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:	Rehabilitation Unit on St Joseph's Ward, c/o Sacred Heart Hospital, Castlebar.
Centre ID:	OSV-0007270
Address of healthcare service:	Pontoon Road Castlebar Co. Mayo Eircode: F23 XV38
Type of Inspection:	Announced
Date of Inspection:	08-09 December 2025
Inspection ID:	NS_0176

About the healthcare service

Model of hospital and profile

St. Joseph's ward known as the 'rehabilitation unit' at Sacred Heart Hospital, Castlebar (SHHC) is a model one HSE publicly funded rehabilitation and community inpatient healthcare service. It operated under the organisational and governance structure of the Community Health Organisation (CHO2), Health Service Executive (HSE) West North-West (WNW) which in turn reported to the Integrated Healthcare Area (IHA) manager under the umbrella of the recently formed and forming regional structures. The hospital campus at SHHC also included a designated centre for older people which was managed under the same governance as the rehabilitation unit, and a low-acuity medical ward (St. John's ward) which was under the separate governance of the local acute hospital, which also reported to the IHA manager. Management told inspectors at the time of inspection, that the new HSE regional health structures and leads under the governance of the Integrated Healthcare Area (IHA), were pending and due to be finalised by end of March 2026.

The rehabilitation unit provided the following care and services:

- rehabilitation for
    - people aged 65 years or more, following stroke, brain injury, surgery or chronic illness
    - people aged 18 to 65 years who were identified as needing a specialist rehabilitation programme with a mixed rehabilitation complexity level.

  and
- respite care for people within the Older People Services.

The following information outlines some additional data on the hospital.

Number of beds	26 rehabilitation beds plus one respite bed for the Older People Services

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 Version 2 2024* (National Standards) as part of 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 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 are 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)
08 December 2025	13:30 – 18:00hrs	Patricia Hughes	Linda Daffy Una Cahill Caroline Hession
09 December 2025	08:55 – 13:45hrs	Patricia Hughes	Linda Daffy Una Cahill Caroline Hession

Information about this inspection

This announced inspection focused on nine National Standards from five of the eight themes [†] of the *National Standards for Safer Better Healthcare*. The inspection focused 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 the Rehabilitation Unit on St. Joseph's Ward.

The unit had a rehabilitation interdisciplinary team, led by a team of three medical consultants and comprised non-consultant hospital doctors, rehabilitation nurses, health and social care professionals from physiotherapy, occupational therapy, speech and language therapy, and medical social work.

The inspection team spoke with representatives of the hospital's management team, quality and risk, human resources and clinical staff.

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.

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

On the first day of the announced inspection there were 23 patients admitted to the unit and two further patients were expected for admission from the local acute hospital.

[†] HIQA has presented the National Standards for Safer Better Healthcare under eight themes within the two dimensions of capacity and capability, and quality and safety.
[‡] Using Early Warning Systems in clinical practice improves 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.

Inspectors spoke with several patients about their experience of care. They expressed satisfaction with the care they received and were complimentary about the staff in the unit.

Patients commented that the unit was *"such a warm happy place", "it's like a home from home", "cosy"*. Patients stated that staff were *"very friendly", "everyone is so nice",* and *"always willing to help".* Other comments referenced the availability and choice of food and satisfaction with the bathroom facilities.

Inspectors observed staff actively engagin with patients in a respectful manner and ensuring patients' needs were promptly responded to. This observation was validated by the patients who said, *"they come straight away"*. Staff were observed promoting patients' privacy and dignity, and curtains were drawn when attending to personal needs and care.

Patients said that they were not aware of the HSE '*Your Service Your Say*' complaints process and said if they had a concern or complaint about their care, they would talk to the staff on the ward. Inspectors saw information on display at the hospital entrance and on the notice boards in the ward which drew attention to the designated complaints officer and how a person could make a complaint, compliment or concern known to the service.

Overall, there was consistency with what inspectors observed in the clinical area, and what patients told inspectors about their experience of receiving care in the unit.

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 standards related to workforce, and its use of those resources.

In summary, the rehabilitation unit was found to be substantially compliant with National Standard 6.1 and partially compliant with National Standards 5.2, 5.5, and 5.8. Key inspection findings leading to these judgments 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.

Organisational charts setting out the hospitals reporting structures provided details of the direct reporting arrangements for hospital management, and the governance and oversight committees within Sacred Heart Hospital Castlebar (SHHC) which included the rehabilitation unit. The organisational charts also depicted the governance oversight and accountability relationship to the Head of Service for Older People in Community Healthcare West (CHW). Hospital management told inspectors that the new HSE regional health structures and leads under the governance of the recently established integrated healthcare area (IHA) were pending and were expected to be in place by March 2026.

The Director of Nursing (DON) was responsible for the operational management of the hospital and reported to the manager for the Older People Services (OPS), who in turn, reported to the general manager. The general manager reported to the head of services (HOS) for OPS, who in turn, reported to the chief officer for CHW. The DON was responsible for the organisation and management of all staff at the hospital apart from medical personnel. The DON held overall responsibility for both the rehabilitation unit and for the designated centre for older people (DCOP). Staff on the rehabilitation unit reported to a clinical nurse manager 2 (CNM2) who reported to the assistant director of nursing (ADON), who in turn reported to the DON. A team of three consultants from the local acute hospital in Mayo held responsibility for the admission and clinical oversight of patients in the rehabilitation unit.

Governance Committees

Director of Nursing Governance meeting

This committee was chaired by the Older People Services Manager (OPSM). The terms of reference (TOR), which were undated and unsigned, set out the vision, purpose and accountability of the committee. The purpose was explained as adherence to statute and HSE policy, progressing HIQA compliance and provision of leadership and support to directors of nursing. Membership included the DON from the Sacred Heart Hospital Castlebar (SHHC). The schedule of meetings was monthly.

Inspectors viewed the minutes provided for two meetings held in May 2025 and September 2025 and found that the committee had not been meeting in line with its terms of reference. The meetings that were held, were well attended with representation from the DON from SHHC at one of the two meetings and from the

General Manager for Older People Services at both. The agenda showed a consistent focus on quality and risk, health and safety and HIQA compliance.

The minutes indicated that the meetings followed a structured format and were action-orientated, but actions were not time-bound. Inspectors saw that while transitions of care, including admissions, bed availability and delayed transfers of care (DTOC) were discussed, there was no reference to the remaining three areas of known harm, infection prevention and control (IPC), medication management or the deteriorating patient in either of the meeting minutes reviewed.

Community Healthcare West (CHW) Older Persons Services (OPS) - Quality and Safety Committee (QSC).

The quality and safety committee (QSC) operated under terms of reference (TOR) which were approved and signed off on 22 January 2025, with a revision date of January 2026. This committee's remit included oversight of risk management processes, service user experience, local and national audits, key performance indicators (KPI), policies procedures and guidelines (PPG's), mandatory education and training, monitoring of quality improvement plans (QIP's) and implementation of recommendations and learning from national reports, audits and investigative reports.

The QSC was chaired by the Head of Service (HOS) and membership included the quality and safety risk advisor, the OPS managers, a DON representative from the district hospitals (Ballina, Belmullet and Swinford), a DON representative from the community nursing units, a home support manager and a representative from the Integrated Care Programme for Older People (ICPOP). The chair of the OPS QSC was operationally accountable to Head of Service. According to the TOR, there were two sub-committees reporting to the QSC, namely the health and safety committee and the drugs and therapeutics committee. The QSC meetings were to be held monthly as set out in the TOR, with a performance measure of eleven meetings annually. Inspectors viewed the agenda and minutes provided in respect of three meetings of the QSC held in July, October and November 2025. The minutes showed that meetings were not held in line with the frequency as set out in the TOR. The minutes followed a structured format and were action orientated although not time bound.

