Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of the unannounced inspection of Letterkenny University Hospital

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: 22 October 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*[1] during the COVID-19 pandemic.

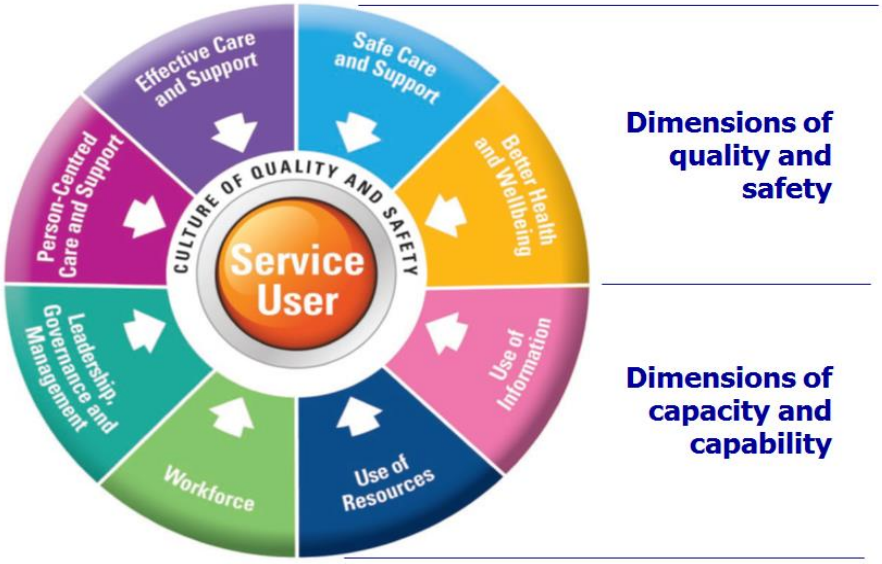
The national standards provide a framework for service providers to assess and improve the service they provide particularly during an outbreak of infection including COVID-19.

Inspection findings are grouped under the national standards dimensions of:

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

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

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



* National standards for 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 hospital's **capacity and capability** through the following standards:

Capacity and Capability	
Theme	**Standard**
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
6: Workforce	**Standard 6.1:** Service providers plan, organise and manage their workforce to meet the services' infection prevention and control needs.

HIQA also assesses acute hospital's service provision under the dimensions of **quality and safety** through the following standards:

Quality and Safety	
Theme	**Standard**
2: Effective Care & Support	**Standard 2.6**: Healthcare is provided in a clean and safe physical environment that minimises the risk of transmitting a healthcare-associated infection. **Standard 2.7** Equipment is cleaned and maintained to minimise the risk of transmitting a healthcare-associated infection.
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. **Standard 3.8** 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:

Compliant	**Substantially compliant**	**Partially compliant**	**Non-compliant**
A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant National Standards.	A judgment of substantially compliant means that the service met most of the requirements of the National Standards but some action is required to be fully compliant.	A judgment of partially compliant means that the service met some of the requirements of the relevant National Standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks which could lead to significant risks for patients over time if not addressed.	A judgment of non-compliant means that this inspection of the service has identified one or more findings which indicate that the relevant standard has not been met, and that this deficiency is such that it represents a significant risk to patients.

1.1 Hospital Profile

Letterkenny University Hospital is a model 3 acute teaching hospital which is owned and managed by the Health Service Executive (HSE) and is part of the Saolta University Health Care Group.[‡] The hospital provides a range of services including acute inpatient, maternity, outpatient and day services. The hospital has a bed capacity of 395 beds.

1.2 Information about this inspection

This inspection report was completed following an unannounced inspection carried out by Authorised Persons, HIQA; Kay Sugrue, Kathryn Hanly and Bairbre Moynihan on 22 October 2020 between 09:40 hrs and 15:50 hrs.

HIQA's focus during this inspection included a detailed evaluation of how 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 practice within the clinical environment in a sample of clinical areas which included:

- Medical 3 ward (COVID-19 pathway)
- Orthopaedic Ward (non COVID-19 pathway)

In addition, inspectors conducted a walkthrough of the emergency department and the Respiratory Receiving Unit (RRU).

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

[‡] 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 announced inspection as follows:

- Section 2.1 Capacity and Capability
- Section 2.2 Quality and Safety

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 5.3: 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 ▪ Insufficient assurance on monitoring of hospital environmental hygiene specifically patient environmental hygiene. ▪ Limited progress in progressing the hospital antimicrobial stewardship programme.

