Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection against the *National Standards for Safer Better Healthcare*.

Name of healthcare service provider:	St Columba's Hospital, Rehabilitation Unit
Address of healthcare service:	Cloughabrody Thomastown Kilkenny R95 YY96
Type of inspection:	Announced
Date(s) of inspection:	29 and 30 January 2025
Healthcare Service ID:	OSV- 0008845
Fieldwork ID:	NS_0116

About the healthcare service

Profile of the hospital

St Columba's Hospital is a statutory hospital, owned and managed by the Health Service Executive (HSE) under the governance of Dublin and South East Regional Health Area.

St Columba's Hospital, Rehabiliation Unit provided the following care and services:

- 10 rehabilitation 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 HIQA's role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors* reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publically available information since last inspection.

During the inspection, inspectors:

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

*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.

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 of this report.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
29 January 2025	13.15 – 17.50hrs	Bairbre Moynihan	Lead
30 January 2025	08.45 – 15.00hrs	Danielle Bracken	Support

Information about this inspection

This announced inspection of St Columba's Hospital, Rehabilitation Unit 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
- medication safety

[†] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.

- the deteriorating patient[‡] (including sepsis)[§]
- transitions of care.[**]

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 (DON)
  - Assistant Directors of Nursing
  - General Manager for Older Persons' Services Carlow Kilkenny and South Tipperary
- Consultant Geriatrician
- Quality and Risk Advisor

- Representatives from each of the following areas:
  - Infection prevention and control
  - Medication safety
  - Deteriorating patient
  - Transitions of care.

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank people using the healthcare service who spoke with inspectors about their experience of receiving care and treatment in the service.

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

During the inspection, inspectors chatted to a number of patients but in more detail with four patients. Overall, patients expressed satisfaction about the care they received in the Rehabilitation Unit and were complimentary about the staff and staff responsiveness to requests. Patients stated that "everyone is brilliant", "they say hello when they pass" and staff are "attentive".

[‡] 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.

The primary reason for admission was for rehabilitation and patients were complimentary about the physiotherapists and had clarity on the days they received physiotherapy.

Inspectors observed patients engaging with staff in a positive manner and staff were observed being kind and respectful in their interactions with patients.

An activities calendar was on display on the noticeboard which outlined when the multi-disciplinary round was and the days of mass. Patients had access to a church on the grounds and mass was celebrated once weekly. Mass was broadcast to televisions within the patient bays and those who could not attend could view it, if they wished. In addition, WIFI was available for those patients who required access to it.

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes the standard related to workforce.

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, who reported to the general manager for older persons' services, and upwards to the integrated health area manager for Carlow Kilkenny and South Tipperary, in 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. A committee organisational chart provided to inspectors indicated that the hospital had committees in place, for example; drugs and therapeutics and deteriorating patient committee. Inspectors were informed that these committees reported to the quality and patient safety committee and the committee organisational diagram was updated while inspectors were onsite to reflect this. The committee organisational diagram indicated that a policy committee would be formed in 2025. While a transitions of care committee was not in place in St Columba's Hospital, it was evident from a review of meeting minutes that this was discussed.

Nursing and support staff reported to CNMs 1 and 2 in the Rehabilitation Unit and upwards to an assistant director of nursing (ADON) and the DON.

The hospital had a medical officer onsite for 20 hours per week Monday to Friday who covered both the Rehabilitation Unit and the residential service. Out-of-hours medical cover was provided by an on-call service.

St Columba's Clinical Governance Committee

This committee, chaired by the manager for older persons' services Carlow, Kilkenny and South Tipperary, provided a forum for communication from hospital to senior management. Membership consisted of the director of nursing, assistant directors of nursing, catering and administration managers. Meetings were held three monthly. The terms of reference (TOR) were up-to-date, dated December 2024, however, they did not indicate the reporting relationship of this committee and they were not dated or signed by the chairperson and members of the committee to indicate that they were agreed. Agenda items included infection prevention and control, clinical risk, auditing and quality improvement initiatives. It was evident from a review of meeting minutes that issues relating to the Rehabilitation Unit were discussed. For example, taped handover. This is discussed under national standard 3.1.

Quality and Patient Safety (QPS) Committee

The QPS committee was chaired by the director of nursing and attended by, for example, assistant directors of nursing, clinical nurse managers, healthcare assistants and housekeeping. The TOR were not dated or signed. These indicated that meetings were held quarterly and that the QPS committee was accountable to the older persons' manager and general manager and submitted an annual report to the general manager. Inspectors were informed and the amended committee organisational chart confirmed that all committees in the hospital reported to the QPS committee. The agenda was aligned to the themes from the *National Standards for Safer Better Healthcare*. Meeting minutes indicated that issues relating to the four key areas of harm which were the focus of this inspection were discussed – infection prevention and control, transitions of care, medication safety and the deteriorating patient.

