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:	Waterford Residential Care Centre – Rehabilitation Unit
Address of healthcare service:	John's Hill Waterford X91 KX25
Type of inspection:	Announced
Date(s) of inspection:	22 and 23 October 2024
Healthcare Service ID:	OSV-0007834
Fieldwork ID:	NS_0101

About the healthcare service

The following information describes the services the hospital provides.

Model of hospital and profile

Waterford Residential Care Centre Rehabilitation Unit is owned and managed by the Health Service Executive (HSE) under the governance of Dublin and South East Regional Health Area.

Waterford Residential Care Centre Rehabilitation Unit has 15 rehabilitation beds. Fourteen of these are assigned to patients transferring from University Hospital Waterford. One bed is assigned to patients who are admitted from the community. Patients have access to a multidisciplinary team which includes for example, nursing, medical officers, consultant geriatrician, physiotherapy and occupational therapy onsite.

The following information outlines some additional data on the hospital.

Number of beds	15 inpatient beds

How we inspect

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

During the inspection, inspectors:

- spoke with people who used the service to ascertain their experiences of the service

** Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare (2012)*

- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the hospital
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors
- 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 service performed in relation to compliance with the national standards monitored during this inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

1. Capacity and capability of the service

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

2. Quality and safety of the service

This section describes the experiences, care and support people using the service receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centred and safe. It also includes information about the environment where people receive care.

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
22 October 2024	13.20 – 17.40hrs	Bairbre Moynihan	Lead
23 October 2024	08.30 – 15.15hrs	Elaine Egan	Support
		Mary Redmond	Support

Information about this inspection

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

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

The inspection team visited Our Lady's Ward.

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

- Representatives of the hospital's and regional health area management team:
  - Director of Nursing
  - Assistant Director of Nursing
  - General Manager for Older Persons' Services
- Quality and Risk Advisor
- Consultant Geriatrician
- Human Resource Manager
- A representative from each of the following areas:
  - Infection prevention and control
  - Medication safety
  - Deteriorating patient
  - Transitions of care.

Acknowledgements

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

† 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

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

Overall, patients expressed satisfaction with the care they received in Waterford Residential Care Centre (WRCC) rehabilitation unit. Patients stated that the staff were attentive and they were informed and kept up to date about their plan of care. WRCC rehabilitation unit had one ward - Our Lady's ward. Also onsite was an 80 bed designated centre for older people.

Our Lady's Ward was a 15 bed rehabilitation ward. All rooms were single, with seven rooms containing en-suite facilities, four rooms had access to a shared bathroom from the bedroom and four patients shared two bathrooms across a corridor.

Staff were observed interacting with patients and families in a kind and caring manner and patients' needs were responded to promptly. This was validated by a patient who stated that "staff care about you".

Inspectors observed positive engagement between staff and patients. Patients who spoke with inspectors knew who to raise a concern or issue with if they had one.

Patients had access to a garden, however, due to cold weather this was not in use at the time of inspection. Notwithstanding this, tables and chairs were available in the garden. Inspectors were informed that there was a plan in place to enhance the garden next year with plants and furniture.

Capacity and Capability Dimension

Inspection findings related to the capacity and capability dimension are presented under four national standards from the themes of leadership, governance and management and workforce. 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.

The director of nursing (DON) was responsible for the operational management of the hospital and reported to the manager for older persons' services, Waterford Wexford, who reported to the general manager for older persons' services, and upwards to the integrated health area manager for the newly established regional health area (RHA) of Dublin and South East region.

Organisational charts setting out the hospital reporting structures detailed the direct reporting arrangements for hospital management. At the time of inspection this was evolving and it did not include the integrated health area manager.

A committee/group organisational chart provided to inspectors indicated that there were committees/groups in place for example; transitional care, quality and safety, infection prevention and control who reported into the clinical nurse managers (CNMs) and DON meetings. However, inspectors identified that these groups were not in place but some, for example, infection prevention and control were standing agenda items at the CNMs and the Hospital Governance Group meeting.

Nursing and support staff reported to CNMs 1 and 2 in Our Lady's Ward, and upwards to an assistant director of nursing (ADON) and the DON.

A local general practitioner service was responsible for the medical care of patients admitted to the hospital. Inspectors were informed that they attended onsite daily for two to three hours Monday to Friday. Out-of-hours medical cover was provided by an on-call service.