A list of committee reports to be presented to the meeting was outlined in the TOR however, it did not include reports related to the four areas of known harm: infection prevention and control, medication safety, the deteriorating patient and transitions of care. Inspectors noted that 'IPC and antimicrobial stewardship (AMS)' was an agenda item on each of the minutes reviewed.

Inspectors noted in the minutes of the meeting dated July 2025 that a new section in the quality and safety report was to include the four areas of known harm and the hospitals were required to forward information under these headings on a monthly basis to the quality and risk advisor however, there was no reference to these in the subsequent meeting minutes provided to and reviewed by inspectors.

Management and staff at the hospital informed inspectors that quality, patient safety and risks issues were reported through the OPSM, who in turn reported these to the General Manager. Issues and actions from the QSC were fed back via the General Manager to the Sacred Heart Hospital Governance Group meeting, which is also described under this National Standard.

Infection Prevention and Control and Antimicrobial Stewardship Committee

The Community Healthcare West (CHW) infection prevention and control and antimicrobial stewardship committee was in place to support the senior management team (SMT) ensure the effective management of infection prevention and control and antimicrobial stewardship services. The TOR, dated September 2025, was unsigned and had no revision date. The committee was chaired by the head of quality, safety and service improvement (QSSI) and multidisciplinary membership included a consultant microbiologist, antimicrobial pharmacist, assistant director of nursing (ADON)-IPC, an epidemiologist, and representatives from public health, disability services, older persons' services, mental health, health and wellbeing, community infection prevention and control nurses and a dental surgeon. An ADON from SHHC was a member of this committee.

Meetings were to take place quarterly. The community hospitals were represented by the OPS manager, and the feedback mechanism was the same as for the quality and safety committee with feedback to the hospital via the Sacred Heart Hospital Governance Group meeting.

The committee had a standing agenda which included updates from the following: each service area, an 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 regulation and risks.

Inspectors viewed the agendas and minutes of the three meetings held in March, June and September 2025 and found that meetings were well attended, followed a structured format and were action-orientated, with a responsible person assigned to actions but these were not always time-bound. It was unclear from the minutes, if matters arising in the rehabilitation unit were discussed. Progress in implementing

actions was monitored from meeting to meeting. Overall, the committee was actively engaged in IPC and AMS activities.

Medication Safety

The rehabilitation unit submitted a statement to HIQA explaining that no committee for medication safety had been established. Inspectors heard how oversight of medication safety was managed via the CHW Quality and Safety Committee. The terms of reference for this committee stated that drugs and therapeutics was a sub-committee that reported into it however, there was no documentation available to validate that.

The Deteriorating Patient

The rehabilitation unit did not have a deteriorating patient committee. This is discussed further under national standards 5.5 and 3.1.

Transitions of Care

Hospital management informed inspectors that clinical handover, transitions of care and bed management were being managed by the Community Healthcare West (CHW) Integrated Discharge Management (IDM) team. This team reported to the OPSM and to the General Manager. Hospital management explained that while there were draft terms of reference for this committee which inspectors viewed, a decision had recently been taken to create site-specific documents for each acute hospital rather than an overall document for all hospital sites. The DON from the Sacred Heart Hospital, Castlebar was a member of the integrated discharge management team. Inspectors heard how referrals for admission to the rehabilitation unit were reviewed and decided upon by a team of three consultant geriatricians from Mayo University Hospital with responsibility for the rehabilitation unit. Inspectors heard from staff that an admission policy was in draft format but was not yet approved.

Serious Incident Management Team

The serious incident management team (SIMT) for the area known as CHO2 Older-People Services**,** was responsible for ensuring that there were effective structures and oversight of all serious incidents (Category 1) and serious reportable events (SRE) that occurred in services within CHO2. The terms of reference for the serious incident management team for CHW Older People Services were out of date since July 2024. The team was led by the Head of Service who chaired the SIMT meetings and membership included the General Manager for Older People Services, the quality and patient safety advisor aligned to the specific service relating to the incident, residential service manager, HR manager, administration support and a service representative from where the incident occurred. The documented frequency of

meetings was weekly using teleconference facilities, or more frequently if required by the senior accountable officer (SAO). Inspectors heard that that there were no serious incidents relating to the rehabilitation unit, currently open to SIMT.

At hospital level

Sacred Heart Governance Group meeting

The Sacred Heart Governance Group meeting operated under TOR signed in July 2016. These had no revision date listed. The TOR outlined a schedule of monthly meetings. Membership included representatives from all staff groups in the clinical areas across the hospital campus, including the rehabilitation unit. The group was chaired by the DON and reported to the manager of OPS. Inspectors reviewed the minutes of three of those meetings held between July and November 2025 and found that the committee had not been meeting in line with its TOR.

Although minutes were comprehensive, there was limited evidence of follow-through from one meeting to the next with actions and outcomes not clearly defined or time-bound. While inspectors found reference to IPC matters and transitions of care in the documentation provided, there was no reference to medication safety or the deteriorating patient. Inspectors note that this represents an area for improvement for update and inclusion as part of the agenda in updating the TOR.

The minutes dated 5th November 2025 referred to an action relating to refurbishment of the rehabilitation unit and recent approval to replace all flooring and windows in ward three, painting of the entire unit and replacing of the flooring in all six wards. The IPC department had submitted a business case for funding for an upgrade of seven toilets to include six en-suites in the unit and a disability friendly toilet on the unit and flooring on the corridors and nurses' stations.

IPC Collaborative meetings

Inspectors noted that at hospital level, IPC collaborative meetings took place monthly. There was no TOR available for this forum, however, based on review of the agenda and minutes for September, October and November 2025, a standing agenda was in place. Inspectors noted evidence of discussions on outbreaks, IPC audits, training, documentation and HIQA action plans. Attendance at the meetings included the DON, ADON, support service manager, IPC link nurse from the rehabilitation unit, as well as the CNM2 or CNM1 from various wards of the Sacred Heart Hospital site. Inspectors noted and heard from staff that there was a plentiful supply of PPE available and that training on standard based and transmission-based infection control was available to staff via HSeLanD. Inspectors noted that there was

no IPC plan for 2026 and no end of year report for 2025 relating to the rehabilitation unit. This presents an opportunity for improvement.

Inspectors viewed three sets of minutes dated September, October and November 2025 while on inspection. The collaborative had been established the previous year following a HIQA inspection of the residential part of the campus. It was unclear from the minutes what elements and actions were related to the rehabilitation unit as it was documented in three sets of minutes that there was no representative present from the rehabilitation unit to give feedback although the DON was present at the meetings.

Staff meetings

Inspectors spoke with staff on the rehabilitation unit who spoke about the twice daily safety pauses and monthly staff nurse and HCA meetings where verbal feedback on audit activity, IPC and incidents were regularly discussed.

In summary, inspectors found that while the service provider at the rehabilitation unit in the SHHC had some formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare, there is a need to improve on these and ensure the following:

- terms of reference to be approved, signed, dated and have review dates agreed and be maintained in an up-to-date manner
- meetings should be held in accordance with the scheduled frequency in the approved terms of reference
- all four areas of known harm to be consistently reviewed and managed under local governance arrangements
- actions should be time-bound, followed through to completion, and regular updates recorded on same
- development of an annual IPC plan for year ahead and compilation of end of year report for the rehabilitation unit to help drive and track improvement.

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 23 patients admitted to the unit. Staff informed inspectors that most patients were transferred for rehabilitation from the acute hospitals in Mayo, Galway, or Dublin (for local residents) following a stroke where there were rehabilitation goals.