Older Persons Directors of Nursing Governance Group

This group was chaired by the head of service older persons, and attended by the manager for older persons' services Carlow, Kilkenny and South Tipperary, the QPS advisor, DONs from community and district hospitals from Kilkenny, Waterford, Wexford, Carlow and South Tipperary. The DON from St Columba's attended these meetings. Meetings were held quarterly and were well attended, however, terms of reference did not indicate the reporting relationship of this committee. Furthermore, the terms of reference were in draft and not signed and dated. Items discussed included incidents, policy development and training needs.

Drugs and Therapeutics Committee - St Columba's Hospital and Castlecomer District Hospital

A Drugs and Therapeutics Committee was established to review and implement policies, procedures and guidelines and review risk management in relation to medication and medication reconciliation across the two hospitals. The committee, chaired by a nurse prescriber, had representation from nursing, a medical officer and a pharmacist from SLGH. Minutes of meetings reviewed aligned with the agenda, previous actions were reviewed and all new actions were time-bound and assigned to an identified person. The TOR were dated and signed. These stated that the committee provided update information and feedback at the in-house clinical nurse manager (CNM) meetings, QPS and clinical governance meetings for communication to staff at unit level and the regional quality safety executive committee (QSEC) as required. However, there was lack of clarity in the TOR on who would escalate issues to the regional QSEC. In addition, as discussed earlier in the report inspectors were informed that all committees reported to the QPS committee in St Columba's Hospital.

Deteriorating Patient committee: St Columba's, Castlecomer District Hospital and Carlow District Hospital

St Columba's hospital joined this committee in November 2024. The committee met quarterly and membership included nursing management from the three hospitals along with a medical officer representative. The TOR were not dated or signed and indicated that the committee reported to the local QPS committee quarterly. Agenda items included parameter setting and updates on the early warning score. There was evidence of sharing of learning across sites at the meeting.

St Columba's Infection prevention and control (IPC) link nurse committee

The hospital had established a local infection prevention and control link nurses[††] committee to provide a forum to act as a communication pathway from the regional IPC team, the IPC CNS and the regional IPC link nurse meetings. The TOR indicated that the committee, chaired by an assistant director of nursing met every two months with attendees including IPC link nurses from all areas within St Columba's hospital and CNS IPC if available to attend. The first meeting was held in November 2024. The TOR were dated and signed. These stated that reporting arrangements were to compose meeting minutes which are sent to all IPC link nurses for reference and for discussion at unit meetings. However, the TOR did not indicate the upward reporting relationship. Meeting minutes were time bound with assigned action owners. Agenda items included, for example; a plan to work on a contingency plan

[††] 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.

for respiratory outbreaks, updates on the regional IPC link nurse meeting and IPC audits.

Transitional care committee (TCC): St Columba's Hospital, St Luke's General Hospital, (SLGH), Castlecomer District Hospital and Carlow District Hospital

The transitional care committee was established to facilitate effective co-ordination and communication between SLGH and the district hospitals within the region. Inspectors were informed that St Columba's had recently joined this committee and attended the first meeting in January 2025. Meetings were held quarterly or more frequently if required. Actions or issues were reported to senior management through appropriate channels for example; DON, general manager or head of service. It was evident from meeting minutes reviewed that meetings were action orientated with areas identified that could provide a safe transition for the patient from the acute hospital to the community service.

Overall, St Columba's hospital had formalised governance arrangements in place for assuring the delivery of high quality, safe and reliable healthcare and evidence was provided of discussion of the four areas of focus at the QPS committee, however, the following areas for action were identified:

- the TOR of a number of committees did not reflect the reporting relationships that inspectors were informed of on the days of inspection
- a number of TOR were not dated and signed by the relevant persons

Judgment: Substantially compliant

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

The DON had identified an assistant director of nursing (ADON) for the Rehabilitation Unit. 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. Staff were aware of these arrangements and the on-call rota for senior management was on display outside the DON's office.

Infection, prevention and control

The DON had identified an infection control link practitioner for the Rehabilitation Unit who had completed the relevant training for this role, attended the regional link nurse practitioner meetings and the St Columba's Infection prevention and control (IPC) link

nurse committee. Inspectors were informed that the IPC link nurse was allocated four hours per week to the link nurse practitioner role. The role included providing advice to staff and addressing questions and concerns in relation to IPC and carrying out IPC audits. The IPC link nurse was supported in the role by the IPC clinical nurse specialist (CNS) from the community who attended onsite during outbreaks and provided face to face training during that time.

