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:	Ballina District Hospital
Address of healthcare service:	Mercy Rd Ballina Mayo Eircode: F26 PP92
Type of inspection:	Announced
Date(s) of inspection:	17-18 July 2024
Healthcare Service ID:	OSV-0005208
Fieldwork ID:	NS_0085

The following information describes the services the hospital provides.

About the healthcare service

1.0 Model of Hospital and Profile

Ballina District Hospital is a 48-bedded publicly funded HSE Rehabilitation and Community In-patient hospital. At the time of inspection, it was a member of, and was managed by HSE Community Healthcare West (CHW) which is also known as CHO2*.

Services provided by the hospital included:

- step-down care
- transitional care
- convalescence care
- respite care
- palliative care

The following information outlines some additional data on the hospital.

Model of Hospital	HSE Rehabilitation and Community In-patient Hospital (RCIH)
Number of beds	48 inpatient beds included 38 beds used for convalescence, rehabilitation or stepdown care, a further eight beds assigned for palliative care and the remaining two beds were assigned for respite care (one bed on each ward).

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 as part of the Health Information and Quality Authority's (HIQA's) role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors† reviewed information which included previous inspection

* *Community Health Organisation (CHO) no. 2 refers to the HSE area comprising Counties Galway, Roscommon and Mayo.*

† *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)*

findings, information submitted by the provider, unsolicited information and other publically available information.

During the inspection, inspectors:

- spoke with people who used the service on Female and Male wards 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 on Female Ward
- observed care being delivered on Female Ward, interactions with people who were receiving care 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. during the inspection

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with 11 national standards assessed during this inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors at a particular point in time - before, during and following the inspection.

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 hospital. 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 11 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
17 July 2024 18 July 2024	13.30 – 17.30hrs 09.00 – 16.30 hrs	Patricia Hughes	Lead
		Aedeen Burns	Support
		Robert McConkey	Support

Information about this inspection

An announced inspection of Ballina District Hospital was conducted on 17 and 18 July 2024.

Ballina District Hospital comprised 48 inpatient beds at the time of inspection. This was a reduction of 10 beds on the original 58 beds (available prior to the COVID-19 pandemic) to ensure adequate spacing for infection prevention and control. Eight of the current 48 beds were assigned for palliative care and two beds were assigned for respite care (one on each ward). Inspectors were told that due to the presence of the hospice at Castlebar, palliative care beds were also used for convalescence, rehabilitation or stepdown care when there was reduced demand for palliative care beds.

Inspectors were told that plans to build a 75-bed facility for a rehabilitation and community inpatient hospital on the existing site had been approved by the HSE in February 2024 and that plans were now to advance to design stage, once prioritisation has been given to the project by National Estates (due November 2024).

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 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 public acute 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

The inspection team visited two clinical areas:

Female ward (full inspection)

Male ward (partial walk through - visual assessment)

During this inspection, inspectors spoke with the following staff at the hospital:

- Representatives of the hospital's Executive Management Team
  - Manager for Older Persons' Services (CHW)
  - Director of Nursing
- GPs who were providing Medical Officer cover for the hospital
- Quality and Risk representative
- Human Resource representative
- A staff representative from each of the following areas as part of the inspection:
  - Infection prevention and control
  - The deteriorating patient
  - Transitions of care
- Pharmacist

Acknowledgements

HIQA would like to acknowledge the co-operation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank people using the service who spoke with inspectors about their experience of the service.

What people who use the service told inspectors and what inspectors observed in the clinical areas visited

Over the course of the inspection, inspectors observed staff to be actively engaging with patients in a respectful and kind way, taking time to speak with and listen to patients. This was validated by patients who described staff in the clinical areas visited and who told inspectors *'I was welcomed here', 'everyone introduces themselves by name'* and *'I feel very safe here'.* Patients' described their experience of care in this hospital and were very positive, '*delighted to be here*', '*very impressed*', '*spotless*', '*food lovely*'.

Inspectors also observed that the privacy and dignity of patients was promoted and protected by staff when providing care and that staff were focused on responding to

patients' needs promptly. For example, inspectors observed staff responding in a timely way to patient call bells and proactively assisting patients' care needs.

Patients recounted how their needs were met quickly during the day. They also remarked however, that staff at night are busy and they may have to wait a little longer, telling inspectors, *'night staff are very busy but even at night the care is great'*.

When asked if they knew how to make a complaint if they had the need to, patients told inspectors that they would '*speak to the person in charge'* , *'go online'* or '*speak to X'* (name of the director of nursing). Inspectors observed the presence of suggestion boxes available on the wards for patients. Information was seen on notice boards at the entrance to the hospital and on the ward, providing information to patients and their families on the following, how to make a complaint, concern or compliment known to the HSE service, '*Your Service Your Say',* access to the advocacy service *'SAGE',* and contact details for the HSE Confidential Recipient.

Overall, there was consistency with what inspectors observed in the clinical areas visited, and what patients told inspectors about their experiences of receiving care in those areas.

Capacity and Capability Dimension

Inspection findings from national standards 5.2, 5.5 and 5.8 from the theme of leadership, governance and management and national standard 6.1 from the theme of workforce are presented here as general governance arrangements for the hospital. Ballina District Hospital was found to be partially compliant with national standards (NS) 5.2, and substantially compliant with NS 5.5, 5.8 and 6.1.

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

Organisational charts setting out the hospital's reporting structures detailed the direct reporting arrangements for hospital management and the governance and oversight committees. The reporting and accountability relationship to Community Heathcare West (CHW) was clearly outlined on the organisational charts.

The Director of Nursing was responsible for the operational management of the hospital and reported to the Manager for Older Persons Services (OPS), who then reported to the General Manager. The General Manager reported to the Head of Services for Older Persons Services, who in turn, reported to the Chief Officer for

CHW. The Director of Nursing (DON) was responsible for the organisation and management of all staff at the hospital apart from the medical officers. The DON was supported by a recently appointed assistant director of nursing (ADON).

Inspectors were told that, in line with upcoming planned changes in the overall HSE structures whereby acute and community care were to be integrated under the management of six Regional Executive Officers (due to formally take accountability for services from 01 October 2024), that governance arrangements may change.

The Medical Officer role provided clinical oversight and leadership at Ballina District Hospital. One whole-time equivalent (WTE) medical officer role was filled by three local GPs and a locum doctor. The Medical Officer post holders reported operationally to the Manager for Older Persons Services. Out-of-hours medical services were provided by the doctor-on-call system, known as 'West-Doc'. Inspectors were told of upcoming changes in the arrangements for the medical officer post at the hospital which had yet to be resolved. This will be discussed further under NS 6.1.

Nursing staff on 'Female ward' reported to the Clinical Nurse Manager 2 (CNM2) who reported to the Assistant Director of Nursing (ADON), who in turn reported to the Director of Nursing.

Inspectors found that the hospital had, through Community Healthcare West, formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services with some exceptions. For example, there was no committee specifically dedicated to the oversight of medication safety within CHW. This is discussed further under medication safety as part of this standard.

Inspectors were told about other community-wide committees involved in the governance of Ballina District Hospital as follows:

OPS Managers and Directors of Nursing Governance Committee at CHW

According to its terms of reference, this committee was chaired by the Manager for Older Person Services (rotating between the two post-holders in this role). Membership included the Director of Nursing from each of the district hospitals and from each of the 16 community nursing units in the area (these units provide residential care). It was also attended by the General Manager for '*HIQA compliance section'* and by the Head of Service '*as required'*. It was scheduled to meet monthly.

The undated and unsigned terms of reference (TOR) for this committee set out the vision, purpose and accountability of the committee. The approval mechanism for the terms of reference was not set out. Improvements in sustainable governance and oversight of medication management especially across the acute, and

rehabilitation community inpatient hospitals including Ballina District Hospital require input and support from CHW level.