Corporate and Clinical Governance

Inspectors reviewed a number of draft hospital governance arrangements which included the governance structures relating to the prevention and control of healthcare-associated infection at the hospital. These organograms were issued in draft on 10 March 2020 and remained in draft up to the day of the inspection. Inspectors found that accountability and responsibility in relation to the prevention

and control of healthcare-associated infection at the hospital rested with the general manager.

The hospital had a multidisciplinary Infection Prevention and Control Committee that reported to the Quality and Patient Safety Committee and upwards to the Hospital Executive Board. The hospital infection prevention and control team had day-to-day responsibility for delivering the infection prevention and control programme. Monthly reports were developed by the team which were communicated through the governance arrangements outlined in the hospital organogram.

In response to the onset of the pandemic, the hospital established a COVID-19 Co-ordination Team meeting with responsibility for pandemic preparedness, plans and oversight. This multidisciplinary committee had been active during the onset of the pandemic, meeting daily and then weekly as needed and covered a range of COVID-19 related issues. Records provided indicated that meetings had occurred on 10 August 2020 and 24 September 2020 and subsequently increased to twice weekly from the 1 October.

A subcommittee was being established to oversee compliance with recently published HSE guidelines for the adult unscheduled care pathway in the pandemic.[2] In this regard, the hospital demonstrated that it was committed to complying with updated guidance in a timely way.

Minutes from committees outlined within hospital infection and prevention and control governance arrangements were reviewed by inspectors. These minutes indicated several of these committees had temporarily suspended planned meetings for several months but had since reconvened.

On review of the above documentation, inspectors found that oversight by hospital management was primarily directed towards COVID-19 which was a significant challenge during that period. Oversight of other aspects of the infections prevention and control programme was via infection prevention and control reports and updates.

The Infection Prevention and Control Committee at Letterkenny University Hospital also reported to the Saolta University Health Care Group Infection Prevention and Control Committee meetings on a quarterly basis. Comprehensive quarterly reports submitted to this committee were viewed by inspectors for the first two quarters of 2020. Committee minutes from a meeting held on 4 February 2020 demonstrated that many of the initial challenges and issues faced by hospitals within the Saolta group in dealing with the novel coronavirus were discussed.

The hospital had a standing outbreak committee, membership of which was multidisciplinary. COVID-19 preparedness and outbreak management will be further discussed in section 2.2 of this report.

Antimicrobial Stewardship Programme

Hospital management informed inspectors that a programme for antimicrobial stewardship was in place although progression of this programme was limited due to resource deficiencies within the antimicrobial stewardship team. The existing antimicrobial pharmacist role had recently been vacated and a second antimicrobial pharmacist position approved in 2018 had not yet been filled. A business case for two antimicrobial pharmacists had been submitted to the Saolta University Healthcare Group and were in the process of being recruited. The progression of the hospital antimicrobial stewardship programme from its current status to one that is fully functioning should be a focus for improvement following on from this inspection.

Emergency Department and Hospital Capacity

Letterkenny University hospital had established pathways in place for the assessment, care and management of suspected and positive cases of COVID-19 patients. The pathways devised related to scheduled and unscheduled care and provided parallel streams segregating patients into possible COVID-19 and non-COVID-19 pathways.

At the time of the inspection, the hospital had dedicated two medical wards for the management of suspected and positive cases of COVID-19 comprising a total of 48 beds. At the time of this inspection, the hospital reported that there were 18 inpatients who were positive for COVID-19. The 48 allocated beds were described as sufficient to meet the demand. However, there were plans to designate the medical block of wards completely as the COVID-19 pathway should the demand increase beyond a defined tipping point. The designation of the medical block had been tried and tested in the early phase of the pandemic and was described by staff to inspectors as having worked very well.

Overall bed capacity at the hospital had also increased in recent months with the opening of 16 beds in a new ward Medical 7 in June 2020. Inspectors were informed that there were plans in place to open an additional 23 beds in the hospital and the hospital was working closely with the HSE Community Health Organisation 1 to identify more step-down beds in the community to assist with the management of potential surges in demand.

Monitoring, Audit and Quality assurance arrangements

The infection prevention and control surveillance programme included surveillance of 'alert' organisms§, 'alert' conditions** and Notifiable Diseases.[3] Hospital antimicrobial consumption rates were also monitored.

