Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

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| Name of healthcare service provider: | St Columcille's Hospital |
| Healthcare service/Organisation ID: | OSV-0001101 |
| Address of healthcare service: | Bray Road<br>Loughlinstown<br>Co. Dublin<br>D18 V9K1 |
| Type of inspection: | Announced |
| Date(s) of inspection: | 22/09/2025 and 23/09/2025 |
| Inspection ID: | NS_0166 |

## About the healthcare service

### Model of hospital and profile

St Columcille's Hospital is a Model 2* statutory, public acute hospital. It is managed by the Health Service Executive (HSE) Dublin and South-East† health region.

Services provided by the hospital include:

- acute medical in-patient services
- medical assessment unit
- injury unit
- day surgery
- outpatient care
- diagnostic services.

### The following information outlines some additional data on the hospital.

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|---|---|
| **Number of beds** | 117 inpatient beds |

## How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare Version 2* (2024) (national standards) as part of HIQA's role to set and monitor standards in relation to the quality and safety of healthcare.

To prepare for this inspection, the inspectors‡ reviewed information which included previous inspection findings, information submitted by the provider, unsolicited information and other publicly available information since HIQA's last inspection.

* A Model 2 hospital provides the majority of hospital activities including extended day surgery, selected acute medicine, treatment of local injuries, specialist rehabilitation medicine and palliative care plus a large range of diagnostic services including endoscopy, laboratory medicine, point-of-care testing and radiology - computed tomography (CT), ultrasound and plain-film X-ray.

† HSE Dublin and South-East health region provides health and social care services to South-East Dublin, Carlow, Kilkenny, South Tipperary, Waterford, Wexford and most areas of Wicklow.

‡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*.

During the inspection, the 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.

## 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.

**The inspection was carried out during the following times:**

| Date | Times of Inspection | Lead Inspector(s) | Support Inspector(s) |
|---|---|---|---|
| 22/09/2025 | 13:30 – 17:30hrs | Danielle Bracken | Laura Byrne<br>Aedeen Burns<br>Linda Daffy |
| 23/09/2025 | 08:45 – 15:00hrs | Danielle Bracken | Laura Byrne<br>Aedeen Burns<br>Linda Daffy |

## 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 Version 2* (2024). The inspection focused in particular, on four key areas of known harm, these being:

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

The inspection team visited the following clinical areas:

- Lourdes Ward (general medical ward)
- St Joseph's Ward (general medical ward).

During this inspection, the inspection team spoke with representatives of the hospital's Executive Management Team, Human Resources team, committee representatives, and clinical staff.

[§] 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 improves recognition and response to signs of patient deterioration.
[††] Sepsis is a life-threatening complication of an infection.
[‡‡] Refers to the various points where a patient moves to, or returns from, a particular physical location or makes contact with a health care professional for the purposes of receiving health care. This includes transitions between home, hospital, residential care settings and consultations with different health care providers in out-patient facilities.

**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

Inspectors spoke with a number of patients, and in more detail with 10 patients, throughout the inspection about their experience of receiving care in the hospital. Overall, there was consistency between patients' experience of care and what inspectors observed in the clinical areas visited.

Patients were positive about their interactions with a variety of different staff. Inspectors were told "everyone is lovely", that staff were "friendly", "kind", "very helpful", and they "go above and beyond".

Care was described by patients as being "pretty good", "very good", and "100%", and that they were "very minded" and "well minded". There were mixed views in relation to the promptness of response to call bells with some patients stating that responses were very prompt and that staff "come immediately", two out of ten patients stated that at night it "takes a little longer", and that when staff were "very busy" there could be a "delay" in answering call bells. Inspectors observed a number of instances where staff responded promptly to patients displaying responsive behaviours, calming and redirecting patients.

Patients were positive in relation to the food at the hospital. Inspectors were told that patients had a choice of meals, and that snacks were available throughout the day. Independence was promoted, a number of patients spoke about working on their mobility, stating they were encouraged to "move about", and to walk to the toilet for independent toileting. Patients told inspectors they were informed of their plan of care, that staff communicated with them and that they felt listened to. An inspector was informed by a patient that they were returned to bed at 6pm each night and it made the day very long. This was brought to the attention of the clinical nurse manager on Lourdes ward. This will be an area for follow up on the next inspection.

