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:	National Rehabilitation Hospital
Centre ID:	OSV-0001475
Address of healthcare service:	Rochestown Avenue Dún Laoghaire Co. Dublin A96 E2H2
Type of Inspection:	Unannounced
Date of Inspection:	4 and 5 March 2025
Inspection ID:	NS_0133

About the healthcare service

Model of hospital and profile

The National Rehabilitation Hospital (NRH) is a publicly funded Voluntary Hospital. The hospital is a specialist hospital and is the national tertiary centre for complex rehabilitation. It is managed on behalf of the Health Service Executive (HSE) by the Regional Health Area HSE Dublin and South-East* through a service level agreement. The hospital provides specialist rehabilitation services to adult and paediatric patients (aged 18 months to 17 years) who, as a result of an accident, illness or injury, acquired a physical or cognitive disability and require specialist medical rehabilitation. Care is delivered by medical consultant-led interdisciplinary teams.

Rehabilitation programmes at the NRH are tailored to meet the individual needs of adult and paediatric patients in the following areas of specialty:

- Acquired Brain Injury (including traumatic, non-traumatic brain injury and other neurological conditions)
- Stroke Speciality Programme
- Spinal Cord System of Care (including traumatic and non-traumatic spinal cord injury)
- Prosthetic, Orthotic and Limb Absence Rehabilitation (POLAR)
- Paediatric Family-Centred Rehabilitation

The following information outlines some additional data on the hospital.

Number of beds	120 inpatient beds 9 day case beds

* The Regional Health Area HSE Dublin and South East HSE Dublin and South-East provides health and social care services to South-East Dublin, Carlow, Kilkenny, South Tipperary, Waterford, Wexford and most areas of Wicklow.

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 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 findings (where available), information submitted by the provider, unsolicited information and other publicly available information since last inspection.

During the inspection, inspectors:

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

About the inspection report

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

[†]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.

Capability and *Quality and Safety*. Findings are based on information provided to inspectors 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 national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1 of this report.

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
04/03/2025	*08:40 – 17:00*	Danielle Bracken	Bairbre Moynihan Elaine Egan Laura Byrne
05/03/2025	*08:40 – 13:00*	Danielle Bracken	Bairbre Moynihan Elaine Egan

Information about this inspection

This inspection focused on 11 national standards from five of the eight themes[‡] of the *National Standards for Safer Better Healthcare*. The inspection focused in particular, on four key areas of known harm, these being:

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

The inspection team visited two clinical areas:

- Daisy unit (paediatric)
- Willow unit (brain injury and stroke speciality programmes)

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

- representatives of the hospital's executive management team
  - clinical director
  - director of operations, deputy chief executive officer (CEO)
  - director of nursing (DON)
  - quality and risk manager
- a non-consultant hospital doctor (NCHD)
- human resource manager
- a representative from the following committees
  - hygiene, infection prevention and control
  - drugs and therapeutics
  - deteriorating patient
  - scheduled care governance

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank people using the healthcare service who spoke with inspectors about their experience of receiving care and treatment in the service.

[‡] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.
[§] Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration.
[**] 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.

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

Inspectors met and spoke with a number of patients and parents (of paediatric patients) about their experiences of being a patient in the National Rehabilitation Hospital. Inspectors were guided on a tour of Daisy unit, a paediatric unit with eight single en-suite rooms. Inspectors observed that facilities in this unit for patients included, for example, a music therapy room, a multisensory room and a sensory bathroom. Children's art was displayed on walls throughout the unit. Toys were available in the waiting area and a 'den' located in the unit had a number of games and activities available, suitable for a range of ages, such as video-games. Outdoors, a courtyard with seating and a playground were available for use by patients and their families and carers. A parent's room was located in the unit and this had tea and coffee making facilities. A school, resourced with two teachers was located within the unit.

Patients and their families were positive about their experience of care in Daisy unit with one saying that they "couldn't fault it". Inspectors were told that therapies scheduled on a timetable "happened as planned". A patient spoke about attending sports activities and school. Staff were described as being "in good form".

Willow unit, which served the brain injury and stroke speciality programmes had 20 single en-suite rooms. Patients here had access to a garden space with raised flower beds. Patients described the facilities and therapies as "brilliant", and the staff as "kind". In relation to their experience of care, patients described this as "every angle is covered".

Inspectors observed additional facilities available in the main building and Cedars building for use by patients. These included a coffee shop, a day room with access to activities, television and a library, an internal courtyard garden with plenty of seating, and an external horticulture garden where gardening activities took place.

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes the standard related to workforce.

Two national standards (5.5, 5.8) assessed on the inspection were found to be compliant with two national standards (5.2, 6.1) substantially compliant. Key inspection

findings informing judgments on compliance with these four national standards are described in the following sections.

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

Hospital management described the corporate and clinical governance arrangements in place at the National Rehabilitation Hospital (NRH). These were consistent with what inspectors found, however, some organisational charts and terms of reference required updating to reflect new governance structures.

