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:	Fermoy Welfare Home
Centre ID:	OSV-0007850
Address of healthcare service:	Fermoy Welfare Home Rathealy Road Fermoy Co Cork P61X367
Type of Inspection:	Announced
Date of Inspection:	11/03/2025 and 12/03/2025
Inspection ID:	NS_0131

About the healthcare service

Model of hospital and profile

Fermoy Welfare Home was a Health Service Executive (HSE) Rehabilitation and Community Inpatient Healthcare Service (RCIHS). It is a member of and is managed by the Regional Health Area South West (RHA SW). The home comprised of 14 beds to include, nine short-stay respite, four convalescence beds and one palliative care bed.

The following information outlines some additional data on the hospital.

Number of beds	14

How we inspect

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

During the inspection, the inspector:

- spoke with people who used the healthcare service to ascertain their experiences of receiving care and treatment
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the hospital
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told the inspector during the inspection

*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.

- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told the inspector during the inspection and information received after the inspection.

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with the national standards monitored during this inspection are presented in the following sections under the two dimensions of *Capacity and 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 Fermoy Welfare Home. It outlines whether there is appropriate oversight and assurance arrangements in place and how people who work in the service are managed and supported to ensure high-quality and safe delivery of care.

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector
11/03/2025	09:45 – 18:00	Marguerite Dooley
12/03/2025	08:30 – 13:30	Marguerite Dooley

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.[**]

During this inspection, the inspector visited the clinical area and also spoke with the following staff at the Fermoy Welfare Home:

- Interim Director of Nursing (DON)
- Interim General Manager (GM), residential services for older persons, Cork, RHA SW
- Medical Officer
- Interim Assistant Director of Nursing (ADON)
- Clinical Nurse Manager 2 (CNM 2)
- Assistant Director of Nursing (ADON) IPC, RHA SW
- Practice Development Coordinator, RHA SW
- 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 the inspector about their experience of receiving care and treatment in the service.

[†] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.
[‡] Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration.
[§] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[**] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

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

Fermoy Welfare Home (FWH) was a 14-bedded unit. On the first day of the inspection there were 10 patients present in the home. The inspector was informed that two admissions and two discharges were expected. The clinical area visited was all comprised of single occupancy rooms with televisions. Six larger rooms had a shared toilet and one standard room had a toilet. An enclosed garden, a spacious day room, and a dining room with a television were available for patient use. Internet access was also available.

The inspector spoke with a number of patients and relatives, all of whom had previous experience of FWH, to ascertain their experiences of receiving care in FWH. Patients said they were "happy with everything", it was a "tremendous facility", "no issues with medications, all explained to me". One patient said there was a "limited choice of food but it was good quality", while the "helping was small you were invited to ask for more". One patient noted that it can take a while to walk to the dining room when using a walking stick, when the patient reaches the dining room, the food "could be warmer". Patients did not have any concerns with the number of available showers and toilets for patient use, "staff offer assistance if you need it" while noting "a lot of time is spent cleaning". One relative said the FWH "has a great reputation".

While patients who spoke with the inspector did not have a complaint, some did not know how to make a complaint but would "speak to a nurse". One relative was aware of the HSE, *'Your Service, Your Say'* and the service user feedback form provided on discharge.

The inspector observed information on independent advocacy services and leaflets about the HSE feedback and complaints process, *'Your Service, Your Say'* on display, and a comment box located centrally. Details on the designated complaints officer for FWH, the GM, the HSE e-mail address and independent advocate was also displayed in the clinical area. In summary patients were very complimentary about the staff and the care received in the FWH and this was consistent with what the inspector observed over the course of the inspection.

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. Fermoy Welfare Home was found to be compliant with three national standards (5.2, 5.8, 6.1) and substantially compliant with one national standard (5.5) 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 the inspector found that Fermoy Welfare Home (FWH) had formalised corporate and clinical governance arrangements in place to assure the quality and safety of healthcare services.

