the day room during meal breaks.
- Both antimicrobial soap and plain soap was located at a number of hand hygiene sinks in Sceilig ward

### **Emergency Department Environment and infrastructure**

As outlined in Section 2.2, Inspectors found that significant reconfiguration and renovations had been undertaken in the Emergency Department to enable separate pathways for patients presenting with suspected and confirmed COVID-19 and non-COVID-19 conditions.

The main Emergency Department had eight cubicles and one single room. This was designated to patients on the non-COVID-19 pathway. In the months prior to the inspection, all eight cubicles had been fitted with doors so that each of these cubicles could be closed off. The single room in the department had an ensuite toilet and shower.

A separate waiting area and triage area had been designated for patients presenting with suspected or confirmed COVID-19. Both waiting areas had seats removed to enable physical distancing.

In addition five single rooms, one of which had a specialised ventilation system and anteroom had been installed in a separate section of the Emergency Department for patients on the COVID-19 pathway. This unit was known as the Respiratory Receiving Unit. Renovation and reconfiguring of the Emergency Department was ongoing at the time of the onsite inspection. This unit had designated medical and nursing staff assigned to care for patients on the COVID-19 pathway.

The Emergency Department's resuscitation room had three bays and could be directly accessed from the Respiratory Receiving Unit and the main Emergency Department. Three separate isolation pods had been installed in the Resuscitation room.

On the day of inspection the Acute Medical Assessment Unit was also used to assess and treat patients presenting to the Emergency Department as the cubicles in the main Emergency Department were full.

#### Scelig Ward (non- COVID-19 pathway)

Scelig Ward was a 24 bedded inpatient ward. The ward had three single rooms, one with ensuite toilet and two with ensuite toilet and shower. None of the single rooms had pressurised ventilation systems. One three bedded ward had a toilet but no shower. On the day of inspection, three patients requiring transmission based precautions were cohorted in this room.

Physical distancing was maintained between beds in multi-occupancy rooms in line with national guidelines.<sup>5</sup>

The inspector found that the function and layout of the ward's day room required review. It was used for storage of patient equipment, and had two ward computers for staff. Staff were also observed to use the room for meal breaks. Inspectors observed that staff were not maintaining physical distancing during meal breaks in the dayroom. This was brought to the attention of the ward manager during the inspection for review.

The ward environment in Scelig Ward was clean with few exceptions. However, the inspector observed issues in relation to maintenance, with surfaces worn and poorly maintained, in particular, in the toilets and shower rooms and as such did not facilitate effective cleaning. Poor maintenance and poor environmental hygiene have been cited as contributory causal factors in serious outbreaks of infection in hospitals. This was reflected in hospital wide environmental hygiene audits where the average score for 2020 was 81% and failed to reach the target of 85%. The

hospital's audit findings also reflected the maintenance issues identified during the inspection and should be an area for improvement following the inspection.

Antimicrobial soap was available in addition to plain soap at hand hygiene sinks throughout Sceilig ward. The use of antimicrobial soaps is associated with skin care issues and is not recommended for everyday clinical practices<sup>11</sup> and therefore should be reviewed. Alcohol-based hand rub was available at the point of care throughout the ward.

Inspectors observed and discussions with staff indicated some staff had dual roles of catering and cleaning duties on the day of inspection. The ward manager stated that in general, these roles were solely dedicated to either catering or cleaning. Shared duties as described are far from ideal. The operational norm in most acute hospitals is that catering and cleaning duties are performed by separate staff positions. There is a risk that dual responsibilities may dilute the effectiveness of both roles and may increase the risk of transmission of infection. Inspectors were informed that a plan was developed in 2018 to reconfigure hygiene services to separate housekeeping and catering duties and discussions were ongoing with relevant stakeholders at the hospital. This should be progressed following this inspection to ensure that potential cross-transmission risks are limited.

#### Annagh Ward (COVID-19 pathway)

On the day of inspection, Annagh Ward was the designated COVID-19 ward. This ward normally functioned as a day ward but in response to COVID-19 had been reconfigured and renovated to include a designated four bedded COVID-19 critical care unit. Due to very low numbers of COVID-19 patients in the hospital at that time, there was no requirements for the placement of patients in this newly renovated four bedded critical care unit on the day of inspection. In addition to this four bedded unit, Annagh Ward had two single rooms with a shared anteroom for donning and doffing of PPE. None of these rooms had specialised ventilation systems. Furthermore, there were two other rooms on the ward which would in more normal times be used as multi-occupancy rooms for day cases. On the day of inspection there were three patients admitted with COVID-19 on the ward, one of whom was in a single room, with the other two patients each individually occupying a multi-occupancy ward room.

Overall therefore, it was observed that contingencies had been made to enable the accommodation of a larger volume of patients with COVID-19 in the context of a public health emergency than the demand observed on the day of inspection. However, infrastructural arrangements on the ward were far from ideal, with only limited single room capacity which did not have ventilation controls.

Hospital management informed inspectors that plans for a High Dependency Unit in Annagh Ward with six single rooms was at an advanced stage with work due to commence on the project in February 2021.