Inspectors reviewed minutes of the last three meetings and found that the committee had not been meeting in line with its terms of reference. There had only been three meetings held between September 2023 and April 2024. Those meetings were well attended with representation from Ballina District Hospital noted at two of the three meetings (by either the DON or ADON). Quality and risk, flu and COVID-19 vaccination and HIQA compliance were listed on the agendas. Medication management and handover were listed on one agenda. The minutes demonstrated that the meetings followed a structured format and were action orientated but these were not time bound. There was limited evidence of follow-through from actions from one meeting to the next. When asked, inspectors were told by staff that meetings were subject to availability of key staff but that if there was a pressing matter, then an online meeting would be scheduled. These deficits represent an area for improvement by the hospital. Inspectors were also told that with the upcoming changes to the HSE structures, these meeting structures may be revised.

Quality and Safety Committee (QSC), CHW level - Older Persons (incorporating Infection Prevention and Control (IPC) as advised by the DoN in pre-onsite documentation):

The Quality and Safety Committee was chaired by the Head of Service. The terms of reference, version 2, dated March 2022, remained marked as draft. It was documented that they had been approved by the Head of Services-OPS for CHW and were to be reviewed annually. There was no further review date documented. Inspectors noted that this committee had met three times in four months rather than at the stated frequency of four-weekly.

Membership was multidisciplinary and included roles such as Older Persons managers, DON representatives, Home Support Manager, Health and Social Care Professional (HSCP), and the Quality, Safety and Risk advisor. Representatives from the following were listed as members on a *'where required'* basis; infection prevention and control (IPC), antimicrobial resistance (AMR), health and safety officer, medical advisor, nursing and midwifery planning development unit (NMPDU) and policies, procedures and guidelines (PPGs) representatives.

Of note, the terms of reference specified both a representative DON from the district hospitals (rehabilitation and community inpatient hospitals) and a representative DON from the 16 CNUs. Inspectors were told however, that a DON from one of the CNUs was the current representative for both the 16 CNUs and four district hospitals (rehabilitation and community inpatient hospitals). Therefore there was no representative from the four rehabilitation and community inpatient hospitals on this committee. This represents an area for improvement given the differences in

focus of services provided by a social care setting versus that by a healthcare facility.

Inspectors were told and the TOR for the QSC stated that, the Health and Safety Committee (of which the DON at Belmullet Community Hospital was a member at the time of inspection) and the IPC committee for Older Persons Services both reported into the Quality and Patient Safety Committee. While the TOR for the QSC set out a list of committee reports to be in place for the meeting, none specifically referred to either of the four areas of known harm which are central to the monitoring against the National Standards for Safer Better Healthcare. These are infection prevention and control, medication safety, the deteriorating patient and transitions of care.

Inspectors reviewed the agenda and minutes of the last three meetings of the QSC held in March, May and June 24. Review of the listed agenda items included '*previous minutes and actions arising'*, '*Quality and Safety'*, and '*infection control and antimicrobial resistance'*. The attendance reflected the presence of a DON representative from the CNUs but none from the district hospitals. This was not in line with the terms of reference as explained above. Although various CNUs were referenced in the minutes, there was no specific reference to Ballina District Hospital or the district hospitals in CHW. The minutes otherwise, showed that the meetings followed a structured format and were action orientated although not time bound. Progress in implementing actions was monitored from meeting to meeting.

On speaking with staff from CHW and management from Ballina District Hospital about these committees, inspectors were told that communication between both parties was regular although often informal and often via telephone calls or online meetings. It is important that discussion and decisions relating to matters of importance to the hospital are formally and regularly recorded. This represents an area for improvement by the hospital and CHW.

Infection Prevention and Control

Inspectors viewed the undated and unsigned draft terms of reference (TOR) for the Community Healthcare West (CHW) Infection Prevention and Control (IPC) and Antimicrobial Stewardship (AMS) Committee. It was stated in the TOR that the CHW IPC and AMS Committee was an advisory body and that governance in relation to IPC and AMS was via the Chief Officer of CHW and the Senior Management Team through the Quality and Patient Safety Committee as described above. The purpose of the CHW IPC and AMS committee was to support the Chief Officer and the Senior Management Team in ensuring the development of infection prevention and control and antimicrobial stewardship services and structures in the community and to prioritise the use of these resources in line with national strategic objectives for IPC and AMS.

The IPC committee was chaired by the Head of Quality, Safety & Service Improvement (QSSI) and membership included the consultant microbiologist (co-chair), antimicrobial pharmacist, ADON for infection prevention and control, epidemiologist and representatives from primary care, public health, disability services, older persons' services, medical - GP, and the quality and risk manager. The Committee met quarterly and reported to the Chief Officer of CHW. It had a standing agenda which included updates from each service area, updates on the annual IPC and AMS plan and report, updates from subgroups, review of key performance indicators, outbreaks, incidents and complaints, and updates on new policies, guidance or regulations.

Agendas and minutes of the three meetings held in September and December 2023 and in March 2024 were reviewed. Meetings were well attended and minutes reflected the terms of reference although it was unclear whether there was representation or updates from Ballina District Hospital. Inspectors were told on inspection and they reviewed documentation that explained that IPC matters were included in the terms of reference of the Quality and Safety Committee as described above. Review of the minutes of three meetings included a report on IPC matters and a report from the antimicrobial pharmacist on each demonstrating progression of actions. Inspectors were told by various staff that there is a direct interface between the hospital staff and the IPC team.

Medication Safety

Inspectors were told and reviewed documentation that explained that there was no structure in place within CHW where concerns around medication safety could be escalated and regularly reviewed at a regional level. This deficit had previously been identified during a HIQA inspection of Ballina District Hospital in 2020. Inspectors were told that a CHW-wide audit had been commenced across the four district hospitals (rehabilitation and community inpatient hospitals) and the 16 community nursing units (CNUs) over the last year and that the findings were to be used to guide recommendations for the future. HIQA communicated the concern in a '*high risk letter'* to the Chief Officer of CHW the day after the inspection and subsequently received assurances that a process whereby medication safety issues could be progressed on an ongoing basis at CHW level would be in place by the end of September 2024.

The Deteriorating Patient

Inspectors were told that all patients admitted to Ballina District Hospital were '*medically discharged from the acute services but have other social or care needs prior to going home*'. This included rehabilitation. Inspectors were told that patients have a baseline set of vital observations taken on admission and care thereafter is

tailored to the patient's status. The hospital had a full-time medical officer role in place whereby patients were medically assessed on admission and thereafter based on clinical judgment of patient status. Out-of-hours services were provided by West-Doc (doctor-on-call service) and staff could also act on their clinical judgment and arrange the transfer of a patient via ambulance to the neighbouring acute general hospital where necessary.

Transitions of Care

Inspectors were told and they reviewed documentation where CHW had recently established (within the last year) an Integrated Discharge Management Team of which the DON of Ballina District Hospital was a member. Draft terms of reference for the '*Integrated Discharge Management Protocol for delayed discharges of care across CHW and the associated acute hospitals'* were viewed by inspectors. The team reported to the General Manager and Head of Service for older persons services through the team lead.

Serious Incident Management Team (SIMT)

Terms of reference for the Serious Incident Management Team for CHW Older Persons Services, dated July 2024 and which were yet to be approved, were provided as part of the documentation requested by inspectors.

The stated aim of the committee was to provide an appropriate structure to oversee the management of Category 1 incidents and Serious Reportable Events within CHW Older Persons Services and report accordingly to CHW Older Persons Services Quality and Safety Committee.