On the 03 March 2025, the RHA SW structure came into effect and detail relating to the reporting structure will be subject to further refining. Organisational charts viewed by the inspector set out the FWH reporting structures detailing the direct reporting arrangements. The Interim Director of Nursing (DON) had overall responsibility and accountability for the governance of FWH and had a direct reporting structure to the Interim General Manager (GM), residential services for older persons, Cork. The GM currently reported to the Head of Service (HOS) for older persons, the Interim Integrated Healthcare Area (IHA) Manager and the Regional Executive Officer (REO). Nursing, Healthcare Assistants (HCAs) and support staff reported to a Clinical Nurse Manager 2 (CNM 2). The CNM 2 managed the unit four days a week from Monday to Friday. The CNM 2 reported to an Interim Assistant Director of Nursing (ADON), who reported to the DON.

The GM chaired 'residential services older persons Cork' DON management team meetings. In line with the terms of reference (TOR), meetings were scheduled fortnightly and the DON noted there was a schedule for the year. Minutes showed meetings followed a structured format, actions were assigned to an individual and were followed up from meeting to meeting. Meetings followed a standard agenda which included Quality and Patient Safety (QPS), risks and the risk register, National Incident Management System (NIMS)[††] incidents and safeguarding. The GM also chaired quarterly QPS 'Cork community hospitals' committee meetings. Attendance included DONs, QPS and the Practice Development Coordinator. Agenda items included IPC, service user

[††] 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).

feedback, incidents, quality improvements, safeguarding and training. Actions were assigned to an individual but were not time-bound. There were two DON meetings, chaired by the HOS held in 2024. The DON had oversight of the hospital risk register, and risks were discussed at the fortnightly DON and quarterly QPS meetings. To ensure governance and oversight, risk assessments were escalated, where required, to the GM, for recording on the GM risk register. This was evident on review of QPS minutes. For incidents that required preliminary assessment, there was a shared online DON folder, to review progress with actions specific to the individual service. A QPS representative was assigned to FWH 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.

Senior nurse management meetings were conducted monthly in line with the terms of reference. The objective of these meetings was to review all aspects of the delivery of a safe, high quality service. Chaired by the DON and attended by the ADON and CNM2s or designate. Meetings followed a structured format and agenda items included nutrition, QPS, IPC, safeguarding and training. Actions were not assigned to an individual and were not time-bound. The CNM chaired ward meetings every two months in line with the TOR. Meetings followed a structured format and agenda items included nutrition, QPS, IPC, safeguarding and training. Actions were not assigned to an individual and were not time-bound.

The Medical Officer was a General Practitioner (GP) who provided cover to both the FWH and the Fermoy Community Hospital. The Medical Officer attended the hospital on a weekly basis from Monday to Friday, and cross cover was provided during periods of leave. An out-of-hours GP medical service was contacted should a patient's condition deteriorate out of hours. Drugs and Therapeutic Committee (DTC) meetings for RHA SW, were convened quarterly. Chaired by a GM, membership included the Practice Development Coordinator and a link DON, trends and risks were discussed. Through the link DON, the DON of FWH could have specific issues raised at the DTC meeting. FWH had a Nurse Prescriber, governance and oversight was provided by the DON, supported by the Practice Development Coordinator.

FWH had an assigned CNM 2 IPC, RHA SW, staff also had access to an ADON IPC, RHA SW. The DON and staff within FWH could contact IPC directly or via a generic e-mail for advice. The inspector was informed that the ADON IPC 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 RHA SW ten hours per week. The ADON IPC attended quarterly IPC and antimicrobial (AMS) meetings with community colleagues. The inspector noted the TOR for these meetings required review since September 2022, it was acknowledged that the TOR would be reviewed to reflect the new RHA structure. Formerly chaired by the Chief Officer, the objective of this group was to support effective governance and coordination of IPC and antimicrobial activities

at RHA 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 the inspector 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. Hygiene services were provided to FWH through an external contractor and the inspector was informed that a service level agreement was in place.

Overall the inspector was satisfied that Fermoy Welfare Home had formalised corporate and clinical governance arrangements in place appropriate to the size and complexity of the service, but recommend actions from meetings are assigned to individuals and are time-bound.

Judgment: 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 inspector found that there were management arrangements structures and mechanisms in place to support the delivery of safe, high quality and reliable healthcare services at Fermoy Welfare Home.