The hospital, which was previously governed by a board of management was now governed by a board of directors. Inspectors were told by hospital management that this arrangement had changed in September 2024 when the hospital moved from an NRH Trust to an NRH Company Limited by Guarantee (CLG). The chief executive officer (CEO) had overall accountability and responsibility for the delivery of safe and reliable services within the hospital, reported to the board of directors, which met monthly. This reporting relationship was outlined on an organisational chart provided to inspectors.

Previously, the CEO had also reported to the CEO of Ireland East Hospital Group (IEHG), however this reporting arrangement had changed since quarter four 2024, in line with the new HSE regional health structures. The CEO now reported to the integrated healthcare area (IHA) manager for the HSE Dublin and South-East health region, who in turn reported upwards to the regional executive officer (REO). This reporting relationship was not depicted on the organisational chart.

The executive management committee was the main governance structure with overall management responsibility for the hospital. Members of the executive management committee, chaired by the CEO, met monthly and included the clinical director and the director of nursing (DON). The terms of reference, dated June 2022 had not yet been updated to reflect moving from a board of management structure to a board of directors. The committee had a structured agenda, and this included staffing and patient safety. Attendance at meetings was tracked. Actions from the meeting were not assigned or time bound.

Governance committees tasked with overseeing the quality and safety of services provided in the hospital included the quality, safety and risk committee and its subcommittees. These subcommittees included the drugs and therapeutics steering group and the deteriorating patient committee. In response to findings from the previous inspection in September 2023, all subgroups of the deteriorating patient committee, such as the cardiopulmonary resuscitation (CPR) subgroup, were now represented on an organisational committee chart provided to inspectors. The hygiene

infection prevention and control committee continued to report directly to the executive management committee. Terms of reference for this committee which were in draft format at the time of the last inspection in September 2023, were now formally signed-off. All of the above-mentioned committees had oversight in relation to the areas within their remit, were meeting in line with their terms of reference and were action-orientated.

The scheduled care committee, reported to the operations management committee. The operations management committee, in turn, reported upwards to the executive management committee. There was evidence in minutes of both the scheduled care and operations management committee that complex discharge planning and delayed transfers of care were discussed. The scheduled care committee was not represented on committee organisational charts.

Clinical governance at the hospital was overseen by the clinical director who was a member of the executive committee and also reported directly to the board of directors at each board meeting. Five specialist rehabilitation programmes operated under the clinical governance structure of the hospital. Each programme, had a medical director and a programme manager operational lead. The medical directors reported to and were accountable to the hospital's clinical director. The rehabilitation programmes include brain injury, stroke speciality, spinal cord system of care (SCSC), Prosthetic, Orthotic and Limb Absence Rehabilitation (POLAR) and Paediatric Family-Centred Rehabilitation.

In summary, formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare were in place at the hospital with the following identified:

- organisational charts did not outline the upwards reporting relationship to the HSE Dublin and South-East health region
- the scheduled care committee was not represented on committee organisational charts.

Judgment: Substantially Compliant

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

Management arrangements in relation to the four areas of focus of this inspection (infection prevention and control, medication safety, acutely deteriorating patients and safe transitions of care) were in place in the hospital to support the delivery of high-quality, safe and reliable healthcare services.

The infection prevention and control (IPC) team remained unchanged since the previous inspection, this comprised a 0.38 WTE consultant microbiologist and 2.0 WTE clinical nurse managers (CNMs), one at grade 2 and one at grade 3. Protected time for antimicrobial stewardship pharmacist duties was one hour per week. An overarching infection prevention and control programme, overseen by the IPC team was implemented at the hospital and this will be discussed further under national standard 5.8. Staff who met with inspectors told them that they had access to the IPC team on a daily basis. Laboratory services were provided to the hospital by St Vincent's University Hospital (SVUH).

A clinical pharmacy service overseen by the chief pharmacist was provided to all clinical areas in the hospital. The pharmacy team included a chief pharmacist, 8.5 WTE pharmacists, 3.0 WTE pharmacy technicians and 1.0 WTE pharmacy assistant. A pharmacist visited the units inspected on at least a weekly basis providing clinical pharmacy services and this included medication reconciliation.[‡‡]

A deteriorating patient improvement programme was implemented in the hospital and was overseen by the resuscitation officer and a consultant lead.

Daily meetings took place to assess patient flow requirements throughout the hospital, including the daily operational safety huddle (DOSH) and these are discussed in more detail in national standard 3.1.

The Daisy unit, which took patients up to and including 17 years of age had 1.0 WTE paediatric consultant in place. This was filled by two paediatric consultants, one consultant also worked at Children's Health Ireland (CHI) at Crumlin with the other also working in CHI at Temple Street.

A consultant was on call 24/7. On-call arrangements for the medical team onsite included one doctor Monday to Friday. At weekends and bank holidays, there were two doctors on duty with a second doctor working 8.30am to 4.30pm.

Judgment: Compliant

[‡‡] Medication reconciliation is the process of comparing a patient's medication prescriptions to all of the medications that the patient has been taking. This process aims to avoid medication errors and can be carried out by pharmacists, doctors and nurses.

