Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of the unannounced inspection at University Hospital Kerry

Monitoring programme undertaken against the *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services*

Date of on-site inspection: 15 June 2017

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent authority established to drive high-quality and safe care for people using our health and social care services in Ireland. HIQA's role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.

HIQA aims to safeguard people and improve the safety and quality of health and social care services across its full range of functions.

HIQA's mandate to date extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has statutory responsibility for:

- **Setting Standards for Health and Social Services —** Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.
- **Regulation —** Registering and inspecting designated centres.
- **Monitoring Children's Services —** Monitoring and inspecting children's social services.
- **Monitoring Healthcare Safety and Quality —** Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment —** Providing advice that enables the best outcome for people who use our health service and the best use of resources by evaluating the clinical effectiveness and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion and protection activities.
- **Health Information —** Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

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1. Introduction

HIQA monitors the implementation of the *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services*[1] in public acute hospitals in Ireland to determine if hospitals have effective arrangements in place to protect patients from acquiring healthcare-associated infection. The *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services* will be referred to as the National Standards in this report.

In 2017, HIQA commenced a revised monitoring programme against the National Standards. The aim of this revised monitoring programme is to assess aspects of the governance, management and implementation of designated programmes to prevent and control healthcare-associated infections in hospitals. This monitoring programme comprises Phases One, Two and Three which will be described next.

The National Standards[1] were updated in 2017 and therefore supersede the previous version. Hospitals should work towards implementing these revised National Standards.

Phase One

All public acute hospitals were requested to complete and return a self-assessment tool to HIQA during April and May 2017. The self-assessment tool comprised specific questions in relation to the:

- hospital infection prevention and control programme and associated oversight arrangements.
- training of hospital personnel to implement policies, procedures, protocols, guidelines and evidence-based practice in relation to the prevention and control of infection.
- systems in place to detect, prevent, and respond to healthcare-associated infections and multidrug-resistant organisms.

The hospital Chief Executive Officer or General Manager and the Health Service Executive (HSE) Hospital Group Chief Executive Officer were asked to verify that the information provided to HIQA accurately reflected the infection prevention arrangements within the hospital at that time.

Phase Two

Using a revised assessment methodology HIQA commenced a programme of unannounced inspections against the National Standards in public acute hospitals in May 2017.

Specific lines of enquiry were developed to facilitate monitoring in order to validate some aspects of individual self-assessment tools completed by hospitals. The lines of enquiry which are aligned to the National Standards are included in this report in Appendix 1.

Further information can be found in the *Guide to the monitoring programme undertaken against the National Standards for the prevention and control of healthcare-associated infections* [2] which was published in May 2017 and is available on HIQA's website: www.hiqa.ie

Phase Three

Phase Three of this monitoring programme will focus on the reprocessing of reusable invasive medical devices and HIQA will commence onsite inspections in this regard in 2018.

Information about this inspection

This inspection report was completed following an unannounced inspection carried out at University Hospital Kerry by Authorised Persons from HIQA; Aileen O' Brien, Noreen Flannelly-Kinsella, Siobhan Bourke and Shane Grogan. The inspection was carried out on 15 June 2017 between 10:10hrs and 18:20hrs.

Prior to this inspection, inspectors reviewed the hospital's completed self-assessment tool and related documentation submitted to HIQA earlier in May 2017.

During this inspection, inspectors spoke with hospital managers and staff, and members of the Infection Prevention and Control Team. Inspectors also reviewed documentation and data and observed practice within the clinical environment in a small sample of clinical areas which included:

- the Intensive Care Unit and
- a surgical ward

Inspection findings presented in this report are aligned to HIQA's monitoring lines of enquiry as shown in Appendix 1. The inspection team used specifically designed monitoring tools during this inspection in relation to aspects of:

- Prevention of invasive device-related infection (Section 2.6.1)

- Prevention and control of transmission of antimicrobial-resistant bacteria (Section 2.7.1)
- Safe injection practice (Section 2.7.2)

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

2. Findings at University Hospital Kerry

The following section of this report outlines the main findings of this inspection. The report is structured as follows:

- section 2.1 outlines risks identified during this unannounced inspection
- sections 2.2 to 2.9 present the general findings of this unannounced inspection which are aligned to monitoring lines of inquiry.

2.1 Risks identified during this unannounced inspection

During an unannounced inspection by HIQA on 15 June 2017, a number of risks were identified at University Hospital Kerry in relation to the prevention and control of healthcare-associated infection. Specifically, risks were identified in relation to:

- a lack of testing of the hospital's water supply and storage system to check for legionella bacteria
- non-compliance with national screening guidelines in relation to multi-drug resistant organisms
- unsafe preparation and storage of medication for injection
- lack of decontamination equipment to thermally disinfect reusable items such as bedpan holders, urinals and measuring jugs in clinical areas.

In addition, risks which were identified by HIQA in November 2015 had not been addressed. These risks included:

- lack of routine consultant microbiologist oversight of microbiology laboratory result reports
- lack of an up-to-date understanding of local patterns of antimicrobial resistance required to guide antimicrobial prescribing practices
- a microbiology laboratory that could not be considered for national accreditation because of deficiencies in governance and resourcing.

HIQA also learned during this inspection that the position of Acting General Manager at the hospital was being vacated on 23 June 2017, the position of Acting Deputy General Manager was soon to be vacated and other members of the Executive Management Team were due to go on scheduled leave at the end of July. At the time of inspection, hospital management interim arrangements to manage the hospital until a new general manager was anticipated to commence at the hospital in September 2017 had not been formalised.

Details of these risks were communicated to the Chief Executive Officer (CEO) position of the Health Service Executive (HSE) South/South West Hospital Group. In

response, the CEO of the South/South West Hospital Group outlined key actions to mitigate the risks identified by HIQA. Specifically, these key actions included:

- the immediate establishment of an Environmental Monitoring Committee at the hospital and exploration of outsourcing of water testing to an external contractor
- submission for funding for surveillance scientist and administrative support (Clerical Officer Grade IV) for the infection prevention and control service
- development of an action plan in relation to unsafe medication practices in the Intensive Care Unit with oversight of implementation of actions by senior management
- submission to the HSE for minor capital funding for bedpan washers in all clinical areas of the hospital
- retraining of staff in relation to a procedure for manually decontaminating bedpans.

In addition, the CEO of the South/South West Hospital Group informed HIQA that arrangements had been made in respect of management oversight and clinical microbiology services to include:

- locum consultant microbiologist cover in the interim of appointment of a permanent consultant microbiologist position anticipated to commence in October 2017, at which time the absence of microbiology laboratory accreditation would be addressed
- appointment of general manager and operations manager positions anticipated to commence at University Hospital Kerry in September and July 2017 respectively
- appointment of the Director of Strategy, Planning and Population Health for the South/South West Hospital Group to manage in the interim of the appointment of a general manager in September 2017.

A copy of the letter issued on 19 June 2017 to the CEO of the South/South West Hospital Group regarding the risks identified during the inspection and a copy of the response received from the CEO of the South/South West Hospital Group are shown in Appendices 2 and 3 respectively.