WRCC Hospital Governance Committee

The hospital had a WRCC hospital governance committee in place for both the designated centre and the rehabilitation unit. The committee was chaired by the manager for older persons' services for Waterford Wexford and attended by the DON and ADONs for the hospital. Meetings took place monthly and agenda items included a review of incidents, complaints and infection prevention and control. This was the only committee at site level in place in the hospital. Agendas and meeting minutes reviewed and discussions with senior management confirmed that medication safety, the deteriorating patient or issues relating to the safe transitions of care were not discussed at the meeting. This meant that there was no formalised governance and oversight of three out of the four areas of risk that HIQA were focussing on. Furthermore, audits and audit results were not standing agenda items at this meeting with the exception of infection prevention and control. Notwithstanding this, meeting minutes evidenced that there was good oversight of agenda items with actions assigned and time bound. The terms of reference for the committee were a standard terms of reference for all community nursing units in the Waterford Wexford area. These did not indicate the upward reporting relationship for this committee.

Inspectors were informed that a representative from senior management attended the drugs and therapeutics committee in UHW. Senior management did not have access to the agenda or minutes from this meeting so it is unclear if any issues from WRCC rehabilitation unit were escalated to the committee. In addition, as discussed above medication safety was not an agenda item at the WRCC hospital governance committee and there was no evidence that there was sharing of information from the drugs and therapeutics committee to management and staff in WRCC rehabilitation unit for example;

drug safety notices. Senior management were unsure if the governance and oversight of medications rested with the drugs and therapeutics committee in UHW.

The hospital collected data on a range of different measurements related to the quality and safety of healthcare services, for example, bed occupancy rate, average length of stay, scheduled admissions, delayed transfers of care, patient-safety incidents, IPC, and workforce. However, inspectors were informed that approximately 20% of patients who were admitted to the rehabilitation unit were readmitted to UHW during the course of their stay, however, the data to support this verbal information was not available for inspectors to review.

Waterford Wexford Community Nursing Units Quality and Patient Safety Committee

The Waterford Wexford Community Nursing Units Quality and Patient Safety Committee was established in 2024 to provide assurance to the general manager that there are appropriate and effective structures, processes and systems in place for the delivery of person-centred safe and, effective care. Members of the committee included DONs from the seven community nursing units in Waterford and Wexford, the manager for older persons' services, quality and patient safety advisor and infection prevention and control. The committee was scheduled to meet quarterly, chaired by the manager for older persons' services. One meeting had taken place to date, in September 2024 and the meeting structure was evolving at the time of inspection. The terms of reference provided to inspectors were in draft format, however, meeting minutes indicated that they were reviewed with a plan for sign off at the next meeting. The agenda was aligned to the themes from the *national standards for safer better healthcare.* Agenda items included prevention and control of health-care-acquired infections, service user experience and quality indicators and outcome measures. However, the deteriorating patient, transitions of care or medication safety were not. The terms of reference indicated that the committee through the chair was accountable to the regional older people's services quality and safety executive committee and the chair will liaise with the committee on a quarterly basis.

Older Persons Directors of Nursing Governance Group

This meeting was chaired by the head of service older persons, and attended by the manager for older persons' services Waterford Wexford, the QSEC advisor, DONs from community and district hospitals from Waterford, Wexford, Carlow and Kilkenny. The DON from WRCC Rehabilitation Unit attended these meetings. Meetings were held quarterly and were well attended, however, terms of reference did not indicate the reporting relationship of this committee.

A review of sample minutes indicated that an agenda was followed, however, actions were not time bound or monitored from meeting to meeting.

Clinical Nurse Managers' (CNM) meeting

The clinical nurse managers' meeting was scheduled monthly, and chaired by the ADON. Meetings followed a set agenda and agenda items included, for example, quality and safety, infection prevention and control and education and training. Similar to the Hospital Governance Committee, three of the four areas of focus were not agenda items at these meetings. Notwithstanding this, meeting minutes were time bound with assigned action owners.

