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:	St Finbarr's Rehabilitation Unit
Address of healthcare service:	Douglas Road Ballinlough Co Cork T12 XH60
Type of inspection:	Announced
Date of inspection:	18 and 19 September 2024
Healthcare Service ID:	OSV-0007274
Fieldwork ID:	NS_0094

About the healthcare service

Model of Hospital and Profile

The rehabilitation unit located at St Finbarr's Hospital (SFH) campus is a 71-bedded unit, which is under the governance of Cork University Hospital (CUH). CUH is a model 4* public acute, tertiary referral centre and university teaching hospital managed by the South/South West Hospital Group (SSWHG)† on behalf of the Health Service Executive (HSE).

Older persons who require rehabilitation can be admitted under a geriatrician to the rehabilitation unit from, the out-patients department (OPD), transitions of care (TOC) unit or prior to discharge home from the acute hospital setting. Criteria for admission to the unit includes patients over 65 years of age, who are medically stable and who are under the care of a consultant geriatrician, and who consent to and are able to participate in rehabilitation.

The following information outlines some additional data on the hospital.

Number of beds	71

How we inspect

Among other functions, the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with the statutory responsibility to set and monitor standards in relation to the quality and safety of healthcare services. This inspection was carried out, as part of HIQA's role to assess compliance with the *National Standards for Safer Better Healthcare.* To prepare for this inspection, the inspectors‡ reviewed relevant information, which included previous inspection

* A model-4 hospital is a tertiary hospital that provide tertiary care and, in certain locations, supra-regional care. The hospital have a category 3 or speciality level 3(s) Intensive Care Unit onsite, a Medical Assessment Unit, which is open on a continuous basis (24 hours, every day of the year) and an emergency department.

† The South/South West Hospital Group is made up of seven hospitals — Cork University Hospital; Cork University Maternity Hospital; University Hospital Kerry; Mercy University Hospital; South Infirmary Victoria University Hospital; Bantry General Hospital; Mallow General Hospital. The hospital group's academic partner is University College Cork.

‡ Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with the *National Standards for Safer Better Healthcare*.

findings, information submitted by the provider, unsolicited information[§] and other publicly available information.

During the inspection, the inspectors':

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

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

This section describes the experiences, care and support people using the rehabilitation unit receive on a day-to-day basis. It is a check on whether the care in the rehabilitation unit is of good quality, caring, person-centred and safe. It also includes information about the healthcare environment where people receive care.

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

A full list of the 11 national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
18 September 2024	13.25hrs – 17:40hrs	Mary Flavin	Lead
19 September 2024	08.45hrs – 16.00hrs	Bairbre Moynihan	Support
		Eilish Browne	Support

Information about this inspection

This announced inspection focused on 11 national standards from five of the eight themes of the National Standards for Safer Better Healthcare and the inspection focused on four key areas of known harm:

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

The inspection team visited one clinical area:

- St Oliver's ward (34-bed general rehabilitation ward).

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

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

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

The inspection team also spoke with the following staff at the hospital:

- representatives of the Executive Management Board (EMB)
- Interim Chief Executive Officer
- Director of Nursing
- Clinical Director for the medical directorate
- the clinical lead for the rehabilitation unit
- quality and patient safety lead medical directorate
- quality and patient safety manager
- a non-consultant hospital doctor (NCHD)
- a representative from the human resources department
- infection prevention and control (IPC)
- the clinical nurse manager 3 (CNM3) for the rehabilitation unit
- the discharge coordinator for the rehabilitation unit
- a representative for the management of complaints for the rehabilitation unit
- representatives from each of the following hospital committees:
    - Drugs and Therapeutics Committee
    - Acutely Unwell Adult Patient Committee
    - Quality and Patient Safety Committee.

Inspectors also spoke with people receiving care in the clinical area visited and staff from different disciplines working in the area.

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 the people using the service who spoke with inspectors about their experience of the unit.

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

St Finbarr's Hospital rehabilitation unit was a 71-bedded unit comprising of two wards, St Oliver's and St Claire's. Inspectors visited St Oliver's Ward, a 34-bedded ward consisting of, five four-bedded multi-occupancy rooms, each with toilet and shower facilities available for patient use. There were 14 single rooms. All single rooms had en-suite bathroom facilities with the exception of one. All bathrooms were wheelchair accessible. There was a visitor's room, a gym therapy room and an enclosed court yard for patients to go outside. Inspectors observed staff actively engaging with patients in a respectful and kind way, taking time to talk and listen to them. Staff were observed promoting and protecting the patient's privacy and dignity when delivering care.

Inspectors spoke with a number of patients receiving care in St Oliver's Ward, who stated they were 'very happy' with the care they received and were very complimentary about staff. Staff were described as 'lovely', 'very attentive', 'kind and friendly', 'approachable, and that staff were 'excellent in their jobs'. The patients' also felt staff were accessible and supportive 'staff were very good to check in, even at night time so I never got lonely'. Patients' were also very happy with being taken outside for 'fresh air', especially in good weather. Patients' stated when asked that they had not received information about the hospital's complaints process and or independent advocacy services. However, the patients' did not have any complaints at the time of inspection, but said they would speak with a member of the nursing staff if they had to make a complaint or raise a concern.

Capacity and Capability Dimension

Inspection findings related to the capacity and capability dimension are presented under four national standards (5.2, 5.5, 5.8 and 6.1) from the themes of leadership, governance and management and workforce. The rehabilitation unit was found to be compliant with one national standard (5.5) and substantially compliant with three national standards (5.2, 5.8 and 6.1) assessed. Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

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

In 2022 the rehabilitation unit came under the governance of Cork University Hospital (CUH). Prior to this it was under the governance of Community Healthcare Organisation (CHO) 4. Inspectors found that there were corporate and clinical governance arrangements in place between CUH and the rehabilitation unit at SFH, to ensure the delivery of high quality, safe and reliable care provided to patients' in the unit. However inspectors identified some areas for improvement to bring this standard into full compliance.

Through discussions with staff and senior management, and from a review of documentation it was evident that staff working in the rehabilitation unit were clear about their roles, responsibilities and reporting arrangements.