HIQA reviewed the response received from the CEO of the South/South West Hospital Group and sent further correspondence on 29 June 2017 to seek additional assurance

HIQA received a response from the Acting CEO of the South/South West Hospital Group, outlining the following additional plans to address the risks identified by HIQA:

- in addition to current locum consultant microbiologist cover, assistance had been from sought from Cork University Hospital and Mercy University Hospital Microbiology Departments as well as a recruitment agency to ascertain the availability of microbiologists to assist the hospital in the interim of commencement of the Consultant Microbiologist position on 01 October 2017
- HSE Estates had been requested to immediately expedite the matter of water testing for legionella bacteria at the hospital
- establishment of an Environmental Control Group at hospital group level to provide advice on the management of findings arising from water testing for legionella bacteria.

The hospital group provided written assurance of satisfaction with the current clinical microbiology service as an adequate interim measure. Specific timelines as to when all of the risks identified by HIQA were not provided by the South/South West Hospital Group management in this correspondence.

A copy of the letter issued to the CEO of the South/South West Hospital Group to seek further assurance regarding the risks identified in University Hospital Kerry is shown in Appendix 4 of this report.

2.2 Governance

Line of enquiry 1.1

The hospital has formalised governance arrangements with clear lines of accountability and responsibility around the prevention and control of healthcare-associated infections.

Governance arrangements

University Hospital Kerry is a statutory hospital owned and managed by the Health Service Executive and is part of the South/South West Hospital Group.

HIQA found during this inspection that governance and management arrangements around the prevention and control of healthcare-associated infection at University Hospital Kerry were insufficient. The hospital had been without a consistent consultant microbiologist contractual arrangement over several years and this deficiency had hindered the progression of an effective infection prevention and control programme at the hospital. Additionally, HIQA found that clinical input from a consultant microbiologist or other experienced clinician to lead and support the infection prevention and control programme had not been consistently resourced at the hospital over a significant period of time.

During a previous HIQA inspection in November 2015, it was identified that that the hospital did not have access to twenty-four hour a day clinical microbiology advice and that there was no consultant microbiologist oversight of laboratory results generated by the microbiology laboratory. Instead, an arrangement was in place for support from a consultant microbiologist who was substantively employed by a nearby private hospital, amounting to a commitment of four hours per week onsite and some telephone access from 9-5pm Monday to Friday. At that time, this risk was communicated to both hospital management and the HSE South/South West Hospital Group by HIQA. In December 2015 a temporary arrangement was put in place whereby a consultant microbiologist from another hospital in the same hospital group provided 24 hour off-site cover to University Hospital Kerry. This arrangement continued for a period of nine months. In late 2016 an experienced retired consultant microbiologist was contracted by the HSE on a locum basis to provide clinical microbiology advice for the hospital in the interim of permanent appointment of a consultant microbiologist.

At the time of this inspection, this Consultant Microbiologist visited the hospital on one day each week and was effectively on call to provide clinical microbiology advice for clinical staff twenty-four hours a day, every day. Hospital management told

inspectors that this support was valued at the hospital particularly in relation to the development of antimicrobial prescribing guidelines and the provision of clinical advice. There was however, no formal allocation of consultant microbiologist input to lead the infection control programme at the hospital or to oversee all clinical microbiology laboratory results.

During this inspection HIQA also learned of changes in relation to executive management at the hospital which included the impending vacation of both the Acting General Manager and Acting Deputy General Manager positions at the hospital. Inspectors were informed that as far back as 2008 the positions of general manager and deputy general manager were undertaken by senior managers working in an acting capacity. Findings in respect of the impending vacation of senior hospital management positions were communicated to the CEO of the South/South West Hospital Group as detailed earlier in this report.

Infection prevention and control service

HIQA found that the Infection Prevention and Control Team at the hospital was under resourced. The team included two full-time infection prevention and control nurse specialists, a senior medical laboratory scientist and an antimicrobial pharmacist. In addition to the current deficiencies in consultant microbiologist resources, the team did not have dedicated administrative support which is a basic requirement. The hospital did not have a surveillance scientist or formalised access to this resource, despite national guidelines which recommended this as far back as 2009. The team was supported by the Chief Medical Scientist in the Microbiology Laboratory who in the absence of a surveillance scientist performed both national and legally mandated reporting in respect of healthcare-associated infection, antimicrobial resistance and infectious diseases. This work was performed by this position in addition to a managerial workload. Hospital management informed inspectors that a request for a surveillance scientist position and for resources for enhanced antimicrobial resistant organism testing had been submitted to the hospital group in December 2016 but had not been approved.

The Infection Prevention and Control Team reported to the Infection Prevention and Control Committee at the hospital. The Infection Prevention and Control Committee reported into the Quality and Patient Safety Committee, in common with 23 other hospital committees and 14 governance groups. The Quality and Safety Committee reported into the Executive Management Board which included the Acting General Manager, Acting Deputy General Manager, Clinical Director, Director of Nursing, Finance Manager and a member of the medical board. The Acting General Manager reported to the South/South West Hospital Group Chief Executive Officer.

Management at University Hospital Kerry had established several hospital committees through which to govern services. HIQA has previously identified through prior monitoring work that other similar sized hospitals have acted to address the challenges inherent in such an arrangement, through the rationalisation of the number of hospital committees reporting into an oversight committee in order to strengthen governance arrangements.[3]

Inspectors were informed that hospital management had planned to establish three clinical directorates to govern clinical services at the hospital. The lack of implemention of this governance arrangement at the time of this inspection was attributed to financial constraints which meant that the appointment of key personnel to support a directorate structure could not be progressed.

Organisational diagrams and terms of reference of the Quality and Patient Safety Committee provided by hospital management did not consistently reflect governance arrangements at the hospital, these require revision.

The Infection Prevention and Control Committee at University Hospital Kerry was chaired by the Acting General Manager or a delegated senior hospital manager. Terms of reference for the committee stated that the committee should meet four times a year and that it reported to the Executive Management Board. This document did not reflect the governance arrangements described by hospital management and requires review. The committee had met once in 2017. Minutes of the last three committee meetings reviewed by HIQA showed that the Consultant Microbiologist had joined the committee in October 2016. HIQA notes that a number of clinical specialities within the hospital were not represented at this forum.

Inspectors were told that all hospital committees and governance groups were required to submit a written report using a specified template to the Quality and Safety committee, twice a year. These were then collated to form a twice yearly report from committees and governance groups. HIQA reviewed the last three reports dated September 2015, May 2016 and May 2017 respectively. Reports from the Infection Prevention and Control Committee were not included in any of these overall reports. Review of minutes of meetings in relation to quality and safety at the hospital did not indicate that an active committee was in place as described in the terms of reference of the Quality and Safety committee. Minutes of meetings showed that members of the Executive Management Board met periodically to discuss quality and safety issues. The risk manager also attended these meetings. Minutes of these meetings reviewed by inspectors showed that the prevention of healthcare-associated infection at the hospital was only briefly mentioned in monthly meetings held from January-May in 2017.

It is recommended that organisational structures, reporting relationships and oversight in relation to the prevention and control of healthcare-associated infection at the hospital are fully reviewed and strengthened to ensure that there are effective governance arrangements in place.