Membership was multidisciplinary and included the Head of Service (Senior Accountable Officer or their nominee) as the Chairperson, the General Manager for Older Persons Services, Quality and Patient Safety Advisor, Residential Services Manager representatives, administration support, service representative where the incident occurred, for example, director of nursing and others '*invited as required by the Senior Accountable Officer (SAO)*' such as the Home Support Manager or the Human Resources Manager. The documented frequency of meetings was '*on a weekly basis through teleconference facilities / face to face as required, or more frequently if required by the Senior Accountable Officer.*' Inspectors were told and received documentation stating that there were no serious incidents from Ballina District Hospital currently open to SIMT.

During the inspection, inspectors found that there was good leadership among management and staff who were all focussed on ensuring and assuring high quality healthcare for the patients however the structures and processes linking the hospital and community services require attention (including for the areas as described

above) to ensure appropriate support and oversight and this necessitates the support of the wider community care organisation.

In summary, inspectors found that although there were some formalised corporate and clinical governance arrangements in place at CHW level for Ballina District Hospital, there were several opportunities for improvement. Specifically, there was an absence of a specific forum to escalate, manage and monitor issues relating to medication safety. This had previously been identified in a HIQA inspection in 2020. A high risk letter was issued to the Chief Officer on this matter after this inspection. The Chief Officer responded with an assurance that this deficit would be addressed by the end of September 2024. Not all committees were meeting in line with their terms of reference and there were deficits noted in some of the documentation relating to committee work as described above. It was unclear to inspectors that the Quality and Safety Committee had oversight of the relevant issues that impacted or had the potential to impact on the provision of high-quality, safe healthcare services at Ballina District Hospital. There was no evidence of representation or input from either the hospital itself or from the other rehabilitation and community inpatient hospitals in CHW on the Quality and Safety Committee. These matters require the input of CHW in conjunction with management of Ballina District Hospital given its size and scope to affect such changes on its own.

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.

At the time of inspection, there were defined management arrangements in place on 'Female ward' to support and promote the delivery of safe, high quality healthcare and inspectors found that these arrangements were functioning well. Management and staff at the hospital were proactive and responsive and there was evidence of good operational grip on oversight of activity and quality of service.

The hospital had management arrangements in place in relation to the four areas of known harm in the clinical areas inspected and for the wider hospital as discussed in more detail below.

Infection, prevention and control

The hospital had a link infection prevention and control nurse which was a role that was incorporated into the CNM2 role for Female ward. Staff also reported good access to a community (CHW) based IPC team comprising two IPC clinical nurse

specialists (CNS), an epidemiologist, an antimicrobial pharmacist and a consultant microbiologist. Inspectors were told that there was effective telephone support from the IPC team including during the out-of-hours period, and from public health, as required during infection outbreaks and with information updates and requests.

The community-based IPC team held online meetings bi-monthly, chaired by one of the CNSs. Inspectors were told that antimicrobial surveillance returns were made to this committee for one day in each month. These in turn were reviewed at IPC and CHW levels. Learning was shared by the link nurse during handover and or at staff meetings.

Inspectors noted that IPC policies, procedures and guidelines (PPGs) were available in hard copy at ward level and also on the desktop of hospital computers for staff to access. Inspectors were told and saw documentation relating to a recent HSE quality initiative in which the hospital participated, called *'Skip the Dip'*. The evidence-based initiative discourages the use of urine dipstick for diagnosing urinary tract infections in people aged over 65. This is part of a broader strategy to combat antimicrobial resistance by promoting responsible antibiotic use and improving IPC practices. When urinalysis was used selectively in line with evidence at Ballina District Hospital, inspectors were told of a measurable reduction found in the use of antimicrobials with no reduction in the quality of outcome for patients.

Medication safety

The hospital had a clinical pharmacy service,[††] which was provided by the 0.5 whole-time equivalent (WTE) hospital pharmacist. A pilot medicines reconciliation process was in place at the hospital since January 2024. It was undertaken by the pharmacist on all patients on admission, Monday to Friday apart from periods of leave of the pharmacist. Notice of changes to medication were entered into a communication book for the information of the visiting medical officer. The pharmacist also retained a record of such changes. Although inspectors saw evidence of this practice, inspectors noticed that it was not always evident on the prescription chart that medicine reconciliation had taken place where there was no changes required. Inspectors were told of staff concerns relating to risks to medication safety arising from discrepancies on discharge prescription forms from the acute hospital. The risks were mitigated by staff in Ballina District Hospital although inspectors were told that review of the original chart was very time consuming and this level of effort was not sustainable into the future within the 0.5 WTE pharmacy resource. HIQA followed up on the risk issue with the acute general hospital and were provided with assurances that incidents reported were reviewed and reported to NIMS and local remedial action taken where appropriate. Inspectors

[††] Clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.

also viewed a business case submitted by Ballina District Hospital to CHW management seeking to implement a sustainable medicines reconciliation system.

Deteriorating patient

While there was no specific committee at hospital or CHW level with oversight of the early recognition of the deteriorating patient, inspectors were told and saw evidence of the following in place to support the early detection, escalation and management of a deteriorating patient;

- full set of clinical notes were transferred from the local acute hospital with the patient, ensuring comprehensive history for reference
- admission by medical officer (Monday to Friday)
- baseline observations established on admission through the nursing process of assessment and care planning using a standard vital observations record
- daily observation of patients against baseline assessment for changes
- changes noted and appropriate nursing interventions implemented, for example, undertake vital signs, reposition, escalation to Medical Officers as appropriate
- review by Medical Officers or West-Doc as appropriate
- access to X-ray facilities on-site, Monday to Friday - if required
- an ambulance base on-site enabling patient transfer to Mayo University Hospital as appropriate
- notification process to the National Incident Management system (NIMS) in the event of patient safety incidents
- if a patient became acutely unwell, inspectors were told of the local practice of nurses to call 999 and arrange an ambulance transfer to the local acute hospital where required.

Inspectors noted that records are maintained and reviewed on transfers out.

Transitions of care

Transitions of care incorporates internal transfers (clinical handover), shift and interdepartmental handover, external transfer of patients and patient discharge. All admissions and discharges occurred in a planned manner. The Community Healthcare West (CHW) Integrated Discharge Management (IDM) Team, of which the Director of Nursing (DON) at Ballina was a member, reported to the Head of Service for OPS and the General Manager in the office of the Chief Officer, through the IDM Team Lead. The purpose of this team was to facilitate the integrated discharge planning processes both between the acute and community services and within the community services. The DON at Ballina District Hospital liaised with the local acute hospital, Mayo University Hospital, on a daily basis regarding patient flow and delayed transfers of care (DTOC's). Matters that arose were escalated to the Lead for Integrated Discharge

Management (IDM). The following structures and processes were also in place to enhance communication and patient flow:

- Mayo Egress Group met weekly to discuss patients who had a delayed transfer of care (DTOC) and complex cases to maintain flow of patients. Egress beds were described as HSE funded-beds in private nursing homes.
- The DON from Ballina District Hospital attended integrated discharge management (IDM) rounds at Mayo University Hospital weekly to discuss referrals and prioritise patient flow.
- A verbal clinical handover from nurse to nurse was received for each patient. An agreed pro-forma was used to ensure that all relevant information was elicited.
- Full nursing and clinical notes accompanied the Mayo University Hospital patients on transfer and these were tracked out on the medical records system to ensure that a comprehensive record of care was available for reference on-site at BDH.
- At ward level, the CNM2 was responsible for oversight of the co-ordination of admission, transfer and discharge by staff nurses and reported to the ADON.

Inspectors were told that it was often the case on admission to BDH, that a final destination regarding home had yet to be determined in conjunction with the patient. For example, this may be dependent upon progress with mobility and inspectors were told that multi-disciplinary (including nursing, medical social work and physiotherapy staff) meetings may be held with families when planning discharge home.