Organisational charts showing the hospital's reporting structures were submitted to HIQA as part of the pre-onsite documentation request. These charts detailed the direct reporting lines for hospital management and the governance and oversight committees. They also clearly outlined the reporting and accountability relationships to the Executive Management Board (EMB), the interim Chief Executive Officer (CEO) of CUH/CEO of the Cork University Hospital Group (CUHG), and up to the CEO of the SSWHG. Inspectors found these arrangements to be consistent during their inspection. The position of CEO of CUH was recently vacated with an interim CEO in post at the time of inspection.

Clinical governance of the rehabilitation unit was managed by the geriatric medicine specialty lead under the medical directorate. The clinical lead in the rehabilitation unit, a consultant physician in geriatric medicine, was responsible for the medical care of patients admitted to the unit. The governance arrangements, lines of responsibility, and the inclusion/exclusion criteria for admission were

formalised in an admission criteria/framework document. The following outlines the governance structure in place for the rehabilitation unit in SFH:

The Executive Management Board

The EMB had a direct reporting relationship to the interim CEO CUH. Terms of reference requested by HIQA as part of the pre on-site documentation, data request were not provided to inspectors. Minutes of the board meetings, submitted to HIQA, showed that meetings followed a structured format. Actions from the meetings were assigned to specific individuals; however, inspectors noted actions were not time bound or progressed from meeting to meeting.

Medical Directorate Leadership Team

The Medical Directorate Leadership Team (MDLT) was the main governance structure assigned with responsibility for the governance and oversight of the healthcare services at SFH rehabilitation unit. Membership for the medical directorate was multi-disciplinary and included; for example, the clinical director, a business manager, nursing lead representative(s), and a health and social care professional representative (HSCP). As per the terms of reference the MDLT met monthly with the clinical leads of each speciality. The chair of the MDLT was operationally accountable to the EMB. The terms of reference for the MDLT were submitted to HIQA were in draft format.

Geriatric Medicine Group

The Geriatric Medicine Directorate (GMD), led by a consultant geriatrician reported to the MDLT. The clinical lead for the rehabilitation unit reported to the lead consultant of the geriatric directorate. Monthly meetings of the GMD were attended by a multidisciplinary team, including the geriatric medicine lead, and chaired by the clinical director of the medical directorate.

Minutes of meetings, reviewed by HIQA inspectors for April, May, and June 2024, showed that the rehabilitation unit was discussed at all three meetings. Topics included staffing shortages, the requirement for additional beds, out-of-hours cover, and criteria for transferring patients from acute care to the rehabilitation unit. However, inspectors noted while actions were assigned to specific individuals actions were not time bound.

Quality, Safety and Risk Committee

The medical quality safety lead for the rehabilitation unit reported into the quality manager in CUH, who was a member of the Quality, Safety and Risk Committee (QSRC). The QSRC reported up to the EMB and onwards to the interim CEO of CUH. The multidisciplinary QSRC committee was chaired by a clinical director from

CUH. The committee met every month in line with its terms of reference, and membership included representatives from all hospital departments including the clinical lead for geriatric medicine.

Minutes of meetings reviewed by inspectors were comprehensive, and showed meetings followed a standard agenda that was aligned with the *National Standards for Safer Better Healthcare.* Meetings were action orientated and progress with the implementation of agreed actions was monitored between meetings. However, inspectors observed that some actions were overdue, and did not have a new date for completion identified; for example, terms of reference to be updated. The organogram provided in the terms of reference was not aligned to the reporting relationship in the CUH clinical governance structure organogram. For example, the terms of reference had the chair of the QSRC reporting into the Executive Quality and Patient Safety Committee (EQPSC) of CUH; however, the organogram documents the chair reporting into the EMB of CUH. This was discussed with senior management at the time who were aware of the discrepancy and confirmed that the QSRC reported into the EMB of CUH.

The QSRC reviewed reports from the various sub-committees that reported into it; for example, Acutely Unwell Adult Patient, Antimicrobial Stewardship, Infection Prevention and Control (IPC) and Serious Incident Management Team (SIMT).

In addition to providing oversight of performance of committees, the QSRC provided updates on the hospital's risk register, reported on patient safety incidents, complaints management, feedback on patient experiences, and progress on implementation of patient safety quality improvements to the hospital's EMB.

Infection Prevention and Control and Antimicrobial Stewardship Committee

Cork University Hospital's multidisciplinary IPC and Antimicrobial Stewardship committees (AMSC) were responsible for the governance and oversight of IPC and antimicrobial stewardship activities at the rehabilitation unit. The multidisciplinary committee, chaired by the director of nursing CUH, reported to the QSRC. The committee met every month in line with its terms of reference and membership included representatives from different health professionals and clinical departments across the group. Several teams reported to the Infection Prevention and Control Committee (IPCC). These include representatives from Infection Prevention and Control Team (IPCT), Hygiene Services Team (HST), Decontamination of Reusable Invasive Medical Devices Team (DRIMD) antimicrobial pharmacist, and a surveillance scientist/medical scientist. While the minutes of these committee meetings were comprehensive, indicated that the meetings followed a structured agenda, were action orientated and the

implementation of agreed actions were monitored from meeting to meeting, inspectors observed that not all actions were time bound or assigned to specific individuals. For example, care bundles were not fully completed; however, inspectors noted an action from the IPCC implemented in the clinical area visited; for example, a poster on the misuse of gloves was displayed on the notice board in St Oliver's ward. Terms of reference for the IPCC were reviewed by inspectors and were overdue for review and update since March 2023.

Drugs and Therapeutics Committee

The Medical Directorate, Cork University Hospital was responsible for the governance and oversight of medication safety practices at the rehabilitation unit. However, inspectors identified opportunities for improvement in the governance and oversight of the pharmacy service provided to the rehabilitation unit. The pharmacist who covered the unit, was employed by the CHO, reported to a general manager for older person's services from CHO 4, and was not part of the DTC in CUH. The DTC, chaired by a consultant physician reported to the Clinical Effectiveness Committee (CEC) in CUH, who reported to the EMB. The committee met every two months in line with its terms of reference and membership was multi-disciplinary with representatives including a consultant microbiologist, chief pharmacist, medication safety pharmacist, senior nurse manager, and risk manager. The committee comprised of a number of sub-teams that reported into the DTC, these included CUH antimicrobial stewardship team, and CUH multidisciplinary medication safety working group. Minutes reviewed by inspectors were comprehensive, and indicated that committee meetings followed a structured agenda; however, actions were not time bound or assigned to a responsible person to action.