Most patients who spoke with inspectors did not have any complaints. Varying experiences with the management of informal complaints is discussed under national standard 1.8.

The cleanliness of the ward was complimented by patients. Feedback given to inspectors about the ward environment included that toilets and showers could do with updating, and there could be more of them. Additionally, space between beds was described as "limited", with no wardrobe or place to keep their things. This was also observed by inspectors, who noted patient belongings stored on the floor and is discussed further under national standard 2.7. It was also described to inspectors that sleeping was difficult at night due to noise in multi-occupancy areas.

## Capacity and Capability Dimension

This section describes the themes and national standards relevant to the dimension of capacity and capability. It outlines the national 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 national standard related to workforce.

St Columcille's Hospital was compliant with two national standards (5.5, 5.8), substantially compliant with one national standard (5.2), and partially compliant with one national standard (6.1) assessed on this inspection.

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

Inspectors found integrated corporate and clinical governance arrangements, with clearly defined responsibilities and accountability arrangements.

New reporting structures had been implemented since the previous inspection in May 2024. The general manager reported to the integrated healthcare area (IHA) manager and upwards to the regional executive officer (REO) of HSE Dublin and South-East health region. Organisational charts accurately reflected reporting arrangements, and aligned with what inspectors were told on inspection.

During a previous inspection of the service in May 2024, inspectors found a number of vacancies in senior management positions in the hospital. There had been interim general managers in place in the hospital since February 2023. The operations manager (deputy general manager) and the quality and safety manager positions were vacant. At the time of this inspection, the general manager position was filled on a permanent basis. A quality and safety manager had been recruited and was due to take up position in October 2025, and the operations manager position had

been advertised. In the meantime, the hospital's general manager was covering these roles.

The general manager, supported by the executive management team (EMT), was the accountable officer with overall responsibility and accountability for the governance of the hospital. Members of the EMT included the interim director of nursing (DON), and the clinical director. The clinical director post which had been vacant briefly in 2025 was now filled, with a new arrangement which allowed for 0.5 whole-time equivalent (WTE)[§§] protected time dedicated to clinical director duties.

Organisational charts submitted to HIQA detailed the direct reporting arrangements of various governance and oversight committees to hospital management, which aligned with inspectors' findings. The key governance structures assigned with the responsibility for ensuring the quality and safety of healthcare services at the hospital were the executive management committee, the clinical governance committee and the quality safety executive committee. Additionally, a risk register committee was in place in the hospital and this is discussed further under national standard 5.8.

Committees reporting into the clinical governance committee that relate to the four areas of focus of this inspection included:

- infection prevention and control
- drugs and therapeutics
- deteriorating patient
- unscheduled care governance.

Committee governance structures for the four areas of focus of this inspection, were unchanged since HIQA's previous inspection with the exception of the discharge planning committee, which was no longer operational. Instead, discharge planning was discussed at the unscheduled care committee as an agenda item. Additionally, documentary evidence provided to inspectors showed that representatives from the hospital attended St Vincent's University Hospital's bed management committee. Patient flow activity from St Columcille's Hospital was discussed as a standing agenda item at each meeting of this committee. A medical emergency team (MET) working group of the deteriorating patient committee had recently been established at the hospital. Lead representatives who met with inspectors outlined that the purpose of this group was to review MET calls that had been responded to by the team.

[§§] 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.

Terms of reference for all committees reviewed by inspectors were up to date, and committees were meeting at the frequency set out in these. There was no frequency of meetings set out in the infection prevention and control committee's terms of reference, however, meeting minutes reviewed evidenced that the committee was meeting on a quarterly basis. A database, overseen by the general manager, was used for ensuring committees had met at the required frequency and for tracking attendance, and this was demonstrated to inspectors.

From a review of meeting minutes and from speaking with lead representatives it was clear that committees had effective oversight of the areas within their remit. The exception to this was oversight of infection prevention and control (IPC)-related training compliance which was not a standard agenda item for discussion at IPC committee meetings. IPC training compliance rates had not met the required target and this is discussed further under national standard 6.1. Actions arising from committees were followed up from meeting to meeting, with action logs to facilitate this in place for the majority of committees.

