Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection against the *National Standards for Safer Better Healthcare*.

Name of healthcare service provider:	Castlecomer District Hospital
Address of healthcare service:	Glebe House Dunguile Castlecomer Co Kilkenny R95A5XC
Type of inspection:	Announced
Date(s) of inspection:	30 and 31 July 2024
Healthcare Service ID:	OSV-0007833
Fieldwork ID:	NS_0088

About the healthcare service

Castlecomer District Hospital is owned and managed by the Health Service Executive (HSE) under the governance of Community Health Organisation (CHO) 5.*

Castlecomer District Hospital has 18 beds; eight transitional care beds, eight respite beds, and two palliative care beds. Patients are admitted to the hospital from acute hospitals and the community and have access to a multidisciplinary team which includes for example, nursing, medical officers, dietetics and occupational therapy onsite. Patients who require physiotherapy are referred to the primary care centre.

How we inspect

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. This inspection was carried out to assess compliance with the National Standards for Safer Better Healthcare. To prepare for this inspection, inspectors† reviewed information which included previous inspection findings, information submitted by the provider, unsolicited information‡ and other publically available information. During the inspection, inspectors:

- spoke with people who used the service to ascertain their experiences of the service
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the ward
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors.

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with the national standards monitored during this inspection are presented under two dimensions of *Capacity and Capability* and *Quality and Safety*.

* Community Health Organisation area 5 consists of South Tipperary, Carlow, Kilkenny, Waterford and Wexford

† Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare (2012)

‡ Unsolicited information is defined as information, which is not requested by HIQA, but is received from people including the public and or people who use healthcare services.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality and safe service is being sustainably provided in the service. It outlines whether there is appropriate oversight and assurance arrangements in place and how people who work in the service are managed and supported to ensure high-quality and safe delivery of care.

2. Quality and safety of the service

This section describes the experiences, care and support people using the service receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centred and safe. It also includes information about the environment where people receive care.

A full list of the national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
30 July 2024	13.00 to 17.30hrs	Bairbre Moynihan	Lead
		Geraldine Ryan	Support
31 July 2024	09.00 to 15.30hrs	Eilish Browne	Support

Information about this inspection

This inspection focused on national standards from five of the eight themes of the *National Standards for Safer Better Healthcare*. The inspection focused in particular on four key areas of known harm, these being:

- infection prevention and control
- medication safety
- the deteriorating patient§ (including sepsis)**
- transitions of care.††

The inspection team were guided on a tour of the hospital and visited St John's and St Barbara's ward. On day two of the inspection, an inspection was completed of St Barbara's ward.

During this inspection, the inspection team spoke with the following staff:

- Acting Director of Nursing/Clinical Nurse Manager 2
- Clinical Nurse Manager 1 (Drugs and Therapeutics representative)
- Acting Clinical Nurse Manager 1 (Infection prevention and control representative)
- Quality, Risk and Patient Safety advisor (CHO5)
- Infection Prevention and Control advisor (CHO5)
- Manager for Older Persons' Services (CHO5).

Inspectors also followed up on issues identified from the previous inspection undertaken at the hospital 21 October 2020.

What people who use the service told us and what inspectors observed

Throughout the days of inspection inspectors spoke with patients accommodated in both wards in the hospital. Patients stated that they were happy with the care they received and were complimentary about the staff.

Inspectors observed that staff actively engaged with patients in a respectful and kind manner and ensured patients' needs were promptly responded to. This observation was validated by the patients spoken with. Patients comments referenced that staff "have put

§ The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in hospitals across Ireland.

** Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.

†† Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

everything in place for me" in relation to the patient's discharge, "there is nothing but good I can say about the place, everything is great" and "love it here, the food is great". A relative stated that "the place is like a hotel, everything is fabulous".

Inspectors observed effective communication approaches used by staff to support patients who may have difficulties with communication. Staff were engaging in a positive manner with patients' relatives and with other staff. Patients spoken with knew who to speak to if they wished to raise an issue and stated they would speak with staff if they had a concern or complaint.

The hospital had a chapel onsite and mass was celebrated twice weekly. Patients who were unable to attend the chapel could access the Mass via the television.

A local shop visited onsite once daily. An activities calendar was on display. Inspectors were informed that on the day of inspection activities were taking place outdoors due to the good weather.

Patients had access to a large well maintained garden with tables and chairs available for patients. The garden was accessed via the dining room in St John's ward and via the nursing office on St Barbara's ward. On the day of inspection, patients were observed sitting in the garden enjoying the sunshine.

Capacity and Capability Dimension

Inspection findings related to the capacity and capability dimension are presented under four national standards from the themes of leadership, governance and management and workforce. Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.

The acting director of nursing (DON) was responsible for the operational management of the hospital and reported to the manager for older persons' services, CHO5, who reported to the general manager for older persons' services, and upwards to the head of service and the acting chief officer (CHO5).

Organisational charts setting out the hospital reporting structures detailed the direct reporting arrangements for hospital management. While inspectors identified that the hospital had formalised governance arrangements in place with defined roles, accountability and responsibilities for healthcare services delivered at the hospital and CHO5 level, these required strengthening. Additionally, the governance and oversight

committees reporting and accountability relationship to the acting chief officer, CHO5 required review as they did not reflect what inspectors were informed of on inspection.

Nursing and support staff within the hospital reported to the acting CNM1 and upwards to the acting director of nursing. The director of nursing post was recently vacated and the clinical nurse manager 2 was acting into the role. While no impact was identified with this arrangement on the day of inspection, this ongoing vacancy is not sustainable. Health and social care health professionals for example dietitians and occupational therapists reported within the CHO5 community structures.

Two local general practitioners were responsible for the medical care of patients admitted to the hospital. On-call medical cover was provided by an out of hour's medical service.

Quality and Safety committee Castlecomer District Hospital and Carlow District Hospital

A quality and safety committee with Castlecomer District Hospital and Carlow District Hospital was in place. However, the terms of reference provided to inspectors did not indicate that the committee was attended by both district hospitals. Furthermore, the terms of reference stated that the purpose of the committee was to, for example: review and update policies, procedures, protocols and guidelines and to introduce and evaluate quality initiatives and learning. However, minutes of meetings reviewed by inspectors reflected that the committee had a broader remit and the committee had oversight of audits, quality improvement initiatives, policy development, patient safety incident reporting, risk registers, education and complaints. Terms of reference reviewed indicated that the committee reported to older persons' south east community healthcare (SECH) quality and safety executive committee (QSEC) via a report, however there was no indication in minutes reviewed of these meetings that Castlecomer District Hospital report was discussed. The Quality Risk and Patient Safety advisor, CHO5 reported to the Quality Risk and Patient Safety manager, worked with and supported local management in services in CHO5 on all matters relating to identifying quality improvement opportunities including reduction of common causes of harm.