Referrals and pre-assessment handover reports were reviewed by the consultants with responsibility for admissions to the rehabilitation unit taking IPC concerns into consideration. Following admission, the multidisciplinary team assessed the patient before agreeing goals which included a predicted date of discharge (PDD). The PDD was recorded on the whiteboard in the office, and in the medical and nursing notes. Where indicated, requirements for home help assistance were assessed and the application process was supported by the rehabilitation medical social worker.

Each consultant conducted a ward round and held a multidisciplinary (MDT) team meeting in relation to patients under their care once a week. In addition, a senior house officer from Mayo University Hospital (MUH) attended to patients in the unit from Monday to Friday during core working hours. Nursing staff had access to medical advice from the on-call medical team at MUH out-of-hours, and at weekends.

A designated clinical nurse manager held operational responsibility for the hospital site at weekends and outside of core working hours.

Access to the respite bed in the rehabilitation unit was via application to a central office in community healthcare. It was available to patients for up to two weeks, whose carers were on leave. In the event of it being already booked up, a respite bed could be offered in another location.

Inspectors heard and saw data relating to the activity of the unit for each of the years 2024 and 2025. In 2024 there had been 202 admissions to the unit and in 2025 up to the date of inspection, there had been 224 admissions. In 2024, 89% of patients had been discharged to their homes, three per cent had been discharged to a nursing home, eight per cent had been transferred back to the acute hospital and there was no mortality. In 2025, 85% of patients had been discharged to their homes, six per cent had been discharged to a nursing home, nine per cent had been transferred back to the acute hospital and there was no mortality.

Infection Prevention and Control

Staff described good access to IPC resources in the community including public health doctors and nurses, a clinical nurse specialist in IPC, a pharmacist in antimicrobial resistance and a consultant microbiologist. The link nurse provided face to face training on hand hygiene. A representative from the rehabilitation unit attended monthly meetings with the IPC clinical nurse specialist where they received regular updates. As most patients were transferred in from an acute hospital, where they had already been screened for *Carbapenems Entreobacterales* (CPE), weekly CPE screening still in progress, was continued until four clear swabs had been achieved. The rehabilitation unit had a system in place to identify such patients and ensure appropriate isolation precautions until such time as negative results were received. Staff reported that this requirement occurred up to once every three months. Inspectors spoke with staff and viewed information displayed on noticeboards. It related to the 'Five Moments of Hand Hygiene', safe use of gloves, point of care risk assessment, and standard and transmission-based precautions. Staff told inspectors that oversight of hygiene standards was mainly undertaken by the service manager and in their absence, the DON was responsible for oversight.

Medication Safety

At the time of inspection there was no pharmacist employed at the rehabilitation unit and this was recorded on the risk register but hospital management informed inspectors that one was being recruited by the pharmacy at the local acute hospital with specific responsibility for pharmacy support for the Sacred Heart hospital campus and was due to start in January 2026. The staff nurse admitting a patient, carried out medicine reconciliation both on transfer in and on discharge out of the unit, and this was documented in the nursing documentation. Inspectors heard that documentation used for this task included the pre-assessment form received in advance of the patients transfer in, the medication received from the acute hospital and the discharge prescription provided by the acute hospital. Staff also discussed medication with the patient themselves and could contact their pharmacy if required. Inspectors heard that where there was any doubt, staff would contact the doctors on duty at the rehabilitation unit and or the pharmacist at the acute hospital. Staff reported access to hard copies of the British National Formulary however inspectors found that these were out of date. This was brought to the immediate attention of the nurse in-charge and to the hospital management team on the day of inspection. Staff told inspectors that pharmacy supplies came from the pharmacy located at the local acute hospital and that medication under the Misuse of Drugs Act and night sedation were checked and securely stored in line with local and national policies and guidelines.

The Deteriorating Patient

Inspectors heard from staff that although patients admitted to the rehabilitation unit were there to work on rehabilitation goals, they had to have been medically stable and require the assistance of no more than one, to enable transfer to the unit.

Their vital signs and levels of orientation were measured and recorded twice daily on a standard vital signs chart. Weight was routinely measured on admission and monthly thereafter or more frequently where indicated.

Staff at the rehabilitation unit used the Irish National Early Warning System (INEWS) scoresheet to record the patient's vital statistics in the event of a deterioration. Staff told inspectors that there was 24/7 access to both the on-call medical registrar at Mayo University Hospital (MUH) and the on-call consultant. Inspectors heard that there was no written standard operating procedure (SOP) for the management of the deteriorating patient. Staff members outlined their response to this situation, which depended on the context and nature of the deterioration. In general, it involved measurement of vital signs and recording of those on a Irish National Early Warning System (INEWS) score sheet, ascertainment of possibility of constipation, cardiac events or neurological deterioration, a medical review via the patient's consultant-during working hours, or via the medical registrar on-call, out-of-hours, blood tests and prescribed medicines. Bloods were transported to the laboratory at the local acute hospital via an approved contracted transport arrangement. An X-ray could also be ordered and performed locally. Where a patient's early warning score exceeded three or more, and or where IV antibiotics were indicated or where staff had used clinical judgment and deemed it necessary for the patient to be transferred to the local acute hospital, transport was organised by nursing staff contacting 999 for an emergency ambulance (999). A nursing transfer letter, a safety alert form, a copy of the patient's prescription record and a hospital note were completed and sent with the patient being transferred to the local acute hospital who were also informed via telephone of the incoming transfer to them. A national incident management form was completed where appropriate and timely communication with the patient's next of kin or nominated contact person regarding the deterioration of the patient. Inspectors noted that it would be beneficial to have this procedure documented and audited. Staff also reported that they did not use the standardised communication tool, **I**dentify, **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation (ISBAR). This presents an opportunity for improving communication.

Transitions of Care

Senior staff at the rehabilitation unit attended the online Mayo University Hospital (MUH) patient flow meetings and their weekly delayed transfer of care (DTOC) meetings. Following the patient flow meetings, they received a weekly report providing them with information on expected admissions. Inspectors also heard that 'a check-in meeting' occurred between MUH, the rehabilitation unit and the district

general hospitals whenever the local acute hospital was in black escalation or during outbreak activity.

A nurse-to-nurse verbal clinical handover took place prior to admission of a patient to the rehabilitation unit. This was supported by use of a complete comprehensive referral form. A full set of clinical notes was transferred from the admitting hospital ensuring a comprehensive history for reference. The medical officer undertook the admission once the patient arrived in the rehabilitation unit and had admission details recorded by nursing staff.

Following determination of multiple factors including rehabilitation potential, rehabilitation progress and the scenario for safe discharge, each patient was provided with a predicted date of discharge.

Hospital management told inspectors that staff at the rehabilitation unit were working on a draft admission policy which was yet to be approved. Inspectors viewed the practice guidelines to support transfers out of the unit and discharges home or to residential care.

In summary, inspectors were not fully assured that the service provider had effective management arrangements in place to support and promote the delivery of high quality, safe and reliable healthcare services, for example:

- staff should have up-to-date access to medication information and at the point of medicine preparation. Inspectors found that the available hard copy information was out-of-date
- introduction of a standardised communication tool for use in clinical handover, and in transitions of care
- progress the approval of the admission policy.

Judgment: Partially 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.

Infection Prevention and Control

Inspectors viewed two sets of infection prevention and control audits relating to the rehabilitation unit as provided during the inspection. While deviations from the

standard and corrective actions were listed, inspectors found that one of the audits was incomplete and dates of the audits were unclear. Both audits were signed off the persons conducting the audit but there was no signature of the person overseeing same.