Monitoring and evaluation

The hospital reported data in relation to the following performance indicators for the prevention and control of healthcare-associated infection in line with Health Service Executive national reporting requirements;

- hospital-acquired *Clostridium difficile* infection
- hospital-acquired *Staphylococcus aureus* bloodstream infections

Minutes of Infection Prevention and Control Committee meetings reviewed showed that data and information in relation to the following parameters were monitored and discussed by the Committee:

- outbreaks of infection
- summary reports of quarterly hand hygiene compliance audits
- European Antimicrobial Resistance Surveillance Network (EARS-Net) data*
- enhanced surveillance and root cause analyses in respect of new cases of *Clostridium difficile* infection.

Written reports were prepared by the Infection Prevention and Control Team following outbreaks of infection. The Infection Prevention and Control Committee also reviewed complaints, incidents and compliments in relation to infection prevention and control at the hospital. There was oversight of occupational health exposures such as sharps injuries and immunisation and screening uptake among staff. Minutes of meetings of the Infection Prevention and Control Committee were available to hospital staff on the hospital intranet.

The Infection Prevention and Control Team performed daily 'alert' organism† and condition surveillance to identify patients requiring infection control precautions and to identify unusual clusters of infection. The team also monitored uptake of infection prevention and control training amongst hospital staff. Action plans had been developed by the team in relation to improving staff hand hygiene compliance. Quarterly audits of implementation of aspects of standard and transmission-based

* EARS-Net performs surveillance of antimicrobial susceptibility of bacteria causing infections in humans including; *Escherichia coli, Klebsiella pneumoniae, Pseudomonas aeruginosa,* Acinetobacter species, *Streptococcus pneumoniae, Staphylococcus aureus, Enterococcus faecalis* and *Enterococcus faecium.*

† Alert organisms are micro-organisms that pose a significant risk of transmission to non-infected patients or healthcare workers.

transmission-based precautions were conducted by the Infection Prevention and Control Team.

University Hospital Kerry had participated in a national point prevalence survey of hospital-acquired infections and antimicrobial use which was part of a European-wide point prevalence study. Feedback in respect of antimicrobial usage had been provided to clinical staff by the Antimicrobial Pharmacist. Preliminary findings around antimicrobial usage in May 2017 indicated that not all antimicrobials were prescribed appropriately. Data from this study should be used to proactively identify and address areas for improvement at the hospital. Clinical staff at the hospital performed a study of meropenem[‡] usage at the hospital; results of this study highlighted the need for consultant microbiologist advice and local guidelines in respect of antimicrobial prescribing. An audit of compliance with recommendations for the diagnosis and treatment of community acquired pneumonia was performed at the hospital in March 2017 and a number of opportunities for improvement were identified. Results of this audit were presented to clinical staff along with recommended local diagnosis and treatment guidelines.

Cases of healthcare-associated meticillin resistant *Staphylococcus aureus* infections were recorded through clinical incident reporting structures. Incidents of lack of availability of an isolation room for patients with infection were formally reported by staff. Hospital staff also recorded incidents of suspected peripheral venous catheter related infection or inflammation. Recording of such incidents is good practice and this information should be used to identify opportunities for improvement.

Hospital hygiene audits

Hospital hygiene audits were performed across the hospital by staff in clinical areas and departments on a regular basis. Similar audits were performed by hospital management and by the Quality Coordinator for Hygiene Services at the hospital. These audits were detailed and included observation of elements of the patient care environment, patient equipment, ancillary rooms, waste disposal, sharps management, isolation rooms, discussion with cleaning staff, care bundles and documentation. Clinical areas were audited in line with HSE recommended frequencies such that higher risk areas were audited more frequently. Audit results were trended and clearly presented to hospital management in overview reports which is good practice and facilitates the identification of areas for improvement. Overview reports of hygiene audit findings for 2016 were reviewed by HIQA. While it

[‡] Meropenem is an ultra-broad-spectrum antimicrobial used for patient with life-threatening infection. Usage of this antimicrobial is restricted in Irish hospitals, in most instances this drug should only be prescribed on the advice of a consultant microbiologist.

is acknowledged that audits tools used by these groups of auditors were slightly different, there was significant variation in audit scores. Overall, hygiene compliance scores in 2016 for local audits, management audits and hygiene service audits were reported as 85%, 68% and 55% respectively which on average was less than the hospital's desirable target of 85% compliance or over. The Infection Prevention and Control Team also performed audits in clinical areas in relation to hospital hygiene and facilities.

Management at the hospital had clearly identified multiple areas for improvement required to facilitate implementation of the National Standards. Hospital management had developed quality improvement plans following hygiene observation audits and risks in relation to hospital infrastructure had been placed on local area risk registers. Although there was extensive monitoring of standards of hygiene at the hospital, hygiene audit findings indicated that recurring deficiencies in relation to cleaning standards and hospital infrastructure had not been addressed at the hospital. This does not facilitate implementation of the National Standards.

Failure to address deficiencies in relation to infrastructural, maintenance and hygiene deficiencies at the hospital was previously identified by HIQA during an unannounced inspection in 2016. While the hospital has worked to address some of these issues, further improvements are clearly required.

2.3 Risk management

Line of enquiry 1.2

Risks in relation to the prevention and control of infection are identified and managed.

Risks in relation to the prevention and control of infection should be identified and effectively mitigated or managed. Inspectors reviewed local risk registers for infection control and pathology. Documentation provided showed that hospital management had identified multiple risks in respect of the prevention and control of healthcare associated infection at the hospital. These risks included:

- a lack of clinical governance in the laboratory and lack of microbiology laboratory accreditation
- delayed delivery of blood cultures to the Microbiology Department
- aged microbiology laboratory diagnostic equipment
- lack of a surveillance scientist
- failure to fully implement national screening recommendations for multi-drug resistant organisms
- lack of air conditioning in the Microbiology Department
- absence of isolation facilities with specialised ventilation for patients with airborne infection
- insufficient isolation facilities for patients with transmissible infection
- inadequate bed spacing in multi-occupancy patient rooms
- lack of bedpan washers in clinical areas
- lack of clinical hand hygiene sinks in single rooms
- lack of resources to implement surgical site and invasive device-related infection surveillance
- insufficient disposable equipment for patients with transmissible infection
- poor hospital infrastructure and condition.

Documentation provided to inspectors showed that these risks had been reviewed by hospital management in 2017 and the majority were rated as high risks in local area risk registers. Hospital management had identified a need for a full-time consultant microbiologist at the hospital. Inspectors were informed by management that high risks were escalated to the South/South West Hospital Group through corporate risk management processes. The hospital group had worked to appoint a consultant microbiologist, to work at the hospital on a part time basis anticipated to commence in October 2017. Hospital management reported that there were ongoing financial

deficits at the hospital which, they stated, impeded the progression of infrastructural maintenance, additional cleaning resources and legionella water testing.

In the self-assessment tool submitted to HIQA in May 2017, hospital management reported that the hospital had significant deficiencies in respect of staffing levels required for cleaning the hospital environment and patient equipment.