Overall, while there were defined roles, accountability and responsibilities for healthcare services delivered at the hospital areas for action were identified:

- medication safety, the deteriorating patient and transitions of care were not standing agenda items at the hospital governance committee or the clinical nurse managers' meeting nor were these committees in place
- there was lack of clarity in the hospital on the governance and oversight of medication safety in the hospital and the role of the drugs and therapeutics committee in UHW in relation to WRCC rehabilitation unit
- audits and audit results were not discussed at the governance meeting in relation to medication safety and the deteriorating patient
- the data on the readmission rates to the acute hospital and the reason for readmission were not available for review
- terms of reference reviewed for the WRCC Hospital Governance Group, the Older Persons' Directors of Nursing Governance Group and the Clinical Nurse Managers group did not outline the upwards reporting relationships.

Judgment: Partially compliant

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

The DON had identified an assistant director of nursing (ADON) for Our Lady's Ward (rehabilitation ward). The ADON was supported in the role by a CNM 1 and 2. Out of hours a senior member of the management team was on-call who was contactable by phone.

The ward had management arrangements in place in relation to the four areas of known harm:

Infection, prevention and control

The ward had identified an infection control link practitioner[**] who had completed the relevant training for this role and represented the hospital at the link nurse practitioner meetings in the community. The IPC link practitioner was allocated four hours per month to do this role which included providing advice, training and auditing of IPC. The IPC link nurse practitioner was supported by an IPC clinical nurse specialist (CNS) from the community who attended onsite to support staff during an outbreak. Inspectors were informed that they received good support from the community IPC CNS and reported that the CNS was onsite on the week prior to inspection to carry out an audit. IPC was a standing agenda item at staff meetings in the hospital.

Medication safety

Pharmacy supplies to the hospital were provided by University Hospital Waterford (UHW). Out-of-hours the hospital could contact a local pharmacy for the required medication. The hospital did not have a clinical pharmacy service, however, inspectors were informed that they could contact the pharmacy department in UHW if they had queries. Staff reported that they could also access the antimicrobial stewardship pharmacist and microbiologist from UHW if required.

Deteriorating patient

The ADON for Our Lady's Ward was the deteriorating patient lead for the hospital. The hospital had introduced a Modified Early Warning Score (MEWS)[††] in 2021. Inspectors were informed that if a patient triggers a high score, the medical officer was contacted with minimal delays in response noted. The hospital had a dedicated number for contacting the ambulance service for transferring patients to UHW if required. The Identify, Situation, Background, Assessment, Recommendation (ISBAR) communication tool[‡‡] was used when escalating a patient who was unwell. Inspectors observed an example of this in a patient's healthcare record. Additional findings will be discussed under national standard 3.1.

[**] Infection prevention and control link nurse is a link between the clinical areas and the infection control team. A key part of their role is to help increase awareness of infection control issues in their ward.

[††] (Modified) INEWS Escalation and Response Protocol: In some circumstances a Registrar or Consultant may decide that a patient's baseline observations fall outside of the normal INEWS physiological parameter ranges. In this instance a modified INEWS Escalation and Response Protocol is documented on the INEWS observation chart which outlines the rationale for alteration of escalation and response for this patient; the timeframe in which the alteration is to be reviewed; and any additional pertinent information about further actions and/or escalation for this particular patient. A patient's INEWS score or the INEWS physiological parameter ranges must not be altered.

[‡‡] Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

Transitions of care

The majority of patients were admitted from UHW with one bed assigned to patients who are admitted from the community. The draft In-Patient Rehabilitation policy outlined the criteria for admission to the unit. This is further discussed under national standard 3.1. An advanced nurse practitioner (ANP) in rehabilitation was employed by UHW with hours assigned to WRCC rehabilitation unit. The ANP reviewed all patients in UHW as to their suitability for rehabilitation and reviewed patients for admission from the community. Inpatients and patients for admission were discussed at a weekly multi-disciplinary team meeting. The clinical nurse managers in Our Lady's Ward were responsible for the safe transitions of patients at admission, discharge and transfer. Inspectors were informed that the average length of stay was two to three weeks.

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 hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

An up-to-date risk register was in place which was reviewed quarterly and a standing agenda item at the hospital's governance meeting. Two risks entered on the risk register were in relation to infection prevention and control and lack of a dedicated pharmacist. A risk in relation to the lack of allied healthcare professionals for the service including dietitian and speech and language therapist was escalated to the general manager. In addition, risk assessments were completed in September 2024 on the deteriorating patient, medication management, transitions of care and staffing and recruitment.

Incidents were logged on the National Incident Management System (NIMS)[§§]. Incidents were tracked and trended and staff informed inspectors that feedback was provided at handover, staff meetings and huddles. A serious incident management team was convened when required.