Medication Safety

The hospital did not have a clinical pharmacy service, however, a pharmacist from SLGH attended onsite once a month. Inspectors observed signage to indicate what day the pharmacist was onsite, if patients wished to speak to them about their medications. Inspectors were informed that staff could contact the pharmacy department in SLGH if they had any queries. Management stated that the antimicrobial pharmacist for the region attended onsite in November and completed an audit.

Deteriorating patient

The ADON for the Rehabilitation Unit was the deteriorating patient lead for the hospital. The hospital had introduced a Modified Early Warning Score (MEWS)[‡‡] in 2022. Inspectors were informed that if a patient triggers a high score, the medical officer who is onsite during working hour, 20 hours a week is contacted. Outside of these times, an on-call service was contacted or the patient was transferred by ambulance to SLGH. The Identify, Situation, Background, Assessment, Recommendation/Read back/Risk ($ISBAR_3$) communication tool[§§] was used when escalating a patient who was unwell. Additional findings will be discussed under national standard 3.1.

Transitions of care

The clinical nurse managers in the unit were responsible for the safe transitions of patients at admission, discharge and transfer.

[‡‡] (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.

The majority of patients were admitted from SLGH. Patients were also admitted from University Hospital Waterford, Kilcreene Hospital, Aut Even, Whitfield, Castlecomer District Hospital or from home for community rehabilitation.

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 at a risk register review meeting. The Rehabilitation Unit had a separate risk register to the residential service. This will be discussed under national standard 3.1.

Incidents were logged on the National Incident Management System (NIMS).*** A serious incident management team was convened when required and evidence was provided of this.

The hospital had recently introduced a new information technology (IT) programme for completing infection, prevention and control audits. Management had undertaken audits in relation to medication safety and the deteriorating patient. In addition, hospital management were collating data on the number of patients admitted to the Rehabilitation Unit, where they were admitted from, the reason for admission, the discharge location and the number of days that patients spent as an inpatient in the unit. Inspectors were informed that they had engaged with the HSE with a plan to commence quality care metrics in 2025. This was confirmed in meeting minutes reviewed. Audits will be discussed in more detail under national standard 2.8.

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

*** 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.

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

The Rehabilitation Unit 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 a dietitian and speech and language therapist.

The unit was allocated a clinical nurse manager (CNM) 2 and 1, and, five whole-time equivalent (WTE) [†††] staff nurse posts with no vacancies at the time of inspection. To support the staff nurses, six healthcare assistant posts were approved with one vacancy. This vacancy was supplemented by agency staff. On the days of inspection the unit had its full complement of staff.

Staff had access to a medical officer who covered the 55 beds in the service and was onsite for 20 hours, Monday to Friday.

Infection prevention and control advice was accessed through the IPC CNS who was assigned to the hospital.

As discussed earlier, the hospital did not have a clinical pharmacy service, however, a pharmacist did attend onsite once a month and staff could access pharmacy advice from SLGH outside of these times.

1.5 WTE physiotherapist and one WTE occupational therapist were allocated to the Rehabilitation Unit. No deficits were identified by staff or patients in relation to this service provision. However, as discussed under national standard 5.8, patients undergoing rehabilitation had no access to a dietitian or speech and language therapist. Inspectors were informed that funding was secured to recruit a 0.5 WTE speech and language therapist and recruitment for that position was ongoing at the time of inspection. In order to mitigate this risk staff requested that patients were reviewed by a speech and language therapist prior to discharge from the acute hospital. Management stated that there was no impact due to a lack of a dietitian vacancy and that access was available to a community dietitian if required.

The DON had oversight of staff training in the hospital and it was an agenda item at the clinical governance meeting and the CNM meeting. CNMs were required to provide an update on compliance training monthly from their clinical areas for example; basic life support (BLS) and hand hygiene. Good training compliance was observed in standard and transmission based precautions, hand hygiene, medication safety, early warning systems and ISBAR. However, 83% of nurses and 62% of healthcare assistants had completed BLS training. Inspectors were informed that two

[†††] 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.

staff had recently completed the training to train staff on BLS and all staff in the Rehabilitation Unit will have completed training in BLS by the end of March 2025.

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

- deficits were observed in BLS training compliance

Judgment: Substantially compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred.

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

Inspectors observed that staff working in the unit were committed and dedicated to promoting a person-centred approach to care. Inspectors observed staff communicating with patients in a manner that respected their dignity and privacy.

It was evident through observation and a review of documentation that staff promoted an environment which encouraged patients' autonomy. Patients were observed mobilising in the unit with the assistance and encouragement of staff. Unit meeting minutes reviewed indicated that staff were advised to promote independence with eating. In addition, it was evident that the dignity of patients was discussed at this meeting.