Directors of Nursing Governance Group – CHO5

This meeting was chaired by the head of service older persons, CHO5 and attended by the manager for older persons' services, the QSEC advisor, directors of nursing from community and district hospitals within CHO5 including a representative from Castlecomer District Hospital.

A review of sample minutes indicated that an agenda was followed, however, actions were not time-bound or monitored from meeting to meeting.

Drugs and Therapeutics Committee - Castlecomer District Hospital and St Columba's Hospital, Thomastown

A Drugs and Therapeutics Committee had been established to review and implement policies, procedures and guidelines and review risk management in relation to medication and medication reconciliation across the two hospitals. The committee, chaired by a nurse prescriber, met quarterly and the terms of reference reflected representation from both hospitals. Minutes of meetings reviewed aligned with the agenda, previous actions were reviewed and all new actions were time-bound and assigned to an identified person. Terms of reference were vague on the reporting relationships and stated that this committee reported to CHO5 as required. There was no evidence from review of meeting minutes of the Director of Nursing Governance Group or the Older Persons' SECH QSEC committee of a reporting relationship with this committee.

Deteriorating Patient committee: Castlecomer District Hospital and Carlow District Hospital

A deteriorating patient committee was established in early 2024 between Castlecomer District Hospital and Carlow District Hospital. The terms of reference indicated that the meetings were held quarterly. The agenda was aligned to the *national standards for safer better healthcare* and agenda items included audit plan, quality indicators and outcome measures, and risk management. Attendees included medical officers and representatives from both hospitals.

The reporting relationship of this committee outlined in the terms of reference indicated that the chair of the deteriorating committee updated a director of nursing representative who would provide updates at the older persons' services south east community healthcare (SECH) quality and safety executive committee (QSEC). However, three sets of minutes of these meetings were provided following inspection and there was no evidence that the deteriorating patient was discussed at the meetings.

Transitional Care committee: Castlecomer District Hospital and St Luke's General Hospital

The committee was set up to create a person-centred approach to effective integrated discharge planning between St Luke's General Hospital Killkenny (SLGH) and Castlecomer/Carlow District hospitals. The committee had a terms of reference, an agenda and representation from both hospitals. The director of nursing representative was responsible for updating the SECH Older persons Services Quality and Safety Executive Committee (QSEC). Terms of reference indicated that meetings were held quarterly. Inspectors were informed of discussions that had been taking place with SLGH in relation to updating and formalising a handover letter for patients transferring between healthcare services. This was confirmed in meeting minutes reviewed.

Clinical Nurse Manager's (CNM) meeting

The terms of reference for the clinical nurse manager's meeting were requested and not provided. The meeting was held infrequently. Three meetings were held since February 2023 with one of these being in 2024. It is unclear what the reporting relationships were in place for this meeting.

Meeting minutes of the most recent meeting in June 2024 were reviewed and evidenced that while meetings followed an agenda, no time-bound assigned actions were identified for actions arising.

Infection Prevention and Control Committee

Structures and committees were in place both locally and at CHO5 level to ensure the effective management of infection prevention and control. The committee met quarterly and was operationally accountable to the acting director of nursing and reportable to the manager for older persons' services, CHO5.

Meeting minutes reviewed reflected that while some actions were identified, they were not assigned to an identified person and actions were not time-bound or followed up in the next meeting. A terms of reference and an agenda for the committee were submitted to HIQA.

Overall, governance arrangements with defined roles, accountability and responsibilities for healthcare services delivered at the hospital and CHO5 level, required strengthening:

- The director of nursing post was vacant with no plans to recruit a replacement DON. The current arrangement is not sustainable.
- There was no evidence that the local governance and oversight committees were reporting in line with its terms of reference.
- The clinical nurse managers were not meeting at regular intervals.
- The terms of reference of deteriorating patient committee were not aligned with the meetings taking place, hospitals represented on the committee and staff who attended.
- A number of meeting minutes reviewed evidenced that while meetings followed an agenda, no time-bound assigned actions were noted or monitored from meeting to meeting.

Judgment: Partially compliant

Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.

Management arrangements were in place to support the delivery of safe and reliable healthcare in the hospital. Inspectors observed and were informed by staff that management continuously engaged with staff and provided additional staff when available. The ward had management arrangements in place in relation to the four areas of known harm:

Infection, prevention and control

The hospital had IPC link practitioners who provided guidance and training on matters concerning infection prevention and control.

An IPC advisor CHO5, described the close links with the hospital's IPC link practitioners. This in turn was validated by the acting director of nursing and link practitioners.

Medication safety

Pharmacy supplies to the hospital was provided by St Luke's General Hospital, Kilkennny (SLGH), where a pharmacist visited the hospital once a month to review medication services. However management of medication stock in the hospital required review. This is discussed further under national standard 3.1

The deteriorating patient

The hospital had recently rolled out the Irish National Early Warning System in the hospital (iNEWS) with oversight provided by the local deteriorating patient committee. The early warning score (EWS) was easy to view for each patient on the "bed management board" located in the staff office. Staff meeting minutes reviewed indicated that ISBAR communication tool and EWS were discussed. Local ward managers were knowledgeable about the deteriorating patient.

Transitions of care

Inspectors were informed that while the hospital did not have a local transitions of care committee, the ward CNM1 was responsible for patient discharge/transfer and operationally accountable to the acting director of nursing. It was evident that bed management, admissions and transfers featured in other hospital committee meetings and at a weekly case conference meeting. Inspectors were informed that patients were admitted for up to 12 weeks for convalescence care from St Luke's General Hospital Kilkenny, University Hospital Waterford or on occasion from other acute hospitals. Patients were also admitted from the community for respite and palliative care. Patient assessments were undertaken prior to admission. If patients became acutely unwell they were reviewed by a general practitioner or an out-of-hours medical service, and transferred if required to St Luke's General Hospital Kilkenny.