Overall, inspectors found that while the ward environment was generally clean on the day of inspection, ward wide issues related to maintenance were observed. Similar to Sceilig Ward some surfaces and finishes in the main ward were chipped and worn and did not facilitate effective cleaning.

Inspectors observed that transmission-based precautions were applied to patients suspected or confirmed to be infected with agents transmitted by the contact and droplet routes in line with national guidelines in both areas inspected.<sup>12</sup> Personal protective equipment was readily available outside isolation rooms and appropriate signage was visible on the doors of isolation 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 areas inspected. They also indicated satisfaction with staff practices they had observed to reduce the risk of spread of infection.

**Standard 2.7** Equipment is cleaned and maintained to minimise the risk of transmitting a healthcare-associated infection.

#### **Judgment Standard 2.7:Substantially compliant**

Some improvement was required to ensure that patient equipment was adequately cleaned and labelled in line with the hospital's processes.

#### Equipment hygiene

Overall, patient equipment in the both areas inspected were 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 on an ongoing basis. A green tagging system was in use on both wards inspected to identify equipment that had been cleaned. Inspectors found that this system was applied on both wards with a small number of inconsistencies noted.

Trended audit results for patient equipment at the hospital from January to September 2020 scored 75% and was below the desirable standard of 85%. The

hospital had identified a requirement to improve cleaning practices in relation to blood pressure machines, intravenous pumps and blood gas analysers. This needs to be progressed.

### **Theme 3: Safe Care and Support**

**Standard 3.1.** Service providers integrate risk management practices into daily work routine to improve the prevention and control of healthcare-associated infections.

**Judgment Standard 3.1: Compliant**

University Hospital Kerry had systems in place for the proactive identification, assessment, mitigation, monitoring and reporting of infection risks in line with HSE risk management and guidance.<sup>13 14</sup>

#### Risk Management

The hospital had a corporate risk register in place that was reviewed and updated at the risk management committee meeting every two months. Attendance at these meetings included the general manager, the clinical director and the hospital's risk manager.

Risk assessments pertinent to the management of COVID-19 at the hospital had been undertaken and were recorded on the hospital's risk register. Inspectors reviewed the corporate risk register and found evidence of regular review. Infection prevention and control risks articulated to inspectors were consistent with risks documented on these risk registers. Infection prevention and control risks recorded on the risk register included the following:

- lack of onsite consultant microbiologist and resultant lack of clinical governance of microbiology services
- lack of a surveillance scientist resulting in a limited surveillance programme
- insufficient single room capacity to meet infection prevention and control requirements for the hospital
- lack of isolation rooms with specialised ventilation systems for patients requiring airborne precautions
- infrastructural deficits across the hospital.

Inspectors were informed that the hospital had sought approval for the development of a 40 single room modular build from the South/Southwest Hospital Group. This had yet to be approved at the time of the inspection.

## Incident Reporting

Hospital management informed inspectors that incidents of healthcare-associated infection were reported on the National Incident Management System (NIMS) <sup>+++</sup> in line with national standards.<sup>1</sup>

One of the key aims of incident management is learning and improvement.<sup>15</sup> Inspectors viewed reports outlining tracking and trending of infection prevention and control related clinical incidents at the hospital. Incidents of healthcare-associated infection were presented and reviewed at the hospital's infection prevention and control committee meetings.

**Standard 3.8** Services have a system in place to manage and control infection outbreaks in a timely and effective manner.

**Judgment Standard 3.8: Substantially compliant**

Lack of onsite testing for norovirus resulting in delays when investigating norovirus outbreaks.

## Measures to Prevent and Control the Risk of COVID-19

Documentation reviewed by inspectors indicated that 120 patients had been admitted to the hospital with COVID-19 from March to November 2020. Hospital management informed inspectors that they had no COVID-19 outbreaks during this time and no evidence of hospital transmission. The hospital established a multidisciplinary group that met twice a week since the onset of the COVID-19 pandemic to prepare and manage COVID-19 at the hospital.

The hospital had implemented a number of measures as part of its COVID-19 preparedness plan. These included but were not limited to:

- In house laboratory testing for SARS-CoV-2<sup>+++</sup> commenced at the hospital in April 2020.
- Reconfiguration and upgrades to the Emergency Department to enable separate waiting, triage and assessment areas for patients presenting with COVID-19 and non COVID-19 related conditions.
- Division of the Emergency Department bays into single room cubicles.
- Installation of single isolation pods into the Emergency Department Resuscitation room.

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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> The virus, which causes COVID-19 infection, is called SARS-CoV-2 and belongs to the broad family of viruses known as coronaviruses.

- Designated wards and critical care beds to the COVID-19 pathway.
- Outsourcing of services to a local private hospital to increase capacity within the hospital.
- Plan for surge capacity for critical care patients.
- SARS-CoV-2 surveillance testing for all patients admitted to the hospital.
- Increased auditing of compliance with transmission based precautions.
- Increased cleaning resources at the hospital.
- Signage throughout the hospital to raise awareness of COVID-19.