Notwithstanding the good practices in place, staff were challenged in maintaining the dignity and privacy of patients by the design and layout of the unit. Staff endeavoured to do this through the use of privacy curtains, however, the unit was a thoroughfare with a lot of activity including nursing staff, healthcare assistants, doctors and catering staff mobilising through the unit. In addition, patients had to mobilise through the thoroughfare to access toilets and showers and staff to access the dirty utility and nursing office. This exposed patients to noise and smells and did not provide an environment conducive to rehabilitation. These along with other findings will be discussed under national standard 2.7.

Inspectors noted that patients' photographs were taken on admission to the unit for inclusion on the medication record. Staff stated that informed consent was taken however, local policy stated that written consent must be taken. Inspectors were informed that this was not taking place.

Overall, while staff endeavoured to promote the dignity, privacy and autonomy of patients, they were challenged by an environment where these could not be maintained. Findings included:

- the unit was open-plan, contained a corridor that was a thoroughfare to access the multiple rooms in the unit. This layout did not afford patients' dignity and privacy
- patient's written consent was not obtained prior to taking a photograph of them on admission.

Judgment: Substantially compliant

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

The staff and management of the Rehabilitation Unit actively promoted a culture of kindness, consideration and respect. Staff were observed on many occasions throughout this inspection interacting with staff in a kind and respectful manner.

When patients were asked if they know how to make a complaint, if required, a patient stated that they "know how and have seen the information", and another stated they would speak to the "person in charge".

Information on advocacy services was available to patients and this information was on display.

A satisfaction survey was completed by eight patients in January 2025. Overall, patients expressed satisfaction with the comfort, warmth, cleanliness, space and security of the unit. Areas for improvement identified by patients were in relation to the infrastructure for example; the partitions in the unit were not suitable in the event of an outbreak of infection, provision of information on admission on contracts and the lighting in the unit. A time bound action plan accompanied the survey. However, it is unclear if the feedback regarding the infrastructure was escalated to senior management.

Overall, staff and management of the unit promoted a culture of kindness, consideration and respect.

Judgment: Compliant

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

The hospital had a process in place to ensure that complaints and concerns are responded to promptly, openly and effectively. The DON was the designated complaints officer for the unit, whose picture and details were clearly displayed on the unit. There was a culture of local complaints resolution in the unit.

St Columba's Hospital used the HSE's complaints management policy '*Your Service Your Say.*'[‡‡‡] '*Your service Your Say'* posters were on display in the unit. In addition, a comment box was available. The management of complaints was guided by local policy which was up-to-date and in line with national policy. The unit maintained a log of complaints which was observed by inspectors. Evidence of tracking and trending of complaints was provided to inspectors and the complaints officer discussed these with inspectors and the outcome of the complaints. Inspectors were informed that no written complaints were received via '*Your service Your say'* in 2024. An audit was completed in quarter 4 2024 of complaints management in the Rehabilitation Unit with a score of 97% achieved.

Meeting minutes reviewed indicated that complaints were discussed at the clinical governance meeting, clinical nurse managers meeting and the unit meeting.

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.

The hospital was built in the 1800s with the addition of the Rehabilitation Unit in the 1980s. At the time of inspection a new community nursing unit was being built on the grounds of St Columba's hospital with a plan to re-locate the residential care service to it. Inspectors were informed that there are ongoing discussions at a senior management level within the regional health area about the Rehabilitation Unit, the

[‡‡‡] 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.

infrastructure and a risk that the unit may become isolated after the relocation of the residential services.

Inspectors were informed that a security firm attended onsite at regular intervals during the night and notify staff if they identify any concerns. In addition, staff had access to panic alarms which alert staff in a unit of the designated centre if they have a security concern. These were observed by inspectors. Contact phone numbers of the security firm were on display.

Wall-mounted alcohol based hand sanitiser dispensers were located throughout the unit with hand hygiene signage clearly displayed. Signage was on display at sinks to indicate that they were for hand washing only.

Two cleaners were assigned, who covered seven days a week. The unit was clean with few exceptions. Staff were using a tagging system to identify items of equipment that were cleaned. Overall, no deficits in the cleaning of equipment were observed on inspection.