Quality and safety 'walk-rounds'*** led by senior management were taking place at the hospital on a scheduled basis, however, these were infrequent in the clinical areas visited, with the last walk-round in Lourdes ward taking place in 2023. While the walk-rounds identified actions in relation to environmental issues, these findings were recurring and identified on inspection indicating the actions were not sufficiently robust enough to be sustained. These findings are discussed further under national standard 2.8.

In summary, formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare were in place at the hospital with the following identified:

- quality and safety walk-rounds were infrequent in the clinical areas visited and actions identified to address findings were not sustained
- IPC-related training compliance was not discussed routinely at the IPC committee.

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.**

*** Structured process to bring senior managers and frontline staff together to have quality and safety conversations with a purpose to prevent, detect and mitigate patient/staff harm.

Effective management arrangements were in place at the hospital to support and promote the delivery of high-quality, safe and reliable healthcare services.

The clinical director had oversight of the management and organisation of the medical workforce. Out of hours cover for the hospital was provided by a registrar and senior house officer, with the consultant on-call accessible via telephone. There was no consultant anaesthesiologist on site in the hospital outside of normal working hours, however, there was access 24/7 to an anaesthesiologist on call in St Vincent's University Hospital, via telephone. Patients requiring a higher level of care were transferred out of the hospital, this is discussed further under national standard 3.1. Medical emergency team (MET) calls and transfers out of the hospital were reviewed. This is discussed under national standard 5.8.

Nursing services in the hospital were managed and organised by the interim director of nursing. Clinical nurse managers (CNM2s) in St Joseph's and Lourdes wards were responsible for the management and oversight of these wards, and were operationally accountable to an assistant director of nursing.

The infection prevention and control team composition was unchanged since the previous inspection of the service in May 2024. A consultant microbiologist was onsite six hours a week. Outside of that time there was access to a consultant microbiologist for advice 24/7 via telephone. Each ward had an infection prevention and control, sepsis, antimicrobial stewardship link nurse, who were supported by the infection prevention and control team.

The provision of the hospital's pharmacy service, led by the pharmacy executive manager included a clinical pharmacy service[†††] which was provided to ward areas daily.

The deteriorating patient committee at the hospital, under the clinical leadership of a consultant anaesthesiologist, with support from two resuscitation officers oversaw the deteriorating-patient improvement programme.

The patient flow team comprised a bed manager, a discharge coordinator, and an admissions coordinator. The team complement was due to be increased with the addition of a patient flow manager position. This new position had been approved and recruited with a start date of November 2025. Arrangements to manage patient flow in the hospital were effective. A number of patient flow meetings took place daily, these are described further under national standard 3.1.

Judgment: Compliant

[†††] Clinical pharmacy aims to optimise the utilisation of medicines through practice and research in order to achieve person-centred goals. Clinical pharmacy is restricted to members of the pharmacy team.

**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.**

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

The executive management committee, clinical governance committee and quality safety executive committee, had oversight of performance data. Information on a range of performance indicators and data related to the quality and safety of healthcare services, which included monthly hospital patient safety indicator reports (HPSIR) were publicly available.

Monthly performance meetings were held between the hospital and representatives from HSE Dublin and South-East health region. A performance report was submitted for discussion at each meeting, providing oversight in relation to patient-safety incidents, risks on the risk register, and complaints.

The hospital's risk register committee, had met in July, August and September 2025 in line with the terms of reference. Minutes of meetings of this committee showed that new and existing risks, control measures and required actions had been discussed. Meeting minutes reviewed indicated that there was an action log in place and actions were being followed up from meeting to meeting. A copy of the hospital's risk register reviewed by inspectors showed that it was up to date, last updated in August 2025. Additionally, the executive management committee, the clinical governance committee, and the quality and safety executive committee had oversight in relation to hospital risks. This was demonstrated from speaking with hospital management and from a review of minutes of these committees.

The hospital's serious incident management team (SIMT) (previously known as the clinical incident review group) met every six weeks on a scheduled basis. The terms of reference outlined that the SIMT would meet on an unscheduled basis on the notification of a Category 1 or serious reportable incident (SRE). SIMT had met in February, April and May 2025. Minutes of these meetings reviewed by inspectors showed that incidents were being discussed, and time-bound assigned actions were followed up using an action log.