The risks reported by hospital management were reflective of the risks identified by HIQA during this inspection which were discussed earlier in this report. Risks in respect of consultant microbiologist input dated back to 2010. Findings identified during this and previous HIQA inspections appear to indicate that the hospital had not been adequately supported at hospital group level to mitigate risks in respect of infection prevention and control at the hospital for a number of years.

Additional risks identified by HIQA in relation to the prevention and control of healthcare-associated infection during this inspection will be discussed further in this report.

2.4 Policies, procedures and guidelines

Line of enquiry 2

The hospital has policies, procedures and guidelines in relation to the prevention and control of infection and hospital hygiene.

Current HSE policy states that hospital policies, procedures and guidelines should be reviewed every three years.[4] The hospital had a suite of infection prevention and control policies which were contained on an electronic document control system. Staff had access to up to date policies, procedures and guidelines through the hospital intranet in clinical areas. Inspectors reviewed infection prevention and control policies available electronically and found that they were up to date and approved by the Infection Prevention and Control Committee, as appropriate.

Inspectors found that there were printed copies of older versions of infection prevention and control policies and guidelines in both clinical areas inspected. This finding should be addressed so that staff only have access to the most up to date versions of these documents.

2.5 Staff training and education

Line of enquiry 3

Hospital personnel are trained in relation to the prevention and control of healthcare-associated infections.

National hand hygiene guidelines recommend that hand hygiene training should be mandatory for relevant staff at induction and every two years thereafter.[5] Inspectors reviewed the hospital's mandatory training policy which showed that relevant staff at the hospital were required to undertake mandatory hand hygiene training at induction. Employees involved in patient areas were required to repeat this training annually and other employees were required to repeat this training every two years. All new staff were required to attend a hospital induction programme which included elements of risk management and medical device management. In addition, staff working in patient care areas were required to undertake training in relation to standard infection control precautions and healthcare-associated infections. The frequency of this training was not specified in the mandatory training policy reviewed by inspectors. Training in respect of decontamination was mandated for staff working in operating theatres and decontamination units. Staff working with chemicals were also required to undertake chemical training. Again, the frequency of these mandatory training requirements was not specified in documentation provided to inspectors.

The Infection Prevention and Control Team provided training in relation to hand hygiene practice and standard infection control precautions with a defined monthly schedule in respect of both. Training records reviewed showed that hand hygiene training sessions were provided monthly across staff disciplines. Staff also had access to elearning in respect of hand hygiene training. A total of 236 staff had completed hand hygiene training in 2017 and 536 staff completed this training in 2016. It was estimated that over 56% of nursing staff, 40% of medical staff, 70% of housekeeping staff and 33% of general support staff had undertaken hand hygiene training in 2016. Hospital management told inspectors that it was difficult to accurately quantify staff training uptake in the absence of a centralised system to identify the number of staff requiring training.

Training sessions had also been provided to staff in relation to standard precautions with 100 staff attending in 2015 and 114 staff in 2016. Training in relation to care bundle implementation and multi-drug resistant organisms had been provided to smaller numbers of staff in 2015. It is recommended that staff training around infection prevention and control is aligned to national guidance for such knowledge

and skills and expanded further to include transmission-based precautions and aseptic technique for clinical staff involved in direct patient care.[6]

All staff at the hospital had access to advice from the Infection Prevention and Control Team and clinical staff had access to advice from the Consultant Microbiologist and the Antimicrobial Stewardship Pharmacist. The Infection Prevention and Control Team facilitated an annual educational Infection Control Week in October and also circulated a prevention and control of healthcare-associated infection newsletter to staff twice a year. The April 2017 edition of this newsletter circulated to staff included information on the installation of three single enclosures[§] to facilitate the isolation of patients requiring transmission-based precautions, information in relation to the safe management of sharps and hand hygiene and environmental hygiene audit results. Information was also provided to staff in respect of HIQA's revised inspection programme and quality improvement plans to be implemented following infection prevention and control audits in relation to maintenance, medication management, equipment cleaning and care bundles.

The Infection Prevention and Control Team provided information about preventing the spread of infection to patients, staff and people attending the hospital through notices, information leaflets and visual display units at the front entrance of the hospital and in the Outpatient Department waiting area. Education sessions around infection prevention and control for staff were also provided periodically outside the staff canteen.

Reports reviewed by inspectors showed that recommendations in relation to control measures were communicated to hospital staff during outbreaks of infection.

[§] Fabricated structures with floor to ceiling walls and a door, which can be retrospectively installed within a multi-occupancy patient ward or clinical area to create a room which can be used to isolate a patient for infection control purposes.

2.6 Implementation of evidence-based and best practice

Line of enquiry 4.1

The hospital has implemented evidence-based best practice to prevent intravascular device-related infection and urinary catheter-associated infection, ventilator-associated pneumonia and surgical site infection.

2.6.1 Prevention of invasive device-related infection

Care bundles to reduce the risk of different types of infection have been introduced across many health services over the past number of years, and there have been a number of guidelines [7, 8, 9] published in recent years recommending their introduction across the Irish health system. The implementation of care bundles to prevent invasive device-related infection was reviewed in both of the clinical areas inspected.

Intensive Care Unit

Inspectors looked at aspects of the prevention of invasive device-related infection in the Intensive Care Unit. Care bundles for intravascular devices, urinary catheter care and ventilator-associated pneumonia had been implemented in the Intensive Care Unit in line with national guidelines. Care bundle audit results reviewed showed some variation in care bundle implementation from January to May 2017 but results for June 2017 showed 100% compliance with care bundle implementation which demonstrates improvement.

Forms were used to record care bundle components and details about invasive devices for each patient. Forms reviewed showed some inconsistencies around what staff were required to complete in nursing records and in the care bundle audit tool. This documentation could be reviewed to make recording and auditing of care bundle elements easier. One element of the urinary catheter care bundle was the use of a clean container to empty a urinary catheter bag. It was noted by HIQA during this inspection that a reusable container to empty a urinary catheter was not decontaminated in line with best practice. Reusable containers for emptying urine drainage bags should be washed and heat disinfected in a washer-disinfector in line with national cleaning guidelines. It is recommended that suitable disposable containers are used until a washer-disinfector is provided in this unit.

Surgical Ward

Care bundles for peripheral vascular catheters and for urinary catheter care were in place in the surgical ward inspected and compliance with care bundle implementation was audited every month. Monthly urinary catheter care bundle audit results showed 100% compliance from January to June in 2017. Monthly peripheral catheter care bundle compliance audit results showed minimal variation in compliance from 98-100% from January to June in 2017. This shows that implementation of care bundles for invasive device care has been progressed on this ward.

2.6.2 Surveillance of invasive device-related and surgical site infection

The surveillance[**] of healthcare-associated infection is one of the core components of an effective infection prevention and control programme.[10,11,12] National guidelines recommend healthcare-associated infection surveillance in relation to surgical site infection, central venous access device-related infection, urinary catheter-associated urinary tract infection and ventilator-associated pneumonia.[13,14,15] Other health systems have advanced the surveillance of healthcare-associated infection to the benefit of both patients and health service providers by demonstrating reductions in these type of infections.[16,17]

Surveillance of these types of healthcare-associated infection was not performed at University Hospital Kerry. HIQA acknowledges that currently this is the case in many public hospitals of similar size and activity level in Ireland. Implementation of a surveillance programme for healthcare-associated infection requires dedicated resources and expertise. Cooperation with other hospitals in the hospital group in this regard may also be worthy of further exploration.