Our Lady's Ward was using the HSE *"Test your care"* audits which were completed monthly and covered audits on the deteriorating patient, infection prevention and control and medication safety. In addition, the hospital had recently introduced a new online programme for completing audits. Audits and audit results were not a standing agenda

[§§] The State Claims Agency National Incident Management System is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation.

item at the hospital's governance meeting. This was discussed under national standard 5.2.

Overall, the hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of services.

Judgment: Compliant

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

Our Lady's Ward had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare with the exception of access to dietitian and speech and language therapist.

The DON was operationally accountable for recruitment. The ward was allocated CNM 1 and 2, and 13 whole-time equivalent (WTE) *** staff nurse posts with no vacancies on the days of inspection. Inspectors were informed that agency staff supplemented unplanned leave. In addition, the ward was allocated 13 WTE healthcare assistants with no vacancies. On day one of inspection the ward had its' full complement of staff.

Staff had access to a medical officer who attended onsite daily. The medical officer was contracted for 20 hours per week for both Our Lady's Ward and the designated centre. Inspectors were informed that they could contact the medical officer outside of this time.

Infection prevention and control advice was accessed through the Waterford Wexford area. The ward had no clinical pharmacy service, however, inspectors were informed that advice could readily be accessed from UHW.

Two WTE physiotherapist were allocated to Our Lady's Ward, one WTE physiotherapy aide, 1.5 WTE occupational therapist and 1.5 occupational therapy aide. No deficits were identified by staff in relation to this service provision. However, as discussed under national standard 5.8, the hospital had no access to a dietitian or speech and language therapist. Inspectors were informed that this was escalated to regional executive officer (REO) and that at the time of inspection approval was awaited to recruit for these posts. In the interim, inspectors were informed that patients were assessed prior to transfer from UHW. If the patient required review while in Our Lady's Ward they were transferred back to UHW.

Training needs was a standing agenda item at the hospital governance committee. Good compliance with training was identified in standard and transmission based precautions,

*** 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.

hand hygiene and medication safety. However, only 50% of nurses had completed basic life support training. Inspectors were informed that this deficit arose due to lack of onsite trainers which has since been rectified with a plan to improve the compliance in this training.

The ward had workforce arrangements in place to support and promote the delivery of quality, safe and reliable healthcare, however,

- the ward did not have access to a dietitian or speech and language therapist
- poor staff compliance results were identified in basic life support training.

Judgment: Substantially compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. Key inspection findings leading to these judgments are described in the following sections.

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

Care in the ward was designed and delivered to promote the dignity, privacy and autonomy of patients in the unit. Inspectors observed staff communicating with patients in a manner that respected their dignity and privacy.

All patients were accommodated in single rooms, seven of which were en-suite with a maximum of two patients sharing bathroom facilities in the remaining rooms. Staff were observed protecting the dignity and privacy of patients by ensuring that doors were closed while providing intimate care. Patients had access to individual call bells and inspectors observed that call bells were responded to in a timely manner.

Personal information was protected as evidenced through the provision of a locked file room where patient records were stored. A whiteboard with minimal patient information was located in the treatment room and only staff had access to this area.

Overall, staff and management in the unit made every effort to ensure patients' dignity, privacy and autonomy were respected 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 was actively promoted by all staff. This was evidenced by observing staff providing care with kindness, consideration and respect who were responsive to patients' individual needs.

Patients were able to identify who they would raise a complaint or concern with. Feedback received from patients was that "all the nurses are very good" and "I won't have to make a complaint".

Patient satisfaction surveys were provided to all patients on discharge. A sample of the feedback received from April to July 2024 was provided to inspectors. 16 surveys were reviewed. Patients were surveyed on, for example, discharge planning, staff and access to health and social care providers. Overall, the feedback was positive with the majority of patients stating that the care was excellent or very good.

Information on advocacy services available to patients was on display.

Judgment: Compliant

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

The director of nursing was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from review of complaints. There was a culture of local complaints resolution in Our Lady's Ward.

Our Lady's Ward used the HSE's complaints management policy '*Your Service Your Say.*'[†††] Information on how to make a complaint was on display in the ward. Inspectors were informed that no written complaints were received via '*Your service Your say'* in the last few years.

Verbal complaints were logged in a complaints log which was reviewed by inspectors.