Staff outlined a range of quality initiatives undertaken in relation to IPC. These included the use of an MDRO alert sign, introduced to ensure appropriate identification and isolation of patients until such time as infection screens were reported as negative. The 'skip the dip' was introduced in 2024 and a urethral catheter resource pack was also introduced across the Sacred Heart Hospital campus as best practice. Staff expressed a need for additional training in audit activity.

Community metrics were completed by night staff in the rehabilitation unit and together with data from the Older People Service on the hospital site, was collated at regional and national level. Inspectors viewed the '*National Regional Health Area-Level Quarterly Report for Quarter Three in 2025 relating to Healthcare Associated Infection, Antimicrobial Resistance and Antibiotic Consumption Monitoring in HSE Older Persons facilities*' issued by HSE AMRIC, which the hospital provided to inspectors following the inspection. Inspectors noted the following: HSE WNW had an 89% response rate, which was less than the national average response rate of 94%. The region reported the highest overall antibiotic use per region with 7.7% of residents and patients on antibiotics for treatment, and a further 3.5% on antibiotics for prophylaxis (the national averages for these results were 5.7% and 2.6% respectively). The region also reported the highest antibiotic use per region for urinary tract infection, with 2.5% of residents and patients on antibiotics for treatment, and a further 2.1% on antibiotics for prophylaxis (the national averages for these results were 1.7% and 1.5% respectively). Urinary devices were used in 9.3% of the regional population in this study (second highest) compared to a national average of 8.5%.

Medication Safety

Inspectors viewed five sets of audits of medication safety provided following the inspection relating to the rehabilitation unit, dated March (ten patients), September (six patients), October (10 patients) November (five patients), and December 2025 (seven patients). Deviations from the standard and corrective actions were listed.

The Deteriorating Patient

Hospital management explained to inspectors that two to three patients are transferred back to the local acute hospital per week. The clinical nurse manager from the rehabilitation unit followed up on their progress with the hospital. Inspectors asked staff if there was any learning from patients who had to be transferred back to the local acute hospital and staff recounted a number of recent

examples where the decision to transfer out had been discussed afterwards and was found to be the correct decision and in the patient's interest. Staff explained that there had been no mortality in the unit over the previous five years and that patient feedback to the unit was predominantly positive.

Transitions of Care

Staff spoke with inspectors about the development of a business plan and quality initiative in progress, aimed at improving the provision of a medical officer on-site for five days per week, up from three days per week.

Inspectors spoke with staff and found the following: the average length of stay related primarily to the reason for rehabilitation for example, a typical orthopaedic patient had a length of stay of between two and three weeks while a patient with stroke had a typical length of stay of between 6 to 24 weeks. Approximately 98% of patients were discharged to their own homes following rehabilitation. Where delayed transfers of care occurred, it usually related to a home not being ready or a home help package not being available. On such occasions, inspectors heard that patients may transfer to long-term residential care for a period of time once they were fit for discharge while their home adaptations were being undertaken. There was, however, no specific audit activity conducted in relation to transitions of care at the unit.

Other initiatives

Hospital management spoke about the quality and patient safety plans initiated in the rehabilitation unit in 2025 and inspectors viewed documentation relating to these. They included: 1) trialling a new referral form to improve communication and help reduce delayed transfers to the rehabilitation unit, 2) introduction of a specific checklist system with specific days for cleaning different areas, 3) renovation of the conservatory area to provide a high quality and safe, sociable environment for patients and family, 4) extension of medical officer cover from three to five days per week, 5) the use of a national assessment tool for providing consistent assessment across different care settings aiding special communication between healthcare professionals and supporting safe effective discharges, 6) the use of comprehensive whiteboard, introduced to enhance communication and coordination of care as a visual cue, 7) provision of a part-time dietetic service from May 2025, 8) development of a handbook for rehabilitation patients with pertinent information in relation to their rehabilitation journey, 9) use of a daily calendar of activities for patients engaged with different therapies and 10), the inclusion of patients from the rehabilitation unit on social activity days out where appropriate. Staff spoke with inspectors and discussed their work in supporting continence so that patients were enabled to have a better quality of life. They also spoke about good access to staff

at the National Rehabilitation Hospital from where some of the patients were transferred.

In summary, inspectors found that while there was evidence of the development of quality initiatives within the unit, there was some evidence of monitoring arrangements to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services,

- there was a lack of an overall plan and organisation around audit activity in the four areas of known harm
- staff expressed a need for support and training in audit activity.

Judgment: Partially Compliant

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

Hospital management explained that there was no formal workforce plan or strategy in place for the rehabilitation units at the time of inspection however, inspectors found that the hospital had workforce arrangements in place to support and promote the delivery of high quality safe and reliable healthcare.

Recruitment was centralised at Community Healthcare West (CHW) level. Inspectors heard from senior management and found on review of meeting minutes, that workforce issues were escalated to the Older People Services Manager (OPSM), to HR and to the business manager, and were discussed at the DON governance meeting. Inspectors noted that the human resource department (HR) for HSE WNW, located in Galway, was responsible for staff recruitment with the hospital DON having operational responsibility.

The CNM2 from the Rehabilitation Unit worked one weekend in seven as the person in charge for the hospital campus and was supernumerary to the rehabilitation unit at that time. Hospital management informed inspectors that the need for a third person to cover the office 24/7/365 had been escalated to the OPSM and the General Manager, however it was not listed on the HR risk register at the time of inspection. Hospital management told staff that a few regular agency staff were utilised to cover staffing deficits in nursing and in health care assistant posts and that the hospital had recently submitted a business case for the approval of a CNM3 post for further management support.

A team of three consultants from the local acute hospital provided the medical cover. Each consultant conducted an in-person consultant round of their patients once a week (Tuesday, Wednesday and Thursday). Their non-consultant hospital doctors (NCHDs), referred to in this unit as 'medical officers', also visited the hospital for half a day, Monday to Friday, to conduct patient reviews, admissions and discharges. Inspectors noted that out-of-hours cover was in place through on-call arrangements at Mayo University Hospital (MUH).

At the time of inspection, the rehabilitation unit had a near full complement of nursing staff. Hospital management outlined the approved and in post workforce as follows: one WTE DON, one WTE Grade 4 clerical support, one ADON and one WTE CNM-nursing office, one WTE CNM2 covering risk management and policies, procedures and guidelines, and 0.5 WTE CNM2 covering practice development and oversight of training of staff for the whole of the SHHC campus. Specific to the rehabilitation unit, there was two wholetime equivalent (WTE) clinical nurse manager 2's (CNM2), 12.77 WTE staff nurses (including one WTE on long-term leave covered by one WTE agency nurse - as and when required and one WTE nursing vacancy (due to retirement) awaiting recruitment). There were 14.84 WTE healthcare assistants (HCAs) approved and in post. There were two WTE multi-task attendants approved and in post. The staffing of the unit comprised three staff nurses and four healthcare assistants on day duty in the morning seven days per week reducing to two staff nurses and four healthcare assistants in the afternoon or evening. There was also a clinical nurse manager on day duty, Monday to Friday. Staffing at night comprised two staff nurses and two healthcare assistants seven nights per week. Inspectors viewed the roster for the previous month and found no regular gaps. While inspectors spoke with staff in the clinical areas and found that they were satisfied with the staffing resource allocated to the ward, hospital management explained that there had been a designated ADON post for the rehabilitation unit which was 'lost' in the '2023-24 pay and numbers strategy'.

The unit had an approved complement of 3.43 WTE physiotherapists and 2.5 WTE physiotherapy assistants, 3.36 WTE occupational therapists (OT), one WTE OT assistant, 0.84 WTE speech and language therapist (SALT) and 0.96 WTE medical social worker. Inspectors heard that a further WTE SALT and a WTE OT were being recruited at this time. A WTE dietician vacant post was being covered by 0.2 WTE agency. Inspectors heard from management that funding for this post was not in place due to it being 'lost' as part of the 'HSE pay and numbers strategy' in early 2024.