Judgment: Compliant

Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Hospital and CHO5 management had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of services provided. Minutes of meetings reviewed reflected that performance data was reviewed at meetings internally and at CHO5 level.

Monitoring service's performance

The hospital collected data on a range of different measurements related to the quality and safety of healthcare services, for example, bed occupancy rate, average length of stay, scheduled admissions, delayed transfers of care, patient-safety incidents, IPC, and workforce. It was evident that collated performance data was reviewed at hospital meetings and quality indicators and outcome measures were a standing agenda item at CHO5 level.

Risk management

The hospital had systems in place to identify and manage risk in relation to the prevention and control of healthcare-associated infections and safe use of medicines, however, not all risks identified on inspection in relation to the hospital, for example; the infrastructure and layout were identified and a risk assessment completed. This was also a finding on the inspection in 2020. These will be discussed under national standard 3.1. Inspectors were informed by management that risks that could not be managed locally were escalated to CHO5.

Audit activity

The hospital had a schedule of audit activity identified for the year. The schedule included audits, for example, on medication management and IPC. There was evidence that findings from audits were addressed in the ward area audited.

Patient-safety incidents

Management stated that incidents were logged on the National Incident Management System (NIMS)[‡‡] in line with the HSE's Incident Management Framework. A serious incident management team was convened when required. Evidence was provided to inspectors that this meeting was convened in 2024 with the record of decision and associated learning.

[‡‡] The State Claims Agency National Incident Management System is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation.

The hospital had systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. Notwithstanding this:

- risks identified on the inspection in 2020 in relation to the infrastructure and layout and remained a risk had not been risk assessed and placed on the risk register.

Judgment: Substantially compliant

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.

The hospital had workforce arrangements in place to support and promote the delivery of quality, safe and reliable healthcare. However, hospital and CHO5 management need to review the provision, sustainability of current pharmacy services.

The hospital's acting director of nursing was operationally responsible for recruitment. It was evident from meeting minutes and from interviews with senior management that workforce was reviewed daily and formally at meetings convened internally and externally at CHO5 level. A very low turnover of staff in the hospital was reported to inspectors. Management stated that the hospital's approved complement of nursing staff was 14 whole-time equivalent[§§] (WTEs) including management grades supported by 8.6 WTE healthcare assistants, 6.1 WTE multi-task attendants for both catering and housekeeping. At the time of inspection there was no staff nurse vacancies, however as discussed under national standard 5.2, the director of nursing post was recently vacated. In addition, there were 0.6 WTE healthcare assistants and 1.4 WTE multi-task attendant's positions vacant.

A medical officer was on-site each day for approximately two hours. Inspectors were informed that the antimicrobial pharmacist post at CHO level was vacant and advice was sought from St Luke's General Hospital Kilkenny, if required.

Inspectors were informed that a pharmacist attended onsite once monthly. Staff reported that they could contact the pharmacy department at any time and received good support. However, deficits were identified in areas such as pharmacy stock control. It was not clear from a review of the hospital's risk register if a specific risk assessment had been completed in relation to the capacity and sustainability of the current pharmacy arrangement at the hospital.

[§§] Whole-time equivalent - allows part-time staff working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to staff working full-time while 0.5 refers to staff working half full-time hours.

Staff training

The acting director of nursing who had oversight of staff training, had systems in place to monitor and record staff attendance at mandatory and essential training. It was evident from staff training records reviewed and from speaking with staff that they were up-to-date with training appropriate to their scope of practice, for example, infection prevention and control, hand hygiene, early warning score. Staff were knowledgeable on for example IPC practices, medication safety and on how to use the early warning score. Good compliance rates were identified in standard and transmission based precautions and hand hygiene with nurses and healthcare assistants achieving 100%. Multi-task attendants and catering had an 80% attendance. However, improvements were required in training on the Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) communication tool [***]with 25% of nurses trained.

Staff had access to external expertise and training in IPC from CHO5 community-based infection prevention and control advisors. Internally, infection control link practitioners facilitated staff training on hand hygiene and donning and doffing of personal protective equipment (PPE).

The hospital had workforce arrangements in place to support and promote the delivery of quality, safe and reliable healthcare, however,

- Deficits in the current pharmacy arrangements were identified.
- Poor attendance levels were identified in ISBAR communication tool training.

Judgment: Substantially compliant

Quality and Safety Dimension

Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.

Overall, inspectors identified that staff promoted a human rights approach to care in the clinical areas visited. Staff were committed to promoting an approach to care and service delivery that understood and respected these rights.

Inspectors observed two rooms (Dinin and Heather) that were available for patients who required end-of-life care. These rooms were spacious single rooms with no en-suite facilities. Rooms provided patients, their families and friends, privacy and dignity at this time. Patients' privacy and dignity was ensured in clinical areas through the use of privacy

[***] Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

curtains which were available at bedsides in clinical areas however, it was noted that the ward accommodation was not designed in a way to promote the dignity, privacy and autonomy of patients, for example:

- a dining area in St Barbara's ward which accommodated nine patients had a dining table and seating available for four patients. Additionally the table and chairs were located within a patient bay area between two beds. This arrangement did not provide privacy and dignity for the patients eating or those who chose to remain within their bed space. Inspectors were informed that the dining area was relocated to the space during the COVID-19 pandemic to create a nursing office for staff.

This will be discussed under national standard 2.7.

Patients' personal information and charts were stored in a secure manner. White boards at the nurses' station were designed to maintain the privacy of the patient.

While generally patients' dignity, privacy and autonomy was respected:

- The layout of the dining area in St Barbara's ward did not promote patient privacy and dignity or a pleasant dining experience for all patients, particularly those accommodated in mobile chairs.

Judgment: Substantially compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.

Overall, it was evident that a culture of kindness was actively promoted by all staff. Staff were observed providing care with kindness, consideration and respect and were responsive to their individual needs.

Patients were communicated with in a sensitive manner and stated they were comfortable raising any issue with staff. Inspectors spoke with many patients, all who expressed how kind staff were.

Some patients were aware of the HSE's '*Your Service Your Say'.*[†††] Leaflets informing patients and relatives on how to raise a complaint were noted in the wards. There was a photograph of the acting director of nursing at the entrance to the hospital identifying her as the designated complaints officer. Patient information leaflets on a range of health topics were available and accessible.