[**] Surveillance is defined as the ongoing, systematic collection, analysis, interpretation and evaluation of health data closely integrated with the timely dissemination of these data to those who need it.

2.7 Systems to prevent and manage healthcare-associated infections and multi drug resistant organisms

Line of enquiry 4.2

The hospital has systems in place to detect, prevent, and respond to healthcare-associated infections and multidrug resistant organisms in line with national guidelines.

HIQA identified a number of risks in relation to the systems in place to detect, prevent and manage healthcare-associated infection at University Hospital Kerry. On the day of inspection HIQA identified the following:

- poor storage facilities with inappropriate storage of patient equipment,
- poor practice in relation to the cleaning of reusable equipment, particularly in relation to reusable bedpans, urinals and measuring jugs,
- insufficient isolation facilities for patients with transmissible infection,
- unsafe practice in relation to the preparation and storage of medication for injection in the Intensive Care Unit,
- incomplete screening of patients for multi-drug resistant organisms in line with current national guidelines.

2.7.1 Preventing the spread of antimicrobial resistant organisms

Inspectors looked at implementation of aspects of transmission-based precautions and measures to prevent the spread of antimicrobial resistant organisms to patients in both of the clinical areas inspected.

Isolation of patients with infection

On the day of inspection 18 patients required single room isolation, 14 of whom were isolated in single rooms and three patients who were cohorted together. One patient requiring transmission-based precautions was not isolated in a single room. Overall, there were insufficient facilities at the hospital to isolate all patients with transmissible infection. The hospital did not have isolation facilities with specialised ventilation for patients with airborne infection. Facilities with specialised ventilation should be available in inpatient facilities in the hospital and in the Emergency Department. There were no isolation facilities in the Coronary Care Unit. The hospital had introduced three single isolation enclosures in 2017; one in the Intensive Care Unit and two in a paediatric ward, in order to increase isolation capacity.

Microbiological screening of patients

Screening of patients at the hospital for multi-drug resistant organisms was not fully aligned to national guidelines. This was attributed to microbiology laboratory staffing and resource deficiencies.

The microbiology laboratory did not have resources to perform rapid testing of specimens for influenza virus, instead clinical specimens were sent to a Dublin laboratory for testing which potentially delayed the identification of infectious patients with influenza. Early identification of influenza cases is recommended so that appropriate isolation precautions can be implemented thus reducing the risk of spreading infection to patients, staff and visitors at the hospital. Resource requirements for microbiological screening should be reviewed at the hospital.

Intensive Care Unit

The infrastructure of the Intensive Care Unit did not facilitate effective infection prevention and control because of a lack of isolation facilities, limited space between beds, and insufficient ancillary rooms to facilitate the storage and management of equipment and supplies. There was one single room in the Intensive Care Unit and as stated above, an additional isolation enclosure has been installed in the unit in 2017 to increase isolation capacity. These rooms did not have specialised ventilation for managing patients with transmissible infection.

There was a failure to appropriately separate clean and dirty activities in the unit. There were insufficient facilities for the storage and management of sterile supplies and medications, linen, patient equipment and cleaning equipment in the Intensive Care Unit. There was no space or room where staff could clean patient equipment. Medical equipment was stored at a staff work station, in a patient toilet, in a staff office and in various locations within the unit. A staff office containing office equipment and paperwork was used inappropriately to store medical equipment and medication fridges. The staff rest room was also used as a storage area for files and paperwork.

Clean and sterile supplies were inappropriately stored in cupboards within the 'dirty' utility room[††]. These included medications, antiseptic solutions and sterile dressings for intravascular devices and toiletries. This practice increases the risk of contaminating clean supplies with faecal or other microorganisms and could increase the risk of spreading infection. This issue needs to be prioritised and these items

[††] A room equipped for the disposal of body fluids and the decontamination of reusable equipment such as bedpans, urinals, commodes and body fluid measuring jugs. Waste, used linen and contaminated instruments may also be temporarily stored in this room prior to collection for disposal, laundering or decontamination.

should be removed from this room. A clean utility room is required where medications and lotions can be stored and prepared in addition to storage of clean and sterile supplies. [18] Cleaning equipment was also stored inappropriately in the 'dirty' utility room next to a sluice hopper. This should be stored in a designated cleaning equipment room. The 'dirty' utility room was not equipped with a washer/disinfector to decontaminate reusable measuring jugs used to empty urinary catheter bags.

In general, environmental surfaces and patient equipment inspected in the Intensive Care Unit were visibly clean. A commode located in a patient toilet was unclean. This is not an appropriate location for commode storage.

An environmental hygiene audit performed by Intensive Care Unit staff showed an overall average compliance result of 91% for 2016. An audit of hygiene and the environment was performed in the Intensive Care Unit by the Infection Prevention and Control Team in January 2017. A compliance score of 67% was recorded for the unit environment. Findings made by HIQA during this inspection were broadly similar to issues identified by the Infection Prevention and Control Team in January 2017. Issues in relation to maintenance, storage, inappropriate storage of cleaning equipment and failure to segregate clean and dirty activities had not been addressed by hospital management in the interim.

Surgical ward

The surgical ward had three single rooms which was insufficient to accommodate all patients requiring isolation precautions on the day of inspection. Some patients with transmissible infection were cohorted together in a multi-occupancy room, as recommended, if there are no available isolation rooms.

Similar to the Intensive Care Unit, the surgical ward did not have a washer/disinfector for heat disinfection of reusable bedpan holders and measuring jugs.

Overall, environmental surfaces inspected in the surgical ward were visibly clean. Hygiene audits were performed locally by ward staff in the surgical ward every two months. Audit elements included the general care environment, patient equipment, aspects of standard and transmission-based precautions, record keeping and care bundle compliance. Local hygiene audits for the surgical ward showed an overall average compliance of 87% for 2016. The surgical ward achieved hygiene compliance scores of 89% and 91% for March and May 2017 respectively. A hygiene audit was also performed by the Quality Co-ordinator for hygiene services in March 2017 and this showed a lower compliance score of 62%. The need for improvement in ward infrastructure was identified.

2.7.2 Safe injection practice

Inspectors looked at implementation of aspects of standard precautions to assess safe injection practice in the clinical areas inspected.

Intensive Care Unit

Seventeen syringes containing reconstituted intravenous medications were either not labelled or insufficiently labelled in a medication fridge inappropriately located in a staff office in the Intensive Care Unit. This issue was brought to the attention of hospital management so that it could be addressed. In addition, a temperature display indicated that the fridge was not operating at the recommended temperature. To reduce the risk of transmission of infection to patients, intravenous medications should be prepared in a clean environment using an aseptic non touch technique immediately prior to use where possible.[19] Some of the medications that had been drawn up are commercially available in single dose prefilled syringes. Introduction of such medications should be explored if required. Medication fridge temperatures should be monitored and discrepancies should be addressed promptly.

