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:	Killarney Community Hospital District Unit
Address of healthcare service:	St Margaret's Road Killarney Co Kerry
Type of inspection:	Announced
Date(s) of inspection:	18 and 19 February 2025
Healthcare Service ID:	OSV-0007275
Fieldwork ID:	NS_0121

About the healthcare service

Model of hospital and profile

Killarney Community Hospital, District Unit was a statutory hospital owned and managed by the Health Service Executive (HSE) and under the governance of Community Healthcare Organisation (CHO 4)*. The unit comprised of 35 beds to include 31 short stay rehabilitation beds, two short stay respite and two palliative care beds. The hospital also had a designated centre for older persons.

The following information outlines some additional data on the hospital.

Model of hospital	Rehabilitation and Community Inpatient Healthcare Service (RCIHS)
Number of beds	35

How we inspect

Under the Health Act 2007, Section 8(1) (c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility to set and monitor standards in relation to the quality and safety of healthcare services among other functions. This inspection was carried out 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 findings, information submitted by the hospital, unsolicited information‡ and other publically available information.

During the inspection, inspectors:

- spoke with people who used the healthcare services in Killarney Community Hospital District Unit to ascertain their experiences of the care and treatment received
- 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

* CHO 4 covers Kerry, North Cork, North Lee, South Lee, and West 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 HIQA's National Standards for Safer Better Healthcare.

‡ 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.

- 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 Killarney Community Hospital District Unit performed in relation to compliance with the 11 national standards assessed during this inspection are presented in the following sections, under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors 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 Killarney Community Hospital District Unit. It outlines whether there is appropriate oversight and assurance arrangements in place and how people who work in the service are managed and supported to ensure high-quality and safe delivery of care.

2. Quality and safety of the service

This section describes the experiences, care and support people using the healthcare service in Killarney Community Hospital District Unit 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 healthcare environment where people receive care.

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

Compliance classifications

Following a review of the evidence gathered during the inspection, a judgement of compliance on how Killarney Community Hospital District Unit performed has been made under each of the 11 national standards assessed. The judgements are included in this inspection report. HIQA judges the healthcare service to be **compliant, substantially compliant**, **partially compliant** or **non-compliant** with national 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.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
18 February 2025	13.00 to 19.00hrs	Marguerite Dooley	Lead
19 February 2025	09.00 to 16.00hrs	Mary Flavin	Support

Information about this inspection

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

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

The inspection team visited the following clinical area:

- District Unit

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

- Interim Director of Nursing (DON)
- Interim General Manager (GM) residential services for older persons Kerry, CHO 4
- Medical Officer
- Clinical Nurse Manager 2 (CNM 2)
- Assistant Director of Nursing (ADON) IPC, CHO 4
- link nurse IPC
- Clinical Development Coordinator, CHO 4
- staff working within the clinical 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 people using the healthcare service who spoke with inspectors about their experience of receiving care and treatment in Killarney Community Hospital District Unit.

[§] The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration. A number of early warning systems designed to address individual patient needs are in use in hospitals across Ireland.
[**] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[††] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

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

Killarney Community Hospital District was a 35-bedded unit. On the first day of the inspection there were 28 patients present in the unit. Inspectors were informed that six admissions were expected. The clinical area visited by inspectors included, six four-bedded multi-occupancy rooms, two double rooms and seven single rooms to include one single room en-suite. An enclosed garden, a quiet room and a spacious day room, with television, radio and reading material, were available for patient use. There was a gym and a therapy kitchen to support rehabilitation.

Inspectors spoke with a number of patients to ascertain their experiences of receiving care in the hospital. Patients said they received "very good care", "could not say enough about the staff", the hospital is "very clean", "they are always cleaning", "they think of everything" and there was "good food, you are given a choice". One patient described how they came to the hospital using a walking frame, following their rehabilitation, could now use the "bicycle" and could walk unassisted. Patients stated they "understood their medications, one of the nurses explained them to me", another said "they got information" about their discharge. While patients who spoke with inspectors did not have a complaint, some did not know how to make a complaint but would "talk to a nurse if worried". A number of patients were aware of the service user feedback form and comment box. Inspectors observed information leaflets displayed about the HSE feedback and complaints process 'Your Service, Your Say'. Information on independent advocacy services, medication and health related topics appropriate to the profile of patients using the service was also on display. Overall patients were very complimentary about the staff and the care received in the hospital and this was consistent with what inspectors observed over the course of the inspection.