FWH had a standard operating procedure (SOP) for admissions, which required review since its approval in December 2019. The SOP outlined the referral and admission process including admission-exclusion criteria. Admissions to the FWH were through referral and transfer from acute hospital services, and referral from Public Health Nurses (PHNs).The DON attended a daily 'check-in-call' meeting at 9.30am with representatives from RHA SW. Updates were provided on available capacity, expected discharges and IPC. Admission required the consent of the patient and admissions were accepted up to 5pm, or later in exceptional circumstances. Acceptance of convalescence transfers from acute services was through the placement coordinator, who linked with the Liaison Community Support Team (LCST). Transfers from acute services generally took place on the same day. Referrals for respite were through the PHN service and could be received a month in advance of the proposed admission date. Patients requiring respite were generally admitted between Tuesdays to Thursday. However patients requiring emergency respite were accepted Monday to Sunday. The inspector noted that practices relating to the updating of healthcare records did not meet the requirement of standards, this was brought to the attention of management.

Nurse-led medication reconciliation was conducted on admission and discharge, each time by two nurses. The inspector saw evidence of this practice in the nursing admission

assessment documentation. The inspector was informed that the Medical Officer conducted a full ward round on a weekly basis, which included a further review of medication. A local pharmacy provided medication dispensing and was open on a daily basis from Monday to Saturday (9am to 6pm). Prescriptions were issued to the pharmacy through Healthlink[‡‡] and the pharmacy delivered the medication to the FWH. On occasions the pharmacist delivered the medications to FWH to provide an opportunity to address any medication related issues.

The FWH had an approved Medication Management Policy dated September 2024. In line with the policy, patients were provided with a medication record or Medicines Prescription and Administration Record (MPAR). The completed MPAR was brought by the patient on admission to the FWH as part of the pre-admission documentation and was valid for three months. The inspector was informed that on a number of occasions, prescription errors were identified by nursing staff when carrying out medication reconciliation on admission. If a prescription error was identified, staff followed a specific process to address the error which included a review of the patient, their medications and amend the MPAR accordingly.

Patients admitted to FWH for convalescence, from an acute service required a prescription as part of the pre-admission documentation. Patients for respite or palliative care brought their own medications on admission and blister packs were not accepted to mitigate potential prescription or medication errors. The MPAR, had the patient's name, address and photographic identification. Patients were asked for their consent to have a photograph taken and if they chose not to consent, a patient identification wrist band was worn. The medication management PPPG had a list of sound-alike-look-alike-drugs (SALAD), high risk medications and outlined a number of risk reduction strategies. Allergy labels were prominent on the MPAR, and management were planning to order high risk medication labels as part of medication safety practice. The inspector noted that adherence to the medication management policy could be improved in relation to a number of points, for example 'checking the patients identification (ID) band prior to drug administration in addition to checking the photographic identification', as the majority of patients did not have an ID band. In addition, the practice for clearly identifying the prescriber for the prescription of the MPAR was identified for improvement in line with local policy. This was brought to the attention of management.

The medical officer and a number of staff had access to diagnostic results and services. A mobile radiology service was available to FWH and staff acknowledged that there was a timely response to requests. Radiology reports were issued through Healthlink. In the event that a patient deteriorated, the Medical Officer was contacted to review the patient while on-site, or could be contacted from Monday to Friday (9am to 6pm). An out-of-

[‡‡] Healthlink is the National Health Messaging broker, funded by the HSE, providing a web-based messaging service which allows the secure transmission of clinical information between Hospitals, Health Care Agencies and Medical Practitioners.

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 the inspector saw evidence of this in a patient's healthcare record. The medical officer or the out-of-hours GP 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 Practice 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 inspector viewed a one page document outlining the escalation process and was informed that both the DON and ADON are available out of hours if required.

Patients were not screened for multi-drug resistant organisms (MDRO) on admission. Staff at FWH were pre-alerted to patients requiring admission who had an active or history of an 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 and the FWH had all single occupancy rooms. The most recent outbreak of infection occurred in July 2024 and a 'review of actions following an outbreak of respiratory infection' 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 through discussion between staff in FWH and IPC. The decision to close an outbreak was taken by the Department of Public Health and this was communicated to the Unit through the CNM 2 IPC or the ADON IPC.

Overall the inspector was satisfied that FWH had effective management arrangements in place to support and promote the delivery of high, safe and reliable healthcare services. However areas for focused improvement include:

- review of medication practices within FWH to ensure they are aligned to policy
- ensure healthcare records are updated in line with standards.