In summary, HIQA was satisfied that the hospital had defined management arrangements in place locally to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the four areas of known harm both in the clinical area visited on the day of inspection and in the wider hospital. However, there are areas for improvement in terms of improved documentation particularly in relation to recording in the patients prescription chart when medicine reconciliation has been undertaken irrespective of whether changes were recommended.

Judgment: Substantially 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.

There were monitoring arrangements in place at Ballina District Hospital and CHW to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services. Minutes of meetings at CHW level were reviewed and these reflected a range of clinical and quality data sources.

Monitoring service's performance

The hospital and CHW collected data on a range of different clinical measurements related to the quality and safety of healthcare services, for example, trending on numbers of admissions and discharges, length of stay, numbers of transfers to acute hospitals, patient-safety incidents, infection prevention and control data, workforce and risks that had the potential to impact on the quality and safety of services. Collated performance data was reviewed at meetings of the relevant committees as outlined under NS 5.2 and at the performance meetings between the hospital and CHW.

Risk management

The hospital, through CHW, had risk management structures and processes in place to proactively identify, manage and minimise risks in clinical areas. The hospital's corporate risk register relating to the four key areas of known harm viewed by inspectors, was maintained by the nurse lead for 'quality and patient safety matters' in conjunction with the DON and included details on the risk, date of entry, the owner, controls and risk rating. Inspectors were told that the risk register was reviewed weekly and matters of concern were escalated by the DON to the Manager for Older Persons Services for QSC at CHW level. Inspectors heard how learning was shared among the district hospitals and community nursing units in the region with specific examples of actions implemented where required. The risk register viewed by inspectors did not include review dates. Inspectors found that knowledge of staff in relation to the presence and use of risk registers more generally, could be improved.

Audit activity

The hospital had a programme of audit for infection prevention and control. This included audits around hand hygiene, sharps disposal, waste management, and inspection of clinical rooms and sluice rooms. The programme set out the aims and objectives, the standards being measured against, the methods to be used and actions to be undertaken in the event of a non or partial compliance. The frequency

of the audits was listed as six times per year. Where compliance was not met, a time bound action plan was in place with assigned responsible persons per action.

Environmental audits were viewed by inspectors for both Male and Female ward. Some non-conformances were dealt with at the time of the audit. Others were detailed in a time bound action plan with assigned responsible persons. Examples of these included the replacement of sink surrounds, broken tiles, new floor covering and re-upholstering of chairs. These were marked as complete at a later date.

Inspectors viewed a comprehensive medication audit conducted over a period from September 2023 through to January 2024. For items that remained open, inspectors noted that where there was a requirement to discuss and consider either the developments in medication safety, or medication safety issues which arose outside of the hospital but which had an impact on the service provided by the hospital, there was an absence of an effective pathway to progress such matters. This was raised with the Chief Officer the day after the inspection and assurances were provided that this would be addressed by the end of September 2024.

Management of patient-safety incidents

Patient-safety incidents and serious reportable events related to the clinical areas visited were reported to the National Incident Management System (NIMS), in line with the HSE's Incident Management Framework. These were reported by staff using a paper-based reporting system to the Director of Nursing and Assistant Director of Nursing before being reviewed by the DON and uploaded to the NIMS system. Inspectors viewed the trending of NIMS reports provided by the hospital for 2023. *'Slips, trips and falls'*, `*violence, harassment, aggression'* and *'medication issues'* were the three most commonly reported incidents in both 2023 and January to June 2024.

The hospital's DON tracked and trended patient-safety incidents and submitted patient-safety incident summary reports to the Quality and Safety Committee. Incidents were rated by severity, category and location. Patient-safety incidents were also discussed at performance meetings with the Director of Nursing Governance Committee at CHW level. Feedback on patient-safety incidents was provided to clinical nurse managers by the Assistant Director of Nursing and the Director of Nursing.

Management of serious reportable events

The hospital's Group Serious Incident Management Team (SIMT) had oversight of the management of serious reportable events and serious incidents which occurred in the hospital and were responsible for ensuring that all patient-safety incidents were managed in line with the HSE's Incident Management Framework. Inspectors

were told and viewed documentation that stated that the hospital had no incidents referred to SIMT at the time of inspection.

Feedback from people using the service

Inspectors found that there was a process in place to collect patient feedback on the service and care received. This was overseen by the Director of Nursing. Inspectors were told that the last survey on patient satisfaction was conducted in 2022 but there was a lower than planned response rate (they were seeking eight responses per month). This represents an area for attention and improvement.

In summary, the hospital were monitoring performance and there was evidence that information from this process was being used to improve the quality and safety of healthcare services. Quality improvement initiatives were implemented in response to audit findings, patient safety incidents and feedback from people using the service although mechanisms to seek feedback from patients remains an area for improvement.

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.

An effectively managed healthcare service ensures that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care and that there are necessary management controls, processes and functions in place.

The hospital had an approved complement of one wholetime (WTE) medical officer. The post was filled by three local GPs and one locum medical officer. Out-of-hours cover was provided by the local doctor-on-call system, West-Doc. Inspectors were told that the continued configuration of the medical officer post as filled at the time of inspection was uncertain due to changes in personnel. Inspectors heard that this has been raised with management for older persons' services and at the time of inspection, there was no update on a resolution. In the meantime, the post holders populated a roster and the DON sought to cover gaps through the use of agency or locum doctors. In addition, inspectors found that medication safety was promoted by the activity and daily presence of the 0.5 WTE pharmacist (Monday to Friday). This was especially important in the absence of a hospital or community-based medication safety or Drugs and Therapeutics forum however, there was no cover for the pharmacist when on leave. There is a need for Ballina District Hospital and CHW

to review the provision and sustainability of the current arrangements for both the medical officer and the pharmacist.

The hospital's HR administration officer was operationally accountable and reported to the Director of Nursing. Inspectors were told and noted that the hospital had workforce management arrangements in place to support day-to-day operations in relation to infection prevention and control, medication safety, the deteriorating patient and transitions of care.

The hospital's total approved complement of staff at the time of inspection was 81.48 WTE. 68.93 WTE of these posts were filled which equated to 83 people leaving a variance of 12.55 WTE vacancies (15.36% vacancy rate overall).

These vacancies included 3.71 WTE nurses (10% vacancy rate), 7.25 WTE healthcare assistants (HCA) and multi-task attendants (MTA) (23.2% vacancy rate), 1.2 WTE health and social care professionals (21.8% vacancy rate which included an occupational therapist post), 0.36 WTE medical officer (36% vacancy rate).

Inspectors were told that maintenance support was provided centrally from CHW.

Absence levels were monitored on an ongoing basis and the absence rate from January to June 2024 was 7.64%. This was an improvement on the absence rate for the same period in 2023 when it was 8.43% however it remains above the HSE target of 4%.

Inspectors were told of staffing arrangements at ward level 24/7/365 and alignment was noted on viewing a sample of current rosters. Inspectors were told of the use of agency to cover some leave among the HCA and MTA staff group and that a community-based panel for replacement HCA and MTA posts had now been established. Approval to fill new or replacement (vacant) posts was sought by the Director of Nursing through the HSE Pay and Management Control Group (PMCG) at CHW level which was being chaired by the Chief Officer. Hospital management told inspectors that efforts to recruit staff had been subject to the HSE recruitment embargo up to the time of inspection. Inspectors were told that recruitment was centralised at CHW level but that the DON reviewed personnel files to ensure that all necessary checks had been conducted, for example Garda clearance.

Counselling services were available to staff to access directly through the HSE Employee Assistance Programme (EAP). CHW provided a region-wide occupational health service accessible directly and or via manager referral.