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.

Systematic monitoring arrangements for identifying and acting on opportunities to improve the quality, safety and reliability of healthcare services were in place at the hospital. Performance data was discussed monthly at meetings between senior hospital management and the relevant integrated healthcare area team from the HSE Dublin and South-East health region.

Quality, safety and risk was discussed as a standing agenda item at the executive management committee. The corporate risk register was discussed at the quality, safety and risk committee. Following inspection, senior management confirmed that the risk register was also discussed at the executive management committee. Inspectors were told by management that risk registers were held at programme manager level, for each rehabilitation programme, with relevant risks escalated to the corporate risk register. Inspectors were told that the hospital's top five risks were escalated at meetings with HSE Dublin and South-East. Risk was a standing agenda item at this meeting and minutes reviewed documented that a quality and patient safety (QPS) report was discussed at meetings.

The serious incident management team (SIMT) had oversight of serious reportable events (SREs), category 1 incidents, and other incidents of note that fall outside of SREs or category 1 incidents. A previous inspection had found that the SIMT was not meeting on a scheduled basis. On this inspection, it was found that SIMT was meeting every six weeks in line with terms of reference which had been updated in 2024.

Feedback from people using the service was gathered in a number of ways and this included monthly patient forums and a consumer satisfaction survey sent out to patients following discharge that allowed for anonymous feedback. The most recent satisfaction survey report covered January to September 2024. Service user experience was discussed as a standing item at the executive management committee and on a scheduled basis at quality, safety and risk committee meetings.

An infection prevention and control (IPC) plan for 2025 was provided to inspectors. An annual report for 2024 had been produced which outlined IPC activity carried out that year. The hygiene and infection prevention and control committee had oversight over performance in relation to IPC activity including audit activity.

An antimicrobial stewardship (AMS) plan and a report of AMS activity was produced each year. The AMS team provided an update on performance at meetings of the drugs and therapeutics steering group where AMS was a standing agenda item. Performance

with AMS was not a standing agenda item at hygiene and infection prevention and control committee meetings, although there was evidence of discussion of AMS activity.

Inspectors were told by the chief pharmacist that the medication safety strategy was currently under review. It was identified at a previous inspection that the medication safety strategy 2022-2024 did not have an associated action plan to support implementation. This had been remedied with a quality improvement plan with short, medium and long-term goals. The plan was last updated in January 2025 and this was provided to inspectors.

All unplanned transfers out of the hospital were discussed at medical peer review meetings which was a subcommittee of and reported to the quality, safety and risk committee. An aggregate review of unplanned transfers was conducted each year and this is discussed further in national standard 2.8.

Judgment: Compliant

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

Arrangements were in place in the hospital to plan, organise and manage the workforce, however these were not fully effective. The number of vacant positions across some disciplines had reduced when compared to the previous inspection of the service. Notwithstanding this, challenges due to vacant positions at the time of this inspection remained. These vacant positions related mainly to health and social care professionals and were having an impact on therapy provision to patients.

Vacant pharmacy posts, evident on a previous inspection of the service in September 2023 had been filled and pharmacy team were fully staffed on this inspection.

Health and social care professional staffing levels across the hospital had improved in some areas on this inspection compared to the last inspection. Previously there had been a deficit across the hospital of 12 WTE physiotherapy posts. At the time of this inspection, this deficit had reduced to 5.5 WTE vacant posts. Vacant occupational therapy posts had reduced from 3.0 WTE to 2.0 WTE, with a 0.5 WTE vacant occupational therapist position in Daisy unit. Daisy unit had a deficit of a 0.5 WTE medical social worker position. Speech and language therapist deficits included 1.5 WTE in Willow unit. Inspectors were told that the impact of these vacant positions included reduced therapy provision. Reduced access to therapy was an issue raised at a patient forum meeting in February 2025 and this is discussed further in national standard 1.8.

Staff shortages, in particular, of health and social care professionals was recorded as a moderate risk on the corporate risk register. Controls to minimise this risk included staff redeployment and rolling recruitment across disciplines. Inspectors who attended the daily operational safety huddle (DOSH) on the second day of inspection noted a discussion on redeployment on that day. Inspectors were informed by the director of human resources that a staffing retention and recruitment group was established in the hospital to support ongoing recruitment campaigns. Senior management at the hospital had escalated staffing resourcing challenges to HSE management and management at the HSE Dublin and South-East health region.

Nursing workforce vacant posts included 0.5 WTE CNM 1 for Willow unit. Vacant healthcare assistant positions existed in both units, with 1.0 WTE vacant post in Daisy Unit and 2.5 WTE vacant posts in Willow. These vacant posts were filled by agency cover and or overtime. At the time of inspection, both units were fully staffed for nursing and healthcare assistants.