The infection prevention and control (IPC) committee had oversight in relation to IPC in the hospital. Progress against the IPC programme for 2025 was being measured and discussed at committee meetings. The programme included carrying out IPC audits in clinical areas. There was an IPC audit plan in place and an audit

summary report had been produced for 2024 which was provided to inspectors. This detailed overall compliance levels within clinical areas with IPC practices, hand hygiene and equipment hygiene. These audits are discussed further under national standard 2.8.

A suite of 13 IPC indicators were measured on a quarterly basis, with the exception of hand hygiene which was measured twice a year. Indicators included rates of infection acquired in the hospital. A quarterly IPC report was provided at clinical governance committee meetings. Committee minutes confirmed this had last been provided in April 2025. A copy of the IPC annual report for 2024 was provided to inspectors which detailed rates of infection, education provided, documentation updated, and compliance with key performance indicators throughout 2024.

The drugs and therapeutics committee had oversight in relation to medication safety practices in the hospital. The drugs and therapeutics committee had developed an annual plan for 2025, progress against which was discussed at committee meetings. A detailed report on medication-related patient-safety incidents was produced each quarter. This is discussed further under national standard 3.3. The committee's annual report for 2024 was reviewed by inspectors which summarised achievements in relation to medication safety that year.

Quarterly antimicrobial stewardship (AMS) reports were produced and both the drugs and therapeutics and infection prevention control committees had oversight in relation to these.

An annual report for the deteriorating patient committee was submitted to the clinical governance committee for 2024. Inspectors reviewed the report which provided an overview of key performance indicators, audit activity, and training compliance overseen by the committee. Minutes of meetings of the medical emergency team (MET) working group for August and September were provided to inspectors after the inspection, which confirmed that MET calls had been reviewed.

Performance in relation to unscheduled care activity and patient flow within the hospital was being monitored. A bi-annual activity report was produced in the hospital which provided an overview of medical assessment unit, injury unit, and in-patient activity. The unscheduled care committee had oversight in relation to this data.

Patient experience, including complaints, was discussed at the executive management committee, clinical governance committee, and quality safety executive committee. The management of and response to complaints about the service are discussed further under national standard 1.8.

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.**

Minimal gaps in the staffing levels were identified on the days of inspection. A number of vacant posts had been identified during a previous inspection of the service in May 2024. As discussed under national standard 5.2, at the time of this inspection the general manager position was filled on a permanent basis, and the quality and safety manager and operations manager posts were progressing. The vacant complaints manager position was now filled by a consumer affairs manager.

High-rated risks on the hospital's risk register relevant to the focus of this inspection included an insufficient number of anaesthesiologists to provide cover Monday to Friday. This resulted in a reliance on locum anaesthesiologists. Controls in place to manage this risk included an anaesthesiologist roster Monday to Friday. An additional anaesthesiologist post had been approved and funded and was progressing at the time of inspection.

Workforce was a standing agenda item at monthly performance meetings between the hospital and HSE Dublin and South-East. A monthly report was submitted by the hospital for discussion at this meeting. Samples of this report were provided to inspectors, the report included information on absenteeism, use of agency staff, and vacancies. At the time of inspection, there was a total of 14 unfilled positions of various disciplines at the hospital. Evidence was provided that recruitment campaigns were ongoing to fill vacant posts.

Vacancies in the clinical areas inspected included 2.49 WTE staff nurse posts on Lourdes ward, 1.0 WTE clinical nurse manager 2, and 3.0 WTE healthcare assistant posts on St Joseph's ward. Lourdes ward was fully staffed on the day of inspection. On day two of inspection, St Joseph's ward were short-staffed by one healthcare assistant, and one staff nurse. This had been escalated to the assistant director of nursing and was being addressed through redeployment and agency staffing. Inspectors were told that the impact of this was on bedside care, for example getting patients up and out of bed. A small number of patients who spoke with inspectors told them they were awaiting a wash.