There was no pharmacist directly employed at the hospital. Staff reported that they could link with the pharmacy at the local acute hospital via phone with any queries and concerns. Hospital management told inspectors that one WTE pharmacist had

recently been approved, with recruitment to commence in Q1 2026. Overall, there was a low vacancy rate across all staff categories.

Absenteeism levels were monitored monthly and the absence rate from November 2024 to October 2025 averaged out at 5.58% with a range of 3.68% in March 2025 to 20.21% in January 2025 in a workforce of 28-29 WTE. An annual absence rate of 5.58% is above the HSE'S target absenteeism rate of up to four per cent. Staff told inspectors that back-to-work interviews were being conducted by the clinical nurse managers (CNM's) at ward level with oversight provided by the assistant director of nursing (ADON) for the hospital campus. Hospital management explained to inspectors that following COVID-19, they had organised staff activities including a motivational event, a family fun day and raffles for staff.

Staff training

The hospital had a system in place to monitor and record staff attendance at mandatory and essential training. The practice development co-ordinator provided oversight of this. Inspectors reviewed staff training records and noted that nursing staff in the hospital undertook multidisciplinary team training appropriate to their roles and scope of practice. Inspectors also noted that there was almost full compliance for mandatory training related to infection prevention and control, medication safety, use of the Irish National Early Warning System (INEWS), basic life support (BLS) and national guidance on clinical handover with ISBAR for nursing and healthcare assistants (HCA). An area noted for improvement related to the uptake of training by housekeeping and cleaning staff in transmission-based precautions which was currently at 75%.

Inspectors heard how new staff underwent both an induction period and a probation period, supported by the CNM2 and overseen and signed off by the DON.

Employee Supports

Inspectors noted that the unit provided staff training on care of patients with stroke, presented by a multidisciplinary team. Hospital management explained that three staff members (a nurse, a physiotherapist and an occupational health therapist) were also being supported to undertake a six-month course, titled 'Advanced Leadership in Integrated Care Excellence' run by one of the professional training bodies, which was starting at the time of inspection. Staff were knowledgeable about the supports available, including access to the employee assistance programme (EAP) and occupational health. Staff across various disciplines, some in post for more than twenty years, described the unit as a positive work environment.

Overall, inspectors found that the service provider planned, organised and managed their workforce to achieve the service objectives for high quality, safe and reliable

healthcare. Inspectors note that to achieve a higher rating in this standard, the service provider needs to

- ensure improved compliance with the HSE target relating to staff absence
- ensure that all staff groups are up to date in mandatory and essential training relevant to their roles.

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.

The rehabilitation unit was found to be substantially compliant with National Standards 1.6, 1.8 and 3.3, partially compliant with National Standard 3.1 and non-compliant with National Standard 2.7. Key inspection findings leading to these judgments are described in the following sections.

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

It was evident that staff promoted a person-centred approach to care. Inspectors observed staff being respectful and caring towards patients.

People who spoke with inspectors reported that staff immediately responded to their needs and requests. Curtains were supplied around each bed and were drawn appropriately to protect patients' dignity and privacy during personal care activities.

Patient hygiene preferences were accommodated with ensuite bathroom facilities in each of the multi-occupancy rooms. Additional bathroom facilities were located off the main ward corridor. Patients told inspectors that they used these if the en-suite facilities were occupied.

A variety of patient information leaflets to help keep patients informed on matters such as the complaints procedure, stroke rehabilitation services, 'FAST' (Face, Arm, Speech, Time), falls prevention - 'NO STUMBLES' (normal, osteoporosis, shoes and slippers, toilet, undercurrents, medication, blood pressure, lighting and environment,

eyes and ears, staffing assistance), and discharge planning were on display on several notice boards on the ward.

Staff in the clinical area informed inspectors that following recent feedback, a conservatory had been renovated for patients and visiting family members which offered a peaceful space for patients and a private setting for patient and family interactions. Staff spoke about a satisfaction survey conducted with nine patients about choices and quality of meals provided. Inspectors viewed these and noted that while they were all positive in the feedback, there was no date on the completed survey forms.

Inspectors saw that healthcare records were appropriately stored and that multi-disciplinary team meetings were being held in a private area of the ward. Staff spoke with inspectors and explained how they take care to ensure privacy of conversations during meetings and clinical handovers. Patients' names however, and their dietary requirements were observed in place over their beds.

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 and were seeking to ensure this as is consistent with the human rights-based approach to care promoted by HIQA. To achieve a higher rating on this standard,

- the service provider could ensure transparency of patient consent regarding the placement of patient names and other details such as, dietary requirements, over patients' bed heads.

Judgment: Substantially 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 DON was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints. Inspectors viewed the in-date complaints management policy.

Reports of complaint investigations were sent to the complaints manager at Community Healthcare West (CHW) who reported on the key performance indicators (KPIs). The DON escalated complaints that could not be resolved locally via the OPS manager to the complaints manager for CHW. Inspectors noted that a local record

of complaints was held by the DON, and inspectors were informed that these were managed in line with national guidance including liaison with the national investigations unit as needed. The hospital used the HSE's complaints management policy '*Your Service Your Say*'. From a review of local governance monthly meetings, inspectors noted that complaints were included as an agenda item for discussion.

Inspectors found that there was a culture of local complaints resolution within the rehabilitation unit. Staff in the clinical area verified that complaints were resolved locally where possible, and they demonstrated awareness of the complaints policy and how to support a patient in raising a concern or making a complaint. Staff said that they were encouraged to undertake complaints management training. At the time of inspection, 100% of nursing staff had completed the training.

Inspectors heard that the rehabilitation unit received minimal complaints, a total of three complaints were recorded in 2024 and one in 2025 up to the time of the inspection. All complaints had been closed at this time. On the contrary, patients frequently complimented the care received in the unit as many of them had transferred in from very busy acute units. Inspectors viewed the complaints and compliments book kept on the ward. It contained compliments only and had no record of any complaints.

While noting the small number of written complaints, inspectors found that documentation to support tracking and trending of complaints data in meeting the HSE's key performance indicator (KPI) for the timeframe for resolution was not available and this presents an opportunity for improvement. Staff told inspectors that patients and their families sometimes express discomfort with the use of a planned discharge date as they feel they may not be ready for discharge however they are reassured on this as progress is continually monitored. Inspectors heard how a quality improvement plan was developed in response to a complaint and learning from the complaint was shared with staff informally at a monthly 'check-in meeting' which was verified by the clinical nurse manager (CNM). Complaints data was included in an annual report compiled by the community health organisation (CHO2).

Overall, there was evidence that hospital management had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service. To receive a higher rating in this standard, the service provider needs to ensure that.

- all elements of the complaints process including tracking and trending and meeting HSE targets are monitored to ensure compliance with HSE policy.

Judgment: Substantially 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 unit was open during the day and access out-of-hours from 9 pm until 8 am was via keypad. There was a sign-in book at the entrance, but the last entry was dated over four week earlier, At the opposite end of the unit, an exit door was used for ambulance access and was also via keypad only.

While inspectors noted that the physical environment was generally clean and tidy, the infrastructure of the ward was in poor general repair. Inspectors saw cracks on walls, floor damage, chipped and peeling paint and skirting boards that were broken. Window closures were defective and some did not close properly. These deficits had the potential to impact upon effective cleaning. A few of the outer casings of electrical sockets were found to be cracked. All of these were brought to the visible attention of management with a request for immediate repair of electrical socket casings at the time of inspection. Inspectors saw evidence of the infrastructure issues having been discussed and recorded in the minutes of the local governance and infection prevention control collaborative meetings. Management informed inspectors that a plan to provide a designated fit-for purpose rehabilitation unit had been delayed, to provide space instead for a stepdown ward for a local acute hospital during COVID-19 and that that arrangement remained in place at the time of inspection. Inspectors also heard that some funding had recently been approved for remedial works to include flooring, windows and painting to be undertaken in the unit while IPC were seeking funding to replace skirting boards and refurbish the en-suite facilities.