The medical workforce was fully staffed in both units. On-call arrangements for the medical team are outlined in national standard 5.5. The hospital were reliant on one on-call doctor present on site Monday to Friday outside of normal working hours, with access by telephone to the consultant on call. This was discussed by inspectors with the clinical director who provided assurances around measures to minimise this risk. This included the provision of guidelines to NCHDs on how to carry out unit rounds at night and a scheduled call each night between the NCHD the clinical house manager and the consultant on call. Sufficient NCHD staffing to support 24/7 medical cover was a high-rated risk on the corporate risk register. Existing controls included monitoring and review of rostering arrangements by the clinical director and human resources department.

The quality, safety and risk committee had oversight of mandatory training compliance which was a standing agenda item. Training lists were available for each discipline of staff, which outlined what training was considered mandatory for that staff member. A sample of a training list for a staff nurse was provided to inspectors and this aligned with training records provided to inspectors. Training dashboard summary reports were distributed at this meeting. A summary report for February 2025 was provided to inspectors, which showed gaps in training rates across a number of disciplines. Overall training rates were as follows: INEWs (67.06%), sepsis (53.92%), hand hygiene (76.79%), and standard precautions training (65.89%). This was also a finding in the clinical areas visited where full compliance with the above training had not been achieved. The exception to this was hand hygiene training for Daisy unit, where 100% compliance was achieved.

Daisy unit, had one paediatric-trained nurse. The lack of paediatric-trained nurses was recorded on the paediatric rehabilitation programme's risk register. An existing control

measure to reduce this risk was an advanced nurse practitioner (ANP) in paediatric rehabilitation for the unit. The director of nursing informed inspectors that interviews for paediatric-trained nurses had recently taken place with plans for recruitment progressing. To mitigate this risk nursing staff in Daisy unit had personal development plans and these included goals such as attending paediatric-specific training.

In summary, overall hospital management were planning, organising and managing the workforce to support the provision of high-quality, safe healthcare, with the following identified:

- health and social care professional vacancies were impacting on therapy provision to patients
- full training compliance levels across a range of disciplines had not been achieved for a number of training types including INEWs, sepsis, hand hygiene, and standard precautions training.

Judgment: Substantially Compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred. Five national standards (1.6, 1.7, 1.8, 2.7, 3.3) assessed on the inspection was found to be compliant, one national standard (2.8) was substantially compliant and one national standard (3.1) was partially compliant. Key inspection findings informing judgments on compliance with these seven national standards are described in the following sections.

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

Inspectors observed that staff respected and promoted the dignity, privacy and autonomy of patients. The physical environment in both Daisy and Willow unit promoted the privacy, dignity and confidentiality of patients. Privacy and dignity was supported through the provision of single rooms with en-suite facilities. Patient's personal information was protected and stored appropriately in both units.

Autonomy was supported with signage in braille to aid way finding. Information was provided on rehabilitation programmes. Patients were encouraged in the setting of rehabilitation goals, goal-setting documentation was in place and patients and staff spoke to inspectors about goal-setting. Individual patient activity schedules were displayed within patient rooms. A school was located in Daisy unit, and this helped to address the transition back to school for patients. Inspectors observed a soft play area where two occupational therapists were interacting with a patient. Communication tools were used to facilitate patients with communication difficulties. A poster outlining the 'just a minute' (JAM) card initiative was displayed. This initiative involved a JAM card that could be presented to staff to highlight that a patient may require extra time when communicating. In Willow unit, a communal dining room was available and patients could attend breakfast group to prepare for going home. Patient education on wellbeing and lifestyle took place in the unit once a week.

Judgment: Compliant

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

Staff in Daisy and Willow unit promoted a person-centred approach to care and were observed by inspectors to be respectful, kind and caring and responsive to patient's individual needs. Inspectors noted a good response to call bells whilst visiting the units.

Examples of kindness and consideration included getting to know patients and their individual needs with initiatives such as "my story" and "who I am", which outlined patients' hopes and vision for life after discharge from the hospital. As mentioned previously, there was access to outdoor spaces for patients to enjoy and this included gardens with seating and a playground. Parents in Daisy unit stayed with their children overnight and there was a parents' room in which they could relax.

Inspectors were told that patients were encouraged to interact with each other, for example group activities were arranged for children for peer support. Adult patients could also partake in group activities, for example, table tennis and other sports. Numerous thank-you cards and compliments were viewed by inspectors on display at the nurses' station in Daisy unit.

It was clear that management and staff within the hospital were open to and encouraged feedback in relation to care and took a person-centred approach to the provision of care.

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.

Systems and processes were in place within the hospital to respond effectively to complaints.

The quality, risk and safety committee and the operational management committee had oversight of the complaints process. Service user experience was discussed on a scheduled basis at the quality, risk and safety committee and as a standing agenda item at operational management committee meetings. Additionally, a patient story featured as a standing agenda item at meetings of the board of directors.

A complaints report was submitted monthly to the HSE and a database to record complaints, including recommendation progress was implemented. A total of 11 formal complaints had been received in 2024, 10 of these (91%) had been responded to within 30 days (national target 75%). Up until the time of inspection in 2025, formal complaints were still within timelines, with no formal complaints received in January 2025.