Monthly updates on performance against key performance indicators were submitted in reports by the infection prevention and control team to senior hospital management. By way of example, updates included in the September 2020 report included:

- hospital infection control surveillance tracking healthcare associated infections in each clinical area (days free from healthcare-associated infection reports and surveillance data)
- infection prevention and control training and education delivered
- compliance with hand hygiene practices in each clinical area (monthly)
- compliance with Carbapenemase Producing Enterobacterales (CPE) controls on admission
- summary of patients confirmed with newly detected CPE from screening
- number of environment swabs taken each month
- care bundles†† compliance levels including peripheral vascular cannula and urinary catheter care bundles in each clinical area and ventilator associated pneumonia care bundle compliance in the intensive care unit.

In addition to the monitoring and surveillance outlined above, the infection prevention and control team had undertaken surgical site surveillance following orthopaedic joint replacements over the last two years. The 2020 Infection Prevention and Control Team Service Plan indicated the focus of this programme for 2020 was surgical site surveillance on patients following caesarean section in the maternity services.

There was evidence that a recent COVID-19 checklist had been completed in October 2020 to ensure appropriate processes were in place to protect staff and patients.

Hospital environmental hygiene was monitored through quarterly hygiene audits and senior management walkabouts both of which had stalled with the onset of the pandemic in March 2020. Recent minutes from the Hospital Services Action Group held on 16 September 2020 indicated agreement that patient environmental hygiene

§ Alert organisms are identified in the microbiology laboratory and include organisms such as CPE and other antibiotic resistant organisms

** Alert conditions include physical symptoms such as skin rashes, vomiting, diarrhoea, respiratory illness that could be due to an infectious illness

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

audits would recommence from 5 October 2020. Inspectors were informed that domestic supervisors performed daily checks in each clinical area and reviewed cleaning checklists. Inspectors found that while the rationale to reduce the footfall within clinical settings was understandable, other measures, such as locally conducted audits could have been implemented locally within patient environments to provide assurance relating to compliance with environmental hygiene standards. Findings in this regard will be presented in section 2.2 in this report.

The hospital had implemented an electronic "close proximity alert" system which provided timely intelligence on close contacts. This system was described as a valuable tool in early identification of close contacts facilitating timely and appropriate patient placement.

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.

Inspectors viewed a number of COVID-19 related documents outlining patient care pathways, protocols and plans to support staff in the management of different patient groups. These patient groups included paediatric patients, pregnant women, and haematology or oncology patients. It was clear from the documentation reviewed that considerable effort had been given to ensuring staff were kept up-to-date with changing guidelines as new information on this novel virus emerged.

Influenza Vaccination

The hospital had increased its uptake of the vaccine during the 2019-2020 influenza season but failed to reach the 60% national uptake target.[4] Inspectors were informed that an influenza vaccination programme had commenced with the aim of significantly improving the uptake in line with the 2020 national target.[5] The programme was being led by the infection prevention and control assistant director of nursing.

Up to the day of the inspection, 398 hospital staff had been vaccinated on site by a team of peer vaccinators. More clinics were due to be provided. Hospital staff reported challenges in obtaining sufficient cold chain supplies of vaccines which were supplied through the occupational health department.

Quality Improvement Plan (QIP)

The hospital had implemented a quality improvement plan to address the findings of a HIQA inspection undertaken on the 28 June 2016. Review of this plan showed that of the documented 40 findings, 32 were completed, six were in progress and two had not met the target date set out in the plan. The hospital had taken action to

address outstanding issues but required external input or funding approval to complete the actionable items.

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: Partially compliant

- Insufficient infection prevention and control team resources in the microbiology service and antimicrobial stewardship programme
- Insufficient regional occupational health resources acknowledged by hospital management as an ongoing challenge and a potential infection prevention and control risk.
- Infection prevention and control training records need to improve as does attendances across all disciplines at training sessions provided.

The hospital infection prevention and control team had responsibility for implementing the annual infection prevention and control plan and programme. To ensure sufficient infection prevention and control advice was available to clinical staff, core working hours had been adjusted to ensure cover was provided up to 9pm each day. Adjustment to core working hours considered anticipated timelines from processing COVID-19 screening and therefore enabled appropriate patient placement based on the results received. In addition, out-of-hours cover was also provided by infection prevention and control nurses to support and supplement consultant microbiology services.

Hospital management received additional support for microbiology and infection prevention and control services. A locum microbiologist was provided during the initial phase of the pandemic to assist with non-COVID related issues. Microbiology services continued to benefit from this locum service for four days each week. A staff nurse in infection prevention and control was also provided for six months to assist the team during the pandemic. One infection prevention and control nurse was dedicated to COVID-19 while the remaining members oversaw the wider infection prevention and control programme throughout the hospital.