When reviewing the CUH clinical governance structure charts, inspectors noted that antimicrobial stewardship reported to the QSRC; however, the DTC's terms of reference have the antimicrobial stewardship reporting to the DTC, which then reported to the CEC. Inspectors brought this to the attention of senior management during the inspection. Senior management informed inspectors that they had met that morning to discuss medication reporting with an action arising that senior management planned to dissolve the CEC and have the DTC report to the QSRC.

Steering Committee for the Acutely Unwell Adult Patient

The CUH steering committee for the acutely unwell adult patient had oversight of the effectiveness of CUH's deteriorating patient improvement programme, which included sepsis management, and was chaired by a medical consultant. This multidisciplinary committee was comprised of clinical representatives from across

CUH including the ADON for the rehabilitation unit. The committee met monthly in line with its terms of reference and reported to the QSRC, who reported up to the EMB. Minutes of meetings reviewed by inspectors were comprehensive and showed meetings followed a structured agenda. All minutes had an action log that identified actions to be completed, which were time bound and assigned to a responsible person. The implementation of agreed actions was monitored between meetings.

At the time of inspection there was no Transition of Care Committee (TOCC) established. However, inspectors were informed by senior management that plans were underway to develop this committee. On review of documentation inspectors noted a transition of care committee being established as part of the CUH clinical governance structure organogram, reporting into the QSRC.

Overall, inspectors found that there were corporate and clinical governance arrangements in place to ensure the delivery of high quality, safe and reliable care provided to patients' in the rehabilitation unit at SFH. However, inspectors identified some areas for improvement to bring this standard into full compliance:

- Improvements in the integration of the governance and oversight of the pharmacy service provided to the rehabilitation unit with CUH DTC
- actions from a number of committee meetings were not assigned action owners and were not time bound (GMD, IPC, DTC)
- terms of reference for a number of committees were out of date or were in draft, for example, MDLT.

Judgment: Substantially compliant

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

Inspectors found that management arrangements were in place in the rehabilitation unit to support the delivery of safe and reliable healthcare. The unit had clear lines of responsibility and accountability for clinical and nursing leadership. The on-site geriatrician consultant was responsible for clinical governance and the day-to-day coordination of the hospital, and reported to the clinical lead for geriatric medicine. The role of one whole-time equivalent (WTE)[§§] geriatric consultant was shared by two geriatric consultants. From Monday to

[§§] Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.

Friday a geriatric consultant was present on site, supported by one medical registrar and two senior house officers (SHOs).

Out of hours the hospital was supported by an on-call consultant geriatrician, a medical registrar, and three SHOs based at CUH. One SHO was the primary contact for any queries from the rehabilitation unit and attended onsite as needed.

The director of nursing CUH was responsible for managing nursing services at the rehabilitation unit. An assistant director of nursing (ADON) based in CUH oversaw nursing care across the medical directorate and could be contacted by phone when not on site. The clinical nurse manager (CNM) 3, supported by a CNM 2 managed the day-to-day operations of the rehabilitation unit from Monday to Friday and reported to the ADON, CUH. A CNM 2 or a designated person in charge was on duty each shift, and was responsible for nursing services after hours and on weekends. Inspectors were informed by senior managers that there was no designated complaints officer; however, complaints were being managed by the quality patient safety (QPS) lead for the medical directorate.

The unit had management arrangements in place in relation to the four areas of known harm[***] and these are discussed in more detail below.

Infection, prevention and control

Staff in St Oliver's ward were supported by a multidisciplinary IPC team under CUH governance. The rehabilitation unit staff had 24/7 access to an on-call consultant microbiologist. An IPC team member was on site once a week, inspectors were informed that they were available by phone when not on site. The IPC nurse reported any issues to the ADON for infection control at CUH, who was part of the IPCC.

Medication Safety

The pharmacy department, which provided services to the rehabilitation unit also covered the residential unit and the out patient departments on SFH campus. It was staffed by 1.8 WTE senior pharmacists, who reported to the general manager for older person's services, CHO 4. At the time of inspection 0.8 WTE senior pharmacist was on temporary leave and the post was being backfilled by locum pharmacists. There was also a senior pharmacist who worked six hours a week in dispensary. Although there was a chief pharmacist at CUH, the pharmacist at the rehabilitation unit was not under CUH's governance and did not have access to CUH's drug and therapeutic updates. Inspectors highlighted this issue to senior management during the inspection. One WTE basic grade technician supported

[***] Infection prevention and control, medication safety, the deteriorating patient (including sepsis) and transitions of care

the pharmacist. The rehabilitation unit received pharmacy supplies from SFH pharmacy department during core working hours. Outside these hours nursing administration accessed the necessary medicines from the pharmacy in SFH.

Deteriorating Patient

A steering committee for the acutely unwell adult patient, chaired by a medical consultant, had oversight of the implementation of the national INEWS and sepsis guidelines at CUH and the unit. The ADON for the rehabilitation unit was a member of this committee. Senior management informed inspectors that there was not a medical lead for the Irish National Early Warning System (INEWS) at the time of inspection. However, inspectors were informed that nurse managers, along with the geriatric clinical lead for the rehabilitation unit had a clear pathway for responding to deteriorating patients, and this was confirmed by documentation seen and reviewed by inspectors. Out-of-hours, patients were referred to the on-call SHO for the unit, who would come on site to review the patient, or to the medical registrar at CUH.

Transitions of care

The rehabilitation unit had one WTE discharge coordinator responsible for managing all admission referrals through a specific database. The coordinator collaborated daily with staff at CUH, such as physiotherapists and occupational therapists, to identify patients who met the admission criteria and were suitable for transfer to the rehabilitation unit. A proforma document, including set goals was completed for all patients transferring to the rehabilitation unit. Patients' notes were transferred between hospitals for individuals transitioning to the rehabilitation unit. On the day of inspection, staff informed inspectors that a business plan had been completed for a coordinator to work between CUH and the rehabilitation unit at SFH to facilitate transfers.