[†††] Your Service, Your Say' is the name of the HSE's complaints process for all users of HSE funded services. In addition to being a complaints process, "Your Service, Your Say" is also a way to provide feedback to the HSE

The hospital had arrangements in place to facilitate access for patients to independent advocacy services where required. Posters displayed within the wards visited provided information on how to access advocacy services.

Judgment: Compliant

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

The acting director of nursing was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. There was a culture of local complaints resolution in the wards visited.

The hospital had a complaints management system and used the HSE's complaints management policy '*Your Service Your Say*.'[‡‡‡] Staff recorded verbal and written complaints locally in a complaints log book, implemented subsequent quality improvement plans, shared learning from complaints and described how they updated the person who raised the complaint. It was evident from documentation reviewed, speaking with staff and management that complaints were managed in line with the HSE's complaints management policy.

Updates on complaints received were captured in minutes of various hospital committees. At CHO5 level, it was noted in a sample of meetings minutes reviewed that complaints, if any, were tracked, trended and learning shared. Staff spoken with were aware of how to support a patient in raising a concern or making a complaint, and of the hospital policy. Staff stated that complaints were addressed at ward level and if a complaint could not be resolved locally, they would escalate the complaint to management. Staff verified that informal complaints were tracked, trended and learning was shared with staff at staff handover meetings.

Posters and leaflets on '*Your Service Your Say'* were observed in the hospital. A suggestion box was available at the entrance to the hospital. An admission pack for new patients also contained information on how to raise a complaint.

Judgment: Compliant

[‡‡‡] Health Service Executive. *Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints*. Dublin: Health Service Executive. 2017. Available online from https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf.

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.

The hospital premises was constructed in approximately 1853 and resultantly the hospital's configuration and infrastructure posed challenges. Despite this, on the day of inspection, inspectors noted that the hospital's physical environment was clean and well maintained. Single rooms were available for patients, particularly patients at end of life and for patients who required transmission based precautions. Inspectors identified that there was good local ownership and oversight in relation to infection prevention and control.

Wall-mounted alcohol based hand sanitiser dispensers were located strategically throughout the hospital with hand hygiene signage clearly displayed. Inspectors noted that hand hygiene sinks, with the exception of sinks in sluice rooms, conformed to requirements.[§§§] Physical distancing of one metre was observed between beds in multi-occupancy rooms.

Infection prevention and control signage in relation to transmission based precautions was observed in areas visited. The hospital had implemented and staff described processes to ensure appropriate placement of patients.

Environmental and equipment cleaning was carried out by healthcare assistants. Equipment was observed to be clean and there was a system in place to identify equipment that had been cleaned, for example, use of tags and checklists. Inspectors were informed that management had oversight of the cleaning and cleaning schedules in the ward visited, and stated they were satisfied with the level and standard of cleaning.

While it was evident that a rolling maintenance programme was in place, some issues identified from the previous inspection undertaken October 2020 remain outstanding:

- Two-multi occupancy wards with some spaces accommodated by patients were subdivided into bays. However these areas were still used as a thoroughfare to reach other patients and areas, such as toilets, dirty utility, the nurse's station and the oratory. This was not risk assessed since the last inspection.
- There was no dedicated clean utility area for the storage and preparation of medications. This area was currently located in a dual function room within the nurses' station.
- The design of clinical hand wash in the sluice rooms sinks did not conform to Health Building Note 00-10 Part C: Sanitary assemblies. This was brought to the attention of staff and a risk assessment was completed while inspectors were onsite with a due date for installation of 01 October 2024.

[§§§] Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf

Additionally, on this inspection it was noted that:

- There was no separate dining area for patients in one ward. A dining table and four chairs were located beside two patient beds in a ward that accommodated nine patients.
- While a dedicated cleaner's room had been established since the last inspection, this room did not have hand washing facilities for staff, and no bucket sink for disposal of liquid waste in line with Health Building Note 00-10 Part C: Sanitary assemblies. Liquid waste was currently disposed of in the sluice room. A risk assessment was completed while inspectors were onsite with a due date for the action to be completed by 31 August 2024.
- Soiled linen from one ward was transported inappropriately via another patient ward and onwards to a dedicated room for storage. This was discussed with management on the day of inspection who concurred with inspectors' observations and agreed to risk assess and review the current arrangement.
- Storage for equipment was inadequate. Patient monitors were stored along the ward corridor and commodes were stored in patient bathrooms.
- Hazardous material and waste were stored externally in bins. However the waste bins (general and clinical waste) located adjacent to where patients sat out in the gardens, were easily accessible as they were not secured in a safe manner. This was identified in a health and safety audit and infection prevention and control audit in January and February 2024. Documentation confirmed that this was escalated to the relevant department in the HSE and funding was secured in May 2024 to secure the bins. However, no progress has been made at the time of inspection in securing them.

Judgment: Partially compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.

Hospital management were proactively and systematically monitoring, evaluating and responding to information from multiple sources to inform improvement and provide assurances to CHO5 on the quality and safety of the service provided to patients.

Reports reviewed by inspectors included a QPS annual report 2023 which captured incidents based on NIMS data which detailed the common causes of harm, for example, slips, trips and falls.

A monthly auditing schedule was implemented by the hospital. Medication safety, IPC and early warning scores were included in the audit schedule. Audits were discussed at clinical nurse manager and staff meetings and they were a standing agenda item at SECH Director of Nursing Governance Group. An IPC audit schedule was displayed for staff on

the first floor which outlined the monthly audit schedule. Inspectors were informed and meeting minutes confirmed that audits were completed by link nurses. Staff outlined how actions from audits were implemented and closed.

Audits completed by the nursing department in relation to the four areas of focus included nursing metrics, medication prescribing and administration, and infection prevention and control. Good compliance levels were identified in medication administration with both clinical areas achieving 100%. However, the audits identified areas for improvement in the documentation of the infection status on admission. Inspectors reviewed a sample of healthcare records during the inspection and identified that this was completed in all cases. Time bound action plans accompanied the nursing metrics audits. An early warning score audit was completed in February 2024 with areas for action identified including that some scores were not calculated, however, the action plan was not time bound. This was also a finding on medication audits and an antimicrobial stewardship audit completed in June 2024.