Hospital management informed inspectors that a business case for a second consultant microbiologist had received approval. Recruitment for this post had commenced. The hospital had also received approval for nine medical scientists at senior and basic grade which were currently filled on a temporary basis. A recruitment process to fill these permanent positions had commenced. Hospital

management identified ongoing challenges is recruiting and retention of skilled staff as a risk which was recorded on the corporate risk register.

The infection prevention and control team comprised;

- one whole time equivalent (WTE) [‡‡] consultant microbiologist plus a locum microbiologist four days each week
- one WTE Assistant Director of Nursing (ADON) in infection prevention and control
- three clinical nurse specialists in infection prevention and control
- six month allocation of infection prevention and control staff nurse
- one WTE surveillance scientist.

In the absence of a hospital dedicated occupational health service, the hospital was supported by a regional occupational health service located near the hospital. Hospital management reported insufficient resources within this service. Limited staff contact tracing was undertaken by the regional occupational health service with much of the responsibility falling to the infection prevention and control team and a locally established contact tracing team. Hospital management reported additional resources had been provided by both the hospital and the CHO1 to the regional occupational health service. The lack of sufficient occupational health resources to address hospital requirements during the pandemic was acknowledged by senior management as an ongoing challenge and potential risk. This risk was not documented on the corporate risk register. Documentation viewed by inspectors indicated that the occupational health department was to receive additional administrative resources which were due to commence on 6 October 2020 to help with the workload.

Infection Prevention and Control Education

Infection prevention and control training was provided to all hospital staff through monthly training sessions delivered by members of the infection prevention and control team. Staff could also complete eLearning via HSELand. Compliance with infection prevention and control training was reported on a monthly basis via established hospital management structures.

Inspectors were informed that fit testing[§§] FFP3 facemasks[***] to avoid COVID-19 transmission was in the process of being provided to clinical staff likely to undertake

[‡‡] 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.
[§§] 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.
[***] An FFP2 facemask is recommended for patients with respiratory symptoms or suspected or confirmed COVID-19 who require an aerosol generating procedure.

procedures that involve or may involve the generation of aerosols (aerosol generating procedures or AGPs).

Hospital-wide infection prevention and control training records were reviewed by inspectors. The hospital was in the process of transitioning to a new format for documenting training of nursing and midwifery staff and healthcare assistants which was linked to an electronic rostering system. Hospital management informed inspectors that extensive informal training on the appropriate use of personal protective equipment (PPE) had been carried out since the onset of the pandemic. However these informal training sessions were not recorded which meant that records viewed by inspectors were not an accurate reflection of training and education provided.

Minutes from the most recent hospital infection prevention and control committee meeting held on 16 October 2020 reported that 83% of staff had attended hand hygiene training within the previous year. However compliance with training relating to other aspects of infection control training such as aspergillosis, Carbapenemase Producing *Enterobacteriaceae* (CPE) and basic infection prevention and control was relatively low across the hospital. These minutes also highlighted the need to improve attendance at multiple training sessions provided to all staff disciplines which should be a focus for improvement following this inspection.

2.1 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

- Improvements were required relating to the pre-triage assessment for the identification of suspected and positive cases of COVID-19.
- Infection prevention and control measures in place on Medical 3 Ward require improvement.
- General maintenance and management of the physical environment on Orthopaedic Ward in addition to oversight of environmental hygiene need to improve.

Emergency Department Environment and Infrastructure

Inspectors visited the emergency department which had been opened as a new build in 2012. Extensive flood damage experienced in 2013 required refurbishment and repair in the department which was reopened in early 2014. There were 14 bays in total which included four single rooms, one of which was dedicated to paediatric presentations. Overall, the department was clean and well maintained. Staff reported that the available toilet facilities were insufficient to meet demand.

The main emergency department was dedicated for non-COVID-19 presentations. Patient waiting areas and emergency department resuscitation rooms had been structurally divided to enable parallel streaming. In addition, there were two pods to facilitate patients waiting to be seen. Inspectors observed relatives waiting with some patients. The hospital should ensure that recommended restrictions on visitors

accompanying and waiting with patients in the emergency department in line with HSE guidelines.[2]

A respiratory receiving unit locally known as the RRU had replaced the Acute Medical Assessment Unit (AMAU) and was designated for patients presenting on the COVID-19 pathway. This unit was under the clinical governance of medical consultants. It comprised 11 bays, one of which was used for donning and storage of PPE. There were two single rooms one of which was a designated isolation room with a positive pressure ventilated lobby and ensuite. This room was designated for patients requiring aerosol generating procedures.