Inspectors were informed of plans to establish a St Finbarr's Hospital Rehabilitation Unit Operational Group, starting in September 2024 that will oversee patient transfers from CUH and escalate unresolved issues to relevant senior management. An approved TOR were provided to inspectors.

Overall, the rehabilitation unit had effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.

Judgment: Compliant

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

Inspectors found that there were systematic monitoring arrangements in place in the rehabilitation unit for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Monitoring service's performance

Data in relation to patient flow was being tracked locally by staff in the rehabilitation unit, this included, total number of admissions, average length of stay (LOS), number of transfers back to CUH, and discharge destination. Data was collected and reported monthly for inclusion in the HSE hospital patient safety indicator report (HPSIR).

Risk management

Risks were identified and managed locally in the clinical areas of the rehabilitation unit by the CNMs' with the ADON's support, and the support of the QPS lead within the medical directorate. Staff in the clinical area confirmed that the CNMs' completed the risk assessments and implemented actions to mitigate any potential and actual risks to patient safety. Risks were recorded on a risk assessment form and maintained in the clinical area. Inspectors observed and reviewed these risk assessments during inspection. Inspectors were informed that risks which could not be managed locally were escalated to the medical directorate level and then to the EMB at CUH. At the time of inspection, there were three risks on the medical risk register for the rehabilitation unit, relating to three of the four areas of harm. This will be discussed further under national standard 3.1.

Audit activity

The CNM 3 in the rehabilitation unit had oversight of local audits. A member of the IPC team carried out audits in hand hygiene and multi-resistant drug organisms (MDRO) associated audits. Environment hygiene and equipment audits were carried out by the household supervisor. Meeting minutes indicated, and inspectors were informed that audit findings were discussed at the IPCC meetings, and the QSRC had oversight of all audits carried out. The HSE Test Your Care nursing and midwifery care metrics were completed monthly; for example, medication safety, patient monitoring and surveillance of INEWS, and health care associated infection prevention and control. Audit results were displayed for staff in the clinical area and discussed at staff meetings, and handover for shared learning. Audit results are discussed further under national standard 2.8.

Management of serious reportable events and patient-safety incidents

CUH had oversight of the reporting and management of serious reportable events (SRE), serious incidents, and patient-safety incidents that occurred in the rehabilitation unit. The Terms of Reference (TOR) outlined that the SIMT oversee the management, communication, and investigation of serious incidents, ensuring compliance with the HSE Incident Management Framework (IMF). Meetings were held monthly and after a serious incident, chaired by the CEO of CUH. The SIMT reported to the QSRC and then to the EMB.

Patient safety incidents, and SREs, were reported to the National Incident Management System (NIMS). At the time of inspection training on direct entry reporting to NIMS had started at the rehabilitation unit, with a go-live date set for October 2024. In the meantime paper incident forms were being completed in the clinical area and sent to the ADON and QPS lead for the medical directorate. There was evidence that quality improvement plans were developed following reported incidents. For example, an operational group review of drugs & therapeutics governance of CUH was initiated in response to medication incidents per 1,000 beds as reported to NIMS.

Feedback from people using the service

Formal complaints were being tracked and trended through QSRC. If further escalation was required, this was done through the clinical lead of the directorate up through the EQPSC, and up to the EMB. Meeting minutes reviewed from the QSRC indicated that the requested quarterly and six-monthly reports on complaints were not provided to the directorates due to staff shortages in the QPS department. This was discussed with senior management on the day who attributed it to staffing deficits.

Patient feedback, complaints and compliments were observed by inspectors to be a standing item on the QSRC agenda and minutes of meetings. The national key performance indicators (KPI) requires that 75% of complaints be investigated and concluded within 30 working days of being acknowledged. However, data submitted to HIQA showed that the hospital was not meeting the national target, with 66% of complaints responded to in quarter two of 2024.

Overall, on the day of inspection while the hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services, the following areas for action were identified:

- requested quarterly and six-monthly reports on complaints were not provided to the directorates

- national KPI target which require 75% of complaints be investigated within 30 working days of being acknowledged were not being met.

Judgment: Substantially compliant

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

The workforce arrangements in SFH rehabilitation unit were planned, organised, and managed to ensure high-quality, safe, and reliable healthcare. One WTE geriatrician consultant was approved for the unit. The clinical lead was a consultant in geriatric medicine. From Monday to Friday, the role of one WTE geriatric consultant was shared by two geriatric consultants. They were supported by one medical registrar and two SHOs within the medical directorate. Nine consultant geriatricians' supported an on-call roster for the rehabilitation unit. Management informed inspectors that all consultants employed at the hospital were on the relevant Specialist Division of the Register of the Irish Medical Council. The rehabilitation unit had an approved complement of 60 WTE nursing staff. At the time of inspection, 53.1 WTE positions were filled and there was 6.9 WTE temporary vacancies. One WTE CNM 3 position was approved and filled. The ADON for the medical directorate provided oversight for the unit and was present on-site when required. Additionally, the ADON was available by phone during core working hours. At the time of inspection, there was one WTE discharge coordinator in place. Nursing staff were supported by an approved complement of 34 WTE healthcare assistants (HCAs); however, at the time of inspection, 28 HCA WTE positions were filled, with 6 WTE temporary vacancies.

On the day of inspection, inspectors observed that staffing numbers in St Oliver's ward were in line with agreed levels. There were five to six nurses and four to five HCAs on duty during the day, and three nurses and two HCAs on duty at night. Staff informed inspectors that any gaps in the roster were filled by staff working overtime. Documentation reviewed by inspectors indicated that there were minimal vacancies in this ward.

The approved workforce for HSCP in the rehabilitation unit as submitted to inspectors included five physiotherapists, five occupational therapists, one social worker, a dietician, and a speech and language therapist. There were 1.5 WTE physiotherapy assistants and 0.5 WTE occupational therapist assistants. The rehabilitation unit did not have a designated clinical pharmacist. This was discussed under national standard 5.2. and 5.5. Inspectors were informed during interviews that there were several vacancies within the QPS department at CUH.

The post-onsite document and data reviewed by HIQA indicated the following vacancies:

- Designated complaints officer
- Risk manager
- Data analysist
- Unscheduled care lead
- Section officer.