Judgment: Substantially Compliant

[§§] 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.

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 inspector found FWH 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 158 admissions to include 129 respite, 25 convalescence and 4 palliative care. Five (3.16%) patients required unplanned transfer to an acute site in 2024. The inspector was informed that staff were vigilant to the potential of prescription errors arising and that there was a positive culture of reporting incidents. The DON had oversight of the risk register, risks were reviewed monthly and at the time of inspection there were eight risks specific to the four key areas of harm prioritised under HIQA's monitoring programme. Patient safety incidents were reported on NIMS. Monthly statistics were reported to antimicrobial resistance infection prevention and control (AMRIC). A healthcare-associated infection, antimicrobial resistance and antimicrobial consumption data set report was issued on a quarterly basis, which included the FWH and the Fermoy Community Hospital.

The inspector was provided with examples of Quality Improvement Projects initiative registration forms related to falls reduction and medication safety 'passport to home' initiative. Implementation of the National Clinical Guideline (NCG) number 21, 'appropriate prescribing of psychotropic medication for non-cognitive symptoms in people with dementia' was being progressed in 2025. FWH had also participated in the 'skip the dip' initiative.

Overall the inspector was satisfied that the Fermoy Welfare Home had monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services provided.

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.

The inspector found the workplace arrangement in place in FWH was planned, organised and managed to ensure high quality, safe and reliable healthcare.

The DON had oversight for human resource management in FWH. The following whole time equivalent (WTE)[***] complement was in place: 1 WTE DON and 1 WTE ADON, both of whom covered the FWH and the Fermoy Community Hospital. There was 0.89 WTE CNM2, 0.88 WTE CMM1, 7.2 WTE Registered General Nurses (RGNs), 8.05 WTE Healthcare Assistants (HCAs) and 3 WTE Multitask Attendants (MTAs). The inspector was informed by management that nursing and support staffing was sufficient to meet the requirements of the home. Agency staffing was not utilised in FWH and staff had been flexible to cover any gaps in rosters during periods of unplanned leave, to mitigate disruption to service provision.

Compliance with mandatory and essential training for nursing staff was 100%. Training included standard based precautions (SBP) and transmission based precautions (TBP), hand hygiene, medication safety, basic life support and sepsis six. HCAs had completed SBP and hand hygiene and compliance was 100%. All managers had undertaken complaints management, risk management and integrated discharge planning training. The inspector was informed that on commencing employment, staff are provided with a list of mandatory training requirements with a 30-day timeline for completion. The management of FWH had oversight to ensure all staff were Garda vetted before commencing employment. Staff had completed children's first training, and the FWH child safety statement was on display. Absenteeism was 2.67% which was below the HSE key performance indicator (KPI) of 4%. 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.

Overall the inspector was satisfied that the workplace arrangement in place in Fermoy Welfare Home 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. Fermoy Welfare Home was found to be compliant with four national standards (1.6, 1.7, 1.8, 3.3) and substantially compliant with three national standards (2.7, 2.8, 3.1) 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.

The physical environment in the clinical area promoted the privacy, dignity and confidentiality of patients receiving care. All rooms were single occupancy, and assessment of individual patient needs, ensured patients with higher dependency requirements were accommodated in the larger rooms. The inspector was informed that visiting was unrestricted for palliative care patients. Patients were assisted with their individual needs. Call bells were available if assistance was required and when activated there was audible alarm near the nurses' station with a digital read out of room location. The inspector observed the majority of patients were out of bed and dressed. Patients told the inspector that they 'sat out' or 'walked around' the enclosed garden and this was observed by the inspector. Healthcare records and personal information was protected in the clinical area. Patient information leaflets on the HSE '*Your Service, Your Say*', information on independent advocacy services and the Ombudsman was on display in the clinical area.

In summary the inspector was satisfied that patients' dignity, privacy and autonomy were protected and promoted in the Fermoy Welfare Home.

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 FWH. This was confirmed by patients who spoke positively about their interactions with staff and was supported by evidence from service user feedback forms that the inspector viewed. Patients with whom the inspector met with, were complimentary of the staff and the care provided to them. The inspector observed FWHs 'mission statement' and safeguarding policy on display.