The patient experience healthcare data manager was the designated complaints officer for the hospital. The HSE's complaints management policy *'Your Service Your Say'*[§§] had been adapted for local use. Complaints procedure signage, information, and comment boxes were observed in both Daisy and Willow unit. Inspectors did not find information on independent advocacy services in either unit, although this information was available on the hospital's website. Patients and parents who spoke with inspectors were aware of comment boxes and or felt comfortable in raising issues with staff.

The patient experience healthcare data manager supported patients to make a complaint and monthly patient forums were held where patients could raise issues. Speech and language therapists attended the forum to facilitate patients with communication difficulties. A common theme which emerged through this forum was reduced access to therapy due to staffing constraints. This was in line with what inspectors were told by staff on the days of inspection. Actions were documented following forum meetings and one action for the patient experience healthcare data

[§§] 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.

manager following the meeting in February 2025 was to forward feedback to therapy professionals.

Staff in both Daisy and Willow units told inspectors that there was a focus in the hospital on local resolution of complaints. A new format for documenting verbal feedback was in place. Inspectors were told by staff that complaints (if any) were discussed at their local unit safety huddle and complaints were included on the prompt sheet for the huddle.

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.

The physical environment in Daisy and Willow unit supported the delivery of high quality, safe, reliable care.

Daisy unit, which operated a Monday to Friday service, was secure, with swipe access to enter and an intercom and camera system. Staff wait to ensure that no child exits unaccompanied while the doors are open and this was observed on two occasions by inspectors. Daisy and Willow unit were well-lit, spacious and tidy. Inspectors found that both units were well maintained. Staff told inspectors that they had access to maintenance staff and maintenance issues could be raised electronically through a ticketing system, with prompt response.

Inspectors noted that clinical hand-wash sinks throughout the units conformed to the required standard.*** Hand-hygiene signage was clearly displayed. Alcohol-based hand sanitiser was readily available. A patient commented to inspectors that their area was kept clean and that staff wash their hands.

Both units consisted of single rooms all of which were en-suite. There was adequate and sufficient facilities for patients requiring isolation due to transmissible infection. Personal protective equipment (PPE) was readily available.

Environmental cleaning was carried out by a contract cleaning company, with schedules for cleaning in place. Cleaners could be accessed when needed and additional deep cleaning was provided as required. Inspectors were told that rooms in the Daisy unit

*** Clinical hand wash basins should conform to Health Building Note 00-10 Part C: Sanitary Assemblies. United Kingdom: Department of Health. 2013 or equivalent standards. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf.

were deep cleaned each Friday. Inspectors found that the environment in both units was clean, with one exception — a bath in the sensory bathroom in Daisy unit required cleaning. This was brought to the attention of local management.

A tagging system was used in both units to identify that equipment was clean. Cleaning checklists were also used. Inspectors found that fridges used to store nutritional supplements in both units, although observed to be clean, did not have up-to-date cleaning checklists and this was highlighted to management. Hazardous material and waste was safely and securely stored. There was appropriate segregation and storage of clean and used linen.

Judgment: Compliant

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

While there were systems and processes in the hospital to systematically monitor, evaluate and continuously improve the effectiveness of the healthcare provided, not all audit findings were addressed through a time-bound quality improvement plan with individually assigned actions.

Quality boards displaying audit results were observed in both Daisy and Willow unit. A suite of 11 infection prevention and control performance indicators was measured in the hospital. Indicators were measured every quarter and included rates of infection acquired in the hospital and compliance with hand hygiene and standard precautions training.

An infection prevention and control audit plan was developed for 2025, audits scheduled included quarterly environmental hygiene, equipment hygiene, and infection screening compliance. Performance in relation to these audits was benchmarked across a number of clinical areas in the hospital. Overall results for environmental audits for 2024 for Daisy unit was 96% and Willow unit 95%. Although environmental compliance was high throughout the hospital, recommendations for improvement accompanied the audit report and this included managers sharing results of the audit with staff. Hand hygiene results for quarter four of 2024 for Daisy unit were 97% and for Willow unit were 100%. Glucometer[†††] audits for 2024 for Daisy and Willow units found 100% compliance. 'Bare below the elbow' audits in November of 2024 showed compliance of 67% for Daisy unit and 50% for Willow unit. These audits were repeated in December 2024 after an infection prevention and control intervention in response to an outbreak

[†††] A glucometer is a medical device for measuring the amount of glucose in the blood.

of infection, which is discussed in national standard 3.1. Compliance increased to 86% for Daisy and 88% for Willow unit. Inspectors observed that non-compliance of bare below the elbow was being tracked in real time in Willow unit.

Medication safety audits had been carried out in both units, with Daisy unit achieving 100% and Willow unit also achieving 100% in January 2025. Results for November 2024 were 99.3% and 100% respectively. Although compliance rates were high across the hospital, areas for improvement had been identified and these included ensuring patients wore red allergy bands where indicated and documenting the date of opening on liquid medications. Quality improvement plans were in place to address findings.