The rehabilitation unit did not have access to a clinical engineering service and inspectors were informed that this post was vacant since December 2023. This vacancy significantly impacted the servicing and maintenance of equipment in the rehabilitation unit; for example, beds, hoists, suction machines, ECG machine, weighing scales, dinamap blood pressure machines. Inspectors observed broken equipment and equipment awaiting servicing past the service date during their visit to the clinical area. Inspectors reviewed emails between March and September 2024, where staff from the rehabilitation unit and the clinical engineering department documented their concerns. This was discussed with senior management at the time of inspection. Inspectors reviewed the risk register for CUH and the rehabilitation unit at the time of the inspection. They noted that no formal risk assessment had been completed or escalated regarding the documented concerns.

Approval for vacant posts went through the human resources department at CUH, the CEO, and the EMB for sign-off. Senior staff informed inspectors that a post prioritisation group to review vacant posts was being established. During the inspection, inspectors were told that a formal resourcing business case for the rehabilitation unit was submitted to SSWHG in 2023. This was approved but was awaiting national funding.

The absenteeism rate at CUH was 4.5%, which is higher than the HSE target of 4% or less. In order to reduce and address absenteeism the hospital had back-to-work interviews in place and access to occupational health support.

Staff training

Training records provided to inspectors for St Oliver's ward demonstrated that overall, there was good compliance with training; for example,

- 94% of nurses and 93% of healthcare assistants were trained in standard based precautions, transmission based precautions, donning and doffing PPE and infection outbreak management
- 94% of nurses and 93% of healthcare assistants were trained in hand hygiene practices, above the HSE's target of 90%
- 91% of nurses were up to date with medication safety education
- 88% of nurses were trained in the irish national early warning system (INEWS).

However inspectors found that the uptake at mandatory and essential training could be improved in some areas for example;

- 60% of nurses had received basic life support training
- 88% of nurses received training on the national guidance on clinical handover with ISBAR.

Management stated that training on INEWS and the use of the ISBAR tool was mandatory. It was provided by clinical nurse managers on site and on the HSE's online learning and training portal (HSELanD). Inspectors reviewed training records, monthly audit results, and local meeting minutes for St Oliver's ward which demonstrated effective processes for addressing patient deterioration.

Overall, inspectors found that the management of the rehabilitation unit were planning, organising and managing their workforce to support the provision of high-quality, safe and reliable healthcare; however, the following was identified on inspection:

- the rehabilitation unit did not have access to a clinical engineering service since December 2023. This was having a significant impact on the servicing and maintenance of equipment in the rehabilitation unit
- some staff were not up to date on mandatory training. The uptake by staff at mandatory and essential training could be improved, for example, basic life support.

Judgment: Substantially compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards from the three themes of person-centred care and support, effective care and support, and safe care and support. The Rehabilitation Unit was found to be compliant with four national standards (1.6, 1.7, 1.8 and 3.3) and substantially compliant with three national standards (2.7, 2.8 and 3.1) assessed. Key inspection findings informing judgments on compliance with these national standards are described in the following sections.

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

The physical environment promoted privacy, dignity and confidentiality of patients' receiving care. For example, staff were observed using privacy curtains when providing assistance and personal care to patients. Spacing between beds facilitated a more comfortable environment for patients carrying out personal care activities. Patients' privacy and dignity was supported and promoted for those located in multi-occupancy areas which had bathroom and shower facilities. A dedicated visitors' room was available for patients and their families.

A collaborative rehabilitation plan was based on individual assessed needs. Inspectors observed staff assisting patients with their mobility. The hospital implemented an initiative encouraging patients to participate in a daily walk at a specified time. This programme promoted patients' independence and also contributed to the patients' rehabilitation. One patient who spoke with inspectors said that 'they enjoyed this initiative'. Patients also had access to a garden. Inspectors observed patients walking in the garden with the assistance of family members and members of staff on the day of inspection.

Inspectors observed a staff huddle taking place in the clinical area where patients' confidential information was protected. In general, inspectors observed patients' healthcare records and patients' personal information were stored securely. Overall, there was evidence that management and staff promoted patient autonomy and independence and were also aware of the need to respect and promote the dignity and privacy of people receiving care in the rehabilitation unit.

Judgment: Compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.
There was evidence that staff promoted a culture of kindness, consideration and respect for patients receiving care in the clinical area visited. Inspectors observed staff to be respectful, kind and caring towards patients for; example, staff were observed by inspectors to take time to talk and listen to patients'. Staff ensured that call-bells were beside the patient for ease of access when needed and patients' who spoke with inspectors told them that staff 'always answered call-bells'. Patients' told inspectors that they were 'very happy with the care they were receiving and that staff were caring, kind and took the time to get to know them'. Inspectors were informed by staff that the rehabilitation unit welcomed feedback from people using the service. Inspectors observed a feedback box in the reception area of the unit. Patients who spoke with inspectors stated that they were comfortable raising any issues or concerns with staff. Leaflets on how to make a complaint; for example, '*your service your say*' were available at the nurses station. Overall, there was evidence that hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the rehabilitation unit.
Judgment: Compliant

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.
There was evidence that service users' complaints and concerns were responded to promptly, openly and effectively in the rehabilitation unit. At the time of inspection there was no approved complaints officer post in CUH. This is discussed under national standard 5.8; however, there were systems in place for the management of complaints in the rehabilitation unit. There was a local resolution approach used by management and staff with regard to managing complaints. Complaints were managed by the CNM 2 in the clinical area. Inspectors were informed by staff that any concerns raised by patients in relation to their care was discussed at the multidisciplinary team meetings, and patient safety huddles to try and resolve the issue. If a complaint could not be managed locally there was a process in place to escalate to the CNM 3, ADON or

QPS medical lead for the medical directorate. Staff who spoke with inspectors stated that complaints were resolved locally. For example, issues related to the physiotherapy services for patients in the unit, such as clarifying the type of physiotherapy they would receive, were addressed on site. Where complaints cannot be resolved locally, patients were encouraged by staff to make a complaint through the HSE complaints management policy '*Your Service Your Say'* [†††] available on the HSE website. Leaflets were also available at the nurses' station. From a review of local meeting minutes, inspectors identified evidence of staff encouraging patients to voice their complaints. Staff informed inspectors that CUH had a designated email address to receive complaints and that formal complaints for the rehabilitation unit were reviewed and acknowledged by the QPS medical lead.