Capacity and Capability Dimension

Inspections findings related to the capacity and capability dimension are presented under four national standards from the themes of leadership, governance and management, and workforce. Killarney Community Hospital District Unit was found to be compliant with two national standards (5.5, 6.1) and substantially compliant with two national standards (5.2, 5.8) assessed. Key inspections 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.

Through discussions with senior management and staff inspectors found that Killarney Community Hospital District Unit had formalised corporate and clinical governance arrangements in place to assure the quality and safety of healthcare services. Organisational charts for Cork Kerry CHO 4 and Killarney Community Hospitals, viewed by inspectors set out the hospitals reporting structures detailing the direct reporting arrangements. The interim Director of Nursing (DON) had overall responsibility and accountability for the governance of the hospital and had a direct reporting structure to the interim General Manager (GM) residential services for older persons Kerry. The interim GM reported to the Head of Service (HOS) for older persons, the Chief Officer older persons CHO 4, (who was not listed on the organogram) and the Regional Executive Officer (REO) Cork Kerry Community Healthcare (CKCH). Nursing and support staff reported to a Clinical Nurse Manager 2 (CNM 2), who managed the unit on a daily basis primarily from Monday to Friday. The CNM 2 reported to an Assistant Director of Nursing (ADON), who reported to the interim DON. The on-site Speech and Language Therapist, Occupational Therapist and Physiotherapists reported to their respective managers in acute services. One Physiotherapist also reported to the Community Network Manager for Killarney South Kerry.

The interim GM chaired 'services for older people' DON management team meetings. Terms of reference were not available for this group and there was no schedule. Minutes showed meetings followed a structured format but actions were not always assigned to an individual and were not time bound. Agenda items included the risk register, IPC, monthly performance and GP out of hours correspondence.

The interim GM also chaired a sub-committee for quality and patient safety (QPS) in line with the terms of reference (TOR). The sub-committee was to ensure there were appropriate systems in place that cover all aspects of clinical quality and safety in Kerry community hospitals. While meetings were to be scheduled monthly in line with the TOR, inspectors were informed that meetings occurred quarterly. Attendance included DONs, QPS advisors and the ADON IPC, agenda items included safeguarding, quality improvement, training and risk. Actions were not assigned to an individual and were not time bound. The DON had oversight of the hospital risk register and monthly reports were submitted to CHO 4 in relation to risk. Inspectors noted that feedback was not consistently provided to the DON in relation to risks escalated. A QPS representative was assigned to the hospital to assist with incident reviews if required. Should a serious reportable event (SRE) occur, the DON would be invited to attend an SRE management team meeting, however there were no SREs reported to have occurred in 2024. Hospital management meetings were conducted quarterly in line with the terms of reference. The objective of these meetings was to review the quality and safety of the service. Chaired

by the DON and attended by nurse managers, with input as required from other health and support staff.

The Medical Officer to the District Unit was a General Practitioner (GP), who attended the hospital on a daily basis from Monday to Friday (9am to 12 mid-day), cross cover was provided during periods of leave. An out-of-hours GP medical service was contacted when required out-of hours. Quarterly Drugs and Therapeutic meetings were convened at CHO 4 level. Chaired by a GM, membership included the Clinical Development Coordinator, and trends and risks were discussed, resulting in some action required by sites.