Staff Meetings

Inspectors were told of two-monthly scheduled meetings between the DON, ADON and CNM staff however, there were no terms of reference or records available for those meetings. This represents an area for focus for the hospital management.

Ward staff meetings

Inspectors were told that there had been no ward staff meeting held to date in 2024 but that information is regularly shared informally and at handover given the small size of the hospital. This represents an area for improvement by the hospital if actions are to be followed through and monitored.

Staff training and education

Nursing and healthcare assistant staff attendance at mandatory and essential training was monitored at clinical area level by clinical nurse managers. The hospital had mandatory training programmes for infection prevention and control, basic life support and medication safety. Nursing and support staff who spoke with inspectors confirmed to HIQA that they had received induction training and had completed training on a variety of topics on the HSE's online learning and training portal (HSELand). Training for infection prevention and control included mandatory training on hand hygiene and standard and transmission based precautions. This is discussed further under NS 3.1.

In summary, HIQA was broadly assured that the hospital had defined management arrangements in place locally to plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare in the clinical area visited on the day of inspection and in the wider hospital. However, there is room for improvement in the following areas: planning and provision of medical officer cover and pharmacy cover, the management of attendance levels and in the formalisation of communication and meetings with staff.

Judgment: Substantially compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. Ballina District Hospital was found to be partially compliant with NS 3.1, substantially compliant with NS 1.6, 2.7 and 3.3 and compliant with NS 1.7, 1.8 and 2.8.

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

Staff promoted a person-centred approach to care and were observed by inspectors to be respectful, kind and caring towards patients. For example, curtains were drawn by staff when attending to patients' needs. A nurse was heard explaining medical terms as part of a conversation encouraging a patient to engage in the rehabilitation process. The patient thanked the nurse for doing so.

Inspectors noted the promotion of independence by patients through the use of HSE posters and patient information leaflets on '*Know, Check, Ask*' being used to empower patients to inform themselves about their medication. Posters were also observed in the ward areas to inform patients on how they could reduce the risk of falls with guidance called *STEPs (Shoes, Time, Exercise, Eye, Protection)*. Bed spacing, clear corridors and access to toilets were also noted to enable patients to mobilise independently where possible.

Inspectors observed that the physical environment in the clinical areas visited promoted the privacy, dignity and confidentiality of patients receiving care, for example, the use of privacy curtains, single rooms based on clinical need, the en-suite facility (the Millennium Suite) on Female ward and the Sunflower room (being refurbished for palliative care services, at the time of inspection) on Male ward.

Patient's personal information in the clinical areas inspected, was observed to be protected and stored appropriately. Names of patients were however, observed to be in place over beds and inspectors were told that this was only done with the consent of patients.

Patients who spoke with inspectors were very complimentary of the staff, the service and the facility, as described at the beginning of this report.

Inspectors observed several references to '*residents*' on notice boards and when asked about this, staff told inspectors that sometimes when work is undertaken

across social care and the district hospitals, the term '*resident*' is used collectively even though patients in the district hospitals are not resident there.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital. The reference to '*residents*' in a rehabilitation and community inpatient hospital represents an area of focus for hospital management and CHW.

Judgment: Substantially Compliant

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

Inspectors observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences. Two health care assistants were observed tending kindly and appropriately to a patient who appeared anxious. This was validated by patients who spoke with inspectors as described earlier in this report.

Inspectors heard from medical officers who described the social needs of some patients using the services and how they thrive in this environment after a short stay following an acute episode of ill health requiring an initial admission to an acute hospital.

Inspectors heard from patients who described their satisfaction with the range and quality of food provided. A two-week menu of meals was noted on display in the ward area.

Overall, HIQA were satisfied that hospital management and staff promoted a person-centred approach to care and a culture of kindness, consideration and respect for people accessing and receiving care at the hospital.

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 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. The DON reported on complaints to the Manager for Older Person Services and via the QSC to the SIMT for the more serious complaints. Inspectors were told that the hospital did not have its own local complaints policy but followed the '*Your Service, Your Say*' flow chart in the management of complaints. Inspectors found that there was a culture of complaints resolution in the clinical areas visited. Staff spoke about seeking to resolve the more minor of complaints at source. Inspectors noted the presence of feedback forms and collection boxes, posters on how to make a complaint containing contact details for the HSE's 'Your Service Your Say', and information on what advocacy services provide and how to contact them - all on display in a public area of the hospital. Inspectors were told that although the use of advocates was employed where possible, there was a waiting period of several months in some cases. Where required, the hospital Medical Social Worker and or Assistant Director of Nursing assisted patients who wished to make a complaint.

The hospital had a complaints management system and used the HSE's complaints management policy 'Your Service Your Say.'[‡‡] The DON formally tracked and reported on the number and type of formal written complaints, received annually. The hospital reported close out of 50% of complaints in 2023 within the target timeline of 30 days which was below the HSE target of resolving 75% of complaints within 30 days. It reported close out of 75% of complaints within 30 days during the first six months of 2024 which met the HSE target. These rates related to low numbers of complaints overall. Inspectors were told that the more complex complaints were managed through the appropriate channels where required. The hospital trended the nature of the complaints and provided evidence of implementation of quality improvement plans arising from these. They included the provision of training to all staff on maintaining dignity and respect in all interactions, regular communication training for all staff and introduction of a system to log both complaints and compliments at the point of contact.

[‡‡] 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.

Collated data and information on the hospital's compliance with national guidance and standards on complaint management was submitted to CHW Quality and Safety Committee. When patients were asked by inspectors if knew how to make a complaint if needed, not all patients were aware of how they could do this but they said that they would ask a staff member for information on this. Inspectors were told that general feedback on complaints was provided to all staff in the clinical area where a complaint originated. Sharing the learning across a wider base can be more effective in the reduction of events leading to complaints.

Overall, HIQA were satisfied that the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service.

Judgment: Compliant

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.

Inspectors inspected 'Female ward' which was a 21-bedded ward comprising one two-bedded room with en-suite facilities, four four-bedded rooms with en-suite facilities and three single rooms including the Millennium suite. One single room on each ward had en-suite facilities. None of the single rooms had ante-rooms. At the time of inspection, 16 beds were occupied on Female ward.

Inspectors were told that there were no neutral or negative pressure rooms in the hospital.

Inspectors observed that overall the physical environment was free from clutter, clean and well maintained, with a few exceptions. There was evidence of minor general wear and tear observed, with a few areas of paint work and wood finishes chipped. Inspectors also undertook a partial walk-through of 'Male ward' and noted the refurbishment in progress of the single en-suite room - the Sunflower room which was planned for use by patients receiving palliative care.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage displayed throughout the clinical areas. Inspectors noted that the majority of hand hygiene sinks throughout the unit conformed to national requirements.[§§] Physical distancing of one metre was

[§§] 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

observed to be maintained between beds in multi-occupancy rooms. There were no patients requiring isolation facilities on Female ward on the day of the inspection.

Environmental cleaning was carried out by an external cleaning contract company whose contracted hours were nine hours per day. Out-of-hours cleaning was performed by the HCA. Terminal cleaning was being carried out by designated cleaning staff. The ward inspected had a dedicated cleaner. The cleaning supervisor and clinical nurse manager had oversight of the quality of cleanliness and of the cleaning schedules on the ward, and inspectors were told that they were satisfied with the level of cleaning staff in place to keep the clinical areas clean and safe. Inspectors were told that this was supported by a monthly walk-around by either the DON or Clinical Nurse Manager Grade 2 (CNM2) and the cleaning supervisor.

Cleaning of equipment was assigned to the HCAs. In the clinical areas visited, the equipment was observed to be clean and there was a system in place to identity equipment that had been cleaned using green tags which were dated and initialled. Hazardous material and waste was safely and securely stored in each clinical area visited. Appropriate segregation of clean and used linen was observed. Used linen was stored appropriately.