Four formal complaints were received year to date for 2024 relating to the rehabilitation unit. Three were in relation to the availability of physiotherapy resources. This was actioned through the development of a physiotherapy information leaflet, which was given to patients' using the service on admission. The leaflet was made available to inspectors at the time of inspection. Management informed inspectors that the number of complaints in relation to this issue has reduced since the introduction of the leaflet. Following any complaint, inspectors were informed by staff in the clinical area that learning was shared at staff meetings, staff hand over meetings, and through a messaging communication system.

The rehabilitation unit did not have access to a Patient Advocacy and Liaison Services (PALS) manager; however, inspectors were informed by staff that patients' had access to a social worker who would refer them to an independent advocacy service when requested.

Overall, there were systems and processes in place to ensure and support a coordinated approach to the management of complaints and concerns in the rehabilitation unit.

Judgment: Compliant

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

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.
On the day of inspection, inspectors visited St Oliver's ward and observed that overall the physical environment was well maintained and clean with few exceptions. St Oliver's ward composed an old and new section. The new section accommodated ten single rooms all with en-suite facilities. In the old section, there were four single rooms, three of which had en-suite facilities and five four-bed multi occupancy rooms. Each four-bed room had a separate wheelchair accessible shower and toilet. While the new section of the ward had been newly renovated, there was evidence of general wear and tear observed in the older section; for example, paint work and wood finishes chipped, presses in patient rooms were chipped and scraped, some flooring was in a state of disrepair. This did not facilitate effective cleaning. The kitchen presses were chipped and rust was observed on the dishwasher. Inspectors were informed by staff in the clinical area that a refurbishment plan for St Oliver's ward had been submitted and was awaiting approval. Wall-mounted alcohol-based hand sanitiser dispensers were readily available for staff and visitors with hand hygiene signage [World Health Organization (WHO) 5 moments of hand hygiene] clearly displayed throughout the clinical area visited. While some hand hygiene sinks met the required specifications,‡‡‡ sinks observed by inspectors in some areas did not meet these requirements; for example, in the sluice room. Inspectors observed adequate physical distancing between beds in multi-occupancy rooms in St Oliver's ward. One patient who spoke with inspectors said "they had loads of storage for my things". Infection prevention and control signage in relation to transmission based precautions was observed in the clinical area and a supply of personal protective equipment was available outside rooms. On the day of inspection, inspectors observed three rooms in use for isolation purposes. Appropriate isolation signage was in place at the entrance of the rooms. A designated cleaner carried out environmental and terminal cleaning. The housekeeping supervisor and CNMs in the clinical area had oversight of the

‡‡‡ Clinical hand wash basins should conform to HBN 00-10 part C Sanitary Assemblies or equivalent standards. *National Clinical Effectiveness Committee. Infection Prevention and Control (IPC) National Clinical Guideline No. 30*. May 2023. Available on line from: gov - Infection Prevention and Control (IPC) (www.gov.ie)

cleaning schedule. CNMs told inspectors they were satisfied with the number of cleaning staff available.

Cleaning of equipment was assigned to the healthcare assistants. On the day of inspection equipment was observed to be clean. There was a tagging system in place to identify equipment that had been cleaned. Emergency equipment such as a resuscitation trolley, suction machine and oxygen were available and accessible. There were two sluice rooms in the clinical area; however, at the time of inspection one sluice room was repurposed as a storeroom for equipment. An old day room was repurposed to store wheelchairs. Inspectors were informed by staff that a risk assessment was being completed to convert this room into a storeroom. Inspectors observed mattresses stored on the floor in one storeroom. Staff informed inspectors that this issue had been escalated previously. Clean and used linen were properly separated and stored in a different room off the floor.

Staff informed inspectors that the lack of maintenance of equipment in the clinical area was an ongoing issue for staff. Inspectors observed broken equipment and equipment with expired service dates, as discussed under national standard 6.1. Inspectors were informed by staff that this issue had been reported on NIMS, and a risk assessment had been completed.

In summary, inspectors found that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care. However, inspectors identified some areas for action to bring this standard into full compliance. These included:

- maintenance and storage of equipment
- areas identified for renovation and refurbishment in the older section of the ward
- a number of hand hygiene sinks that did not meet required specifications.

Judgment: Substantially compliant

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

Inspectors found that SFH rehabilitation unit had systems to monitor, evaluate, and respond to information from various sources, such as KPIs, audit findings, and complaints. These systems help continuously improve healthcare services.

Infection prevention and control monitoring

The IPCC had oversight of monitoring of infection prevention practices in the rehabilitation unit. Audits completed in St Oliver's ward were provided to inspectors at the time of inspection and pre inspection through the pre onsite document and data request. The IPC nurse conducted hand hygiene, care bundles and screening audits for MDROs. Follow up actions and feedback from the audits were observed by inspectors through emails and quality improvement plans reviewed in the clinical area during inspection. Action plans were created for scores of 90% or below, with assigned owners and were time bound.

Hand hygiene practice audits reviewed by inspectors for June, July and September 2024 were compliant with the HSE target of 90%. Audits for screening of *Carbapenemase-Producing Enterobacterales* (CPE), *Methicillin-resistant Staphylococcus aureus* (MRSA) and *Vancomycin-Resistant Enterococci* (VRE) reviewed for March and September 2024 showed compliance levels of 92% and 93% respectively.

Environmental audits were completed by the household supervisor. Inspectors reviewed samples of these audits and found that compliance rates varied. In March 2024, the compliance rate was 83%. It improved to 86% in June 2024 but dropped to 79% in August 2024. Repeat issues were found in the audits, such as overdue service for some medical equipment. Audits included a list of actions with assigned owners, but the actions were not time bound.

Monthly "Test Your Care" metrics included audits for preventing and controlling healthcare-associated infections. Inspectors reviewed the results, which showed a 100% compliance rate in June, a drop to 75% in July, this was because the patient infection status was not documented in their care plan; however, following corrective action taken it returned to 100% in August 2024. Inspectors were informed that a draft annual report for 2023 had been completed, but it was not reviewed on the day of inspection.