The hospital had an assigned IPC ADON from CHO 4 with whom the DON and staff within the District Unit could contact directly or via a generic e-mail for advice. The ADON IPC in turn linked with the Department of Public Health, on a fortnightly basis. Staff had access to advice from an antimicrobial pharmacist and a consultant microbiologist was available to CHO 4 ten hours per week. The ADON IPC attended quarterly IPC and antimicrobial (AMS) meetings with the CKCH in line with the terms of reference (TOR). Chaired by the chief officer, the objective of this group was to support effective governance and coordination of IPC and antimicrobial activities at CHO level in line with national strategic objectives for prevention and control of healthcare associated infection (HCAI) and antimicrobial resistance. Membership was multidisciplinary, minutes from meetings reviewed by inspectors showed items discussed included IPC, AMS, risk, updates from both services and the consultant microbiologist. Actions were not always assigned to an individual and were not time bound, and inspectors noted the TOR required review since September 2022.

Inspectors were satisfied that Killarney Community Hospital District Unit had formalised corporate and clinical governance arrangements in place appropriate to the size and complexity of the service but recommend:

- terms of reference are developed for 'services for older people DON management team meeting'
- ensure frequency of meetings are aligned with the terms of reference
- actions from meetings are assigned to an individual and are time bound
- develop an annual schedule of meetings
- ensure the DON receives feedback following escalation of risks and concerns.

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.

The inspectors found that there were management arrangements structures and mechanisms in place to support the delivery of safe, high quality and reliable healthcare services at Killarney Community Hospital District Unit.

The hospital had an admission and discharge policy which outlined the referral, admission and discharge process, including admission-exclusion criteria for rehabilitation, respite and palliative care patients. Admissions to the unit were through referral and transfer from acute hospital services, GPs, Public Health Nurses (PHNs) and the Kerry palliative care team. The DON attended a daily 'older person check-in-call' meeting at 9.30am with representatives from CHO 4 and acute services. Updates were provided on available capacity, expected discharges and IPC. Transfers from acute services were through a single point of contact, Liaison Community Support Team (LCST). The DON reviewed all referrals prior to acceptance with the majority of transfers taking place on the same day. Weekend transfers to the Unit from acute settings was through direct communication from the hospitals. Patients for respite care were admitted mid-week on receipt of a PHN referral. While the majority of patients were discharged to home, a number transitioned to long term residential care facilities.

The Medical Officer carried out the medical admission of all patients to the District Unit to include medication reconciliation. A full ward round was conducted weekly, which included a further review of medication. The hospital had a pharmacy on the campus, staffed by a senior pharmacist four days a week from (9am to 12 mid-day) and on Wednesday from (9am to 5pm). Staff could not access the pharmacy outside of these hours and contingency arrangements were through two local community pharmacies. Patients admitted to the District Unit for rehabilitation from an acute service required a three day prescription as part of the pre-admission documentation. Inspectors were informed that on a number of occasions, prescription errors were identified by nursing staff when nursing medication reconciliation was conducted on admission. Errors were brought to the attention of the Medical Officer, the prescriber was contacted, a new prescription was requested, which was sent electronically to the District Unit. Patients attending for respite and palliative care brought their medications on admission. Blister packs were not accepted to mitigate potential prescription or administration errors. The Medicines Prescription and Administration Record (MPAR) or medication record, had the patient's name, address and photographic identification, and an identification wrist band was worn to mitigate against medication administration errors. Inspectors were informed about, and viewed high risk medication and allergy labels which were displayed prominently on the front of the medication record or MPAR as part of medication safety practices.

The medical officer and a number of staff had access to diagnostic results and services. A mobile radiology service was available to the Unit. In the event that a patient

deteriorated, the Medical Officer was contacted to review the patient while on-site, an out-of-hours GP medical service was contacted should a patient deteriorate out-of-hours. The identify, situation, background, assessment, recommendation (ISBAR3)[‡‡] communication tool was used, and inspectors saw evidence of this in a patient's healthcare record. The medical officer or the out-of-hours GP service made the clinical decision if a patient required transfer to an acute hospital setting. Transfer was via the National Ambulance Service (NAS) having contacted the national emergency number '999'. The Clinical Development Coordinator supported the development of policies, procedures, protocols and guidelines (PPPGs) in relation to medication safety and the deteriorating patient with input from relevant stakeholders.