There was no clean utility room in the Intensive Care Unit. Inspectors found that the Intensive Care Unit did not have a clearly designated area for medication preparation. It is recommended that a separate work space is provided for the preparation of medication for injection and that this area is free of stored supplies.[18]

Surgical ward

Staff spoken with were able to describe recommended practice in relation to giving injections safely. There was no clearly designated area in the surgical ward for the preparation of medication for injection.

Red staining was visible on one of the trays inspected and a staff member did not decontaminate a reusable injection tray after use. Both these issues were brought to the attention of staff and addressed at the time of the inspection.

Trays with integrated sharps containers used to transport medication for injection were stacked on top of other trays. It is recommended that sharps containers are stored safely to avoid spillage of contaminated sharps which would pose a risk of injury to hospital staff.

A medication fridge in the ward did not appear to have been cleaned for some time.

Medical equipment was inappropriately stored in a public waiting area and in an ancillary room which was used as an office for medical and administration staff. Medical equipment should be stored in a separate designated area.

Hygiene audits performed locally in the surgical ward showed that results for patient equipment hygiene were 78% and 72% for March and May 2017 respectively. This is less than the desirable standard of at least 85%. Cleaning of patient equipment in this area requires improvement. The ward cleaning specification should include elements to be cleaned, cleaning frequency, cleaning method and staff discipline responsible. Patient equipment should be cleaned in line with recommended cleaning frequencies.[20,21] Sufficient resources need to be provided to facilitate patient equipment cleaning.

2.7.3 Other measures to prevent the transmission of infection

Hand hygiene

University Hospital Kerry participates in the national hand hygiene audits, results of which are published twice a year. Results for the latest HSE hand hygiene monitoring period were not available at the time of inspection.

Quarterly hand hygiene audits were performed across the hospital by the Infection Prevention and Control Team. Overall hand hygiene compliance among hospital staff was 93.3% for Quarter 2, 2017; this was an increase on Quarter 1, 2017 compliance which was recorded as 89%.

Staff hand hygiene compliance was 93.3% for Quarter 2, 2017 in the Intensive Care Unit. Staff hand hygiene compliance was 93.3% for Quarter 1, 2017 in the surgical ward inspected.

The Infection Prevention and Control Team had developed a hospital-wide hand hygiene quality improvement plan and aimed to achieve a hand hygiene compliance rate of 90% or over across the hospital in line with current national performance indicators.

Outbreak management

Documentation reviewed showed that there had been a number of outbreaks of infection within the hospital in the preceding 12 months. Outbreak reports reviewed showed that these outbreaks were effectively contained and managed. There were no outbreaks ongoing on the day of inspection.

The hospital had experienced an outbreak of a resistant strain of *Staphylococcus aureus* in neonates. A review of outbreak reports showed that the Infection Prevention and Control Team and clinical staff at the hospital had limited advice from a consultant microbiologist. Records reviewed indicated that this risk was also escalated to the South/South West Hospital Group during the outbreak in 2016. Additional screening of neonates needed to be performed during the outbreak;

however, hospital management told inspectors that additional resources had not been allocated to support this screening.

An outbreak of measles occurred at the hospital in May 2016, records reviewed showed that during that time the Infection Prevention and Control Team and clinical staff at the hospital did not have advice from a consultant microbiologist. Factors that contributed to the outbreak included insufficient facilities to isolate patients presenting with symptoms of viral respiratory illness. Additionally, not all single rooms had ensuite toilet/showering facilities and clinical hand hygiene sinks as required.

Prevention of water-borne infection

Risks in relation to legionella controls in University Hospital Kerry previously identified by HIQA during an inspection in 2015 had not been effectively addressed. As outlined earlier in this report, this identified risk was escalated to the CEO of the South/South West Hospital Group.

Following the HIQA inspection in 2015, a formal independent legionella risk assessment had been performed for the first time at the hospital. However, the hospital did not perform water testing for legionella bacteria as recommended in the report of the legionella risk assessment performed. Additionally, the hospital did not have up to date schematic drawings for the hospital domestic water system as recommended in the risk assessment report and in line with current national guidelines.[22] Maintenance work in respect of water supply management was performed by HSE Estates. There was no formalised line of reporting or communication between the hospital manager in University Hospital Kerry and HSE Estates so it was unclear how the hospital manager could be sufficiently assured that remedial works recommended in the legionella risk assessment had been fully implemented.

Going forward, it is recommended that water supply risk assessment and risk assessment review are performed within the timeframes recommended in current relevant national guidance.[22,23] Governance and management arrangements need to be implemented in respect of water supply management as a priority.

Following this unannounced inspection, HIQA communicated concerns around legionella control at University Hospital Kerry to the Health and Safety Authority with whom HIQA has a memorandum of understanding, given their possible role and responsibilities related to this issue under the Health and Safety at Work Act. The South/South West Hospital Group were also informed in relation to this referral, in writing, following this inspection.

2.8 Quality improvement initiatives

Hospital management were asked to provide inspectors with information about any quality improvement initiatives that had been implemented in relation to the prevention and control of infection at the hospital.

The Antimicrobial Pharmacist presented findings from a cohort study of meropenem usage at the hospital at a national conference for hospital pharmacists.

2.9 Progress since the previous HIQA inspection

HIQA reviewed the latest version of the quality improvement plan developed by the hospital following the last HIQA inspection in 2016. Inspectors found that some but not all of the issues identified during the previous inspection had been addressed. Refurbishment work had largely been completed in the Operating Theatre Department which included repainting, upgrade of flooring and finishes in some areas, upgrade of staff changing facilities and upgrade of ventilation units. Infrastructural issues in respect of the Oncology Unit had been addressed whereby the unit had been permanently moved to another part of the hospital. Hospital management was also exploring options for future development of infrastructural requirements for oncology patients attending the hospital. The hospital had also worked to improve the management of maintenance requests and had implemented an improvement programme to improve hand hygiene compliance. These are welcome developments and showed a commitment by hospital management and staff to improving the quality and safety of patient facilities at the hospital.

Issues which hospital management had been unable to progress included:

- upgrading of hospital infrastructure in other clinical areas
- implementation of legionella risk assessment recommendations
- improved isolation facilities
- hand hygiene sink upgrade and installation of additional sinks
- a surveillance scientist resource
- a surgical site infection surveillance programme and sufficient staffing for hospital cleaning.

Failure to progress these issues was attributed to the need for additional HSE funding which was beyond the control of hospital management. These issues need to be addressed by the South/South West Hospital Group.

3. Conclusion

Multiple risks were identified by HIQA in relation to the prevention and control of health care-associated infection at University Hospital Kerry during this inspection. Risks included the relative degree of clinical microbiology service oversight and resources at the hospital in light of its size and level of service complexity, equipment decontamination facilities, infection surveillance, legionella risk management and injection practice. Inspectors learned that hospital management had in many cases escalated risks and sought assistance in addressing deficiencies outlined in this report at hospital group level. However, this inspection also identified that in many instances identified risks remained unresolved for a sustained period of time, in some cases despite specific prior concerns also being raised by HIQA following previous inspection. In addition, this inspection also revealed that more broadly, leadership, governance and management deficiencies at the hospital needed to be strengthened and sufficiently resourced.