Inspectors identified good local ownership and oversight in relation to infection prevention and control. While it was evident that hospital management had endeavoured to maintain the unit, the design and layout posed challenges and this did not facilitate effective infection prevention and control practices. For example;

- the unit contained five two bedded bays and a single room. These bay areas were divided into three bays on one side of the entrance to the unit and two on the other side of the entrance. The bays were effectively an open-plan area divided by partition walls which did not extend to the ceiling.
- a corridor was used to access each of these bays and this was a thoroughfare. At one end of the unit was the kitchen and at the other end was the single room (previously the dining room). In addition, storage facilities were accessed externally through an exit at one end of the unit. A patient expressed to an inspector their concerns about the layout of the unit and the patient's concerns about contracting influenza during an outbreak on the week prior to inspection
- cleaning staff did not have access to a household room and therefore had to fill and empty cleaning buckets in the dirty utility. This increased the risk of the transmission of multi-drug resistant organisms
- commodes, dirty linen and the cleaning trolley were stored in a patient shower room. Management had endeavoured to mitigate this risk by installing a perspex screen, however, this this did not extend to the ceiling and again posed a risk of cross infection
- the design of the clinical hand wash in the single room did not conform to Health Building Note 00-10 Part C: Sanitary assemblies[§§§]

[§§§] 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

- the single room which was used for isolation purposes, did not contain en-suite facilities. Inspectors were informed that a shower and toilet was designated to the patients who were isolating, however, the unit had two showers and this reduced the number of showers available for the other nine residents to one
- a treatment area, covered by a curtain, contained integrated sharps trays. These were not stored securely and could be easily accessed by patients and the general public. In addition, the temporary closure was not engaged on a sharps box observed
- the nurses' station was both a clinical room and administrative room. Medication trolleys and monitoring equipment were stored in a room where patients' files were kept and nursing staff updated their notes
- chipped paint on walls, skirting and doors was observed. This did not aid effective cleaning
- inspectors were informed that a chlorine based solution was routinely used on frequently touched areas. This is not in line with national guidelines which inspectors were informed and documentation confirmed that the hospital were following.

In addition, inspectors were informed that the dining room was changed to an isolation room in 2020 to facilitate the isolation of patients during the COVID-19 pandemic. Staff expressed their concerns at the loss of the dining room and the impact that this had on patients' dining experience and socialisation. As a result patients had to sit by their bedsides at all times. However, management stated that they had to balance this with the requirement for isolation facilities.

Overall, while hospital management were generally maintaining the unit, they were challenged by the design and layout of the physical environment which presented infection prevention and control risks to patients as outlined above.

Judgment: Partially compliant

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

Hospital management were systematically monitoring, evaluating and responding to information in order to identify opportunities for improvement and provide assurance within the regional health area on the effectiveness of healthcare services delivered at the Rehabilitation Unit.

An annual review on the quality and safety of care was completed for St Columba's Hospital at the end of 2024 which included information on the Rehabilitation Unit. Information on staffing, the priorities for 2025 and a plan to review the layout of the unit were outlined in the review.

Auditing was either a standing agenda item or was discussed at the clinical governance, assistant director of nursing, quality and patient safety, infection prevention and control, clinical nurse manager and unit meetings.

As discussed under national standard 5.8, the hospital had commenced using a new computerised system at the time of inspection for completing infection prevention and control audits. Audits on laundry, storage of linen, the sluice room, mattresses and pillows, patient equipment, glucometers and hand hygiene facilities were completed monthly. All audits scored 100%, however, the hand hygiene facilities audit identified that all sinks conformed to HBN 00-10 Part C sanitary assemblies and as discussed under 2.7, this was not the case. An antimicrobial stewardship audit was completed in November 2024. The audit identified a prevalence of antimicrobial prescribing of 10% (one patient) which is above the national rate of 8.5%. This is in line with antimicrobial prescribing on previous audits carried out in the unit and the region. However, given the small number of patients in the Rehabilitation Unit any prescription of antimicrobials will result in a rate above the national average.

Two audits on the modified early warning score were provided to inspectors. One was completed by a quality and patient safety advisor in June 2024 with an overall compliance score of 83%. The audit indicated that 43% of patients' MEWS charts reviewed had no evidence of increased monitoring when an increase in the early warning score (EWS) was detected. The audit indicated that the quality improvement plan was devised by the hospital. However, this was not provided with the audit at the time of inspection. A local audit was completed in September 2024. This audit identified that observations were re-checked with an increased EWS however, only the observation that was altered was re-checked and a full set of observations was not completed. An overall score of 72.36% was achieved. A time bound action plan with an assigned action owner accompanied this audit which indicated that the actions were completed. There was evidence in unit meeting minutes reviewed that the findings were discussed at the unit meeting in October 2024.

A medication management audit was completed in April, July and November 2024. Audit scores of between 81-100% were recorded. A time bound action plan with assigned action owner accompanied each audit. Repeat findings were observed on each audit where patient details needed to be recorded on each page of the medication record. While the action in November was to discuss it at the unit meeting, there was no evidence in the December meeting that this was completed. Staff were also collating data on the use of antibiotics. Inspectors were informed that this data was provided to Antibiotic Resistance and Infection Control (AMRIC).