Inspectors found that in the absence of pre-triage COVID-19 process for assessment, ambulatory patients presenting to the emergency department self-determined which pathway to follow until triaged. This posed a potential weakness in the process for early identification of suspected and positive cases of COVID-19 and should be addressed in line with HSE guidelines[2] following this inspection.

Hospital management informed inspectors that the relocation of the AMAU had negatively impacted the patient flow through the emergency department. A proposal submitted by the hospital to the SAOLTA hospital group to re-establish the AMAU proximal to the emergency department had been reviewed by the group, the hospital and HSE estates and considered not feasible for 2020. Efforts to identify an alternative pathway for the AMAU were suspended due to increasing challenges posed by COVID-19 outbreaks experienced in November. The hospital had completed a risk assessment and planned to re-submit the proposal to address increasing presentations and general practitioner referrals to the department which would normally present to the AMAU.

Medical 3 Ward

Medical 3 ward was one of two wards dedicated for patients admitted under the COVID-19 pathway since March 2020. The ward had 24 beds. There were 14 single rooms with ensuite toilet and shower facilities, four of which had negative pressure ventilation systems suitable for the management of patients with airborne infections.

There were 14 patients on the COVID-19 pathway who were either cohorted in multi-occupancy rooms with transmission-based precautions or isolated in single rooms. The remaining seven inpatients were not being treated for any COVID-19 related illness. Physical distancing was maintained between beds in multi-occupancy rooms in line with national guidelines.[6] PPE was applied appropriately and extended use of PPE was only used in rooms cohorting patients positive with COVID-19.

Patients with COVID-19 were accommodated in rooms on both sides of the ward and not necessarily located in close proximity to each other within a defined zone as

recommended in national guidelines. The inspector noted that signage for infection prevention and control precaution was generically placed on doors to all patient rooms. This resulted in a lack of clarity on differentiating non-COVID patients from those on the COVID-19 pathway. Isolation signage must be placed at the entrance to the patient's room to restrict entry and clearly indicate the level of transmission-based precautions required, namely contact and droplet precautions. There was also potential to reduce the footfall onto the ward which was very busy with medical teams at the time of the ward assessment.

From discussions with ward staff, inspectors were not fully assured that crossover between clinical teams did not regularly occur. Nursing staff were generally split into two teams, however staff reported that some crossover between teams did occur should assistance be required and during breaks. Medical teams and ward cleaning resources were not assigned to COVID or non-COVID teams at the time of the inspection. Household staff informed the inspector that a 'clean to dirty' process was applied during daily cleaning of patient clinical areas. The hospital should risk assess the systems in place to prevent crossover of staff between COVID-19 and non-COVID-19 cases following this inspection.

The inspector found the ward to be clean and well maintained at the time of the inspection. Enhanced cleaning and decontamination practices were in place in line with national guidelines. A decision was made at the onset of the pandemic that quarterly patient environmental hygiene audits would be deferred to help reduce the foot fall on the ward. As a result, it was reported that environmental hygiene audits had not been undertaken on the ward in over six months. Regular monitoring to ensure cleaning standards are met should be employed in high risk areas such as clinical areas designated to accommodate COVID-19 patients.

Orthopaedic Ward

Orthopaedic Ward comprised 37 beds, 25 of which were open on the day of the inspection. There were eight single rooms with ensuite facilities. The ward was an older design and had a number of multi-occupancy rooms. Not all of these rooms had ensuite facilities.

Overall the inspector observed that improvements were required in the general maintenance and management of environmental hygiene on the ward. General wear and tear on surfaces and finishes were noted. Dust, rust and stains from spillages were observed on some surfaces. The dirty utility room did not have a designated hand hygiene facility. Some laundered cleaning textiles were inappropriately stored in the dirty utility.

Patients requiring isolation with transmission based precautions were managed appropriately. Signage alerting staff to the precautions to be taken were in place in all but one of the room doors.

Similar to Medical 3 Ward, patient environmental hygiene audits were relatively limited in 2020. Inspectors were provided with an audit undertaken on 3 July 2019 in which maintenance issues similar to those observed during this inspection were identified. Completion dates for actionable items were recorded on the follow up action plan for hygiene issues and some maintenance issues. However, many of the maintenance issues such as painting were not addressed.