The hospital had implemented processes to ensure appropriate placement of patients for example, the infection prevention and control status was identified on the hospital's electronic operating system for patients transferring from the acute hospital and the IPC status for patients being admitted from the community was provided by the GP. The single room with en-suite facilities was prioritised for use by patients requiring either isolation or end-of-life care. The CNM2 reported that if an isolation room was not available, then patients in need of isolation were managed in line with the hospital's isolation prioritisation policy.

Inspectors were told that where patients had known or suspected cognitive issues which may increase their risk of wandering, an alarm bracelet system was in place for use with the consent of the patient and or their family to alert staff if a patient went beyond the defined ward area. Inspectors noted the system in place.

In summary, HIQA was assured that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care, especially vulnerable patients while acknowledging the limited isolation facilities.

Judgment: Substantially compliant

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

HIQA was satisfied that the hospital had systems and processes in place to monitor, analyse, evaluate, and respond to information from multiple sources to inform continuous improvement of services. There was evidence that performance metrics and quality improvements were reviewed at local governance forums and at CHW level.

Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-associated infection. The Infection Prevention and Control Committee were actively monitoring and evaluating infection prevention practices in clinical areas. The committee had oversight of findings from environmental, equipment and hand hygiene audits, and audits of compliance with infection prevention guidelines and protocols. Sharps disposal, waste management, clinical room, and sluice room audits were conducted six times per year with time-bound action plans developed and a responsible person identified. Recommendations plus re-audit were put in place in line with the hospital's requirement to do so where compliance fell below 80%. Inspectors noted time-bound action plans were developed to address areas requiring improvement. Issues identified in environmental audits which were not within the scope of staff locally to resolve had been escalated to the DON and 'Estates' department.

The hospital submitted a healthcare-associated infection surveillance report to the Infection Prevention and Control Committee every month. These reports were shared within CHW and staff in clinical areas.

In line with CHW's reporting requirements, the hospital reported on incidents of:

- clostridioides difficile
- carbapenemase-producing enterobacterales (CPE)
- outbreaks.

There was evidence of monitoring and evaluation of antimicrobial stewardship practices. These included participating in the national antimicrobial point prevalence study conducted in 2021 and reporting on compliance with antimicrobial stewardship key performance indicators every month. Inspectors reviewed CHW quarterly reports received from the hospital for quarters one, two and four for the '*Monthly Monitoring of a Healthcare Associated Infection - Antimicrobial Resistance (HCAI/AMR) and Antimicrobial Consumption minimum dataset*'. These are not currently available on the HSE website. Inspectors were told that the quarter three report was not available. The remaining three reports for 2023 showed one case of clostridium difficile per 10,000 bed days used and no cases of CPE in 2023. These were within national key performance indicators. There were three documented infection

outbreaks, two of which related to COVID-19. Inspectors heard how the hospital had participated in the HSE's "*Skip the Dip*" initiative which had resulted in reduced use of urine dipsticks in patients over 65 years of age, decreasing antibiotic usage from 9% to 3% in catheterised patients with no adverse impact on outcome of care.

There was evidence that initiatives were introduced to improve medication safety practices at the hospital, for example, inspectors were told of a CHW wide audit which had commenced across the 16 CNUs and four district hospitals in September 2023. It had identified 36 items for action across topics including the policy, the ordering process, drug Kardex, fridge, transitions of care (admission and discharge). At the time of inspection, nine items were marked as complete, seven as partially complete, two not actioned and the remainder remained as actionable items to be undertaken. Those that remained to be closed out required external input from CHW. The hospital pharmacist had commenced a pilot programme to undertake medicine reconciliation on all patients in January 2024 which was ongoing at the time of inspection. Incidents and near misses were reported via the National Incident Management System (NIMS). This work also revealed concerns regarding how risks could be further mitigated and managed and the hospital had been in contact with CHW to seek the establishment of a joint interface or forum to progress such issues. Inspectors followed up with both the CHW Chief Officer and with the general manager of the neighbouring acute hospital on these matters after the inspection and received assurances from the Chief Officer that this would be in place by end of September 2024. The QPS registered nurse (RN) also conducted monthly medication management audits on a minimum of 20% of patients. Actions were allocated to responsible persons, including the DON. Recommendations included double-checking high-risk medications (APINCH[***] and immunosuppressant's). Ward practice was found to match policy on medication safety.

Clinical handover occurred at shift handover (twice a day). Daily huddles involving representation from nursing, physiotherapy, medical social work, management, and discharge planning teams were also held to review patient status and discharge planning. Audits were conducted by the Quality and Patient Safety (QPS) RN, with feedback provided to the Clinical Nurse Manager (CNM) at handover. The QPS RN was actively involved in monitoring the ward every morning, speaking with patients, and attending all family meetings. Individualised care plans were developed with patients and carers. Evidence of good practice was demonstrated through audits of care plans conducted in January 2024 (71-100%), March 2024 (97-100%), and May 2024 (85-100%). Action plans and escalation of issues were evident after the January audit, with further evidence of re-audit. A falls audit conducted in 2022

[***] APINCH is an acronym for a list of high risk medications; anti-infective agents, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anitocaogulants.

resulted in a quality improvement plan (QIP) with actions leading to a reduction in falls.

Overall, HIQA was satisfied that the hospital were systematically monitoring and evaluating healthcare services provided at the hospital.

Judgment: 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 and processes in place to identify, evaluate and manage immediate and potential risks to people attending the hospital. Risks were managed where appropriate at department level with oversight of the process by the clinical nurse manager and assistant director of nursing. There was a central risk register for the hospital which was reviewed weekly by the QPS RN and DON. Inspectors found that awareness of the use of the risk register among staff more generally could be improved. Risks not manageable at hospital level were escalated to CHW via the QSC and the 'DON and OPS managers' governance meetings'.

Patients admitted to the hospital from an acute hospital were either isolated or co-horted for five days and were screened for methicillin-resistant staphylococcus aureus (MRSA) and where there was history of multidrug-resistant organisms (MDRO), screening was continued in line with national guidance. CPE screening was carried out in line with national guidance. The infection status of each patient was recorded on the hospital's electronic operating system. A prioritisation system was used to allocate patients to the single rooms. Staff confirmed that terminal cleaning[†††] was carried out following suspected or confirmed infectious cases. Infection prevention and control audit summary reports submitted to HIQA showed the cumulative results for audits for the period January-June 2024. Compliance with the sharps audit overall was 90.5%, which was up by 1.5% from 2023, compliance with correct waste management was over 90%. Results for compliance with clinical room environmental audits was 78.5%, down from 81.5% in 2023 and the sluice room environmental audit was 78.15%, down from 82% in 2023.

The hand hygiene audit results from Male ward did not meet the KPI of 90% or more on three out of six of the monthly audits conducted between January to June

[†††] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

2024. Compliance with the KPI of 90% was met on four out of six of the monthly audits on Female ward conducted during the same time period.

Inspectors noted evidence of follow-up by the CNM on required actions in respect of audits. Results were reported to the Director of Nursing and shared with clinical staff. HIQA noted that failure to achieve the required compliance triggered a re-audit and time-bound action plans to support the implementation of corrective actions to address findings were developed.

Inspectors noted that in the absence of a regular forum in which to escalate, manage and monitor medication safety events, the oversight by the pharmacist and director of nursing were key to daily detection and prevention of medication safety incidents however the amount of effort required to maintain such vigilance was not sustainable. Inspectors noted that the Hospital had escalated such matters to CHW and that this was also a finding by HIQA in 2020. Inspectors followed up with the Chief Officer of CHW on this matter after the inspection and received assurances that a process would be in place by end of September 2024 through which the wider medication safety issues across CHW could be addressed and progressed to resolution.