The rehabilitation unit comprised one single room primarily used for patients who required isolation for infection prevention and control reasons. All other patient rooms were multi-occupancy with four to five patients accommodated in each with good clinical spacing between beds observed (physical distancing of at least one metre between beds). Call-bells were available for patients to alert staff if they needed attention. All of the multi-occupancy-based rooms had en-suite facilities. Two additional shower and toilet facilities were located on the corridor for patients use. Although the unit was reported to have 27 beds including the respite bed, inspectors found that there were 34 beds present in the unit as follows: six beds in room one (although the sixth bed was reported to be not in use), five beds in room

two (although one was not in use and was marked for repair- which had been reported), four beds in room three, and six beds in each of the rooms numbered, rooms four, five and six. Each bedside was supplied with piped oxygen. Twenty three beds were occupied at the time of inspection. Staff told inspectors that cleanliness and hygiene of patient equipment was the responsibility of all staff in the clinical area. Inspectors observed equipment and found it to be visibly clean. There was a tagging system in use to identify cleaned equipment.

Inspectors noted that, except for room six, hand hygiene sinks conformed to national requirements and there were wall-mounted alcohol-based hand sanitiser dispensers strategically located and readily available with hand signage clearly displayed throughout the clinical area. Inspectors found that there was no service due date displayed on the macerator in the sluice room.

On the day of inspection, signage to communicate isolation precautions was available for use and donning and doffing techniques was observed on display outside of the single room. The door to what used to be an anteroom leading into the single room had been removed and had not been replaced. Personal protective equipment was available outside all rooms including the isolation room.

Inspectors found that the medication press was tidy with the range and number of available medicines applicable to the range of patient conditions cared for in this Unit.

An automated external defibrillator was mounted on a wall across from the nurse's station together with a safety bag and inspectors noted that checks were completed and signed off.

Hazardous material and waste were safely and securely stored. There was appropriate segregation of clean and used linen. The storage room was organised and tidy. There was a system of top-up in place however there was a general lack of appropriate storage facilities, with additional equipment for example, the hoist and the 'sit–to–stand' aid, being stored in multi-occupancy rooms. Patient suitcases, extra bed tables and mattresses were found stored in a bathroom on the corridor. Staff told inspectors that this bathroom was "rarely used but cleared out if it is needed when the ward is very busy". Inspectors heard and saw that the drug fridge temperature was checked daily and recorded in a logbook.

The CNM2 had oversight of the quality of cleanliness on the ward and reported any issues to the ADON and DON in the absence of the service manager. Environmental and terminal cleaning was carried out by designated household staff. Inspectors viewed the cleaning schedules and noted that the cleaning checklists were up to date. Changing of curtains was undertaken by laundry staff in line with unit policy and dated accordingly with one exception which was brought to the attention of the

ward manager during the inspection. Inspectors noted that there was no dedicated household room on the ward and so the cleaners' trolley was stored on the ward corridor, when not in use. Inspectors noted remnants of a sticky substance on walls (possibly used to display posters and not properly removed afterwards). Inspectors viewed the legionella guidelines which were in date and which stated that weekly flushing was to be carried out. Inspectors viewed the sign off sheets provided from 23 September 2025- to date of inspection and found that these related to 2-3 weekly intervals, apart from one. This observation was brought to the attention of staff during the inspection.

Inspectors heard how staff had access to off-site maintenance services and they reported no difficulty in accessing maintenance support. Items requiring attention were emailed by staff and for any urgent requests, the CNM2 or DON made direct contact with maintenance staff. A list of contact telephone numbers as may be required in the event of an emergency, was on display at the nurses' station.

Inspectors viewed a notice board at the nurses' station displaying information on the following: standard precautions, fire protocol, dealing with a missing person situation, contact number for hairdressing service for service users, violence and aggression guidance, a list of administration numbers in case of emergency and a signature bank.

In summary, inspectors found that the physical environment did not fully support the delivery of high quality, safe, reliable care and protect the health and welfare of service users as follows:

- several significant infrastructural issues as described above, had the potential to impact on cleanliness and infection prevention and control measures
- there was only one single room in the unit
- there was no dedicated household room on the ward
- there was a lack of general storage for large patient equipment resulting in evidence of some inappropriate storage arrangements
- no service due date displayed on macerator
- evidence of compliance with the flushing guidelines to help prevent Legionalla was not in line with the stated frequency of flushing.

Judgment: Non 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 some systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the hospital. Inspectors viewed the hospital's corporate risk register onsite. It contained a list of 16 sub-headings under the title of infection prevention and control. Each one was risk rated and contained a description of the controls currently in place. Inadequate infrastructure, risk of carbapenem resistant *Enterobacter ales* (CRE) and the infrastructure in the rehabilitation unit were all risk rated as red. Additional controls were described for the rehabilitation unit, and these had been escalated to senior management and HSE Estates. Inspectors saw that the status timeline was described as 'ongoing'.

A further risk related to the quality of auditing procedures in place at the hospital. Additional controls included staff training in auditing and completion of action plans to enable the hospital to systematically review care against standards for quality improvement covering the audit cycle. Staff had also expressed a need for training in audit activity. This was risk rated as red with a timeline of January 2026.

Risks at ward level were managed where appropriate. Staff in the clinical area escalated issues of concerns to the CNM2 who completed a risk assessment and forwarded it to the manager on duty in the hospitals' administration office and to the DON, who had oversight of the process. Hospital management explained that risks not manageable at hospital level were escalated to Community Healthcare West (CHW) via the quality and patient safety manager and upwards to the General Manager if necessary. Inspectors viewed the central risk register for the hospital which was updated quarterly and reviewed annually by management. Inspectors saw that risks related to the four areas of harm were recorded on the risk register however, several risks had no record of the risk owner or review date.

Inspectors viewed the safety alert form in use. This provided a record of assessment of risk of the following: epilepsy, seizures, swallowing difficulties, falls risk, diabetes, confusion, violence and aggression, sensory deficit in vision, speech, or hearing, allergies and anything else that might compromise personal safety, signed off by the assessor with review dates with time and signature. Inspectors also viewed the Sacred Heart Hospital wide nurse transfer letter which included demographic details, allergies, infection status, reason for transfer, vital signs, nursing assessments, medical history and medications.

Infection Prevention and Control

Staff demonstrated awareness of the possibility and impact of infection and outlined

the steps to be taken in the event of a potential or actual outbreak including early liaison with the IPC and public health teams. They told inspectors that they viewed the lack of isolation facilities as an ongoing risk as there was only one single room and it was rarely empty. Staff told inspectors that the IPC team were involved in signing off method statements relating to refurbishments. Inspectors heard and saw how risk assessments relating to infection prevention control were completed by the unit's clinical nurse manager and forwarded to the nursing administration office for inputting onto the hospital's risk register. These were discussed at the local monthly governance meeting which was chaired by the director of nursing and attended by clinical nurse managers, occupational therapists, physiotherapists, and heads of department. The DON escalated serious issues to the OPSM, and these were discussed at the DON governance meeting. Although inspectors found some evidence of audit of infection prevention and control, there was no tracking or trending of this and when IPC risk assessments were sought at ward level, they could not be located as the assessments in the folder were more than five years old. The unit had no guidance or policy on sepsis.