Overall, the hospital were systematically monitoring and evaluating the service, however;

- Action plans were not time bound.

Judgment: Substantially compliant

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.

The hospital had systems in place to identify and manage risks. Risks in relation to the service were recorded on a risk register and reviewed quarterly. Inspectors were informed that risks assessments are completed by staff and discussed at the quality and safety meeting. Meeting minutes confirmed that it was an agenda item at these meetings and inspectors were informed by two members of the management team that risks that could not be managed at local level were escalated to the manager for older persons' services.

Inspectors were informed that risk registers were a standing agenda item at the Older Persons' SECH QSEC committee every two months and meeting minutes reflected this. Risks reviewed had controls and actions in place to manage and reduce recorded risks. One risk relating to the four areas of focus was on the hospital risk register in relation the risk of patients acquiring a healthcare associated infection. However, as discussed under national standard 5.8, risks in relation to the infrastructure and the layout were not risk assessed and placed on the risk register. This was also identified on the inspection in 2020.

The hospital had an IPC Team/Committee comprising IPC link practitioners who had access to the CHO5 IPC advisor. An infection prevention and control quality improvement plan for 2024 was completed and identified areas for improvement. One of these was the flushing of unused taps and showers with a review date of August 2024. Inspectors requested the

date of the last legionella risk assessment on the day of inspection and following inspection. This was not provided. Inspectors were informed and the infection prevention and control quality board confirmed that all patients were tested for COVID-19 on transfer from the acute hospital and patients who were admitted for respite. The hospital had an outbreak of COVID-19 in January 2024. While the outbreak was contained to one ward no outbreak report was completed at the end of the outbreak in line with national guidance to identify learning.

Staff had access to a washer disinfector. Inspectors were informed that staff were decanting human waste into the sluice hopper prior to placing the bedpans and urinals into the washer disinfector. This procedure increases the risk of the spread of multi-drug resistant organisms, for example, *clostridioides difficile*.

The hospital had a list of high-risk medications. The acting CNM1 described the use of risk reduction strategies to support safe use of medicines in relation to, for example, antibiotics, anticoagulants, insulin and opioids. The hospital had a list of sound-alike look-alike medications (SALADs), A-PINCH[****] and high risk medications, however, all of these were out of date since 2019.

Inspectors were informed that formalised medication reconciliation[††††] was not routinely carried out in the hospital but staff on site undertook medication reconciliation on patient admission and prior to discharge. This was confirmed by staff whom inspectors spoke with. Management stated that patients' prescriptions were received before or on the day of admission. A verbal report was given to the ward from the referring hospital. Any discrepancies were followed up with the referring hospital by staff.

Inspectors were informed that a pharmacist from St Luke's General Hospital, came onsite once a month and completed medicines record reviews for patients. Outside of this, staff informed inspectors that they could contact the pharmacy department in the hospital if they had any queries. Medications were supplied from St Luke's General Hospital twice weekly. Arrangements were in place for accessing medications out of hours supplied from a local pharmacy. It was noted on this inspection that the hospital was over stocked on all medications and staff recording of hospital stocks of medication required ongoing oversight as a priority. This was brought to management's attention at the close out of the inspection.

Medicines were stored in a secure manner. While a designated fridge for medicines requiring storage at a required temperature was available, the fridge in St Barbara's was not fully operational necessitating staff to manually take the temperature. This had been highlighted by staff prior to inspection and actioned again by management on the day of

[****] APINCH is an acronym used to identify high risk medicines and includes anti-infective agents, potassium, insulin, narcotics and sedatives, chemotherapy and heparin and other anti-coagulants.
[††††] Medication reconciliation is the formal process of establishing and documenting a consistent, definitive list of medicines across transitions of care and then rectifying any discrepancies.

inspection. Fridge temperatures were recorded on a daily basis. Prescribing guidelines including antimicrobial prescribing were accessible to staff at the point of care.

The hospital had introduced the Irish National Early Warning System (INEWS), in early 2024. Both medical and nursing staff were knowledgeable on the escalation processes and modification of the early warning score. There was evidence from a review of documentation and from discussions with staff that the hospital had introduced the Identify, Situation, Background, Assessment, Recommendation (ISBAR) tool. Documented processes were place for staff to follow in the event of a patient becoming unwell. Staff spoken with were able to describe the procedures in place.

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services and support safe discharge planning. From review, it was evident that the patient's personal details, medical history, current medications and infection status were recorded on the discharge and transfer forms. Discharge plans also included for example, home support, assessment by MDT, medication, contact and or correspondence with the public health nurse, patient's general practitioner (GP). Patients planned discharges were discussed at the huddle which was held daily in clinical areas, one of which was attended by inspectors. The hospital had access to a mobile x-ray which attended onsite if required. This reduced the necessity of a patient having to attend an acute hospital for an x-ray.

As the hospital did not have an electronic document management system. A number of hard copy policies, procedures, protocols and guidelines (PPPGs) to guide and inform staff were available. Policies in relation to transitions of care for example; an admission policy was up to date. Inspectors were informed that the hospital followed the national policy for infection control, however, while staff also had access to a suite policies in relation to this area, most were out of date. The medication safety policy was out of date since July 2023 and inspectors were informed that the hospital was awaiting approval of an updated policy. This was confirmed in meeting minutes reviewed. Staff had no access to a policy on the deteriorating patient and were unaware of the national policy in place. Furthermore, the risk management and incident policy was out of date since October 2023.

The hospital had undertaken a satisfaction survey. Inspectors were provided with 11 comment cards that were completed by patients. No date was contained on the comment cards and the results were not collated at the time of inspection and time bound action plan devised. Samples of positive feedback included the cleanliness of the hospital and compliments about the staff however, patients also commented on the lack of wardrobe space and lack of access to the garden area.

In summary, while the hospital had systems in place to identify and manage potential risk of harm associated with areas of known harm — infection prevention and control, medication safety, transitions of care and the deteriorating patient. The following areas for action were identified:

- No outbreak report was completed following an outbreak in January 2024 to identify any learning.
- Staff were inappropriately decanting human waste into the sluice hopper.
- The date of the last legionella risk assessment was requested and not received.
- Lists of sound-alike look-alike medications (SALADs), A-PINCH‡‡‡‡ and high risk medications were out of date since 2019.
- The medication fridge was not operational in St Barbara's ward on the days of inspection.
- There was lack of oversight on medication stock management.
- A number of policies were out of date and in some instances multiple versions of the policies were available for staff.
- Patient comment cards were not collated and a time bound action plan devised to address the feedback.