Medication safety monitoring

There was evidence of monitoring and evaluating medication safety practices in St Oliver's ward. Monthly audits on medication safety and the storage and custody of medications were done through "Test Your Care" metrics. Inspectors saw that compliance with medication safety, such as legible prescriptions and patient ID wristbands, was below the 90% target: 74% in June, 75% in July, and 83% in August 2024. Time bound action plans were developed to address areas needing improvement. There was 100% compliance for medication storage and custody in June, July, and August.

Deteriorating patient monitoring

The INEWS chart was used in the clinical area, and the escalation process followed national guidelines for early warning systems and sepsis management for adults. Compliance with the early warning system escalation and response protocol was audited monthly as part of the "Test Your Care" metrics. Action plans were developed for scores below 90%, with assigned timelines for completion. Inspectors were informed by staff that the nurse practice development department supported staff in the clinical area in the auditing of INEWS charts.

Compliance rates in St Oliver's ward varied in the months before the inspection. June 2024 had a compliance rate of 75%, which increased to 86% in July but dropped back to 75% in August. Inspectors found that low compliance was due to; for example, issues with documented evidence that the nurse in charge was not notified about an upward change in INEWS for one patient, and 12-hourly INEWS was not completed for all patients.

Action plans were created to address these issues, and findings were discussed at staff meetings. Audit findings were shared with staff in the clinical area through email, at clinical hand over, patient safety huddles and at staff meetings. They were also displayed on the quality board for staff to view.

Transitions of care monitoring

Audits conducted from January to June 2024 in the rehabilitation unit looked at the average LOS, where patients were discharged to, and the number of out-of-hours transfers. The audit indicated that the average LOS was 30 days. Inspectors found that 59% of patients were transferred from St Oliver's ward out of hours to CUH from January to June 2024. To address this, an initiative was introduced where all out-of-hours transfers to CUH had to be reviewed by an NCHD. Senior managers told inspectors that this initiative was reducing the number of out-of-hours transfers.

Overall, while there were some assurance systems in place to monitor and evaluate healthcare services, areas for action identified included:

- auditing of compliance with clinical handover and ISBAR use was not in line with national guidance
- some action plans were not time-bound; for example, environmental audits
- findings from audits were not actioned; for example, overdue service for some medical equipment.

Judgment: Substantially compliant

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

Arrangements were in place in the rehabilitation unit to ensure proactive identification, evaluation, analysis, and management of risks to the delivery of safe care. In St Oliver's ward, there was evidence that a risk identified was assessed and analysed by CNMs and an ADON. Risk assessments were completed at ward level and controls were in place to mitigate the risks to patients. It was the responsibility of the CNM to implement and oversee the effectiveness of these controls. At the time of inspection, three risks relating to the four areas of harm were recorded on the medical directorate risk register for the rehabilitation unit. One risk related to NCHD cover for out of hours as discussed in national standard 2.8. Inspectors were provided with a risk assessment that stated there was a lack of isolation rooms across CUH; however, on discussion with senior management, management stated that the risk assessment was a generic risk assessment for CUH and this was not a concern for St Oliver's ward, as they had 14 single rooms available. Any concerns about patients were discussed at morning and evening handover, patient safety huddles which took place twice a week in St Oliver's ward and at weekly multidisciplinary team meetings.

Infection prevention and control

On review of documentation, inspectors observed that patients were screened for CPE in line with national guidelines. Patients admitted to the rehabilitation unit from outside CUH were screened for MDROs, including CPE, MRSA, and VRE. Patients transferred from CUH were screened before transfer. The IPCT monitor compliance with MDRO screening, overseen by the IPCC.

There were no infection outbreaks in the rehabilitation unit at the time of the inspection. Inspectors reviewed outbreak reports which demonstrated effective monitoring and management of outbreaks by the IPCT. The reports were comprehensive, detailing control measures to mitigate risks to patient safety. The IPC nurse presented outbreaks updates and reports to the outbreak committee. Meetings were held every two weeks, or more often if needed. Staff confirmed that the IPC nurse linked directly with staff in the unit in relation to any issues that needed to be addressed.

Medication safety

As discussed earlier in the report the clinical pharmacy service provided at the rehabilitation unit was delivered by a pharmacist who covered all of SFH campus. Inspectors were informed during the inspection that pharmacist-led medication reconciliation was conducted within 24 hours of admission for all patients. However, upon reviewing a sample of patient charts, inspectors found no evidence

of medication reconciliation documented in the patient records. This was discussed with staff at interview and inspectors were informed that the pharmacist records the medication reconciliation on a separate sheet, which is then filed in the pharmacy department rather than in the patient's chart. Recommended changes were flagged to doctors verbally or documented in a book or noted on the patient's kardex. All charts reviewed indicated that a clinical pharmacist's review was documented. Medication stock control was carried out by a pharmacy technician employed by older persons services CHO4. Inspectors observed a list of high-risk medications aligned with the acronym 'A PINCH',[§§§] a list of sound alike look alike drugs (SALADs) and a direct oral anticoagulants (DOACS) dosing chart displayed in the treatment room in St Oliver's ward. Inspectors were informed that staff implemented risk-reduction strategies with high-risk medications; for example, insulin pens were labelled as one person, one pen and stored with the patient's name on them. Prescribing guidelines, antimicrobial guidelines and medicines information were available and accessible to staff at the point of care and via computer access. Inspectors observed that the temperature for the medication fridge in St Oliver's ward was checked daily and was within the recommended temperature parameters.

Deteriorating patient

The INEWS chart was implemented in the unit to support the recognition, response and management of a deteriorating patient. Staff in St Oliver's ward who spoke with inspectors were knowledgeable about the INEWS escalation and response protocol. Staff were able to describe the processes in place to ensure the timely management of patients with a triggering early warning system. The ISBAR communication tool was used by nursing staff when escalating patient care. This was observed by inspectors when reviewing minutes of ward meetings. Inspectors found evidence in patients' charts reviewed in St Oliver's ward that the INEWS chart had been completed.