Medication Safety

Inspectors heard that the rehabilitation unit had no access to a drugs and therapeutics committee. The risk of no on-site pharmacy resources was listed on the hospital's risk register and inspectors viewed a risk assessment relating to that issue however, hospital management explained that the post had been approved for the SHHC campus (which would be under the governance of the pharmacy at the local acute hospital) and it was expected recruitment was to commence by January 2026. Staff described how pharmacy stocks were maintained, stored and checked on a regular basis. Inspectors viewed the medication management policy while on-site and although there was no separate 'sound alike, look alike drugs' (SALAD) list and no high-risk medicine list available on the unit, these were outlined in the medication management policy. Inspectors noted that the hard copies of medicines information were both out of date and there was no evidence of antimicrobial guidance being available to staff on the ward. This was brought to the attention of the CNM and hospital management during the inspection. Staff reported to inspectors that tablet crushing was only undertaken after contacting the pharmacy for advice beforehand and if the medicine was not suitable for crushing, the prescription was referred to the doctor who prescribed syrup instead. There was, however, no documentation in place guiding this action. Staff told inspectors that they received alerts from pharmacy in the local acute hospital. Inspectors noted that any medication safety issues were discussed at the daily safety pauses held on the unit at 8 am, 3 pm and 8.30 pm respectively. They were also discussed at staff meetings. Inspectors heard that staff were required to attend medication safety education on HSeLanD at least on an annual basis and this was overseen by practice development. While inspectors

viewed evidence of medication safety audits, there was no tracking or trending found in relation to these.

The Deteriorating Patient

Inspectors viewed a risk assessment relating to the potential risk for the non-detection of patient deterioration and potential for poor patient outcomes in such an event. It listed the existing control measures which included an admissions policy and admission criteria for rehabilitation, clinical handover and medical officer reviews, medication management policy and guideline for the discharge or transfer of a patient from the rehabilitation unit. Hospital staff told inspectors that the Advanced Nurse Practitioner (ANP) for stroke patients visited the rehabilitation unit once a week and provided guidance and support to nursing staff as well as review of patients. Inspectors observed the use of a log to record 'bedrail-checks' which was placed outside of each of the rooms. It was used to record 30-minute checks of patients for whom bed rails were in place in each room.

Transitions of Care

Inspectors viewed a risk assessment relating to the potential risk for patients at transitions of care including medication errors, current treatment errors, patient specific risks and IPC risks resulting in a potential for poor outcomes for patients. Existing control measures were described, and this was to be reviewed on an annual basis by the DON.

Policies, Procedures and Guidelines

Inspectors viewed the Community Healthcare West (CHW) policy on standard based and transmission-based precautions plus the policies on outbreak management and prioritisation of patients for single room isolation. There was also a guideline covering equipment and environmental cleaning and decontamination in place.

The CHW-wide medication management policy included medicine reconciliation, 'sound alike and look alike drugs', a list of high-risk medicines and there was a section on the use of continuous positive airway pressure (CPAP) as used on patients with sleep apnoea. Inspectors noted that the latter is a treatment rather than a medicine and as such, warrants its own policy for use.

There was no written guidance on what to do if concerned about a patient who, for example, was deteriorating, although staff clearly outlined how they manage such situations.

Inspectors found that the admission policy and criteria was in draft format. The guideline relating to discharge and transfer from the rehabilitation unit was in-date.

Inspectors also viewed a local policy and procedure in the rehabilitation unit covering risk management, emergency planning and incident management.

In summary, inspectors found that the service providers broadly protected service users from the risk of harm associated with the design and delivery of healthcare services as set out above however, inspectors found several deficits as follows:

- incomplete risk register as outlined above
- no policy on the recognition of sepsis or deterioration in a patient
- no pharmacist – although due to be in place by early 2026
- no use of the communication tool, ISBAR.

Judgment: Partially Compliant

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

The hospital had a patient safety incident management system in place to identify, manage, respond to and report on patient–safety incidents in line with legislation and national guidance. Staff nurses and healthcare assistants reported issues to the CNM2 of the rehabilitation unit who escalated those to the ADON and DON who had oversight of all incidents.

Clinical incidents were reported via the national incident management system (NIMS). Inspectors spoke with staff who were knowledgeable about how to report a patient safety incident, and they reported that falls were the most commonly occurring patient safety incident reported. A total of 50 incidents were reported in 2024 with 72% related to slips, trips and falls. Thirty-five incidents had been reported in 2025 at the time of this inspection and 74% of these related to falls. Several measures were in place to mitigate this risk including the undertaking of a falls risk assessment, education of patients on the use of the call-bell system, and the use of 'crash mattresses' as observed in use, by inspectors in the clinical area. Inspectors viewed documentation which showed that 33 of the 35 incidents had been reported to NIMS within 30 days, and this met the HSE target for reporting times.

Inspectors heard and saw how patient safety incidents were tracked and trended. Inspectors viewed an analysis report of incidents occurring in 2024 and 2025 based on injury type. Inspectors viewed the summary report of volume and type of incidents and the minutes of staff meetings where they saw evidence of patient

safety incidents being discussed. Staff confirmed to inspectors that feedback on incidents was provided to them verbally during staff meetings, at handover and during safety huddles. Forty one of the 50 incidents in 2024 resulted in no injury and four incidents related to medication safety. Thirty of the 35 incidents in 2025 resulted in no injury. Inspectors noted that although four of the 50 incident reports related to medication safety in 2024, none of the 35 incidents reported in 2025 related to medication safety. Inspectors discussed this with hospital management, noting the possibility of under-reporting.

Inspectors viewed a comprehensive closure notice of an infection outbreak in 2025.

Staff spoke with inspectors in relation to the challenges associated with patients who had a brain injury and the need to ensure safety. Staff explained how this was supported by effective staff to patient ratio, close monitoring, 24/7 access to the medical registrar and consultant on-call, and where indicated, transfer to the local acute hospital to help promote and maintain patient safety.

In summary, inspectors found that while the service providers had a system in place to identify, manage, respond to and report on patient-safety incidents, their data showed there was a possible potential for under-reporting, particularly in the area of medication safety where no incidents had been reported for the year to date by the time of inspection. This underlined the need for continuous tracking and trending of information to further enhance patient safety.

Judgment: Substantially Compliant

Conclusion

The rehabilitation unit was found to be substantially compliant with National Standards 6.1, 1.6, 1.8 and 3.3, partially compliant with National Standards 5.2, 5.5, 5.8 and 3.1 and non-compliant with National Standard 2.7.

Overall, patients reported high levels of satisfaction with the care provided and staff reported job satisfaction. However, inspectors found that the physical infrastructure was in a poor state of physical repair.

Capacity and capability

While the service provider had some formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare, there is a need to improve on documentation relating to governance and alignment with terms of

reference. There was no annual IPC plan for the year ahead or compilation of an end of year report for the rehabilitation unit to help drive and track improvement.

Inspectors were not fully assured that the service provider had effective management arrangements in place to support and promote the delivery of high quality, safe and reliable healthcare services, for example, the available medication information was out of date, there was no standardised communication tool in use and the admission policy was in draft format.

Inspectors saw evidence of the development of quality initiatives within the unit and there was some evidence of monitoring arrangements to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services however, there was a lack of an overall plan and organisation around audit activity in the four areas of known harm and staff expressed a need for support and training in audit activity.

Inspectors found that the service provider planned, organised and managed their workforce to achieve the service objectives for high quality, safe and reliable healthcare, although there is an opportunity for the service provider to further improve compliance with the HSE target relating to staff absenteeism levels.