Poor maintenance and poor environmental hygiene have been cited as contributory causal factors in serious outbreaks of infection in hospitals. Hospital management acknowledged that the ward was on a high priority list for upgrade and maintenance which had not received approval for the necessary funding.

Incidental findings

Documentation reviewed by inspectors following this inspection found a recurring reference across multiple documents on the lack of allocated cleaning resources in the Radiology Department. This issue was attributed to resource constraints and was documented on the corporate risk register and discussed at the hospital infection prevention and control committee meeting held on 16 October 2020. Cleaning resource constraints were not highlighted as an issue by hospital management during discussions with inspectors. The hospital should review and address cleaning resource deficiencies it has identified as a priority following this inspection. Subsequent information received following this inspection indicated that this issue had been fully resolved.

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

Judgment Standard 2.7: Partially compliant

- Improvements in the management of patient equipment hygiene was required on Orthopaedic Ward
- Regular audit of equipment hygiene was not undertaken in the areas inspected.

Equipment hygiene

Overall, equipment in Medical 3 Ward was clean and well maintained. A green tagging system was in use to identify equipment that had been cleaned. Designated

patient equipment such as monitoring equipment was available in each of the isolation rooms.

However, significant improvement in the management of equipment hygiene in Orthopaedic Ward was identified. For example, inspectors observed evidence of sub-standard cleaning on dressing trolleys, a resuscitation trolley and a mobile patient monitoring trolley. While a green tagging system was in use, the inspector observed stains on one trolley with a green tag indicating it had been cleaned on 21 October 2020.

Evidence viewed indicated that blood glucose monitors and their holders which contained sterile supplies were brought to the patient bedside for blood sampling on Orthopaedic Ward. This practice should be reviewed as it potentially increases the risk of equipment contamination. It is recommended that only the equipment required for a single procedure on an individual patient should be brought to a patient bedside.

Similar to environmental hygiene audits, monitoring of compliance with patient equipment hygiene was relatively limited since March 2020.

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: Substantially compliant ▪ Risks relating to infection prevention and control need to be more clearly identifiable on the corporate risk register.

Risk Management

Letterkenny University Hospital had a risk management systems in place. The hospital risk manager was a member of the Quality and Patient Safety Committee and the Hospital Executive Board.

A corporate risk register was in place and was updated at the Quality and Patient Safety Committee meetings. Risks not managed locally were escalated upwards to the Hospital Executive Board and Saolta Hospital Group in line with HSE risk management processes.[7]

In discussions with inspectors, hospital management consistently demonstrated awareness of risks relating to infection prevention and control. However some of the risks outlined to inspectors were not clearly identifiable in the risk descriptors recorded on the corporate risk register. The hospital needs to ensure that the corporate risk register gives an accurate description of the impact, cause and

context of the risk to effectively identify the necessary controls required to manage the risk.[8]

Incident Reporting

Hospital management informed inspectors that it was hospital policy to report incidents of healthcare-associated infection and non-compliance with infection prevention and control guidelines on the hospital electronic document and national incident management system. Documentation viewed demonstrated that outbreaks were reported as incidents on this system.

Incident reported on the system creates an alert sent to relevant senior nurse managers at directorate and ward level. Documentation viewed by inspectors demonstrated that incidents were tracked and trended and an overview of reported incidents was discussed as a standing agenda item at the hospital infection prevention and control committee.

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

- Reports for outbreaks that had occurred at the hospital from the beginning of 2020 including COVID-19 outbreaks were not provided.

COVID-19 Preparedness

The hospital convened a multidisciplinary meeting for COVID-19 escalation on 6 March 2020. Following on from this meeting, many measures were implemented to decrease the potential incidence of COVID-19 outbreaks and staff infection. As previously discussed, processes were initiated to facilitate parallel streaming of patients into COVID-19 and non COVID-19 pathways for unscheduled and scheduled care. Other measures implemented included but were not limited to:

- plan for surge capacity in ICU from six beds to 12
- increased COVID-screening capacity enabling 400 to 500 tests daily with same day turnaround times
- additional rapid tests for SARS-CoV-2 testing facilitating patient flow through the emergency department and inpatient placement
- testing of all patients for SARS-CoV-2 on admission
- patient placement
- SARS-CoV-2 patient testing facilitated on most wards
- SARS-CoV-2 testing for symptomatic staff located near the hospital
- monitoring of the appropriate use and supply of PPE
- informal monitoring of transmission based precautions during daily ward visits by infection prevention and control nurses

- signage throughout the facility to raise awareness of COVID-19
- enhanced communication in relation to COVID-19 and infection prevention and control to support hospital staff.