#### Management of outbreaks of non-COVID-19 infections at the hospital

In November 2020, the infection prevention and control team investigated and managed a suspected outbreak of gastroenteritis among five symptomatic patients at the hospital. Immediate actions were taken by hospital management and the infection prevention and control team to manage the suspected outbreak including isolation and cohorting of affected patients, enhanced cleaning and reporting to public health.

Documentation reviewed indicated that there was no laboratory confirmation of any organisms and the outbreak team determined that the incidents did not meet the criteria of an outbreak. The hospital laboratory did not provide onsite Norovirus testing and therefore samples were sent to the National Virology Reference Laboratory. The hospital identified that this impacted on the management of the suspected outbreak and resulted in delayed discharges as the turnaround time for samples sent to the National Virology Reference Laboratory were reported as approximately five days. This should be addressed following this inspection.

#### *Clostridioides difficile* infection

Inspectors were informed that the hospital had identified an increase in the incidence of healthcare-associated *Clostridioides difficile* infection in 2020. Documentation reviewed by inspectors found that there was no indication that any outbreaks had occurred in 2020. The onsite consultant microbiologist had completed root cause analysis on hospital-acquired cases at the hospital to identify any contributing factors from April to July 2020. Inspectors noted that contributory factors arising from these reports included:

- non-compliance with the hospital's antimicrobial guidelines,
- sub optimal hand hygiene audit findings among medical staff
- and poor environmental infrastructure in the CCU and Scelig ward.

Reported trends indicated that more needs to be done to reduce the incidence of *Clostridioides difficile* infection and to ensure better performance against HSE performance indicator for *Clostridioides difficile*. The hospital should review the

incidence of *Clostridioides difficile* infection it has experienced in the context of the inspection findings. Prevention and control of this infection must be a focus of improvement for all hospital staff.

### **3.0 Conclusion**

Overall this inspection identified that University Hospital Kerry was compliant with one, substantially compliant with three, partially compliant with one and non-compliant with one of the six *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services* assessed.

#### 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. Additional arrangements were established to ensure the hospital had adequate plans to prepare and oversee the hospital's COVID-19 response. Inspectors found that national guidelines on COVID-19 were reviewed and implemented at the hospital. The hospital had undertaken extensive infrastructural work to implement separate pathways for patient presenting with COVID-19 and non COVID-19 conditions. The hospital had also undertaken upgrade and refurbishment of the Intensive Care Unit since the previous HIQA inspection.

While the hospital had an antimicrobial stewardship programme in place, these activities were limited due to staffing resources for the programme.

The hospital had improved the uptake of influenza vaccine among staff at the hospital and were working to meet the 2020/2021 HSE target of 75%.

#### Workforce

The hospital had identified that the infection prevention and control team at the hospital was under resourced. The lack of an onsite consultant microbiologist impacted on the effectiveness of the infection prevention and control activities at the hospital. This high risk was identified during inspection and escalated to the Chief Executive Officer of the South/South West Hospital Group following inspection so the identified risk could be mitigated.

Other vacancies in the positions of surveillance scientists and microbiology laboratory scientists hindered the effectiveness of the hospital's infection prevention and control programme. Recruitment and retention of these key personnel should be a key area of focus following this inspection.

The infection prevention and control team had experienced additional workload and challenges arising from the COVID-19 pandemic and had provided additional training and advice to support staff and management at the hospital. While the uptake of training in relation to COVID-19 and the appropriate use of personal protective

equipment (PPE) at the hospital was good, uptake of hand hygiene training required improvement across all disciplines.

### Effective Care & Support

Overall patient equipment and the environment in the wards inspected were generally clean with some exceptions. However a number of infrastructural and maintenance issues which had the potential to impact on infection prevention and control measures were identified during the course of the inspection. The hospital had identified these issues from environmental audits and should work to address these issues through upgrading and refurbishment.

The hospital had identified inadequate isolation room capacity as a risk to effective infection prevention and control at the hospital. Hospital management should review the functionality of the ward dayrooms and ensure staff maintain physical distancing during meal breaks.

### Safe care and support

Systems were in place to identify and manage risk in relation to the prevention and control of healthcare-associated infections. Overall, senior management had good oversight of the infection prevention and control risks on the corporate risk register.

The hospital had implemented a number of strategies to mitigate and manage the risk of hospital transmission of COVID-19. Patients were streamed in the Emergency Department for possible COVID-19 and non COVID-19 conditions, and identification of beds in the event of surge capacity being required. Onsite testing for COVID-19 had been implemented at the hospital.

Any lowering of guard or relaxation of protective precautions can potentially create a potential risk of transmission for this opportunistic highly transmissible SARS-Cov-2 virus. Therefore if outbreaks are to be prevented, close monitoring and strict adherence to infection prevention and control guidelines and interventions is required for the duration of the COVID-19 pandemic.

University Hospital Kerry, as a member of the South/ Southwest Hospital Group, needs to be supported within group and national structures to effectively address issues in relation to hospital infrastructure, capacity and resources in order to meet unscheduled care demand and effectively manage a potential resurgence of COVID-19 cases.



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