Quality and safety

Inspectors found 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 and were seeking to ensure this as is consistent with the human rights-based approach to care promoted by HIQA however, the service provider could ensure transparency of patient consent regarding the placement of patient names and other details such as, dietary requirements, over bed heads. Patients commented that the unit was *"such a warm happy place", "it's like a home from home", "cosy"*. Patients stated that staff were *"very friendly ", "everyone is so nice",* and *"always willing to help".* Other positive comments referenced the availability and choice of food and satisfaction with the bathroom facilities available.

Inspectors observed staff actively engaging with patients in a respectful manner and they ensured patients' needs were promptly responded to. This observation was validated by the patients who said, *"they come straight away"*. Staff were observed promoting patients' privacy and dignity, and curtains were observed to be drawn when attending to personal needs and care.

Inspectors found that the service provider had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service.

Inspectors found that the physical environment, however, did not fully support the delivery of high quality, safe, reliable care and protect the health and welfare of service users. There were several significant infrastructural issues including defective window closures, cracks in walls, damaged floor covering, and damaged paintwork, all of which had the potential to impact on safety and cleanliness, and infection prevention and control measures. There was only one single room in the unit, there was no dedicated household room on the ward, and there was a lack of general storage for large patient equipment resulting in evidence of some inappropriate storage arrangements.

Inspectors found that the service provider broadly protected service users from the risk of harm associated with the design and delivery of healthcare services however deficits included: an incomplete risk register and non-availability of up-to-date risk assessments, no policy on the recognition of sepsis or deterioration in a patient, no pharmacist – although this was due to be in place by early 2026, no use of the communication tool, ISBAR and no evidence of tracking or trending audit activity which could be used to drive improvement. The service provider was substantially compliant with National Standard 3.3 relating to the identification, management and evaluation of incidents.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the progress in relation to compliance with the National Standards identified above as partially or non-compliant.

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	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.	Partially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting	Partially Compliant

on opportunities to continually improve the quality, safety and reliability of healthcare services.	
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.	Substantially 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.	Substantially Compliant
Theme 2: Effective Care and Support	
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.	Non 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.	Substantially Compliant

Compliance Plan for

Rehabilitation Unit at Sacred Heart Hospital, Castlebar.

Inspection ID: NS:0176.

Date of inspection: 08 and 09 December 2025

Introduction

This document sets out a compliance plan for healthcare service providers to outline action(s) completed or intended to be completed following an inspection by HIQA whereby the service was not in compliance with the *National Standards for Safer Better Healthcare Version 2 (2024)*.

Any substantially compliant judgments indicate that some action is required to bring the service into full compliance. These actions should be addressed locally and do not form part of this compliance plan.

This compliance plan only relates to:

- standards that were deemed **partially compliant or non-compliant** by HIQA

The compliance plan should be completed and authorised by a representative of the service provider with responsibility to act on behalf of the service, for example the service's Chief Executive Officer, Chief Officer, or other relevant designated manager.

It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frames. The compliance plan should detail how and when the service provider will comply with the national standards.

Instructions for use

The healthcare service provider must complete this plan by:

- outlining how the service is going to come into compliance with the relevant national standard(s)
- outlining timescales to achieve compliance.

The provider's compliance plan should be SMART in nature:

- **Specific** to the non-compliance identified with the national standard(s)
- **Measurable** so that progress towards compliance can be monitored

- **Achievable**
- **Relevant**
- **Time bound** – The proposed actions outlined in the compliance plan should be accompanied by clear delivery dates and key milestones (where appropriate)

Healthcare Service Provider's responsibilities

- Service providers are advised to focus their compliance plan action(s) on the overarching systems that they have, or will put, in place to ensure compliance with a particular national standard, under which a partially compliant or non-compliant judgment has been made.
- Service providers should change their systems as necessary to bring them into compliance rather than focusing on the specific failings identified.
- The service provider must take action within a **reasonable** time frame to come into compliance with the standards.
- It is the service provider's responsibility to ensure they implement the action(s) within the time frame as set out in this compliance plan.
- Subsequent action and plans for improvement related to urgent risks already identified by HIQA during the inspection and responded to by the service provider should be incorporated into this compliance plan.

As part of the continual monitoring to assess compliance, HIQA may ask the service provider before and during subsequent inspections to provide an update on how it is implementing its compliance plan.

Continued non-compliance

Continued non-compliance with the national standards resulting from a failure by a service provider to put in place appropriate action(s) to address the areas of risk previously identified by HIQA may result in increased monitoring activity including further inspection activity, seeking compliance plans and assurance reports from the provider. It may also result in further escalation into the relevant accountable person(s) in line with HIQA policy.

Long-term and medium-term work to meet compliance with the standards.

HIQA recognises that substantive and long-term work may be required to come into compliance with some national standards and that this may take time and require significant investment. An example of this may be in relation to non-compliance and risks identified with infrastructure. In such cases, the medium- and long-term solutions should be outlined to HIQA with clear predicted time frames as to how the service provider plans to improve the level of compliance with the relevant national standard.

HIQA requires assurance and details of

- how mitigation of risk within the existing situation will be addressed
- information on medium and long term mitigation measures to manage risks and improve the level of compliance with standards.

Compliance descriptors

The compliance descriptors used for judgments against standards are 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.

Compliance plan - Provider's response:

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: - Terms of references for all relevant committees are presently being reviewed and updated to reflect the formalised changes to governance under Mayo IHA. - We are reviewing a calendar of the scheduled meetings, this will be maintained on site by the relevant convener. - All four areas of known harm, IPC, Transitions of care, medication safety and deteriorating patient are all now added to the monthly governance group meeting as a standing agenda. - An annual IPC plan for 2026 is being completed and an end of year report for the rehabilitation unit will be compiled. - Actions identified in various committees and meetings will be time bound, followed through to completion and updates recorded regularly.	
Timescale: 02/10/2026	
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	**Partially Compliant**
Outline how you are going to improve compliance with this national standard: - Up to date British National Formulary will be made available for all staff which will ensure up to date access to medication information.	

- The standardised communication tool, ISBAR is currently being used in the unit for clinical handover, and in transitions of care.

- The new admission policy is being finalised to reflect the changes in the governance structure following transition to Mayo IHA.

Timescale: 30/10/2026

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.	**Partially Compliant**

Outline how you are going to improve compliance with this national standard:

- An audit schedule to include all four areas harm and other relevant areas is now place

- Staff who are involved in audits are being monitored and supported by a dedicated staff member to assist them in meeting standards in audit procedures and reporting.

- A training programme in clinical auditing is now available to the senior staff members to enhance their skill in this area.

Timescale: 28/08/2026

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.	**Non Compliant**

Outline how you are going to improve compliance with this national standard:

- There is a planned programme underway at present to remedy the damaged, defective and unsuitable surfaces identified on inspection. At present the defective flooring and skirting boards have been replaced in 4 of the wards and the works are ongoing. All the damaged electric sockets have been replaced.

- Funding has been procured to refurbish the on-suite toilet and shower facilities on the ward.

- The risk of having only one single room has been updated in the hospital risk register and escalated to senior management.

- A household storage room has been identified in the main Sacred Heart Hospital area.

- We have reminded staff that when not in use, large patient equipment to be returned to the dedicated storage bay on the unit.

- The service due date is now displayed on the macerator.

- we have formal cover arrangements in place while the dedicated person for flushing is unavailable or on leave.

Timescale: 27/11/2026

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:

- The risk register is being updated on a regular basis and now include the areas identified on inspection.

- Our SESPIS SOP is being updated at present

- We are presently finalising an SOP on the deteriorating patient and is expected to be in place by the 30th August

Pharmacist post has been recruited into. They are presently on planned leave with current support being provided by their colleagues from the local acute hospital.

- ISBAR communication is currently in use.

Timescale: 30/10/2026