Judgment: Partially compliant

Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.

The hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. Staff were knowledgeable about how to report an incident and were able to describe incidents that they had previously reported and the process for reporting them. There was evidence that hospital and CHO5 management had oversight of the management of incidents.

Reports and meeting minutes reviewed evidenced that patient-safety incidents were tracked and trended. Patient-safety incidents were also discussed at director of nursing governance meetings and the local quality and safety meeting. There was evidence that incidents were discussed at the older persons' south east community healthcare (SECH) quality and safety executive committee (QSEC) in CHO5.

Overall, the hospital effectively identified, managed, responded to patient safety incidents relevant to the size and scope of the unit.

Judgment: Compliant

‡‡‡‡ APINCH is an acronym used to identify high risk medicines and includes anti-infective agents, potassium, insulin, narcotics and sedatives, chemotherapy and heparin and other anti-coagulants.

Appendix 1 – Compliance classification and full list of standards considered under each dimension and theme and compliance judgment findings

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in any compliance plan submitted.

HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, 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 people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Partially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially compliant

Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan for Castlecomer District Hospital

OSV-0007833

Inspection ID: NS_0088

Date of inspection: 30 and 31 July 2024

Compliance Plan Service Provider's Response

National Standard	Judgment
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Partially compliant

Outline how you are going to improve compliance with this standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.

(b) where applicable, long-term plans requiring investment to come into compliance with the standard

Compliance Improvement Plan for Standard 5.2

Objective: Strengthen governance arrangements to ensure high-quality, safe, and reliable healthcare delivery at Castlecomer District Hospitals.

Interim Actions to Mitigate Risks

1. **Vacancy in the Director of Nursing (DON) Role**
   - **Current Status:** The Director of Nursing post, was vacated in June 2024 and was left unfilled due to the subsequent HSE national recruitment pause. The post is now approved for filling and the vacancy is currently advertised with closing date at end of October 2024.
   - **Interim Measures:** Until the appointment is finalized, the Clinical Nurse Manager 2 (CNM2) will continue as the acting DON, supported by senior nursing staff to ensure continuity in leadership and operational management.
   - **Completion Target:** The vacant post is now advertised and "live" for applications with a closing date at the end of October 2024. Interviews are scheduled for mid-November and expected filling of post before end of year.
2. **Review and Update of Governance Structures and Reporting Framework**

- **Action Plan:** A comprehensive review of the reporting structures and terms of reference for local committees will be conducted to establish well-defined communication pathways between the teams, hospital management, and higher regional governance bodies such as the Clinical Governance, Regional QSEC, and Directors of Nursing Governance meetings.
- **Target Completion:** Expected close out and completion by year end 2024
- **Interim Measures:** Existing governance structures will remain operational, with any critical issues escalated through temporary communication channels to maintain oversight during the review process.

3. **Regularisation of Clinical Nurse Manager (CNM) Meetings**
   - **Action Plan:** Establish a structured timetable for CNM meetings to be conducted on a bimonthly basis. The first meeting under the new schedule will be held within the next two months, followed by regular intervals.
   - **Interim Measures:** Initiate a provisional communication plan to ensure ongoing dialogue and action between CNM meetings.
4. **Review and Restructure of the Deteriorating Patient Committee**
   - **Action Plan:** The terms of reference for the Deteriorating Patient Committee, which includes representatives from the Carlow/Kilkenny region, will be reviewed to align meeting agendas and reporting structures with current governance requirements.
   - **Scheduled Review:** November 2024.
   - **Interim Measures:** The existing Modified Early Warning Score (MEWS) system and ISBAR communication protocols will remain in effect to ensure patient safety while the review is conducted.
5. **Implementation of a Standardised Template for Meeting Minutes**
   - **Action Plan:** Introduce a new template for documenting meeting minutes, which will clearly outline action items, responsibilities, and timeframes. This will facilitate tracking of progress and follow-up at subsequent meetings.
   - **Implementation Date:** October 2024
   - **Interim Measures:** Use the current template to capture critical action points and ensure follow-up in interim meetings.

Long-term Plans Requiring Investment

1. **Permanent Recruitment of the Director of Nursing (DON)**
   - **Investment Required:** Budget allocation for recruitment, onboarding, and potential training for the new appointee.
   - **Expected Completion:** The vacant post is currently advertised and interview dates agreed. It is expected that the post will be filled before year end 2024.
2. **Strengthening the Quality and Patient Safety (QPS) Committee**
   - **Action Plan:** A thorough review of the local QPS Committee's structure and communication pathways will be undertaken to ensure that roles and

responsibilities are clearly defined, and effective channels for feedback are established between Castlecomer and Carlow District Hospitals. Representation will include the IPC Clinical Nurse Specialist, Health and Safety Advisor, Re-enablement Occupational Therapist, Catering team and Dietitian.
    - **Scheduled Review:** Next QPS meeting scheduled for 21st November 2024
3. **Enhancement of Reporting Structures for the Drugs and Therapeutics Committee**
    - **Action Plan:** Establish a formal reporting pathway from the Drugs and Therapeutics Committee (D&T committee with rehab unit St Columba's, Thomastown) to the Regional Directors of Nursing Group or Older Persons SECH QSEC. This will ensure that decisions and risk management actions are communicated effectively at higher levels.
    - **Timeline:** Formalization to be completed by end of January2024
4. **Expansion and Structural Review of the Deteriorating Patient Committee**
    - **Action Plan:** The committee will expand its representation to include additional sites within the Carlow/Kilkenny area. A review of the committee's structure and terms of reference will be conducted to align with national standards for safer healthcare.
    - **Target Completion:** January2024
    - **Investment Required:** Resources to support the expansion and operational activities of the committee. ISBAR training onsite organised for November 2024 various dates.
    - **Transitions of Care**: Castlecomer District Hospital is part of the Transitional Care committee in conjunction with Carlow District Hospital, St Columba's Thomastown St Luke's Hospital Kilkenny, the focus of committee is to improve the quality and safety of patients/service user transitioning between community and acute services as per national standards. Next meeting scheduled 14th January 2024. Weekly MDT meetings with public health liaison nurse are maintained and minuted.
5. **Enhancing Infection Prevention and Control (IPC) Practices**
    - **Action Plan:** Coordinate three on-site IPC training sessions in collaboration with the IPC Clinical Nurse Specialist (CNS). Implement quarterly IPC audits as per the existing audit plan. Establish a dual-site IPC Committee for Castlecomer and Carlow District Hospitals to enhance representation and compliance monitoring.
    - **Target Date for Training Sessions:** Within 12 weeks; specific dates to be confirmed.
    - **Investment Required:** Allocation for protected time for IPC Link Nurses (4 hours weekly), training resources, and IPC CNS attendance at biannual committee meetings.
6. **Formalization of Communication Pathways Between CNM2, CNM1, and DON**