During this inspection, HIQA identified a number of areas that the hospital need to improve practice in related to infection control and hospital hygiene. However, it was also observed that recurrent deficiencies identified by hospital staff and management in respect of isolation facilities, hospital infrastructure, facilities, maintenance and hygiene had not been effectively addressed. This was attributed by hospital management to a lack of funding.

Notwithstanding these deficiencies, HIQA also observed good practice around the provision of staff education and the availability of local policies for the prevention and control of healthcare-associated infection. Staff at the hospital had also implemented care bundles to reduce the risk of invasive device-related infection which is good practice. In addition, environmental surfaces in two clinical areas inspected were visibly clean. Scope for improvement in relation to patient equipment hygiene was identified in the surgical ward inspected; resources and processes around patient equipment cleaning require review.

Overall however, the composite of findings prompted HIQA to twice seek assurance at hospital group level around the composite of outstanding and in some cases persistent risk. Indeed, the ongoing non-resolution of previously identified issues was of significant concern to HIQA, and in the case of legionella control, HIQA additionally highlighted these concerns to the Health and Safety Authority for further possible follow-up.

Clinical services must be appropriately resourced and effectively governed to ensure patients receive safe and effective care. The HSE through the South/South West Hospital Group should now proactively assess the findings identified by HIQA in this

report to ensure that the risks and deficiencies identified are effectively managed and that University Hospital Kerry is sufficiently supported to progress the implementation of National Standards.

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5. Appendices

Appendix 1: Lines of enquiry for the monitoring programme undertaken against the National Standards for the prevention and control of healthcare-associated infections in acute healthcare services

Number	Line of enquiry	Relevant National Standard
1.1	The hospital has formalised governance arrangements with clear lines of accountability and responsibility around the prevention and control of healthcare-associated infections.	2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 5.2, 5.3, 5.4, 6.1, 7.1
1.2	Risks in relation to the prevention and control of infection are identified and managed.	2.1, 2.3, 2.5, 3.1, 3.6, 3.7, 3.8
2	The hospital has policies, procedures and guidelines in relation to the prevention and control of infection and hospital hygiene.	2.1, 2.5, 3.1, 3.6, 3.8, 5.4, 7.2
3	Hospital personnel are trained and in relation to the prevention and control of healthcare-associated infection	2.1, 2.8, 3.1, 3.2, 3.3, 3.6, 6.1, 6.2
4.1	The hospital has implemented evidence-based best practice to prevent intravascular device-related infection and urinary catheter-associated infection, ventilator-associated pneumonia and surgical site infection.	1.1, 2.1, 2.3, 3.5
4.2	The hospital has systems in place to detect, prevent, and respond to healthcare-associated infections and multi-drug resistant organisms in line with national guidelines.	2.1, 2.3, 2.5, 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.8,

Appendix 2: Copy of the high risk letter issued to the South/South West Hospital Group regarding the findings of an unannounced inspection to University Hospital Kerry

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Gerry O' Dwyer
Group Chief Executive Officer
South/South West Hospital Group
gerry.odwyer@hse.ie

19 June 2017

Ref: PCHCAI 2017/04

Dear Gerry

Immediate High Risk Issues identified during a routine monitoring inspection at University Hospital Kerry

During the course of an unannounced monitoring inspection against the *National Standards for the Prevention and Control of Healthcare Associated Infection* at University Hospital Kerry on 15 June 2017, inspectors identified a composite of risks that raise significant concern, both with respect to infection prevention and control practices, and indeed wider leadership, governance and management at the hospital.

Inspection against National Standards on the day identified a number of high risks which were identified for immediate mitigation as follows;

- Lack of implementation of routine *Legionella* water surveillance testing measures, identified as required in the hospital site *Legionella* risk assessment which was conducted in 2015
- Non-compliance with national screening guidelines in relation to multi-drug resistant organisms – which means that measures to ensure that patients with potential colonisation with key multidrug-resistant organisms may not be identified, and risk of transmission to other patients may not therefore be sufficiently mitigated

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- Unsafe medication management practices in the Intensive Care Unit, whereby intravenous medication were being drawn up in advance of use, left unattended and unlabelled for a prolonged period of time, with in one instance a syringe being left uncapped. This presents both an avoidable infection risk, and a risk of drug administration error.
- Lack of washer/disinfector facilities for bedpans in clinical areas, which has resulted in a practice where staff need to hand wash bedpans after use. This is not an acceptable long term situation and increases the risk of infection transmission
- Poor management and cleaning of patient equipment, and failure in some instances to properly decontaminate reusable equipment

In addition, this inspection also identified that some high risks related to the microbiology laboratory which were identified following an antimicrobial stewardship inspection in 2015 - and flagged to you in writing at that time in a letter dated 3 November 2015 - have still not been satisfactorily addressed. Outstanding risk issues which have not been addressed are as follows;

- There is still no routine Consultant Microbiologist oversight of laboratory result reporting
- The hospital still does not have an up-to-date understanding of its pattern of resistance to key microbial pathogens (an antibiogram)
- Given ongoing deficits with staffing and resourcing arrangements, the Microbiology laboratory still cannot be considered for Irish National Accreditation Board (INAB) accreditation.

Collectively, these issues may present a serious risk to the health or welfare of patients at University Hospital Kerry, and immediate measures need to be put in place to mitigate these risks.

Finally I note with concern that senior staff at the hospital reported that the current General Manager is leaving the organisation on Friday 23 June 2017, and worryingly they appeared unaware of any interim governance arrangements in place to cover this post until September 2017. In addition, information provided on inspection suggests that this reported gap in assigned leadership may be further compounded by additional planned departures from other members of the hospitals management team.

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In light of these very worrying findings, please formally respond to this letter by 5pm on 21 June to qualityandsafety@hiqa.ie marked for my attention, outlining the measures that have been enacted to mitigate the identified risks. These must include how you intend addressing and mitigating any risks associated with reported interim senior management vacancies. Details of the risks identified, and proposed mitigating actions will be included in the report of the inspection.

Should you have any queries, please do not hesitate to contact me at qualityandsafety@hiqa.ie. Please confirm receipt of this letter by email (qualityandsafety@hiqa.ie).

Yours sincerely

SEAN EGAN
Acting Head of Healthcare Regulation

CC: Liam Woods, National Director of Acute Services, Health Service Executive
Mary Dunnion, Director of Regulation, Health Information and Quality Authority
Maria Godley, General Manager, University Hospital Kerry

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Appendix 3: Copy of the response letter received from the South/South West Hospital Group regarding the high risks identified during the HIQA inspection of University Hospital Kerry

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

OFFICE OF THE CEO
SOUTH / SOUTH WEST HOSPITAL GROUP
ERINVILLE
WESTERN ROAD
CORK
Tel: 021 - 4921509

21st June, 2017.

Mr. Sean Egan,
Acting Head of Healthcare Regulation,
Health Information & Quality Authority,
Head Office,
Unit 1301 - City Gate,
Mahon,
Cork.

Ref: PCHCAI 2017/04

Dear Mr. Egan,

I write in response to your letter of 19th June 2017 following the unannounced monitoring inspection against the *National Standards for the Prevention and Control of Healthcare Associated Infections* at University Hospital Kerry (UHK) on 15th June 2017. I would like to thank you for bringing these issues to my attention. I have set out below the key actions to mitigate the immediate risks identified.