The hospital used a standard vital observation chart to monitor patients' conditions together with ongoing clinical judgment by clinical staff including medical officer review to detect and act upon deterioration of a patient. During the out-of-hours periods, the local doctor-on-call system (West-Doc) provided medical services and in the event of an sudden or acute deterioration in patient status, nursing staff could arrange the transfer of a patient to the acute hospital using the ambulance service. The Director of Nursing reviewed the data on the frequency and nature of transfers back to the acute hospital.

Clinical handover was held twice a day at shift handover and a daily multidisciplinary safety huddle was held in the hospital to discuss the status and discharge plans of all patients. Agreed pro-forma templates were in use between the acute and the rehabilitation and community inpatient hospital in advance of a transfer to ensure a comprehensive handover of care when accepting a patient from the acute hospital. The acute hospital provided the patients chart to accompany them on admission to Ballina District Hospital. A verbal handover (nurse to nurse) was also in place on the day of the transfer.

Inspectors viewed a list of applicable policies, procedures, protocols and guidelines (PPPGs) for staff to read, with good compliance noted. Some PPPGs however, were outdated, and the service did not have a policy to monitor PPPGs due for revision. This was discussed with the DON. Staff had access to the PPPGs on the desktop PC, however there was no version control recorded on them. Inspectors were told that

work was in progress at CHW level to create a region-wide database to centralise PPPGs.

Examination by inspectors of the overall uptake of mandatory training by hospital staff in hand hygiene in the last two years showed that compliance with attendance was below the HSE target of 90%. This requires attention by the hospital particularly in light of the level of non-compliance noted at hand hygiene audits.

- 88% for nursing staff
- 79% for healthcare assistants
- 75% for health and social care professionals.

Staff uptake of mandatory training in standard (SBP) and transmission (TBP) based precautions and donning and doffing personal protective equipment in the last two years was better:

- 94% for nursing staff (in SBP and TBP), 91% for donning and doffing
- 89% (SBP) and 79% (TBP) for healthcare assistants, 79% for donning and doffing
- 75% health and social care professionals (SBP only)

The uptake of mandatory training in medication safety in the last two years was 100 % for nursing staff and for basic life support it was also 100% of nursing staff.

In summary, HIQA was not fully satisfied that the hospital were protecting service users from the risk of harm associated with the potential risk of infection. Staff attendance at and uptake of mandatory and essential training especially in the area of hand hygiene is an area that could be significantly improved especially as the monthly hand hygiene audits also require significant improvement. It is essential that hospital management ensure that all clinical staff undertake mandatory and essential training appropriate to their scope of practice and at the required frequency, in line with national standards.

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 who spoke with HIQA were knowledgeable about how to report a patient-safety incident and were aware of the most common patient-safety incidents reported. The hospital tracked and trended patient-safety incidents and an incident summary report was submitted to the QSC each month.

The Pharmacist reviewed medication incidents and the Director of Nursing reviewed all of the incidents. They were then uploaded to the NIMS by administrative staff. Seventy per cent of incidents were being reported to NIMS within 30 days of date of the event as is required.

The hospital reported a total of 103 incidents to NIMS with 'slips, trips and falls', 'violence, harassment and aggression' and 'medication errors' being the three most commonly reported incidents in 2023. Over 70% of reported incidents did not result in injury which indicates a positive reporting culture. The hospital reported a total of 56 incidents to NIMS with 'slips, trips and falls', 'medication errors' and 'violence, harassment and aggression' being the three most commonly reported incidents in the first half of 2024.

Feedback to staff in clinical areas was provided informally by clinical nurse managers, the pharmacists and the infection prevention and control link nurse. Inspectors observed shared learning notices displayed in the clinical area noticeboards.

Overall, HIQA was satisfied that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents, in particular, in relation to the four key areas of harm and to ensure that learning was shared among staff.

Judgment: Substantially Complaint

Conclusion

HIQA carried out an announced inspection of Ballina District Hospital to assess compliance with national standards from the *National Standards for Safer Better Health*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care.

Capacity and Capability

Inspectors found that the hospital was partially compliant with NS 5.2 and substantially compliant with NS 5.5, 5.8 and 6.1**.**

Inspectors found that although there were some formalised corporate and clinical governance arrangements in place at CHW level for Ballina District Hospital, there were several opportunities for improvement. Specifically, there was an absence of a specific forum to escalate, manage and monitor issues relating to medication safety. This had previously been identified in a HIQA inspection in 2020. A high risk letter was issued to the Chief Officer on this matter after inspection. The Chief Officer responded with an assurance that this deficit would be addressed by the end of September 2024.

It was also unclear to inspectors that the Quality and Safety Committee had oversight of the relevant issues that impacted or had the potential to impact on the provision of high-quality, safe healthcare services at Ballina District Hospital. There was no evidence of representation or input from either the hospital itself or from the other rehabilitation and community inpatient hospitals from the Quality and Safety Committee minutes reviewed by HIQA. These matters require the input of CHW in conjunction with management of Ballina District Hospital given its size and scope to affect such changes on its own.

The hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality and safety of all services. The hospital was monitoring performance and there was evidence that information from this process was being used to improve the quality and safety of healthcare services. Quality improvement initiatives were implemented in response to audit findings and patient safety risks although inspectors found that mechanisms to seek feedback from patients could be improved.

HIQA was broadly assured that the hospital had defined management arrangements in place locally to plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare in the clinical area visited on the day of inspection and in the wider hospital. However, there is room for improvement in the planning and provision of medical officer cover and pharmacy

cover which both require the input and support of CHW. The formalisation of communication and meetings with staff is also an area for focus on improvement.

Quality and Safety

Inspectors found that the hospital was partially compliant with NS 3.1, substantially compliant with NS 1.6, 2.7 and 3.3 and compliant with NS 1.7, 1.8, 2.8.

Inspectors heard from medical officers who described the social needs of some patients using the services and how they thrive in this environment after a short stay following an acute episode of ill health requiring an initial admission to an acute hospital. Inspectors also observed staff actively listening and effectively communicating with patients in an open and sensitive manner, in line with their expressed needs and preferences. Inspectors heard from patients who said, *'I was welcomed here', 'everyone introduces themselves by name'* and *'I feel very safe here'.* Patients also described their satisfaction with the range and quality of food provided. A two-week menu of meals was noted on display in the ward areas.

Inspectors noted that while hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital, there were several references to '*residents*' both when referring to patients and as observed in documentation and posters on display. This represents an area of focus for hospital management and CHW.

While the hospital was limited by the number of single rooms with en-suite facilities available for isolation and other clinical needs, the physical environment was found to be clean and uncluttered throughout. HIQA, however, was not fully satisfied that the hospital were protecting service users from the risk of harm associated with the potential risk of infection. Inspectors found that staff attendance at and uptake of mandatory and essential training specifically in the area of hand hygiene was an area that could be significantly improved especially as the monthly hand hygiene audits also required significant improvement.

Following this inspection, Ballina District hospital submitted their compliance plan and have provided updates on the findings outlined in this report. The hospital management has also indicated what further steps are being taken to bring the hospital into compliance with the standards where they were found to be partially or non-compliant. HIQA will, through the compliance plan (see Appendix 2), continue to monitor the progress in relation to these outstanding actions and standards.

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	
Overall Governance	
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.	**Substantially 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**
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**

Capacity and Capability Dimension	
Judgments relating to wider hospital and clinical areas findings only	
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.	**Substantially Compliant**
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	**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.	**Substantially Compliant**

Appendix 2

Service Provider's Response

Compliance Plan for Ballina District Hospital

OSV-0005208

Inspection ID: NS_0085

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 national standard. This should clearly outline:

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

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

1. **Medication Safety:**

   A Drugs and Therapeutics committee met for the first time on November 2024 to look at the terms of reference and membership of the group. The next meeting is the 23rd January 2025. It is envisaged that this group along with the Quality and safety group will monitor the progress of the CHW medication management audit. The Chairperson of the current Saolta group has been approached to ask for CHW representation on this existing Drugs and therapeutic committee.