The Unit had seven single rooms to include one en-suite, staff were pre-alerted to patients requiring admission who had an active or history of a multi-drug resistant organism (MDRO) through review of the admission documentation. Staff could access the online IPC and antimicrobial stewardship (AMS) team catalogue that provided information and resources relating to IPC to determine the appropriate precautions required. Patients with MDROs were accommodated in a single room, on occasions where this was not possible, patients were placed on IPC precautions in a two or four-bedded room, following completion of a risk assessment. There had not been an outbreak of infection since 2023. Inspectors were shown a 'review of actions following an outbreak of respiratory infection' which outlined the details of the outbreak, IPC advice and what worked well. The decision that a patient no longer required isolation following an outbreak was discussed by staff and IPC. The decision to close an outbreak was taken by the Department of Public Health and was communicated to the Unit through the ADON IPC.

Overall the inspectors were satisfied that Killarney Community Hospital District Unit had effective management arrangements in place to support and promote the delivery of high, 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.

The inspectors found Killarney Community Hospital District Unit had monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services provided.

Daily activity was recorded on the HSE community bed management system. Annual activity showed there were 754 admissions to include 682 rehabilitation, 21 palliative care

[‡‡] ISBAR3 – Identify, Situation, Background, Assessment, Recommendation, Read Back, is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

and 52 respite. 15.2% (104) patients required transfer back to an acute site, for issues such as post-operative infection (1.6%) or cardiac and respiratory conditions (2.8%). Transfers back to one acute service accounted for 13.7% and inspectors were informed that this had been escalated to CHO 4. A functional independence measure and functional assessment measure (FIM FAMS) tool was available to measure the effectiveness of rehabilitation interventions, however data was not consistently captured.

Inspectors were informed that staff were vigilant to the potential of prescription errors arising. It had been emphasised by management, that a national incident report form (NIRF) should be completed for all incidents. However review of the National Incident Management System[§§] (NIMS) data would indicate that this practice was not consistent with six incidents recorded for 2024.

The DON had oversight of the risk register and at the time of inspection there were thirteen risks specific to the four key areas of harm prioritised under HIQA's monitoring programme. Open risks were reviewed monthly and dated. Patient safety incidents were reported onto NIMS. The CNM 2 reported monthly stats to antimicrobial resistance infection prevention and control (AMRIC). A healthcare-associated infection, antimicrobial resistance and antimicrobial consumption data set report was issued to Killarney Community Hospital on a quarterly basis. Inspectors were provided with a list of eighteen Quality Improvement Programmes (QIPs) developed in 2024 and 2025, eleven were completed and seven remained in progress or ongoing. QIPs related to antimicrobial use, 'skip the dip' campaign, and oral hygiene. QIP initiatives to commence in 2025 included catheter care and make every contact count.

The Killarney Community Hospital District Unit had monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services provided at the hospital but areas for focused improvement include:

- ensure all incidents and near misses are reported to NIMS
- ensure all prescribing errors and near misses related to transfers from acute services are communicated to the acute service to review and consider actions required
- communicate the incidence of transfers back to acute services to ensure any necessary action is taken.

Judgment: Substantially compliant

[§§] The National Incident Management System is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation on the States Claims Agency (Section 11 of the National Treasury Management Agency Act 2000 as amended).