In relation to *Legionella* water surveillance testing measures, UHK management team will immediately establish an Environmental Monitoring Committee with the expertise of infection control and estates who will review the current risk assessment and progression of best practice controls identified. In recognising that capacity for testing may be identified as a limiting factor to effective controls I have requested the Group's Chief Operations Officer to explore outsourcing to a third party provider.

In relation to non-compliance with national screening guidelines in Multi-Drug Resistant Organisms (MDROs) the hospital group has submitted requirement for a Surveillance Scientist and Grade IV clerical support as a critical unmet need for UHK within the estimates process to the Acute Hospital Division.

With regards to the unsafe medication practices observed within the Intensive Care Unit, UHK management brought this to the immediate attention of the Assistant Director of Nursing who investigated the matter on the day of the inspection. An action plan is currently being developed with staff of the Intensive Care Unit and Anaesthetic Department which will be monitored for implementation by the Intensive Care Governance Group and hospital management team.

Cont'd.....

Minor capital renovations are undertaken throughout the hospital group with the support of HSE Estates against the budget allocation and priorities identified by the hospitals and hospital group. Refurbishment work has been undertaken in UHK in a number of ward areas and the waste holding areas, equipment store and sluice areas require further upgrade works. The requirement for facilities for bedpan washers in all clinical areas has been identified as a critical need within UHK and has been submitted for minor capital funding and it is a group priority to have this work completed as soon as possible.

UHK management team acknowledges that incorrect equipment decontamination procedures were followed on the day of inspection. UHK policy for equipment cleaning recommends neutral detergent and warm water and disinfection with Klorosept. The correct procedure was reiterated to Staff, Staff were requested to re-familiarise themselves with the hospital policy and an action plan has been developed for all staff to be re-trained on the policy. UHK Management continues to work with housekeeping and third party providers to seek improvements. Significant change processes have been identified to improve overall management of cleaning within the hospital; however budget constraints remain challenging for the hospital and hospital group in the resources identified.

In relation to Consultant Microbiology oversight in UHK, the hospital and hospital Group have worked over the past two years to address this deficit. The immediate action taken by the Group in 2015 was securing sessional commitment and more recently locum Consultant Microbiology cover for infection control issues, whilst continuously striving to recruit a permanent Consultant Microbiologist. The recruitment process for the Consultant Microbiologist has now been completed and the successful candidate will take up post on 1st October, 2017.

As previously identified the hospital group has submitted requirement for a Surveillance Scientists and Grade IV clerical support as a critical unmet need for UHK within the estimates process to the Acute Hospital Division.

The microbiology laboratory within UHK has engaged fully with the strict quality management system implemented throughout the entire pathology department over a number of years. The absence of a permanent Consultant Microbiologist has impacted on the Microbiology Laboratory's ability to receive Irish National Accreditation Board (INAB) accreditation. This will be addressed with the appointment of the new Consultant Microbiologist on 1st October, 2017.

In regard to the concerns raised in relation to governance and management arrangements in the hospital, the recruitment of the new management team; the Hospital Manager and the Operations Manager has been completed and the successful candidates will take up post in September and July respectively. In the interim, the Director of Strategy, Planning & Population Health, South / South West Hospital Group with the agreement and support of the leadership team has been appointed to manage the hospital. The A/Deputy General Manager / Operations Manager has agreed to continue in post until the permanent appointment is processed and to support the Director of Strategy, Planning and Population Health.

Cont'd.....

I trust this letter outlines sufficiently the measures being taken by the hospital management team and the leadership team of the hospital group to mitigate the high risks areas identified. My office is available at any time should you require any additional information. The Leadership Team would value an opportunity to meet with you, along with the hospital management, when the new management team is in place.

Yours sincerely,

Gerry O'Dwyer

Mr. Gerry O' Dwyer
CEO,
South/South West Hospital Group

E-mail gerry.odwyer@hse.ie

CC Mr. Liam Woods, National Director of Acute Services, Health Service Executive
Ms. Mary Dunnion, Director of Regulation, Health Information & Quality Authority
Dr. Gerard O'Callaghan, Chief Operations Officer, South/South West Hospital Group
Dr. Orla Healy, Director of Strategy, Planning & Population Health, South / South West Hospital Group
Dr. Ken Walsh, Interim Chief Clinical Director, South/South West Hospital Group
Ms. Maria Godley, General Manager, University Hospital Kerry

Appendix 4: Copy of the letter issued to the South/South West Hospital Group regarding the response to the initial high risk letter

Health Information and Quality Authority
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29 June 2017

Ref: PCHCAI 2017/06

Dear Gerry

Immediate High Risk Issues identified during a routine monitoring inspection at University Hospital Kerry

I am writing in response to your letter of 21 June 2017 (your Ref: 2017/04), which you wrote in response to an immediate high risk letter sent on 19 June 2017.

I note the contents of your response, and am writing to seek further specific assurance around intended measures to address a number of potentially high risk issues that HIQA have repeatedly identified through monitoring, but which it would appear from your most recent response have still not been addressed to a satisfactory level, and within an appropriate timeframe.

Firstly, I note that despite HIQA raising concerns around the extremely limited level and nature of Consultant Microbiologist cover at a hospital of the size and complexity of University Hospital Kerry in 2015, measures enacted to date still do not ensure that there is regular onsite oversight of laboratory reporting that would be consistent with other comparable hospitals, or which would enable consideration for accreditation.

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Therefore, I am writing to seek assurance that microbiological cover at the hospital is immediately strengthened to ensure that an appropriate level of onsite clinical oversight of laboratory reporting is put in place as a matter of urgency, in the interim of the planned appointment of a Consultant Microbiologist in October.

In addition, I note the very recent repeated assurance provided in your letter that adequate legionella control measures will be enacted at the hospital, in line with national guidance and legislation. Notwithstanding that prior similar assurances were given in 2015, HIQA's most recent inspection identified that as part of its wider identification that legionella control measures remain absent at the hospital, the hospital does not currently test water outlets for legionella.

Testing of outlets is a practice required in national guidance, and conducted as a matter of routine in other hospitals as a baseline safety surveillance measure. Legionella sampling on an ongoing basis was also recommended in the Legionella risk assessment conducted in University Hospital Kerry in August 2015. I am writing to seek assurance that in the interim of further control measures being put in place, that the hospital acts a matter of urgency to ensure sampling of water outlets for legionella, and that any findings that require action are rapidly addressed with relevant expert input as necessary.

In light of the very serious nature of these issues for resolution, please formally respond to this letter by **5pm on 6 July 2017** to qualityandsafety@hiqa.ie marked for my attention, outlining you plan to urgently address these outstanding risks.

Finally, I wish to inform you that HIQA have contacted the Health and Safety Authority as per our memorandum of understanding, to inform them of our repeated findings in this regard, given their possible role and responsibilities related to this issue under the Health and Safety at Work Act.

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Yours sincerely

SEAN EGAN
Acting Head of Healthcare Regulation

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Mary Dunnion, Director of Regulation, Health Information and Quality Authority
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