[†††] 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.

There was evidence that complaints were documented, reviewed and any change in practice documented as a result of the complaint.

The complaints process was underpinned by a local complaints policy which was up-to-date and aligned with HSE complaints management policy '*Your service Your say'*.

Complaints were an agenda item at the hospital's governance meeting. Staff informed inspectors that complaints were discussed at staff meetings and handover. Only a small number of complaints were received in 2024, tracking and trending was not required.

Overall, there was evidence that the hospital had systems and processes in place to respond effectively to complaints and concerns raised by people using the service.

Our Lady's Ward used the HSE's complaints management policy '*Your Service Your Say.*'[‡‡‡] Information on how to make a complaint was on display in the ward. Inspectors were informed that no written complaints were received via '*Your service Your say'* in the last few years. Verbal complaints were logged in a complaints log which was reviewed by inspectors. There was evidence that complaints were documented, reviewed and any change in practice documented as a result of the complaint. The complaints process was underpinned by a local complaints policy which was up-to-date and aligned with HSE complaints management policy '*Your service Your say'*.

Complaints were an agenda item at the hospital's governance meeting. Staff informed inspectors that complaints were discussed at staff meetings and handover. Only a small number of complaints were received in 2024, tracking and trending was not required.

Overall, there was evidence that the hospital had systems and processes in place to respond effectively to complaints and concerns raised by people using the service.

Judgment: Compliant

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

Our Lady's Ward had undergone significant refurbishment since the inspection in September 2020. The ward was bright, clean and well maintained. Inspectors identified that there was good local ownership and oversight in relation to infection prevention and control with oversight provided by a link infection prevention and control nurse on the ward.

[‡‡‡] 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.

Wall-mounted alcohol based hand sanitiser dispensers were located throughout the ward and readily available for staff and visitors with hand hygiene signage clearly displayed. Inspectors observed that clinical hand wash sinks conformed to requirements.[§§§]

Infection prevention and control signage in relation to transmission based precautions was observed in the clinical area. Personal protective equipment (PPE) was available for staff outside isolation rooms.

Environmental and equipment cleaning was carried out by healthcare assistants and staff nurses. Equipment was observed to be clean and there was a system in place to identify equipment that was cleaned, for example, use of tags and checklists. All ancillary rooms including the clean utility, dirty utility and storage areas observed by inspectors were clean and tidy with no evidence of excessive stock or inappropriate storage of equipment. Staff reported that they had access to the maintenance department in UHW with a timely response, when required.

There was evidence that security in the unit was recently reviewed and a security firm attended the grounds of the centre at regular intervals during the night. Management had ensured that external access to Our Lady's Ward was secured. This was confirmed by management and from a review of documentation

Inspectors were informed that the hospital had won a national award for the hygiene in the hospital and this certificate was on display on a corridor.

Overall, the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of patients receiving care in the ward.

Judgment: Compliant

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

Hospital management were proactively and systematically monitoring, evaluating and responding to information from multiple sources to inform improvement and provide assurances to the IHA manager in Waterford Wexford on the quality and safety of the service provided to patients.

The hospital did not have an audit schedule in place, however it was evident from a review of audits that they were completed approximately bi-monthly on medication safety, infection prevention and control and the deteriorating patient. Audit scores less

[§§§] Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf

than 85% required an action plan, however none of the audits reviewed were less than this.

Infection prevention and control audits were completed on for example, hand hygiene, sharps, laundry, equipment, glucometer and the environment. An IPC link nurse completed the majority of the IPC audits with the exception of the environmental audits which were completed by a cleaning contractor. Environmental audits completed for July, August and September 2024 scored 92%, 91% and 92% respectively. The audits identified minimal findings, however, they were assigned to either cleaning staff or nursing staff.

Gaps were identified in a '*test your care'* medication safety audit in July, for example, that patients' weights were not recorded on the medication record. An action plan was devised with a plan to provide medication safety education. Improvements were noted on the re-audit in October with scores of 100% and inspectors reviewed three medication records where it was completed in all three cases.

Good compliance levels were identified on '*test your care'* patient monitoring and surveillance audits in September 2024, however on a review of the audit it was documented that a sepsis screening form is used where infection is suspected to be the cause of the deterioration. This was discussed with management at interview who stated that this was an error in the audit and that no patient required sepsis screening as patients are transferred to UHW if there is a deterioration or if sepsis is suspected.