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.
Inspectors found the workplace arrangement in place in Killarney Community Hospital District was planned, organised and managed to ensure high quality, safe and reliable healthcare. At the time of the inspection, inspectors were informed that the RHA SW had oversight for the approval of posts. The following whole time equivalent*** (WTE) complement was in place for the District Unit: 1 WTE DON, 1 WTE ADON, 1 WTE CNM2, 18.2 WTE Registered General Nurses (RGNs) to include 1.2 WTE to facilitate training; 1.8 WTE Physiotherapists, 1 WTE Occupational Therapist, 1 WTE Speech and Language Therapist with a current deficit of 0.5WTE due to leave; 14.8 WTE Healthcare Assistants (HCAs) with a deficit of 0.2 WTE; 5.5 WTE hygiene staff which was above approved rate by 0.2 WTE. A Dietitian was available to attend the Unit following receipt of a referral. A Medical Officer provided 15 hours a week to the Unit and a Pharmacist provided 19 hours a week to the hospital campus. Inspectors were informed by management that nursing and support staffing was sufficient to meet the requirements of the Unit. Mandatory and essential training was recorded as 100% and included complaints management training. Open disclosure training was recommended for staff and at the time of inspection, 89% of staff had completed this training. Training was also provided on assisted decision making. Inspectors were informed that all staff were Garda vetted, had completed children's first training, and the hospitals child safety statement was on display. Absenteeism was 4% in line with the HSE key performance indicator (KPI). Back to work interviews were conducted following periods of unplanned leave and staff had access to the HSE employee assistance programme (EAP) and occupational health. Inspectors were satisfied that the workplace arrangement in place in Killarney Community Hospital District Unit was planned, organised and managed to ensure high quality, safe and reliable healthcare.
Judgment: Compliant

*** Whole time equivalent (WTE) is the number of hours worked by a staff member compared to the normal full time hours for that role.

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. 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. Killarney Community Hospital District was found to be compliant with four national standards (1.6, 1.7, 1.8, 3.1) and substantially compliant with three national standards (2.7, 2.8, 3.3) assessed. Key inspections findings informing judgements on compliance with these seven national standards are described in the following sections.

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

Staff promoted a person centred approach to care and were observed by inspectors to be respectful, promoting the dignity, privacy and autonomy of patients. Inspectors observed communication between staff and patients to be respectful and kind. The physical environment in the clinical area promoted the privacy, dignity and confidentiality of patients receiving care. Of the seven single rooms, two would be made available for patients requiring palliative care and visiting by family members was unrestricted for this cohort of patients. 'Stop, knock, wait' signage was on the doors of patient rooms and staff were observed adhering to this practice. Patients were assisted with their individual needs, privacy curtains or screens were used while attending to personal care and call bells were available if assistance was required. Inspectors observed patients who required rehabilitation were out of bed and dressed and staff described a multidisciplinary approach to rehabilitation. Inspectors were shown a designated room where private discussions could take place between hospital staff, patients and family members. Healthcare records and personal information was protected in the clinical area. Patient information leaflets on the HSE 'Your Service, Your Say', fundamentals of advocacy and national safeguarding were on display in the clinical area.

In summary inspectors were satisfied that patients dignity, privacy and autonomy were protected and promoted.

Judgment: Compliant

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

It was evident that a culture of kindness consideration and respect was actively promoted for people accessing and receiving care at the hospital. This was confirmed by patients who spoke positively about their interactions with staff, and was consistent with the service user feedback data collated at quarterly intervals. Inspectors observed kind interactions between staff and patients and it was evident that staff had a holistic approach to patient care. Patients with whom inspectors met with, were complimentary of the staff and the care provided to them. Patients felt there were good meal choices and inspectors were told patients could ask for snacks at any point between meals. The Inspectors observed the hospitals 'statement of purpose' and 'philosophy of care' on display in the clinical area.

Inspectors were satisfied that service users were treated with kindness and respect in Killarney Community Hospital District 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.

The hospital had a complaints procedure in place which outlined how to make a complaint, timelines for the process and feedback. It included the process to refer a complaint to the HSE, Chief Inspector or the Office of the Ombudsman, and advice on how to access independent advocacy services. The DON was the designated complaints officer and had oversight of all complaints to the hospital. The DON ensured complaints were investigated within 30 working from acknowledgement of the complaint. The DON was responsible for ensuring implementation of recommendations arising from any review. Staff were encouraged to resolve complaints locally. Verbal complaints were tracked with a log maintained by the CNM 2, feedback was provided informally to staff at daily meetings. If staff could not resolve the issue locally, the complaint was escalated to the complaints officer.