   Medication safety concerns from Ballina District were raised as an agenda item at the CHW Quality and Safety meeting on the 18th December 2024. An action from this meeting is to circulate a learning notice to complement the learning notice issued from Mayo University Hospital. This will be circulated by 30th January 2025.

   We are currently exploring the suggestion of funding a Pharmacist in Mayo University Hospital, part of their role will be ring fenced to ensure that any

potential transfers to CHW District Hospitals/CNUS will be seen by this Pharmacist. Funding for this post will be made available by decommissioning posts within CHW to ensure that we do not breach the Pay and Numbers strategy. Initial discussions will be completed by 30th January 2025

We are planning on engaging an external company to update the medication policy suite. This update would incorporate observations and recommendations from the recent audit to ensure comprehensive policy enhancement.

2. Governance and Oversight

OPS Managers and Directors of Nursing Governance Committee at CHW:

- Following correspondence with the Chair of this committee, it has been agreed that the Terms of Reference (TOR) will be reviewed and amended to include a formal approval mechanism.
- The meeting schedule will be revised to align with the TOR, ensuring meetings occur as prescribed.
- Action points within meeting minutes will now include time-bound targets to ensure accountability and follow-through.

Quality and Safety Committee:

- Following correspondence with the Chair, it has been agreed that the TOR will be reviewed, amended, and formally approved.
- The frequency of meetings will be revisited, and a definitive schedule will be implemented to ensure consistency.
- Membership representation has been addressed. Since September 2024, the Director of Nursing (DON) from Ballina District Hospital (BDH) has been sitting on this committee.
- It has been requested that dedicated updates under the heading "District Hospital Updates" will form part of the monthly Quality and Patient Safety Report, covering:
  - Infection Prevention and Control (IPC)
  - Medication Safety
  - The Deteriorating Patient
  - Transitions of Care

Infection Prevention and Control Committee:

- The TOR were agreed on the 15th of November 2021 and have not been updated since. A commitment has been secured to review and sign off the TOR for this committee once the changes in the RHA structures have been confirmed. HIQA viewed the draft of the new TOR's during the inspection. The 2021 TOR's stand at present.
- Since the HIQA visit, the DON from BDH now represents Older Persons Services (OPS) on this committee, ensuring direct input and oversight.

Serious Incident Management Team (SIMT):

- It has been agreed that the TOR will be finalised and signed off by Q1 2025, providing a more robust framework for managing Category 1 incidents and Serious Reportable Events (SREs).

The revised TOR for the OPS Managers and Directors of Nursing Governance Committee, Quality and Safety Committee, IPC Committee, and SIMT will define clearer governance structures and align their functioning with national standards. Continued investment in training and administrative support will be crucial to sustain these improvements.

Ensuring consistent representation of district hospitals, including BDH, on key committees will require ongoing investment in staff resources and operational support.

The actions outlined are designed to address the deficiencies identified by HIQA during their inspection, strengthen governance and oversight structures, and ensure compliance with national standards. These steps, including enhanced representation, formalising processes, and ensuring consistent committee activity, demonstrate a commitment to improving the quality and safety of care at Ballina District Hospital and across Mayo IHA (was Community Healthcare West at time of inspection). By capitalising on these opportunities for improvement, along with appropriate resource allocation and monitoring, a more robust and sustainable compliance framework will be achieved. It is acknowledged that changes are expected as we transition to IHA, Mayo fully. Governance arrangements and committees may be realigned but core purpose will remain the same.

Timescale:

- **Q1 2025:**
  - Finalisation and approval of the revised TOR for governance committees.
- **Ongoing through 2025:**
  - Continuous monitoring of medication safety improvements.
  - Regular reviews and updates to the TOR for key committees.

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 national standard. This should clearly outline:

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

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

1. **Hand Hygiene Audit Results – Male Ward:**
   The hand hygiene audit results for the male ward have improved since the HIQA inspection to 100%, as the installation of new clinical hand wash basins, which was underway during the inspection, has now been completed. This upgrade addresses the suboptimal facilities that contributed to the previous poor audit results. Compliance with hand hygiene audits is expected to continue improving as a result of this enhancement.
2. **Mandatory Training for Hand Hygiene:**
   Mandatory training attendance for hand hygiene has shown marked improvement, now standing at 100% for clinical staff. Efforts are ongoing to achieve and maintain the HSE target of 90%. Additionally, an Infection Prevention and Control (IPC) Link Practitioner has completed specialised training and will now provide ongoing education and support to clinical staff to ensure compliance with Key Performance Indicators (KPIs).
3. **Medication Safety:**
   A Drugs and Therapeutics committee met for the first time on November 2024 to look at the terms of reference and membership of the group. The next meeting is the 23rd January 2025. It is envisaged that this group along with the Quality and safety group will monitor the progress of the CHW medication management audit. The Chairperson of the current Saolta group has been approached to ask for CHW representation on this existing Drugs and therapeutic committee.

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   We are planning on engaging an external company to update the medication policy suite. This update would incorporate observations and recommendations from the recent audit to ensure comprehensive policy enhancement.

4. **Policies, Procedures, Protocols, and Guidelines (PPPGs):**
   A meeting has been scheduled to review the Older Persons Services (OPS) approach to PPPGs and to develop a strategy for Q1 2025. Key considerations include the implementation of a region-wide database for PPPGs and the

introduction of version control to ensure staff access the most up-to-date guidance.

b) Long-Term Plans Requiring Investment to Achieve Compliance

1. **Infection Prevention and Control:**
    - The cumulative IPC audit results for January–June 2024 show areas of improvement but also highlight gaps, such as the compliance rates for clinical room and sluice room environmental audits. Action plans are being implemented to address these findings. As part of the action plan, an application for IPC Minor capital funding has been made to address the deficits in the clinical room and sluice rooms.
    - A structured programme of IPC audits, coupled with ongoing staff training, will be a focus of investment in 2025 to drive compliance rates above 90% across all areas.
2. **Mandatory Training Compliance:**
    - Hospital management is committed to improving mandatory training compliance across all staff categories, particularly in hand hygiene and standard and transmission-based precautions (SBP and TBP). Hand hygiene training compliance is at 100% in December of 2024.
    - A dedicated schedule of training sessions, facilitated by the recently trained IPC Link Practitioner, bringing the number of Link Practitioners on site to three, has been implemented to facilitate uptake, and progress will be monitored monthly.
3. **Governance of PPPGs:**
    - Investment in a CHW-wide PPPG approach will ensure consistent access to current policies and guidelines. The introduction of version control as part of this initiative will eliminate ambiguity and enhance compliance.
4. **Medication Safety Governance:**
    - To address sustainability concerns, a CHW-wide process for managing medication safety issues is being established.

Summary

The actions outlined aim to address the findings identified during the HIQA inspection. Key improvements include enhanced hand hygiene facilities, strengthened governance processes for PPPGs, and a clear strategy to improve compliance with mandatory training. These measures, coupled with ongoing investment and a structured approach to governance, will ensure that the hospital continues to align with national standards and prioritise the safety of service users.

Timescale:

- **Q1 2025:**
    - Finalisation of the CHW-wide PPPG strategy, including version control.
    - Comprehensive review and alignment of IPC audit processes.

- Establishment of the CHW-wide medication safety governance framework.
- Continued improvements in hand hygiene compliance through enhanced training and support by the IPC Link Practitioner.