- **Action Plan:** Establish a structured communication framework to ensure consistent updates and feedback between CNM2, CNM1, and the new DON once appointed.
- **Timeline:** to be determined following appointment of new DON before year end 2024.

Compliance Monitoring and Evaluation

- **Progress Reporting:** Updates on the implementation of this compliance plan will be provided at QSEC meetings, detailing milestones achieved, outstanding actions, and any barriers encountered.
- **Reviews:** A comprehensive review of all action plans and compliance progress will be conducted to ensure alignment with national standards and identify any areas requiring additional investment.

Summary Timeline:

- **Immediate:** Prioritise immediate actions such as DON recruitment, review of governance structures, scheduling of CNM meetings, and IPC training.
- **3-6 Months:** Focus on structural improvements, such as expanding committee representation, establishing new reporting pathways, and completing long-term governance reviews.

Timescale: Completion March 2025

National Standard	Judgment
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant

Outline how you are going to improve compliance with this standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.

(b) where applicable, long-term plans requiring investment to come into compliance with the standard

Compliance Improvement Plan for Standard 2.7

Objective: Achieve full compliance with Standard 2.7 by addressing infrastructure challenges and optimizing the physical environment to support the delivery of high-quality, safe, and reliable care at the hospital.

(a) Interim Actions and Measures to Mitigate Risks:

1. **Risk Assessment of Multi-Occupancy Area**
    - **Action Taken:** Risk assessment for the multi-occupancy area in the female section completed and entered into the hospital risk register on October 17, 2024.
    - **Status:** Action completed.
2. **Environmental Walkabout for Dedicated Medication Storage Area**
    - **Action Taken:** An environmental walkabout was conducted on October 8, 2024, with representatives from the Infection Prevention and Control (IPC) team, Health and Safety team, Quality and Patient Safety (QPS) advisor, Catering Manager, Fire Officer, and Management. The goal was to identify a dedicated space for clean medication storage, currently housed in a dual-function room.
    - **Next Steps:** Awaiting input from Technical Services to finalize the dedicated space.
3. **Compliance of Hand Hygiene Sinks in Sluice Rooms**
    - **Action Taken:** The IPC team was notified of the non-compliance on October 8, 2024. Technical Services were informed on October 11, 2024, and installation of compliant sinks is scheduled for completion by January 2025.
    - **Interim Measure:** Staff are instructed to use alternative handwashing facilities while installation is pending.
4. **Review of Dining Facilities for Female Ward**
    - **Action Taken:** A review of the female dining room was conducted on October 3, 2024, with a plan to consolidate dining facilities to one dedicated dining room, improving the dining experience and fostering patient interaction.
    - **Next Steps:** Awaiting input from Technical Services on the reconfiguration. Dining room furniture to be ordered by November 2024
5. **Housekeeping Room Review for Handwashing and Waste Disposal Facilities**
    - **Action Taken:** Reviewed the housekeeping room on October 3, 2024, to assess the feasibility of installing handwashing and bucket sink facilities. Confirmed the feasibility during an environmental walkabout on October 8, 2024, with IPC and Health and Safety representatives.
    - **Next Steps:** Awaiting confirmation of funding for modifications from Technical Services.

6. **Transportation of Soiled Linen**
    - **Action Taken:** Staff training on appropriate linen trolley use was conducted on August 2, 2024. An IPC specialist nurse reviewed and approved the current process on October 8, 2024. Daily IPC education is provided during handovers.
    - **Status:** Action completed.
7. **Equipment Storage**
    - **Action Taken:** A review on October 3, 2024, identified potential solutions for equipment storage. However, the Fire Officer raised safety concerns on October 8, 2024, requiring further review with stakeholders. An off-site storage solution may be considered.
    - **Next Steps:** Conduct additional reviews to identify a compliant storage solution. Ongoing engagement with technical services to provide a solution.
8. **Storage of Hazardous Material and Waste**
    - **Action Taken:** Technical Services assessed the issue on October 10, 2024, and will collaborate with the Environmental Services Officer to determine whether bins can be relocated or if a fence can be erected to secure them.
    - **Target Completion:** February 2025.

(b) Long-term Plans Requiring Investment:

1. **Infrastructure Upgrades to Meet Modern Healthcare Standards**
    - **Investment Needs:** Investment is required to modernise the hospital's infrastructure, including the layout of multi-occupancy wards, storage solutions, and compliance of clinical facilities (e.g., sluice room sinks).
    - **Action Plan:** Submit a funding request for infrastructure upgrades, focusing on high-priority areas identified during environmental walkabouts and risk assessments. Submission to be escalated to OPS manager for funding
2. **Consolidation and Renovation of Dining Facilities**
    - **Investment Needs:** Resources are needed to reconfigure the existing dining area and purchase suitable furniture for a combined dining room to enhance patient experience.
    - **Action Plan:** Coordinate with Technical Services and Management to finalize plans and secure funding.
3. **Expansion of Equipment Storage Capacity**
    - **Investment Needs:** Funding is required to build or secure additional storage space either on-site or off-site to comply with fire safety regulations and clinical requirements.
    - **Action Plan:** Conduct feasibility studies and seek investment approval for construction or lease of additional storage.
4. **Enhanced Security Measures for Hazardous Waste Storage**
    - **Investment Needs:** Allocate funds to secure hazardous waste bins, potentially involving the installation of fences or other barriers.

- **Action Plan:** Finalize an action plan with Technical Services and the Environmental Services Officer.