The inspector was satisfied that service users were treated with kindness and respect in Fermoy Welfare Home.

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 FWH had a complaints procedure in place which outlined how to make a complaint, timelines for the process and feedback.

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 also responsible for ensuring implementation of recommendations arising from any review. Staff were encouraged to resolve complaints locally. Verbal complaints were tracked and a log was maintained by the CNM 2, the patient was invited to sign the verbal complaint log. If staff could not resolve the issue locally, the complaint was escalated to the complaints officer. At the time of the inspection, all managers had completed complaints management training. The inspector was provided with evidence of four verbal complaints from 2023 to 2025. Two verbal complaints were closed and two complaints relating to patient discharge remained open at the time of inspection. Patients were provided with evaluation forms to complete on discharge and uptake had noticeably increased. The inspector viewed a number of completed evaluation forms, all of which contained positive feedback. The DON and CNM 2 reviewed the feedback and forwarded the data to the Assistant Director for Public Health Nursing (ADPHN) who arranged for the data to be collated.

The inspector was satisfied that there were systems and processes in place in Fermoy Welfare Home 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, the inspector observed the overall physical environment in the clinical area visited was well maintained and clean.

Wall-mounted alcohol hand gel dispensers were strategically located and readily available for patient and staff use. However the inspector noted two dispensers that were empty and brought this to the attention of management. Signage promoting the five moments of hand hygiene was clearly displayed. While hand hygiene sinks were available, not all sinks conformed to national standards. All rooms were single occupancy. Storage in the standard rooms was limited, for example, ability to hang clothing and the management were exploring available options to address this issue.

External hygiene staff rostered from Monday to Sunday (9am to 3pm) were responsible for environmental cleaning with oversight from the CNM 2, this included an increased cleaning scheduled during periods of outbreaks. The inspector saw evidence of cleaning schedules and sign off sheets to indicate cleaning had taken place. There was an individual cleaning booklet for each room. FWH had a separate 'clean' and 'dirty' utility room for storage of cleaning equipment and supplies. Posters on display indicated colour coding system for cloths used when cleaning. The inspector noted that in the 'dirty' utility, cleaning solutions for equipment were prepared but not labelled and this was brought to the attention of the management. The inspector observed that while disposable bedpans were in use, wipes could not be disposed of in the macerator. This resulted in staff, while wearing personal protective equipment (PPE), handling wipes to dispose of in the clinical waste, before disposing of the bedpan and contents into the macerator. The inspector was informed that various macerator suitable wipes had been trialled but were not suitable for use. This practice should be risk assessed and reviewed.

The inspector noted there was a tagging system in place to indicate if a piece of equipment had been cleaned. However evidence of this was not seen and this was brought to the attention of management. Portable suction and oxygen compressors were used and an automated external defibrillator (AED) was available. An electronic request was forwarded to maintenance if equipment required repair and there was generally a timely response. The inspector noted that service history details were not available or was overdue on some equipment seen, for example the service history on the bed pan washer was recorded as 2020.

The external hygiene contractors carried out weekly tap flushing for taps not in use and the CNM 2 received weekly compliance reports. While water testing for legionella was not conducted, the inspector was shown a legionella risk assessment for FWH. One of the standard single rooms had a toilet and each of the six larger patient rooms had a shared toilet. However these toilets were not wheelchair accessible. The inspector noted there was not a toilet paper dispenser in one toilet and this was brought to the attention of management. There were three wheelchair accessible toilets and two wheelchair accessible showers available for 14 patients. While management said this was sufficient, the inspector recommended that a risk assessment should be completed, identifying existing control measures and monitoring the risk on a regular basis. The risk assessment was provided during the course of the inspection.

There was a designated medication preparation area, with a controlled drugs press and one dedicated drugs fridge. Medications were stored securely, however non-controlled medications were stored in the controlled drugs press and this was brought to the attention of the management. There was also a fridge to hold samples for transfer out to a hospital laboratory, on the day of inspection, there were no samples in the fridge. While the drugs fridge was not locked, entry to the clinical room was authorised access only. The inspector saw evidence of documented daily temperature log checks.