The hospital had a database for mandatory training reporting, overseen by the human resources manager. A separate database had been developed to facilitate oversight of training for nursing staff and this was demonstrated to inspectors. Compliance with Irish National Early Warning System (INEWS), and medication safety training in both wards visited was 92% or greater. Overall hospital compliance with standard and transmissions based precautions training was 43% (target 90-

100%). Compliance with this training varied in the clinical areas inspected with Lourdes ward achieving 89% for nursing staff and St Joseph's ward achieving 16% for nursing staff. Lack of training compliance was also a finding on the inspection in May 2024. Additionally, overall hospital compliance with hand hygiene training had not reached the expected target for all staff disciplines of 100% with 97% achieved in Lourdes ward and 59% in St Joseph's ward for nursing staff. Training compliance was discussed with representatives from the infection prevention and control (IPC) team, who told inspectors a training schedule was in place. The schedule of face-to-face IPC training was provided to inspectors, which showed that 17 IPC refresher and hand hygiene training sessions had been scheduled for 2025.

While there was evidence that hospital management were organising and managing the workforce, the following was identified:

- uptake of hand hygiene training, and standard and transmissions based precautions in the hospital was below the expected target. Training compliance was also an issue identified on an inspection in 2024.

Judgment: Partially Compliant

## Quality and Safety Dimension

This section discusses the themes and national standards relevant to the dimension of quality and safety. It outlines the national 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.

St Columcille's Hospital was compliant with two national standards (1.7, 3.3), substantially compliant with three national standards (1.6, 1.8, 2.8), and partially compliant with two national standards (2.7, 3.1) assessed on inspection.

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

Inspectors observed some instances in which privacy, dignity, and autonomy were not fully maintained. However, patients who spoke with inspectors did not highlight any concerns regarding their privacy or dignity. Inspectors observed privacy curtains were in use in multi-occupancy areas.

Inspectors observed a shower book where patients were scheduled and allocated showers on Saturdays and Sundays. Inspectors were informed that showers were carried out at the weekend when the ward was quieter. Inspectors were told by ward management that showers outside of these times could be requested. However, bed baths were routinely provided during the week and patients who spoke with inspectors confirmed this.

Inspectors observed 'get up, get dressed, get moving' signage on display. Patients who spoke with inspectors told them that they were encouraged with mobility. Inspectors observed multiple instances of patients mobilising and exercising with and without assistance. Patients recounted their experience of autonomy and independence being promoted, for example, in relation to activities of daily living in preparation for discharge home.

Patients' healthcare records were protected and stored appropriately. Patient names and details such as pending investigations were displayed on a whiteboard on Lourdes ward, where they could be viewed by those passing by. This was brought to the attention of the manager on the ward, and to senior management.

A room was available in Lourdes ward where difficult conversations could be held and this was observed in use on the day of inspection. The use of a single room with appropriate signage to discreetly indicate end-of-life care was observed on Lourdes ward. Inspectors were told that the family room suite on the ground floor could be accessed when needed, for example, in the case of a patient that was at end of life.

Instances of task-orientated care which does not support patients' specific individual needs were identified:

- a shower book indicated that showers were provided in St Joseph's ward on a scheduled basis at weekends
- patient names and pending investigations were displayed on a whiteboard on Lourdes ward which could be seen the general public.

Judgment: Substantially Compliant

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

Patients spoke positively about their interactions with staff, and inspectors observed kind, considerate, and respectful interactions between staff and patients on St Joseph's and Lourdes ward. However, individual patient needs were not always considered as part of a person-centred approach, as discussed under national standard 1.6.

A bright, sunny day room was available for use by patients and their families in St Joseph's ward. An activities schedule for the room was displayed. An inspector observed the room being used by patients at various times throughout the inspection, and noted that music was playing. St Joseph's ward motto and names of staff working on the ward were displayed.

An inspector noted multiple kind and respectful interactions between various staff disciplines and patients on St Joseph's ward that displayed responsive behaviours. Staff members were observed engaging in a calm way with patients to de-escalate the responsive behaviours.

Inspectors were told by patients and staff on St Joseph's and Lourdes ward that every effort was made to ensure individual food preferences were catered to.

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.**

Systems and processes were in place at the hospital to respond to complaints and concerns from those using the service.