Judgment: Compliant

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

The hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people attending the hospital. Risks were managed locally on Our Lady's Ward and where they could not be managed they were escalated to the assistant director of nursing. This was further discussed under national standard 5.8.

The ward had access to a community IPC CNS and IPC link nurse practitioner. This was discussed under national standard 5.5. Two hand hygiene train the trainers were available onsite to provide training.

Patients were not routinely screened for multi-drug resistant organisms or COVID-19 on admission to the ward. Patients were tested for COVID-19 if they developed symptoms on admission or following admission. Staff reported that there were three COVID-19 outbreaks in 2024 in the ward to the date of inspection. Inspectors were informed that there was no crossover of staff to the designated centre and the outbreaks were contained within the ward. Notwithstanding this, no outbreak reports were completed on any of the outbreaks.

This is not in line with national guidelines.[****] At interview, management stated that the learning from outbreaks was shared at handover, however it was not formally documented.

As discussed earlier in the report the hospital did not have a clinical pharmacy service but had established close links with the pharmacy department in UHW. Pharmacy orders were delivered on a Wednesday. A form completed and sent to UHW if there is a change in a patient's medication within the week. Out-of-hours arrangements were in place with a local pharmacy.

The ward had introduced individual medication lockers for the safe storage of patients' medications. Staff and management reported that this was a positive initiative which had reduced the number of medication errors. This was confirmed in documentation reviewed. A designated medication fridge was available with temperatures checked daily. Prescribing guidelines were available to staff at point of care. A noticeboard on Our Lady's Ward contained a list of high-risk medications and inspectors observed risk reduction strategies in place in relation to the storage of insulin. The noticeboard also contained a safety alert from the Irish Medication Safety Network and a knowledge check on drugs requiring strict control measures.

Inspectors were informed that medication reconciliation[††††] was completed on discharge from UHW and again by nursing staff on admission. A sample of medication records reviewed confirmed that this did take place on discharge from UHW but was not completed when patients were admitted to the ward. Furthermore, this is not in line with the hospital's medication reconciliation guideline which states that the medication reconciliation should be completed within 24 hours of admission and on every patient.

Hospital management were proactive in introducing systems to identify a patient who was deteriorating. As discussed earlier in the report the hospital had developed a modified early warning score record specific to their service in 2021. Staff had access to HSE-Land online training and inspectors were informed that staff followed the national clinical guidelines for the INEWS. However, due to the nature of the service, the escalation processes deviated from national policy and no local policy supported this practice. This was discussed with hospital management at the end of the inspection.

Hospital management had completed a risk assessment in September 2024 to assess the risk of harm to patients due to inadequate recognition, assessment and response to deteriorating patient conditions. The risk assessment was not risk rated so it was difficult to determine the level of risk. Control measures were in place and actions required for

[****]. Department of Health. Dublin. National Clinical Effectiveness Committee. *Infection Prevention and Control (IPC), National Clinical Guideline No.30.* Dublin. 2023. Available from: gov.ie - Infection Prevention and Control (IPC)

†††† Medication reconciliation is the formal process of establishing and documenting a consistent, definitive list of medicines across transitions of care and then rectifying any discrepancies.

example, "update and reinforce early warning protocols and ensure all staff are trained in the latest version". These were assigned to an action owner and were time bound.

Emergency equipment was readily available if required such as a resuscitation trolley and an Automated External Defibrillator (AED) which were checked weekly. Oxygen points were at each bedside and one portable oxygen cylinder was available if required for an emergency situation.

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services and support safe discharge planning. Hospital management had completed a risk assessment to assess the risk of harm to patients due to ineffective management during transitions of care. This was risk rated and controls and actions were in place which were assigned to an action owner and time bound. From review, it was evident that the patient's personal details, medical history, current medications and infection status were recorded on transfer forms. Patients discharged from UHW to the ward were admitted with their healthcare record and medication record from UHW. Patient discharge plans were discussed at the huddle which inspectors attended on day two of inspection. The hospital had access to a mobile x-ray which attended onsite if required. This reduced the necessity of a patient having to attend an acute hospital for an x-ray.