Hospital management were collating data on the number of admissions to the Rehabilitation Unit, the source of admission, for example, SLHK, the discharge location, and length of stay. One hundred and twelve patients were admitted to the Rehabilitation Unit in 2024. Of those 53 were admitted from SLHK and 28 from

University Hospital Waterford. Of the 112 admissions 80 patients were discharged home.

Overall, the hospital were systematically monitoring and evaluating the service, however;

- repeat issues were identified in a medication audit and there was no evidence that these were discussed at the unit meeting.

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

As discussed under national standard 2.8, the Rehabilitation Unit had a risk register in place. Three risks on the risk register were in relation to infection prevention and control, one in relation to the lack of health and social care professionals for the service (speech and language therapist and dietitian in the Rehabilitation Unit) and, one in relation to non-compliance with the admission policy, procedure, protocol and guideline (PPPG). An inspector was informed that three red rated risks from the Rehabilitation Unit were escalated to the manager for older persons' services risk register and upwards to the general manager's risk register, who confirmed this with inspectors. One of these risks was in relation to the infrastructure in the Rehabilitation Unit. In addition, risk assessments were completed on transitions of care and the deteriorating patient.

The unit had access to a community IPC CNS and an IPC link nurse practitioner. This was discussed under national standard 5.5. The IPC link nurse was a hand hygiene trainer and training was provided to staff as required.

Patients were not routinely screened for multi-drug resistant organisms or COVID-19 on admission to the unit. Patients were tested for COVID-19 if they developed symptoms on admission or following admission. Inspectors were informed that a recent influenza outbreak was closed by public health on the week prior to inspection. The outbreak was contained to a small number of patients. In 2024, there were two outbreaks of COVID-19 in the unit. An outbreak reflection was completed following the outbreaks which identified what went well and what improvements could be made for the next outbreak. The report stated that it was discussed at a unit huddle. Outbreaks were also discussed at the QPS committee and at the St Columba's IPC link nurse meeting.

Building works were in progress for a new residential unit. Inspectors were informed that an aspergillosis risk assessment was completed in October 2023 and evidence was provided that a discussion had taken place, however, while management stated that no actions were required for the Rehabilitation Unit, there was no documentation

to confirm this. This was requested during the inspection and after inspection and not received. Inspectors requested the date of the last legionella risk assessment. While this had not been completed at the time of inspection, documentation provided following inspection confirmed that it would be.

The hospital had established links with the pharmacy department in SLGH. Pharmacy supplies were supplied by SLGH on a Tuesday and Thursday. Out-of-hours the hospital could contact a local pharmacy for an emergency supply which was then replaced by SLGH. Medicines were stored in a secure manner. A designated medication fridge was available with fridge temperatures checked daily.

Staff had access to commercial drug prescribing guides at point of care. No online prescribing access was available. A list of high risk medications from the Irish Medication Safety Network dated 2018 was available and inspectors observed a sound-alike-look-alike (SALAD) medicines poster on display. Inspectors were informed that no alert stickers were used on high risk medications and sound-alike-look-alike medications supplied from SLGH other than cytotoxic medications. However, some high risk medications such as direct oral anti-coagulants were supplied on a named basis only to mitigate the risk. Evidence was provided that a medication safety day took place in September 2024. During this day staff could review examples of medication incidents that had taken place in SLGH, SALAD lists and five moments for medication safety.

Inspectors were informed that medication reconciliation**** was completed on admission and a sample of medication records reviewed confirmed this. Management described a quality improvement initiative that was being introduced at the time of inspection where medication reconciliation would be ticked on a patient's prescription on discharge confirming that it was completed.

Hospital management had introduced the modified early warning score in 2022. Staff were knowledgeable on the escalation process and there was evidence in a healthcare record reviewed that a patient was escalated in line with the process and an early warning sticker used in the patient's chart. This was supported by an up-to-date standard operation procedure and national clinical guidelines. Emergency equipment was available if required such as an Automated External Defibrillator (AED). Staff had access to oxygen cylinders and suction equipment which were placed at patient's bedside if required in an emergency.

There was evidence from a review of documentation and from discussions with staff that the hospital had introduced the Identify, Situation, Background, Assessment, Recommendation/Read back/Risk ($ISBAR_3$) tool. However, inspectors were informed that clinical handover was taped prior to the end of each shift and listened to by the staff coming on duty. This method of clinical handover presented particular risks, for

**** 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; it did not afford staff coming on duty to ask questions and it may present communication barriers. Hospital management were aware of the risks and had identified moving to verbal handovers for 2025 as a quality improvement initiative. This was confirmed in meeting minutes reviewed. A risk assessment was requested following inspection and provided which identified that the practice of taped clinical handovers would be discontinued by the end of February 2025. Inspectors were informed and the risk assessment confirmed that the handover was deleted daily.