Safe transitions of care

The rehabilitation unit had effective systems in place to enable the safe transfer of patients into the unit, between healthcare services and safe and effective discharge processes. There was set criteria for admission to the unit. A co-ordinator was assigned to the unit who received all referrals for admissions on a database. This was discussed in more detail under national standard 5.5. A weekly virtual meeting was conducted with CUH to discuss delayed discharges. Each patient had a planned date of discharge. This was observed by inspectors on a

[§§§] Medications represented by the acronym 'A PINCH' include anti-infective agents, anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants.

whiteboard. Inspectors were informed by staff that family meetings were held to go through any concerns they had. Bi-weekly patient safety huddles and weekly multidisciplinary team meetings took place to identify and address any concerns or issues that needed to be address to meet their set goals, and facilitate the discharge of patients. Staff told inspectors that issues that impacted on the discharge process, complex discharge cases and action required to enable the safe discharge of patients were discussed at these meetings.

Policies, procedures and guidelines

Staff had access to a range of up-to-date infection prevention control, medication safety, transitions of care and the deteriorating patient policies, procedures, protocols and guidelines. All policies procedures and guidelines were accessible to staff via a document management system. Inspectors observed a number of policies out of date; for example, a policy on high-alert medication was dated 2017.

Overall, the rehabilitation unit had systems in place to identify and manage potential risk of harm associated with the four areas of harm - infection prevention and control, medication safety, the deteriorating patient and transitions of care; however,

- there were a number of policies, procedures and guidelines out of date.

Judgment: Substantially compliant

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

There was a system in place in the rehabilitation unit to identify, manage, respond to and report patient-safety incidents, in line with national legislation and standards, policy and guidelines.

The CNM reviewed patient-safety incidents with the ADON and the QPS lead for the medical directorate as required. Management reported on the number of clinical incidents per 1,000 bed days used (BDU) monthly. All patient-safety incidents and serious reportable events were reported to the QPS lead for the medical directorate and the SIMT, with oversight provided by the QSRC.

A report of patient-safety incidents reported to the National Incident Management System (NIMS) specific to the rehabilitation unit was made available to staff through the QPS department, CUH. Patient-safety incidents occurring in St Oliver's ward were reported using the National Incident Report Form (NIRF) and entered

on NIMS. In 2023, 152 patient-safety incidents were reported in St Oliver's ward including 15 related to care management.

There was 17 medication patient-safety incidents reported in 2023 and 12 medication-safety incidents year to date in 2024. Medication related patient-safety incidents were categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation and were reported to the DTC.

Staff who spoke with inspectors were knowledgeable about what and how to report and manage a patient-safety incident. Staff were aware of the most common patient-safety incidents occurring in the ward. A number of measures were introduced on the ward to reduce risks; for example, ensuring that patients always had the correct identification bands in place.

Medication safety reports and incidents causing harm were discussed at the DTC. The IPCT reviewed all relevant patient-safety incidents, made recommendations for actions, and reported these to the IPCC. Inspectors reviewed minutes showing that information on patient-safety incidents was shared with staff at ward meetings. Inspectors also observed that patient-safety incidents were discussed at twice weekly patient safety huddles. Inspectors were informed that incidents related to delayed INEWS response times were reported on NIMS. This was confirmed by ward meeting minutes.

Overall, the rehabilitation unit had a system in place to identify, report, respond to and manage patient-safety incidents.

Judgment: Compliant

Conclusion

An announced inspection of the Rehabilitation Unit, St Finbarr's Hospital, Cork was carried out to assess compliance with 11 national standards from the *National Standards for Safer Better Health*. The inspection focused on four areas of known harm – infection prevention and control, medication safety, deteriorating patient and transitions of care.

Capacity and Capability

There were formalised corporate and clinical governance arrangements in place, to ensure the delivery of high quality, safe and reliable care provided to patients' in the rehabilitation unit. However, some areas for improvement were identified. These included a gap in the governance and oversight of the pharmacy service provided to the rehabilitation unit, actions from a number of committee meetings were not assigned action owners and were not time bound, and terms of reference for a number of committees were out of date or were in draft form. The rehabilitation unit had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services. There were systematic monitoring arrangements in place in the unit for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. However, some areas for improvement were noted. For instance, requested quarterly and six-monthly reports on complaints were not being provided to the directorates, and the national KPI target for investigating 75% of complaints within 30 days of acknowledgment was not being met. The rehabilitation unit planned, organised and managed their workforce to achieve high quality, safe and reliable healthcare. However, a shortfall of clinical engineering staff significantly impacted the servicing and maintenance of equipment in the rehabilitation unit. There were also gaps in staff attendance and uptake of mandatory and essential training could be improved.

Quality and Safety

The rehabilitation unit promoted a person-centred approach to care. Inspectors observed staff being kind and caring towards people using the service. Hospital management and staff were aware of the need to respect and promoted the dignity, privacy and autonomy of people receiving care in the unit. People who spoke with inspectors were positive about their experience of receiving care in the unit and were very complimentary of staff. The rehabilitation unit were aware of the need to support and protect more vulnerable patients. The unit's physical environment mostly supported the delivery of high-quality, safe, reliable care to protect people using the service. There were a number of areas identified for renovation in the older section of St Oliver's ward. A number of hand hygiene

sinks did not meet the required specifications and the maintenance and storage of equipment was observed to be an issue at the time of inspection. The rehabilitation unit was monitoring and evaluating healthcare services provided at the unit to improve care. However, auditing of compliance with clinical handover and ISBAR should be an area of focused improvement. Findings from audits were not always actioned and not all action plans were time-bound. The unit had systems in place to identify and manage potential risk of harm associated with the four areas of harm; however, there were a number of policies, procedures and guidelines out of date. There was a system in place in the rehabilitation unit to identify, manage, respond to and report patient-safety incidents, in line with national legislation and standards, policy and guidelines.

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 the 11 national standards assessed during this inspection of Rehabilitation Unit, St Finbarr's Hospital was made following a review of the evidence gathered pre onsite, 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 was identified, HIQA issued a compliance plan to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in any compliance plan submitted.

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

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.

Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Capacity and Capability Dimension	
National Standard	**Judgment**
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare.	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.	Substantially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	

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