There was appropriate segregation of linen and the inspector was informed that an external contractor laundered the linen for FWH. While there was a washing machine and dryer in the clean utility, these were not used. There was appropriate segregation of clinical waste and the inspector observed posters in relation to disposal of healthcare waste, sharps and management of blood spillages. Sharps bins were partially closed, signed and dated. There was a secure room for hazardous materials. The inspector noted that the FWH did not have security personnel but authorised access and security cameras were in place.

Overall the physical environment supported the delivery of high quality, safe, reliable care, areas for focused improvement include:

- ensure current tagging system for equipment, identifying that is has been cleaned is used consistently
- ensure all cleaning solutions when prepared for use are labelled
- address the risk posed to staff through unnecessary exposure when handling waste.

Judgment: Substantially Compliant

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

Fermoy Welfare Home 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.

Practice development provided the FWH 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. However through discussion with management, it was noted that QIPs could be developed without actions assigned to an individual or being time-bound and measures were being taken to address this. Environmental audits showed compliance ranged from 99% to 100%. Clinical waste audits ranged from 88% to 100% and linen audits ranged from 0% to 100%. However the inspector noted linen and waste audits were not conducted quarterly which could be an area for improvement.

The CNM 2 had oversight of equipment cleaning. Audits provided to the inspector showed compliance ranged from 81% to 100%. Mandatory hand hygiene training records for staff were 100%. The inspector was informed that hand hygiene audits were also conducted by the CNM 2 IPC when they visited FWH. Audits in relation to medication safety showed overall compliance with usage and legibility of prescriptions ranged from 84% to 100%, while medication administration was 94% to 100%. However the inspector noted the psychotropic drugs audits ranged from 40% to 100% with an overall compliance of 81%. Documentation audits ranged from 77% to 100% and there was evidence of re-audit and improved compliance since September 2024.

Fermoy 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, were anonymised, but each provider had a unique code to interrogate 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 Fermoy Welfare Home 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 example linen and waste management
- improve compliance with audit results, for example psychotropic drugs

- 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

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

There were two RGNs and two HCAs rostered on day duty from Monday to Sunday, and one RGN and two HCAs on night duty. A CNM 2 worked during Monday to Friday and a CNM 1 was available to cover in their absence. Patients admitted to the clinical area 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 (8am and 8pm) to communicate issues related to patient care using an electronic print out, based on the ISBAR communication tool, concerns were identified in red bold print. A daily safety pause was also conducted at 3.30pm. The inspector noted practices related to updating of healthcare records was not in line with standards this was brought to the attention of management. The inspector observed 'hourly flow sheets' in patient's rooms. This sheet indicated the patient had been checked on an hourly basis, records were signed and dated. On discharge, nurse-led medication reconciliation was carried out and this was documented in the admission assessment nursing care plan. If any changes to medication had been made, the Medical Officer contacted and wrote to the patients GP, providing a rationale for the change, a recent example was provided relating to diabetic medication. On discharge, the patient was provided with a nursing discharge letter, a copy was sent to the patients GP and the PHN, and all copies were kept on file.

Patients for respite and palliative care brought their medications on admission. Nurse-led medication reconciliation was conducted on admission and discharge. The inspector was informed that the Medical Officer conducted a weekly ward round which included review of medication. A British National Formulary (BNF) was available to access medication information and red aprons were available to wear during medication administration to mitigate interruption. FWH had a medication management policy, however the inspector noted a variance between policy and practice and brought this to the attention of management. Medication safety training was arranged by the Practice Development Coordinator and regular 'toolbox talks' education sessions were conducted. There were eight medication incidents reported to NIMS in 2024 and the DON would be notified in the event of any Health Products Regulatory Authority (HPRA) alerts.

In the event that a patient deteriorated, the medical officer was contacted to review the patient while on-site. However the inspector was informed that the Medical Officer regularly took queries from staff in the FWH outside of normal working hours, to include weekends. An out-of-hours GP medical service was contacted should a patient deteriorate out-of-hours. The ISBAR3 communication tool was used and the inspector saw evidence of this in a patients' healthcare record. Information leaflets 'I have an infection could this be sepsis' and information on 'respiratory rate the most neglected vital sign' were available in the FWH.