Inspectors were informed that the majority of patients for admission were referred by a consultant to assess their appropriateness for rehabilitation or discussed at a weekly multi-disciplinary meeting if the patient is for admission from a community setting. All patients who were admitted required a discharge destination on admission. Hospital management provided a weekly report to the manager for older persons' services on a Friday which identified the planned date of discharge and the number of patients whose discharge was delayed. The general manager for older persons' services attended a delayed transfers of care meeting in UHW on a Friday. An in-patient rehabilitation policy provided to inspectors outlined the admission criteria for rehabilitation, however, this was in draft format and had not been reviewed or updated since 2022. In order to support the smooth transfer from the acute hospital to the rehabilitation ward an advanced nurse practitioner in rehabilitation attended onsite with a rehabilitation consultant and registrar and reviewed the patients twice weekly.

Inspectors were informed that a policy portal was being launched on 12 November 2024 where all policies, procedures, protocols and guidelines could be accessed across the region with a plan to have standardised policies. Inspectors were informed that policies were being reviewed at the time of inspection. Notwithstanding this, the majority of policies reviewed by inspectors were ratified and up-to-date. As discussed in the report, there was no policy on the identification and management of the deteriorating patient and the in-patient rehabilitation policy was in draft format.

In summary, while the hospital had systems in place to identify and manage potential risk of harm associated with areas of known harm — infection prevention and control,

medication safety, transitions of care and the deteriorating patient. The following areas for action were identified:

- outbreak reports were not completed following the closure of an outbreak
- there was no documentary evidence that medication reconciliation was routinely taking place on admission to the ward
- a policy was not available on the identification and management of a deteriorating patient and the in-patient rehabilitation policy was in draft format and had not been updated since 2022
- a risk assessment completed on the risk of inadequate recognition, assessment and response to deteriorating patient conditions was not risk rated

Judgment: Partially compliant

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

The hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. Staff were knowledgeable about how to report an incident and described incidents that they had previously reported and the process for reporting them.

Reported incidents were tracked and trended by the Quality and Patient Safety Advisor for Waterford Wexford. Inspectors were informed that tracking and trending of incidents was shared at the CNM meetings. Clinical incidents were a standing agenda item at this meeting. There was evidence from a review of meeting minutes of the hospital governance meeting that incidents were discussed.

Patient-safety incident reporting to NIMS was not in line with national targets in July 2024 and August 2024 at 41% and 78% respectively, however, management had identified this and actioned it and evidence provided on inspection indicated that this had improved to 96% in September 2024 and which was in line with the national key performance indicator of 70% of incidents reported to NIMS within 30 days from date notified.

Overall, the hospital effectively identified, managed, responded to patient safety incidents relevant to the size and scope of the unit.

Judgment: Compliant

Conclusion

An announced inspection of Waterford Residential Care Centre Rehabilitation Unit was carried to assess compliance with 11 national standards from the *National Standards for Safer Better Health*. Overall, the inspectors found eight national standards were compliant, one was substantially compliant and two national standards were partially compliant.

Capacity and Capability

Inspectors' identified that while the hospital had formalised governance arrangements in place with defined roles, accountability and responsibilities for healthcare services delivered at the hospital, organisational charts required updating to reflect the arrangements in place. Furthermore, the hospital had a WRCC hospital governance committee in place which provided oversight of the rehabilitation unit and the designated centre. While there was good oversight of agenda items with actions assigned and time bound, medication safety, the deteriorating patient or issues relating to the safe transitions of care were not agenda items at this meeting.

Notwithstanding this the hospital had management arrangements in place to support and promote the delivery of high-quality safe and reliable healthcare.

Workforce arrangements in the unit were planned, organised and managed to ensure the delivery of high-quality care. There were no deficits in nursing or healthcare assistants on the days of inspection, however, hospital management had identified a deficit in dietitian and speech and language therapist. This was on the hospital's risk register and inspectors were informed it was escalated within the RHA.

Quality and Safety

Care in the ward was designed and delivered to promote the dignity, privacy and autonomy of patients in the unit. Inspectors observed staff communicating with patients in a manner that respected their dignity and privacy. Management and staff promoted a culture of kindness, consideration and respect. The hospital had systems and processes in place to respond effectively to complaints and concerns raised by people using the service.

The rehabilitation ward had undergone significant renovation since the inspection in September 2020 and the ward supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people.

There was evidence that the quality and safety of care was measured in the rehabilitation unit. The centre protected service users from the risk of harm associated with the design and delivery of healthcare services with opportunities for improvement identified and outlined in this report.