Inspectors were informed that in order to meet the challenges posed by rising numbers of COVID-19 positive patients presenting to the hospital, elective surgeries were reduced by 50%.

Documentation reviewed by inspectors indicated the hospital had identified non-compliance with national guidelines on visiting practices. This should be reviewed and addressed following this inspection.

COVID-19 Outbreak

The hospital had experienced a number of relatively small outbreaks of COVID-19 between March and April 2020 involving a total of 19 cases (8 patients, 8 clinical staff and 3 clerical staff). Outbreak reports for these outbreaks were not provided for review following this inspection. Inspectors were informed that during the first phase of the pandemic, an early cluster identified in patients was attributed to atypical presentations and staff not wearing masks for all patient contact (which was in line with national guidelines at the time). Two staff clusters were managed by the Occupational Health Department.

A potential COVID-19 outbreak was identified in an inpatient ward on the morning of the inspection but had not yet been declared. Two close contacts of a community acquired asymptomatic positive inpatient were isolated in a six bedded unit. There were no other patients in this room.

In addition, minutes from an outbreak meeting held on 30 September 2020 indicated that a COVID-19 outbreak had been declared on a different inpatient ward on that day. There were two positive cases, one patient and one staff member. This outbreak was quickly contained through the implementation of appropriate infection prevention and control measures. Inspectors were informed that outbreak reports would be prepared once these outbreaks were officially declared over.

In line with best practice, a multidisciplinary outbreak team was in place to advise and oversee the management of the COVID-19 outbreaks. A representative for the Public Health Department linked into these meetings via teleconference. Minutes of these meetings showed that the outbreak control committee met weekly.

CPE Outbreak

The hospital experienced an outbreak of CPE in September 2020 and acted to implement measures to quickly contain the outbreak. A period of 90 days without a newly detected CPE patient was required before this outbreak could be declared

over; therefore a report was not available. In addition, minutes from the hospital infection prevention and control meeting held on 15 July 2020 indicated that a CPE outbreak was ongoing in Medical 5 ward. Shower facilities were identified as a potential reservoir for the organism.

Inspectors were informed that CPE was an ongoing challenge in the hospital. A multifaceted approach had been adopted to manage and contain the threat posed by CPE. Measures included:

- multidisciplinary input from hospital management, domestic supervisor, facilities manager, maintenance and the infection prevention and control team
- alerts on electronic patient information systems to rapidly identify patient admitted with the last 12 months who should be screened for CPE
- regular auditing of compliance with isolation and screening protocols
- enhanced surveillance in each clinical area(5083 CPE samples processed from January to August 2020)
- environmental screening (water outlet and drainage systems)
- disinfection of outlets
- review of cleaning regimes
- closure of beds to admission if required.

Documentation reviewed by inspectors indicated that the decision to admit patients to CPE outbreak wards was an ongoing discussion relating to patient safety. This issue related to the requirement to inform patients that they were being placed on an outbreak ward and was discussed at the hospital infection prevention control committee as an ongoing issue from 18 December 2019. It was recommended as an action, that patients admitted to CPE outbreak wards be provided with information leaflets and a record kept in the patient care plan that this information was provided to the patient. Follow up discussions in minutes from 16 September 2020 meeting indicated that practices were in line with other hospitals in the Saolta hospital group.

Overall, inspectors found it difficult to ascertain a comprehensive view on the number of outbreaks experienced or the learning gleaned by the hospital from outbreaks experienced in the first two quarters of 2020. Requested outbreak reports were not provided to inspectors to review. Recent outbreak committee minutes from September and October 2020 reviewed by inspectors indicated that in general, appropriate measures were implemented to contain small outbreaks identified.

The hospital had also identified an increase in the incidence of healthcare associated *Clostridioides difficile* infection from January to June 2020 which were reported in quarterly reports to the Saolta Group Infection Prevention and Control Committee. From January to August 2020 there were 22 hospital acquired cases equating to 3.5 per 10,000 bed days which was above the There was no indication that an outbreak had occurred in documentation provided. 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*. Contributory factors were not evident in documents provided to inspectors. 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 Letterkenny University Hospital was substantially compliant with three of the six of the *National standards for the prevention and control of healthcare-associated infections in acute healthcare services* assessed. A judgment of partially compliant was made against three standards.