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 at transitions of care. This was risk rated and controls and actions were in place which were assigned to an action owner. However, the actions were not time bound. The hospital had a discharge form which included the patient's personal details, medical history, current medications and infection status. In addition, a verbal handover form was available which included an area to document the MEWS score. Admission, discharge and transfer policies were up-to-date to support practices.

A weekly multi-disciplinary meeting was in place to discuss the current inpatients, their planned discharge date and patients in acute hospitals awaiting rehabilitation and their suitability for rehabilitation. This meeting was attended by nursing management, a consultant geriatrician from SLGH, the medical officer and health and social care professionals. Inspectors were informed and documentation confirmed that the unit did not accept admissions from the acute hospitals after 12 midday on a Friday due to lack of availability of a medical officer on a Friday afternoon. A risk assessment on this was provided to inspectors.

A draft guide for patients on the Rehabilitation Unit was devised with a plan to provide it to patients when being discharged from the acute hospital. Meeting minutes indicated that this was provided to the acute hospital for review. In addition, an information leaflet was developed for patients in the unit which included information on the rehabilitation team and visiting times.

Management stated that a new PPPG committee was set up in the region to review new PPPGs. The DON was responsible for updating current PPPGs in the hospital. PPPGs reviewed by inspectors were up-to-date. However, medication reconciliation was not included in the medication management and administration policy available in the clinical area. At the end of inspection, management showed inspectors the version which included medication reconciliation which was stored online. Staff did not have access to this version of the policy.

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:

- no documentary evidence was available to confirm that no actions were required in the Rehabilitation Unit to mitigate the risk of aspergillosis during building works
- a legionella risk assessment was not completed
- staff had minimal access to up-to-date medicines information at the point of care
- the process of clinical handover was recorded and no verbal handover was taking place
- a risk assessment completed on transitions of care was not time bound
- the most up-to-date policy on medication management and administration policy was not available in the clinical area.

Judgment: Partially Compliant

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

The unit had systems in place to identify, manage, respond to and report patient-safety incidents, in line with national legislation, standards, policy and guidelines. Staff who spoke with the inspectors outlined how to report and manage patient-safety incidents.

Reported incidents were tracked and trended by the Quality and Patient Safety Advisor for Kilkenny, Carlow and South Tipperary. Staff informed inspectors that feedback on incidents was provided at handover and staff meetings. It was evident from a review of meeting minutes that incidents were discussed at the Drugs and Therapeutics Committee, Quality and Patient Safety Committee, CNM and unit meetings.

100% of patient-safety incidents were reported to NIMS within 30 days from January to October 2024. This was within the HSE target of 70%.

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

Judgment: Compliant

Conclusion

An announced inspection of St Columba's Hospital, Rehabilitation Unit was carried out to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare.* Overall, the inspectors found five standards were compliant, four were substantially compliant and two were partially compliant.

Capacity and Capability

Governance arrangements were in place for assuring the delivery of high quality, safe and reliable healthcare which were appropriate for the size, scope and complexity of the centre. However, terms of references of some committees did not reflect the reporting relationships described over the two days of inspection. Management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services were in place. There were systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of services provided. Workforce arrangements in the unit were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare. However, deficits in basic life support training were identified.

Quality and Safety

Staff and management in the unit made every effort to ensure that patients' dignity, privacy and autonomy were respected and promoted. However, this was challenging in an environment that was effectively open plan with a corridor that was a thoroughfare through the unit. A culture of kindness, consideration and respect was promoted. The hospital had systems and processes in place to respond effectively to complaints and concerns raised by people using the service. The design and layout of the unit did not fully support the delivery of high-quality, safe, reliable care. Management were aware of this and it was escalated through the reporting structures within the region. The hospital protected service users from the risk of harm associated with the design and delivery of healthcare services with some opportunity for improvement identified and outlined in this report. Hospital management effectively identified, managed, responded to patient-safety incidents relevant to the size and scope of the service.

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

Compliance classifications

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

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

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

Capacity and Capability Dimension	
Theme 5: Leadership, Governance and Management	
National Standard	**Judgment**
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
National Standard	**Judgment**
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
National Standard	**Judgment**
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	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 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.	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.

Environment

Findings

1- Challenging design and physical layout of the unit which did not support or facilitate the staff to deliver of high quality of care particular in relation to infection control practices particularly. Management had identified this on their risk register since 2020 and had been escalated to senior management. Areas of particular concern included

- The open plan layout with a corridor which was a thorough fare.
- Open plan bay areas divided by partion walls which did not extend to ceiling.
- Lack of storage areas to accommodate storage of commodes, cleaning trolley and dirty linen.
- No access room for housekeeping staff who had to use the dirty uility room increasing risk of transmission of multidrug resistant organisms.
- Single isolation room did not contain ensuite facilities.
- The number of showers on site if a patient was isolating inadequate.
- Location of the treatment room which was not secure with only space to install a curtain could be easily accessed by residents and general public.
- The only Nursing station was both a clinical and administrative room.
- No dining room available as this was readapted in 2021 to create the unit's only isolation room in response to the Covid 19 pandemic requirements to ensure the safety of all.