The processes in place in relation to the reporting and management of patient-safety incidents at the hospital were clear and understood by staff.

Appendix 1 – Compliance classification and full list of standards considered under each dimension and theme and compliance judgment findings

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in any compliance plan submitted.

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

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Capacity and Capability Dimension	
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.	Partially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.	Substantially compliant
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.	Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Appendix 2 - Compliance Plan

Service Provider's Response

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

Outline how you are going to improve compliance with this national standard. This should clearly outline:

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

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

1. Medication safety, the deteriorating patient and transitions of care are now standing agenda items at the hospital governance meeting & the clinical nurse managers' meeting. Oversight including policy, audit and resultant action plans of these key areas will be reviewed at each governance meeting. In place 06.01.2025.

2. A review of structures and processes to form committees for medication safety, the deteriorating patient and transitions of care is currently in progress. Relevant stakeholder engagement has commenced and ongoing. Defined lines of accountability will be demonstrated in the terms of reference for each committee. – Expected completion: June 2025

3. The WRCC Assistant Director of Nursing with responsibility for the rehabilitation unit is a member of the University Hospital Waterford Drugs & Therapeutic Committee. We are currently progressing plans to form an onsite WRCC drugs and therapeutic committee to incorporate medication safety in collaboration with WICOP (Waterford Integrated Care of the Older Person), WRCC Medical Officer, Geriatrician Consultants, Advanced Nurse Practioner in Rehabilitation, WRCC nurse prescribers & UHW pharmacy department. This is in the early stages of development, initial engagements have commenced and project plan in development. Expected completion - September 2025

4. Data on acute readmissions reasons and rates from the WRCC rehabilitation unit is now being tracked and recorded. This readmission data will reviewed at ward and hospital governance meetings with trends identified and action plans developed & monitored- In place 11.11.2024

5. Terms of reference for the WRCC Hospital Governance Group, the Older Persons' Directors of Nursing Governance Group and the Clinical Nurse Managers group have been amended to outline the upwards reporting relationships- Complete 06.01.2025

Timescale: Action 1 – Complete Action 2 – June 2025 Action 3 – September 2025 Action 4 – Complete Action 5 - Complete

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

Outline how you are going to improve compliance with this national standard. This should clearly outline:

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

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

1. An outbreak report template is now in place to evaluate the outbreak response following the closure of an outbreak. This is completed by our nursing team in collaboration with WRCC IPC link nurse & Community IPC CNS, the learnings are disseminated to all WRCC rehabilitation unit team members and across the site if applicable. Learnings that may be relevant across sites, can be raised at the Waterford-Wexford Community Nursing Units Quality & Patient Safety Committee and onwards to the CHO5 Older Persons Services Quality & Safety Executive as required. Complete 18.11.2024.

2. All WRCC rehabilitation medication kardexs/prescriptions have a section to facilitate documentation of medication reconciliation. Medication reconciliation is to routinely take place for all admissions/discharges to the ward by our rehabilitation ANP, Admitting doctor or our nursing team within 24 hours in line with national guidance.
3. Medication management training and education incorporating medication reconciliation is currently being undertaken by all nursing staff on the unit – Expected completion: 31/03/2025.

4. Medication management auditing is included in our monthly nursing metrics audits & separate medication audits including audit of medication reconciliation are now scheduled for 2025, first audit due for completion 10/03/2025.

5. The WRCC rehabilitation unit follows the HSE national clinical guidelines for the identification and management of a deteriorating patient which primarily is used in an acute setting. We have further addended this document with a local standard operation procedure (SOP) on the management of the deteriorating patient using the modified early warning score to reflect the resource available in a sub-acute setting. This SOP is also supported by a training manual for the national early warning score and associated education program. Completed 17/02/2025

6. Our in-patient rehabilitation policy has been reviewed and updated – it's now for review and sign off by all relevant stakeholders – Expected completion 31/03/2025

7. The Risk assessment on the risk of inadequate recognition, assessment and response to deteriorating patient conditions has been reviewed and updated to include a risk rating and associated controls and actions. Complete 11/12/2024

Timescale:
Action 1 – Complete

Action 2 – Complete

Action 3 – 31/03/2025

Action 4 – 10/03/2025

Action 5 – Complete

Action 6 – 31/03/2025

Action 7 – Complete.