Performance in recognising and responding to deteriorating patients was measured in the hospital. Irish National Early Warning System (INEWS) audit results for Daisy unit were 89.4% and 96.2% for Willow unit in January 2025. Results for November 2024 were 94.2% and 98.2% respectively. Areas identified for action included recording observations and checking vital signs at the required frequency, with quality improvement plans to address findings. INEWS, Paediatric Early Warning Score (PEWS) and sepsis audits had been carried out in the hospital every second month in 2024 with performance benchmarked between audits. Quality improvement plans were developed to address findings, although these were not assigned to a named individual for action or time bound. The Identify, Situation, Background, Assessment, Recommendations (ISBAR)[‡‡‡] communication tool was not being used to document escalation of care in all cases. For example, in response to INEWS and PEWS observations. Overall findings from INEWS audit results in 2024 were that while compliance with recording observations had improved, some observation sets were incomplete and observations were not being recorded electronically. Findings for PEWS audits were that observations and vital signs were not being recorded at the required frequency and escalation of care was not being documented as per the PEWS escalation protocol. These are in line with the findings from the day of inspection of Daisy unit and remained an issue. This will be further discussed in national standard 3.1. Sepsis audit findings included compliance in initiating the sepsis form had increased, however, documentation of patient risk factors was an area for improvement.

Clinical handover audits had been carried out in the hospital in February 2024 and repeated in February 2025, this included the use of $ISBAR_3$. Compliance of 92% had been achieved for Daisy unit and 85% for Willow unit. This represented an improvement for Willow unit where 73% compliance had been achieved the previous year, compliance for Daisy unit remained unchanged. A number of recommendations

[‡‡‡] The ISBAR clinical communication tool is a structured framework which outlines the information to be transferred when communicating information verbally and in writing between healthcare professionals.

were made to address findings, for example, regularly updating the contents of the clinical handover sheet, although these were not assigned or time bound.

An aggregate review of unplanned transfers in 2024 had been carried out, with data on the reason for transfer for each rehabilitation programme recorded. The number of unplanned transfers had reduced in 2024 to 51 when compared to 2023 when there had been 59 transfers. A recommendation arising from this audit was to continue with the patient's interdisciplinary team review of an unplanned transfer within seven days of transfer.

In summary, while systems and processes were in place at the hospital to measure and improve the effectiveness of healthcare services, the following was identified:

- quality improvement plans to address audit findings were not always assigned to a named individual for action or time bound.

Judgment: Substantially Compliant

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

The hospital's systems and processes to identify, evaluate and manage immediate and potential risks to patients were not fully effective. An area for action was recording patient's observations and vital signs in line with national policy on early warning systems.

The corporate risk register was reviewed on a scheduled basis by the quality, safety and risk committee, and at meetings of the board of directors. During a previous inspection, it was found that risks associated with long-term ventilated patients had not been escalated to the corporate risk register. As part of this inspection, inspectors reviewed the corporate risk register and noted that this risk had been added. Inspectors were told an advanced nurse practitioner in respiratory care was employed in the hospital to reduce this risk. The risk register was last updated in December 2024. At the time of this inspection, there were no long-term ventilated patients being cared for in the hospital. Staff who spoke to inspectors in both units were knowledgeable in relation to risk and risk assessment.

A daily operational safety huddle (DOSH) was held at 9.15am. Staff from clinical areas including Daisy and Willow unit provided an update at this meeting. Staff on both units attended a local safety huddle prior to attending the DOSH. Risks, such as overnight concerns, were discussed as part of the DOSH, which had a set agenda.

Afterwards the highlights and actions arising from this meeting were sent to staff by email.

Infection prevention and control risk was assessed as part of the pre-admission assessment for patients. Patients were screened for multidrug-resistant organisms (MDROs) on admission, this included Carbapenemase-Producing *Enterobacterales* (CPE), and Methicillin-resistant *Staphylococcus aureus* (MRSA). MRSA screens were repeated on a monthly basis. A poster outlining the management of CPE was observed by inspectors displayed in Daisy unit. One instance of non-adherence with local policy in relation to transmission-based precautions and use of PPE was observed by inspectors in Willow unit. This was brought to the attention of the CNM. There were six outbreaks of infection in the hospital in 2024. Outbreak reports were completed and these included recommendations and learning. For example, an outbreak of MRSA was declared in three units on 14 November 2024. A detailed MRSA outbreak overview report for 2024 showed that there had been seven cases, both linked and unlinked, over a five month period. The report indicated that this was above baseline, and the infection prevention and control team identified a concern of cross transmission between units that were distant from each other. The summary report included a number of recommendations, for example, continuing to audit hand hygiene and bare below the elbow compliance. Control measures to minimise the outbreak were outlined by staff who spoke with inspectors about the bare below the elbow initiative. Inspectors observed multiple 'bare below the elbow' posters displayed. The outbreak was closed on 9 January 2025.