At the time of the inspection, there was 100% compliance with complaints management training for nursing staff, 90% for HCAs and 85% for support staff. Inspectors were provided with evidence of six complaints received in 2024, to include three, stage two complaints. Four of the complaints had been resolved, one verbal compliant was closed and one complaint relating in particular to medication administration remained open awaiting recommendations from an external review. Patients were provided with a service

user feedback form to complete prior to discharge. The DON collated the feedback, which inspectors viewed, and provided an update to staff at quarterly intervals.

Inspectors were satisfied that there were systems and processes in place in Killarney Community Hospital District Unit to respond to complaints and concerns in a coordinated and timely manner.

Judgment: Compliant

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

At the time of inspection, inspectors observed the overall physical environment in the clinical area visited was generally well maintained and clean with few exceptions.

There was evidence of wear and tear, with rust evident on some radiators which did not facilitate effective cleaning. Inspectors saw evidence of cleaning schedules and sign off sheets to indicate cleaning had taken place. Wall-mounted alcohol hand gel dispensers were strategically located and readily available for patient and staff use. Signage promoting the five moments of hand hygiene was clearly displayed. While hand hygiene sinks were available, not all sinks conformed to national standards. Inspectors observed appropriate spacing between beds. Hygiene staff were responsible for environmental cleaning with oversight from the CNM 2, this included an increased cleaning scheduled during periods of outbreaks. While water testing for legionella was not conducted, a tap flushing schedule was in place for taps not in use, records were held by maintenance. Disposable curtains were in use in some areas of the Unit, whilst there was not a curtain changing schedule, inspectors noted all had been changed recently. Fabric curtains within the remaining rooms appeared visibly clean. There were six wheelchair accessible toilets and six showers available for patient use.

The CNM 2 had oversight of equipment cleaning. Inspectors noted that there was not a system in place to indicate if a piece of equipment had been cleaned, for example a tagging system. For the most part inspectors found patient equipment to be clean with some exceptions, to include an examination table with tears in the covering. Portable suction and oxygen compressors were in use and inspectors recommended placing an oxygen cylinder in the gym with the automated external defibrillator (AED). Ceiling hoists were available in two rooms, with reusable slings which were laundered onsite. An electronic request was forwarded to maintenance if equipment required repair and there was generally a timely response. Service history details were available on some equipment seen by inspectors.

There was a designated medication preparation area with a controlled drugs press and a dedicated drugs fridge. While the drugs fridge was not locked, entry to the clinical room

was authorised access only. Inspectors saw evidence of daily temperature log checks. There was appropriate segregation of linen and clinical waste, sharps bins were partially closed, signed and dated. Inspectors observed posters in relation to disposal of healthcare waste and sharps and how to deal with spillages. Inspectors noted that the Unit did not have security personnel but authorised access was in place. A new purpose built hospital was scheduled to be opened in 2025 which would have 130 single en-suite rooms.

Whilst the physical environment for the most part supported the delivery of high quality, safe, reliable care, inspectors would recommend implementing:

- a system to identify equipment that has been cleaned
- repair or replace equipment where covering is damaged.

Judgment: Substantially compliant

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

The hospital had systems and processes in place to monitor, analyse, evaluate and respond to information from a variety of sources in order to inform continuous improvement of services.

The clinical development coordinator advised inspectors that there was a suite of 32 audit tools available for use. Pratice development provided the Unit with an annual schedule of audits to be conducted. A range of audits were conducted on a monthly basis, through the use of an electronic audit tool, specific audits were conducted quarterly. Audits were designated to nursing staff and if the required standard was not met, a quality improvement plan (QIP) was developed. Inspectors were informed it was the responsibility of the staff member conducting the audit to implement the QIP and re-audit. Inspectors noted that actions in a non-compliant entries dated November 2024 were not assigned to an individual and were not time bound. Inspectors noted environment, equipment and mattress audits had only been conducted on three occasions in 2024 as opposed to quarterly. Environmental audits, segregation of linen and clinical waste audits showed compliance was 100%.