Actions taken to date.

- Communication and review of the environment was undertaken by the HSE Assistant National Director of Capital & Estates Dublin and South East on 21st March 2025 and currently awaiting communication on the matter.
- Copy of Draft HIQA report has been sent to the IHA dept. for Dublin and South East
- There are ongoing meetings between estates and Integrated Healthcare Manager for Carlow/Kilkenny & South Tipperary together with Head of Service for Older Persons to explore alternative options in relation to the rehab environment.

Timescale for completion 1st September 2025

2 Chipped paint on walls, skirting's and doors which did not aid effective cleaning.

Actions taken

- Technical services department awaiting quotations to complete.

Timescale for completion: 1st August 2025

3 - The design of the clinical hand wash basin in the single room did not conform to Health Building Note 00-10 Part C:

Actions taken

- Awaiting costings and timeframe for installation.

Timescale for completion: 1st August 2025

- **Infection Control**

Findings:

1- Use of a chlorine based solution used on frequently touched areas which is not in line with national guidelines.

Actions taken

- Education provided staff with ongoing education and monitoring for compliance by Nurse in Charge.
- Education from the Infection Control Specialist Nurse organized for 25th March 25

Action's Completed on 25th March 2025.

2. - Sharps box did not have the temporary closure in place and was located in the treatment room which was easily accessed by residents and general public.

Actions taken

- Relocation of the sharps box into the Nursing station which is a secure room with keycode access when not in use undertaken on 30th January 25
- Importance of ensuring temporary closure in place after in place after use communication to all via safety pause. Action completed on 14th February 25
- Ongoing monitoring of sharps box and sharps auditing undertaken monthly.
- Education on sharps via Hseland for staff requested

Aim for completions of actions (not already actioned) by 11th April 25

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

- Discussion ongoing with estates Dept and IHA re suitable environment for Rehabilitation service.

Timescale: Dec 2025

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.

Findings

Legionella risk assessment not completed by technical services

- Technical services have since undertaken a risk assessment on 12th February 25 with no abnormalities reported.
- Ongoing testing with technical supports with the sensor probes to ensure legionella not present in the Hospital. Results received weekly.
- SOP on Flushing guidelines for water outlets in place prior to inspection and adhered to with documentary evidence of same at unit level.
- Infection Control Specialist Nurse training to include risk of legionella organized for 25th March 2025.

Action completed.

Clinical nursing daily morning Handover was recorded with no verbal handover taking place

Actions taken

- This process of taped handover has been discontinued and replaced with verbal handover since 17th Feb 2025.

Action completed.

Transitional care Risk Assessment was not time bound

- Transitional care risk assessment reviewed with time bounded review date entered on 13th March 2025.

Action completed.

Medication Safety Findings

- Whilst the most updated policy medication management and administration policy was online it was not available at unit level.
- Minimal access to up-to-date medications were

available. Actions Taken

- The most up to date Hospital medication policy which includes medication policy, which was on the Portal Policy system now in hard copy at ward level. Action completed 30th January 2025
- BNF online access is available for all the staff nurses in all units with access to up-to-date medicines information at the point of care
- Training session on how to access BNF online was completed by Pharmacist on 20/02/25
- Information on how to access most updated BNF online is send to all the wards, same attached to medication trolley Action completed.

Actions completed.

Aspergillus: No documentary evidence available to confirm no actions required in relation to building of the new community nursing unit.

Actions Taken

- Communication with the infection control team has been ongoing in relation to Aspergillus and associated risks.
- A number of meetings took place involving estates, contractors, IPC, management, consultant microbiologist and medical Officer. The outcome was that the risk was low due to distance and the awareness was key for staff.
- Education was commenced for staff with the supports of IPC. There has been no medical issues identified with residents.
- The rehabilitation unit is situated at the furthest point from the ongoing works
- Ongoing staff education in place to highlight the potential risk and ongoing monitoring in place.

Time frame 1st August 2025

- ***Where applicable, long-term plans requiring investment to come into compliance with the national standard***

    - Ongoing monitoring for Legionella by technical services and construction.
    - Compliance with Hospital's SOP on Flushing of water guidelines with technical supports undertaking 3 monthly risks assessments and water sampling as required.

Timescale: 1st August 2025