FWH had assigned two IPC link practitioner nurses, providing support for staff on a daily basis. The IPC link nurses met with the ADON IPC on approximately ten occasions throughout the year. FWH had a COVID-19 contingency plan however this required updating since its approval in 2019. The regional IPC had introduced online IPC training sessions for staff and FWH had access to training from an AMS pharmacist. Conducting point-of-care risk assessment was recommended and rooms were single occupancy which mitigated the risk of transmission when accommodating patients with MDROs. One patient requiring contact precautions had signage displayed on the door, PPE was available for staff and door of the room was kept closed.

FWH had a risk management PPPG which required review. The risk register was reviewed on a monthly basis, and updates on the risk register were sent to the GM on a quarterly basis. Risks that could not be managed locally were escalated to the RHA SW. Risks were also discussed at the fortnightly DON meeting and the quarterly QPS meeting. The inspector viewed a number of risk assessments, developed by the DON, control measures were put in place and residual risk determined. Twenty-three falls incidents were reported in FWH 2024 and posters on falls reduction and falls management were on display. The inspector was informed that there was a four-hour physiotherapy service provided to cover the FWH and the Fermoy Community Hospital. Staff expressed the need for a full-time physiotherapist to provide a service to include patients requiring respite.

Recreational activities were provided to patients on a daily basis from Monday to Friday by an external contractor, or HCA. Posters were on display identifying the various activities and services available. FWH facilitated first responder training on a number of occasions throughout the year. The inspector was informed about and viewed a document indicating that all first responders were Garda vetted and had completed the national safeguarding training. The inspector recommended that this training was reflected in a PPPG.

Overall the inspector was satisfied that Fermoy Welfare Home had systems in place to protect service users from the risk of harm associated with the design and delivery of healthcare services however areas for focused improvement:

- ensure medication practice is aligned with the medication management PPPG
- ensure healthcare records are updated in line with standards
- ensure all PPPGs are updated where required.

Judgment: Substantially Compliant

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

Fermoy Welfare Home 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 the RHA SW on a weekly 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 FWH in 2024 and compliance with the national KPI was 80.8%. The number of falls reported in 2024 were 25, to include one classified as moderate-category two. There were eight medication incidents reported to NIMS, classified as minor-category three. A high rate of incident reporting is considered a marker of a strong patient safety culture and management should continue to raise awareness amongst staff, on the importance of reporting all incidents and near misses.

Feedback to staff was on an informal basis at the daily handovers. Staff who spoke with the inspector were knowledgeable about how to report and manage a patient safety incident. 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 discussed at the fortnightly DON meeting and the quarterly QPS meeting.

In summary, the Fermoy Welfare Home 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.

Judgment: Compliant

Conclusion

HIQA conducted an announced inspection of Fermoy Welfare Home 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 inspector found evidence of compliance with seven national standards (5.2, 5.8, 6.1, 1.6, 1.7, 1.8, 3.3) and substantial compliance with four national standards (5.5, 2.7, 2.8, 3.1).

Capacity and Capability:

Fermoy Welfare Home had clear lines of accountability and responsibility in relation to corporate and clinical governance. Frequency of meetings were aligned with the terms of reference and there was a schedule. There were effective management arrangements in place to support the delivery of high quality, safe and reliable healthcare, however areas for improvement include practices relating to recording updates in the healthcare record in line with standards. In the absence of specific committees, the interim DON had oversight for IPC, the deteriorating patient, medication safety and transfers of care. The inspector viewed contingency plans for COVID-19, however a number of PPPGs viewed were not in date. At the time of inspection there were no reported nursing, HCA or MTA staffing deficits identified to the inspector by management. Patient safety incidents were reported and risks were discussed at regional DON and QPS meetings. Risks that could not be managed at a local level were escalated through the line management structure of the RHA SW.

Quality and Safety:

It was evident to the inspector 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 FWH. The physical environment supported the delivery of high quality, safe care and the number of available toilets and showers for patient use will be monitored. While FWH had safe systems in place to protect the patient from harm, medication practice should align with the medication management PPPG. The inspector found there was a system in place to identify, report and manage patient safety incidents. FWH was meeting the national KPI of 70% whereby incidents were reported to NIMS within 30 days and management would continue to raise awareness on the importance of reporting all incidents and near misses.

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

Compliance Classifications

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

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

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

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially 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	Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality,	Substantially Compliant

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