Monitoring and Evaluation:

- **Environmental Walkabouts:** Scheduled biannually to assess progress on interim measures and identify any new risks.
- **Risk Register Meetings:** Ongoing monitoring and updating of the risk register quarterly to reflect the current status of non-compliance issues.
- **QPS and Health & Safety Meetings:** Biannually meetings to review progress on compliance actions, with updates provided to stakeholders.
- **Audits and Reviews (via ViClarity):** Conduct scheduled audits to evaluate compliance with the standard and effectiveness of risk mitigation measures.

Timescales:

- **3 Months:** Focus on immediate actions such as installation of compliant sinks, staff education, and securing hazardous waste bins.
- **6 Months:** Complete upgrades to the dining room, finalize plans for equipment storage, and initiate infrastructure investments.
- **Continuing and Ongoing:** Ongoing monitoring and infrastructure modernization, with evaluations conducted quarterly to ensure sustained compliance.

Timescale: Expected completion March 2025

National Standard	Judgment
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant

Outline how you are going to improve compliance with this standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.
(b) where applicable, long-term plans requiring investment to come into compliance with the standard

Compliance Improvement Plan for Standard 3.1

Objective: Achieve full compliance with Standard 3.1 by strengthening the hospital's systems for protecting service users from risks associated with healthcare design and delivery.

(a) Interim Actions and Measures to Mitigate Risks

1. **Outbreak Reporting and Learning**
    - **Action Taken:** Initiate an outbreak report template that follows national guidance to ensure documentation of learning and action steps for future outbreaks. A retrospective report for the January 2024 COVID-19 outbreak will be completed by end of October 2024.
    - **Status:** Outbreak reporting process implemented for all future incidents.
2. **Decanting Human Waste Procedure**
    - **Action Taken:** Staff education on appropriate procedures for handling human waste has been initiated. Additional training on using the washer disinfector without prior decanting will be provided to all staff by IPC link nurse. Action completed.
    - **Interim Measure:** Ongoing audits on waste handling procedures have commenced to ensure compliance.
3. **Legionella Risk Assessment**
    - **Action Taken:** Schedule a legionella risk assessment with a certified provider, to be completed by end of October 2024.
    - **Interim Measure:** Implemented an immediate routine flushing schedule for all taps and showers while awaiting the assessment by household staff.
4. **Updating Medication Lists (SALADs, A-PINCH, and High-Risk Medications)**
    - **Action Taken:** Reviewed with pharmacist in acute services most updated lists of sound-alike look-alike medications (SALADs), A-PINCH, and high-risk medications is 2019 version sam in place.
    - **Interim Measure:** Staff will be educated on identifying these medications and risk reduction strategies during the daily safety huddles and in-house education provided by nurse prescriber.
    - **Pharmacist from acute services to provide education to staff on monthly visits to be arranged.**
5. **Medication Fridge in St Barbara's Ward**
    - **Action Taken:** Fridge has been sourced and is operational as of 2nd August 2024.
    - **Action closed**
6. **Medication Stock Management**
    - **Action Taken:** overstock items removed and sent to acute service hospital by 1st September 2024
    - Stocktaking schedule where medication inventories are reviewed weekly by CNMs.
    - Partnership with local pharmacist if immediate medication required.
    - **Action completed**
7. **Policy Updates and Review**
    - **Action Taken:** Initiate a full policy review, prioritizing the medication safety policy, risk management policy, and policies on infection control.

- **Interim Measure:** Assign a designated policy lead to ensure all policies are reviewed and updated by end of January 2025.
- **Short-term Goal:** Remove outdated versions and provide staff with the latest guidelines by November 30th, 2024.

8. **Patient Feedback Action Plan**
   - **Action Taken:** Immediate collation of existing patient feedback from the 11 comment cards. Develop a time-bound action plan to address any recurring issues by end of November 2024. Audit nurse to undertake hospital audits and suggested actions commencing post in Castlecomer district Hospital in September 2024
   - **Interim Measure:** Introduce a Standardised patient satisfaction survey form with bimonthly reviews to track improvements.

(b) Long-term Plans Requiring Investment

1. **Document Management System**
   - **Investment Need:** Implementation of policies, procedures, and guidelines on G Drive system to ensure staff have access to up-to-date documents.
   - **Action Plan:** commence folder and place all PPGs on same
2. **Medication Management System**
   - **Investment Need:** Implement a medication management system with pharmacist from acute services for tracking inventory, high-risk medications, and ensuring adequate stock levels.
   - **Action Plan:** communication ongoing with pharmacist to ensure limited essential stock only in Castlecomer District Hospital.
3. **Enhanced Infection Prevention and Control Resources**
   - **Investment Need:** Additional IPC resources such as more advanced washer disinfectors and training programs to minimise infection risks.
   - **Action Plan:** Submit a proposal to upgrade IPC equipment and facilities, with a target completion date of September 2025.
4. **Infrastructure Upgrades for Waste Handling**
   - **Investment Need:** Improve facilities to ensure safe handling of human waste, such as installing advanced sluice hoppers and bedpan disposal units.
   - **Action Plan:** Meeting with head of Maintenance 10th October 2025 with a plan to manage waste in compliance with standard 3.1 ongoing meeting with maintenance service and environmental services officer scheduled for week 14th October 2024. Schedule infrastructure upgrades in stages, completion February 2025
5. **Patient Satisfaction and Feedback Systems**
   - **Investment Need:** Allocate resources for updated patient satisfaction booklet

- **Action Plan:** Implement a new system by July 2025 to integrate feedback into continuous improvement plans.

Monitoring and Evaluation:

- **Monthly Safety Huddles:** Regular safety discussions to address progress on infection prevention, medication safety, and policy updates.
- **Policy Review Timelines:** Track progress monthly to ensure all policies are current.
- **IPC Audits and Walkabouts:** Conducted biannually by IPC specialist, with reports submitted to the QPS Committee.
- **Patient Feedback Surveys:** Scheduled bimonthly analysis to monitor changes in patient satisfaction and identify areas for further improvement.

Timescales:

- **Immediate (0-3 months):** Focus on interim measures such as staff training, manual oversight, and short-term infrastructure solutions.
- **Medium-term (3-6 months):** Complete policy updates, implement automated inventory schedules, and secure funding for larger projects.
- **Long-term (6-12 months):** Execute comprehensive plans for electronic systems, major infrastructure changes, and enhanced infection control resource