The CNM 2 had oversight of equipment cleaning. Audits provided to inspectors showed compliance ranged from 67% to 100%, mattress audits ranged from 50 to 100%. Mandatory hand hygiene training records for staff were 100%. Hand hygiene audits were conducted and inspectors observed staff carrying out hand hygiene in the clinical area. Inspectors noted audit of documentation was 48% for October 2024.

Audits in relation to medication safety showed overall compliance with usage and legibility of prescriptions was 96% and medication administration was 98%. Inspectors were informed that as a result of a near miss incident, related to medication administration, a

QIP was developed and patient identification bands were introduced in conjunction with the existing photographic identification. Person identification was audited quarterly and an overall compliance score of 96% was recorded for 2024.

Killarney Community Hospital submitted data for the monthly HSE Community Operations, monitoring of a healthcare-associated infection (HCAI) antimicrobial resistance (AMR) and antimicrobial consumption minimum data set. Reports were published on a quarterly basis and the hospital had a unique code to identify their results. The aim was to provide an ongoing level of assurance to management in relation to quality and safety of services, the burden of HCAI and AMR and the effectiveness of IPC and antimicrobial stewardship measures.

While Killarney Community Hospital District Unit had systems and processes in place to monitor, analyse, evaluate and respond to information from a variety of sources in order to inform continuous improvement of services. Areas for focused improvement include:

- ensure adherence to quarterly audit schedule for environment, mattress and equipment
- timely re-audit if compliance is below national KPIs, for example mattress and documentation
- ensure QIPs are completed for all audits with non-compliance, actions are assigned to an individual and time bound.

Judgment: Substantially compliant

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

The hospital had systems in place to protect service users from the risk of harm associated with the design and delivery of healthcare services.

Patients admitted to the Unit underwent a nursing assessment using standardised documentation to mitigate risk, prompts on the documentation included observing for signs of sepsis and delirium. Staff conducted daily handovers to communicate issues related to patient care, a second handover was conducted at 12.15pm to ensure instructions given by the Medical Officer were communicated. On a weekly basis a multidisciplinary team (MDT) meeting to include Health and Social Care Professionals (HSCPs) was convened to plan for rehabilitation admissions to the unit. On occasions, patients would remain in the Unit if the MDT determined patients had more rehabilitation potential. On admission patients received an information 'admission pack'. On discharge, a letter from the Medical Officer was posted to patients GP detailing current medications to include reasons for any changes. A nursing discharge letter was provided to the patient, and a copy was sent to the Assistant Director of Public Health Nursing (ADPHN),

all copies were kept on file. Family meetings were conducted for complex discharges. If a patient was being discharged to a long term care facility, a more detailed letter was provided to mitigate errors in handover.

Pre-admission documentation was required for patient transfers before 2pm, which facilitated ordering medications from the pharmacy. Patients for respite and palliative care brought their medications to the Unit on admission. Nurse-led medication reconciliation was conducted on admission and discharge. The Medical Officer conducted medication reconciliation during the medical admission and on the weekly ward round. Medication administration was conducted by staff wearing red aprons to mitigate interruption. High risk medication labels were observed on the medication record or MPAR. Inspectors were informed that there was a dual checking system for the administration of controlled drugs and high risk medications. The Unit had a medication management policy and posters relating to 10 rights of medication and medication safety were displayed. The pharmacist would notify the Unit of any Health Products Regulatory Authority (HPRA) alerts. Medication safety training was arranged by the Clinical Development Coordinator and regular 'toolbox talks' education sessions were conducted.

In the event that a patient deteriorated, the medical officer was contacted to review the patient while on-site, the out-of-hours GP medical service was contacted should a patient deteriorate out-of-hours. The ISBAR3 communication tool was used and inspectors saw evidence of this in a patients healthcare record. The hospital had assigned an IPC link practitioner nurse, providing support for staff on a daily basis. The IPC link nurse met with the ADON IPC on a regular basis throughout the year. A 'line list' of patients was issued to the Department of Public Health during periods of outbreaks and the Unit had a COVID-19 contingency plan dated 2024. Online IPC training sessions had been introduced for staff and the Unit had access to training from an AMS pharmacist. Patients with MDROs were accommodated in single rooms where possible to mitigate risk of transmission. Risk assessments were developed by the DON, control measures were put in place and residual risk determined. Inspectors viewed examples of risk assessments. The risk register was reviewed on a monthly basis and risks that could not be managed locally were escalated to the CHO 4.