A clinical pharmacy service was provided in the hospital and this included medication reconciliation which was completed for patients on admission, weekend leave and on discharge. An electronic prescribing and administration record was used in the hospital. This system along with guiding documentation was demonstrated to inspectors by the chief pharmacist. Medications were dispensed on a named patient basis only. Signage in relation to high-risk medicines, sound-alike-look-alike medicines and medication safety notices were observed by inspectors displayed in Daisy and Willow units. Staff outlined to inspectors how they could access medicines information online and how they would check weight-based doses of medication for paediatric patients.

Patients admitted to the hospital had to be medically stable, this was included in the admission criteria for each of the rehabilitation programmes. On Daisy unit, inspectors were told that a paediatric liaison nurse identified medical issues in advance of patient admissions and relevant training was provided to staff where required. Measures were in place to reduce the risk of harm associated with delays in recognising and responding to a patient who was acutely deteriorating. The relevant early warning systems such as the Irish National Early Warning System (INEWS) and the Paediatric Early Warning System (PEWS) were implemented in the hospital. The ANP supported staff with paediatric emergency scenario training. A range of paediatric emergency

scenario instruction sheets were available to staff in Daisy unit. These included responding to airway obstruction, cardiac arrest and septic shock. Paediatric emergency scenario training took place in the unit where staff were tested on their knowledge and response to a different emergency each month. Findings in relation to what worked well and needed improvement were documented. Recommendations included providing additional education sessions on certain topics, and improving communication.

At the time of the last inspection, PEWS observation charts from an acute paediatric hospital were in use, these had now been modified and ratified for use in the hospital. Inspectors noted in relation to paediatric patients that required escalation that staff documented this in the patient's paper chart and in their electronic healthcare record. This practice reduced the nurses' time from doing other nursing duties. Inspectors observed instances where the PEWS policy was not adhered to, for example, observations for two escalated paediatric patients were not being carried out at the required frequency as per national guidance. This was also a finding from PEWS audits as discussed in national standard 2.8. Inspectors were informed that a verbal instruction for a reduced frequency of observations had been given, although this was not documented in either the paper chart or the electronic healthcare record or in line with the national guidelines. Similarly, in Willow unit, a verbal instruction in relation to acceptable parameters for oxygen saturations had been recorded in the nursing notes but had not been recorded in the medical notes or electronic healthcare record. Appropriate documentation of modified observation parameters was raised by inspectors with hospital management.

There were processes in the hospital to support safe handover, transfer, and discharge of patients. The nursing clinical handover process for Daisy and Willow unit used the ISBAR tool to facilitate effective communication. Medical handover of patients took place daily at 8.25am at the medical quality and safety huddle (QUASH). Pre-admission checks were carried out by the CNM prior to transfer and admission of patients and risk assessments were carried out on new admissions as required. An interdisciplinary team (IDT) huddle took place in Daisy unit at 8.50am each day, this was attended by an inspector on day two of inspection. Assessed patient needs for patients due for admission were discussed as part of this huddle.

Unplanned transfers were recorded in the electronic patient healthcare record. A policy regarding unplanned transfers was up to date. The process for unplanned transfers included the completion of a transfer form with a copy of the patient's medication prescribing and administration record sent to the receiving hospital.

The estimated date of discharge for paediatric patients was established at the end of week two of the patient's admission. Paediatric patients went home each weekend and a case conference was held on Monday mornings prior to children returning to discuss

their progress with goals and discharge requirements. Inspectors were told that a follow-up call was made for paediatric patients six weeks following discharge.

Staff in both Daisy and Willow unit, found it difficult to access specific policies, procedures, protocols and guidelines when at the request of inspectors. This was discussed with hospital management who were aware of the challenges of accessing documentation. Inspectors were told that measures were being taken to improve the search function for documentation to make it easier for staff to find the information they needed. At the time of inspection, the Paediatric Early Warning System (PEWS) policy and sepsis pathway and the revised Standard Operating Procedure (SOP) for the Management of the ventilator-dependent patient at the National Rehabilitation Hospital (NRH) were in draft format. Inspectors were told that documents were due for sign off in quarter one and two of 2025 respectively.

While processes were in place to minimise the risk of harm to patients in Daisy and Willow unit, the following was identified:

- multiple findings of non-adherence with INEWS and PEWS guidelines were observed on the days of inspection as outlined in this standard
- the hospital's PEWS policy and sepsis pathway were in draft format at the time of inspection
- staff on both Daisy and Willow unit had difficulty in locating policies, procedures, protocols and guidelines on the computer system.

Judgment: Partially Compliant

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

Systems and processes were in place in the hospital to ensure that patient-safety incidents were identified, managed, reported and responded to effectively.

Patient-safety incidents were discussed at meetings of the quality, safety and risk committee. A monthly incident dashboard summary report was submitted to the board of directors and an annual summary report was produced. This detailed number, type and outcome of reported patient-safety incidents. Medication-related patient-safety incidents were discussed as a standing agenda item at the drugs and therapeutics steering group meetings. An aggregate review of medication incidents was completed each year. Relevant incidents were discussed as a standing agenda item at hygiene

infection prevention and control committee meetings and were scheduled for discussion three times a year at deteriorating patient committee meetings.