Leadership, Governance and Management

Inspectors found that improvements were required in the governance and management arrangements for the prevention and control of healthcare-associated infection at Letterkenny University Hospital. Documented governance arrangements viewed by inspectors had not been finalised. However, these arrangements and changes made to the governance structures at the onset of the pandemic were understood and articulated by staff in discussions with inspectors. The hospital should finalise governance arrangements which were in draft format since early 2020.

The COVID-19 Coordinating Team was responsible for overseeing all aspects of the hospitals' response to the management of COVID-19 had increased the frequency of its meetings at the beginning of October in response to rising cases of COVID-19 in the community. Many of the committees governing infection prevention and control had temporarily suspended scheduled meetings for several months but had resumed normal function by the beginning of the third quarter of this year.

The hospital had implemented parallel pathways for the streaming of patients into COVID-19 and non-COVID-19 services and was working on ways to ensure compliance with updated HSE guidance relating to pre-triage assessment in the emergency department. Increases in bed capacity was also achieved with additional beds to follow.

While the hospital had some measures in place relating to the antimicrobial stewardship programme, it was acknowledged by senior management that progress to date with this regard had been relatively slow. Antimicrobial stewardship programmes benefits patient outcomes ensuring appropriate and safe antimicrobial prescribing for patients. The importance of this programme is of particular relevance in the context of rising *Clostridioides difficile* levels identified by the hospital in the first six months of 2020. Therefore ensuring the programme progresses to a fully functioning one should be a focus of improvement following this inspection.

Inspectors noted that more assurances were needed relating to the regular monitoring of patient environmental areas particularly in the context of the ongoing pandemic.

Workforce

Inspectors were informed that the infection prevention and control team had benefitted from additional resources to assist in meeting the extra challenges and workload experienced by hospital staff in managing COVID-19. The hospital had submitted business cases to fill the vacant antimicrobial stewardship pharmacist role and to augment consultant microbiology services at the hospital. Recruitment and retention of skilled staff was identified as an ongoing challenge faced by the hospital. Every effort should be made at group and hospital level to support the hospital in filling vacant roles within the resources allocated to the prevention and control of healthcare associated infections in a timely way

Inspectors noted that improvements were needed in the documentation of infection prevention and control education and training provided to staff was require to ensure the records accurately reflected what was achieved to date. This was acknowledged by hospital management at the time of the inspection.

Effective Care and Support

Inspectors assessed two clinical areas with differing age profiles and infrastructure. Medical 3 Ward, a newer build, was well maintained and generally clean. Orthopaedic Ward (regarded as a high risk clinical area) had an older infrastructure and general wear and tear was evident. Deficiencies in ward maintenance in the older hospital wards can potentially contribute to outbreaks. The hospital needs to address the maintenance issues already identified by the hospital and seen by inspectors following this inspection to ensure the patient environment facilitates effective cleaning in line national guidelines and standards.

While patient equipment was clean on Medical 3 Ward, improvements were required in the management of patient equipment on Orthopaedic Ward.

The processes in place on Medical 3 Ward designated as one of the COVID-19 Wards needs to be revisited to ensure that COVID and non-COVID zones and signage provide better clarity for staff. Greater assurance on the processes to limit staff crossover was also required.

While overall findings at the time of the inspection did not present an immediate high risk to patients, the composite nature of the issues identified were relatively poor in the context of an ongoing pandemic. These findings should be addressed as a priority following on from this inspection.

Safe Care and Support

The hospital had systems in place to identify and manage risk in relation to the prevention and control of healthcare-associated infections. While senior

management had oversight of the infection prevention and control risks, inspectors found these risks were not clearly described or identifiable on the corporate risk register. Systems and processes were also in place to record and manage infection prevention and control related incidents.

The hospital had implemented multiple measures to mitigate and manage potential threats posed by COVID-19. Much had been done to functionally separate clinical areas into COVID and non-COVID parallel streams. Additional inpatient bed capacity had been provided which was to increase further in the coming months.

COVID-19 testing capacity had been increased enabling rapid turnaround times. The infection prevention and control team had adjusted their core working hours to be available to advise on patient placement each day and also provided out-of hours cover which is to be commended. In addition to the issues highlighted in Medical 3 Ward, improvements were also required relating to pre-triage assessment and limiting where possible those waiting in the emergency department to patients requiring treatment.

Following this inspection the hospital needs to address the areas for improvement identified in this report and requires the support of the hospital Group to effectively address issues highlighted in order to facilitate compliance with the *National standards for the prevention and control of healthcare-associated infections in acute healthcare services* and other existing national healthcare standards.

4.0 References

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