Inspectors were satisfied that Killarney Community Hospital District Unit had systems in place to protect service users from the risk of harm associated with the design and delivery of healthcare services.

Judgment: Compliant

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

The hospital had patient safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines.

National incident management forms (NIRF) forms were completed manually and scanned to CHO 4 on a monthly basis for upload to NIMS. Incidents were classified by category and type. Data was sent to the DON, who had oversight of all incidents, on a monthly basis. The HSE national key performance indicator (KPI), where incidents should be entered onto NIMS within 30 days of notification of the incident is 70%. There were 47 incidents reported to NIMS by the Unit in 2024 and compliance with the national KPI was 57.4%. The number of falls reported in 2024 were 23, to include two classified as moderate-category two. A number of measures were in place to include a screen falls assessment, sensor mats, communication to use the call bell for assistance and falls audits were conducted. Inspectors observed some patients using non-slip slipper socks when mobilising. Feedback to staff was on an informal basis at the daily handovers. Staff who spoke with inspectors were knowledgeable about how to report and manage a patient safety incident. However on review of NIMS data and in speaking with management, all near miss medication prescribing errors may not been captured. There were no SREs reported to have occurred in 2024. No safeguarding incidents were reported to have occurred in 2024 and all staff had completed safeguarding training. There was a risk management PPPG and incidents were a standing item on the sub-QPS agenda.

While Killarney Community Hospital District Unit had patient safety incident management systems in place, areas for focussed improvement include:

- review current process to improve compliance with 30 day incident reporting onto NIMS to meet HSE KPI 70%
- raise awareness on the importance of reporting all incidents and near misses
- provide staff training on risk assessment and risk management.

Judgment: Substantially compliant

Conclusion

HIQA conducted an announced inspection of Killarney Community Hospital District Unit to assess compliance with 11 national standards from the Nationals Standards for Safer Better Healthcare. The inspection focused on four key areas of harm – infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall the inspectors found evidence of compliance with six national standards (5.5, 6.1, 1.6, 1.7, 1.8, 3.1) and substantial compliance with five national standards (5.2, 5.8, 2.7, 2.8, 3.3).

Capacity and Capability:

Killarney Community Hospital District Unit had clear lines of accountability and responsibility in relation to corporate and clinical governance. Frequency of meetings should align with terms of reference (TOR) and TOR should be developed for all meetings. There were effective management arrangements in place to support the delivery of high quality, safe and reliable healthcare. In the absence of specific committees, the interim DON had oversight for IPC, the deteriorating patient, medication safety and transfers of care. Inspectors viewed contingency plans for COVID-19 and PPPGs viewed were in date. At the time of inspection there were no reported nursing or support staffing deficits identified to inspectors by management. Patient safety incidents were reported, updates on the risk register were forwarded to CHO 4 on a monthly basis. Risks that could not be managed at a local level were escalated through the line management structure of the CHO4. Inspectors recommend developing a process for providing structured feedback to the DON for all risks escalated.

Quality and Safety:

It was evident to inspectors that the hospital staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital. Patients spoke positively of receiving care in the hospital. The hospitals physical environment mostly supported the delivery of high quality, safe care and inspectors noted the expected opening of a purpose built hospital in 2025. Inspectors found there was a system in place to identify, report and manage patient safety incidents. However the importance of reporting all incidents and near misses should be emphasised, training in developing risk assessments and risk management is recommended. Reporting incidents to the NIMS within 30 days was not meeting the national KPI of 70%. It is recommended to review the current process where NIRFs are scanned to CHO on a monthly basis in order to seek improvement with the national target.

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.

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	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	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially compliant

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