Staff who spoke with inspectors in Daisy and Willow unit were knowledgeable on how to report a patient-safety incident and entered these directly in to an interactive (electronic) national incident report form. The incidents were then entered in to the National Incident Management System (NIMS). The percentage of incidents reported onto NIMS within 30 days of notification of the incident was 99% for January 2025 and 100% for February 2025. This was a performance indicator that was tracked on a monthly basis. All serious incident reviews had been completed within 125 days of notification in 2024 and up until the time of inspection in 2025.

Tracked and trending of information on incidents were sent to clinical areas through an e-mailed report on a monthly basis. The report for Daisy unit was demonstrated to inspectors. Patient-safety incidents were discussed as part of the standard agenda at daily operational and safety huddles. This huddle was attended by inspectors on day two of inspection where two patient-safety incidents were discussed.

Judgment: Compliant

Conclusion

An unannounced two-day inspection of the National Rehabilitation Hospital was conducted on 4 and 5 March 2025. 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 and safe transitions of care.

Capacity and Capability

Governance arrangements were in place in the hospital, although organisational charts did not reflect all reporting arrangements. The management arrangements in the hospital, including for the four areas of focus of this inspection were clear. Systematic monitoring arrangements were in place within the hospital to measure performance and identify areas for improvement. There were arrangements for effectively organising the workforce, however, there were health and social care professional vacancies at the time of inspection. Full training compliance levels for a variety of training had not been achieved for a number of staff disciplines.

Quality and Safety

Patients and parents of patients who spoke with inspectors were positive about the experience of receiving care and treatment in the hospital. It was clear that management and staff within the hospital were open to and encouraged feedback in relation to care and took a person-centred approach to the provision of care. The physical environment in which care was provided was clean and maintained to a high standard. Service users were protected from the risk of harm associated with the design and delivery of healthcare services with some opportunity for improvement identified as detailed in national standard 3.1. This included adequate documentation in relation to patient observations and vital signs. Systems and processes were in place in the hospital to ensure that patient-safety incidents were identified, managed, reported and responded to effectively.

HIQA will, through the compliance plan submitted by hospital management as part of this monitoring activity, continue to monitor the progress in implementing actions to address compliance with national standard 3.1.

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 national standards is identified, a compliance plan was issued by HIQA to the service provider. In the compliance plan, 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 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.

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
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
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	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	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality,	Compliant

safe, reliable care and protects the health and welfare of service users.	
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan for the National Rehabilitation Hospital

Inspection ID: NS_0133

Date of inspection: 4 and 5 March 2025

Compliance plan provider's response:

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

The NRH is committed to improving our compliance with the national INEWS and PEWS policy. Actions taken:

Regarding the recording of patient's observations and vital signs in line with national policy on early warning systems- INEWS and PEWS dashboards for all inpatients highlighting daily scores including incomplete observation sets are now in use. Daily status reports are now circulated to all nursing and medical teams. Follow up is then initiated if any incomplete records are found on each unit outlining actions/escalations required to comply with standards by the Resuscitation Officer/Sepsis Lead/CNM1 Projects lead.

The dual recording of PEWS observations on paper and electronic records continues as we seek clarification from our colleagues in the HSE on the most appropriate documentation required for completion with our specific paediatric cohort. We continue to work with all stakeholders to create one single healthcare electronic record for patients. This work is being led by the NRH Deteriorating Patient Committee.

PEWS observations, escalation and response refreshing training courses will be delivered in conjunction with the Assistant Director of Nursing Sepsis HSE Dublin Southeast.

Local INEWS and PEWS audit frequency was increased to weekly for a 4-week period following the inspection to address any issues identified and are now completed on a bi-monthly basis. Reports are circulated to unit and nursing management teams for review and action.

Regarding verbal instructions being used for a reduced frequency of patient observations, within the NRH, exclusion criteria/parameter amendments must be written and are valid for a 7-day timeframe only as approved by the NRH Deteriorating Patient Committee. These observations will be reviewed weekly on consultant rounds and extended as appropriate with a new expiration date as required. To ensure identification of patients requiring updated parameters the dates of these exclusion orders, these are visible in the INEWS/PEWS dashboard for daily reference for unit staff to access. A toolbox was circulated outlining acceptable parameters (modified escalations), time zero on 28th April 2025 to staff.

The Paediatric Early Warning System (PEWS) policy and sepsis pathway-the draft policy is the final stages of review and due for approval by the National Rehabilitation Hospital Deteriorating Patient Committee in July 2025.

In relation to staff difficulty in accessing policies, procedures and guidelines, the NRH is currently undertaking a hospital wide project to create an electronic policies, procedure, protocol and guideline document management system that will be accessible to all staff via the NRH intranet site. This is being led by the risk management team and is due for completion in Q3 2025.

Timescale: As above