The consumer affairs manager was the designated complaints officer with responsibility for managing complaints. The HSE's *"Your Service Your Say"* (YSYS) policy was implemented in the hospital. Signage in relation to YSYS, ways to provide feedback, and information on independent advocacy services was displayed. Notwithstanding the availability of this information, not all patients who spoke with inspectors were aware of how to make a complaint. Comment cards and feedback boxes were available in the clinical areas inspected. A patient liaison officer provided support to patients who required assistance in making a complaint.

From a review of meeting minutes, it was evident that complaints were an agenda item at meetings of the quality and safety executive committee, and the clinical governance committee. Complaints were also an agenda item at performance meetings with HSE Dublin and South-East health region, where compliance with complaints response timelines were monitored. Performance data reviewed by

inspectors showed that 71.5% of complaints in July 2025 had been investigated within 30 working days, which was below the HSE's target of 75%.

A feedback dashboard was used at the hospital to track and trend feedback including complaints, this was demonstrated to inspectors. Data up until the end of July 2025 showed that 20% of complaints received year to date were currently open. Data from the hospital's complaints database provided to inspectors showed documentary evidence that feedback had been given to staff for each closed complaint.

Staff in clinical areas who spoke with inspectors were knowledgeable about the complaints management process and focused on local resolution of complaints. Patients' experiences of local resolution of complaints varied. A patient who spoke with inspectors was not satisfied that their informal complaint had been effectively actioned. This was highlighted to ward management and senior management on the days of inspection.

Overall, while systems and processes were in place at the hospital to respond to complaints and concerns from those using the service, the following was identified:

- not all patients who spoke with inspectors were satisfied that their informal complaint had been effectively resolved
- the HSE's target for complaints resolution had not been achieved in July 2025.

Judgment: Substantially 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 physical environment in clinical areas visited did not fully support the delivery of high-quality, safe and reliable care that protects the health and welfare of patients.

The hospital's aging infrastructure, and insufficient and inadequate isolation facilities were issues identified on previous inspections of the service in 2022 and 2024. St Joseph's was a 29-bedded ward, and comprised a mixture of four and six-bedded rooms and one single room. Lourdes ward was 34-bedded, with one eight-bedded room, five four-bedded rooms, three single rooms and a high observation room that catered for three patients.

Infrastructural challenges observed on this inspection included multi-occupancy rooms in St Joseph's ward that did not have doors. Single rooms used as isolation facilities did not have en-suite toilet or shower facilities. Inspectors observed that

there was not enough space for patient belongings, which were observed on the floor beside patient beds. An outdoor garden space at St Joseph's ward was overgrown. The door to this space was locked on the days of inspection, patients did not have direct access to this area. Hospital management were aware of this, as discussed further in national standard 2.8.

Hospital infrastructure was a high-rated infection prevention and control risk on the hospital's risk register. Existing controls to minimise the risk of transmissible infections included screening of patients for infection and a policy which detailed isolation practices. Compliance with isolation practices was audited in the hospital and this is discussed further in national standard 2.8. Additional controls to minimise this risk included building a new hospital block. Hospital infrastructure was discussed monthly at risk register committee meetings. Inspectors reviewed a sample of minutes for these meetings which showed that the hospital's development control plan was discussed at regular meetings. The general manager outlined to inspectors that the control plan had now progressed to the design stage for building works.

Inspectors found that all patients on the days of inspection that required isolation facilities were accommodated in single rooms, although these did not have en-suite toilet or shower facilities. Toilets and showers on Lourdes ward were limited, for example, there was one toilet and shower for 12 patients in rooms 8, 9, and 10. St Joseph's ward had two showers and five toilets for 29 patients. Personal protective equipment (PPE) was readily available, as was alcohol-based hand gel. Clinical hand-wash sinks observed throughout clinical areas conformed to requirements.[‡‡‡] Hand-washing technique posters were displayed beside clinical hand-wash sinks. Linen and waste was observed by inspectors to be appropriately stored and segregated.

Evidence of wear and tear observed by inspectors included chipped paintwork on walls and radiators in St Joseph's ward, and damaged flooring in a store room and bathroom. A toilet on St Joseph's ward was out of order at the time of inspection and this had been reported to maintenance. Maintenance requests were logged in a maintenance book which was observed by an inspector. Ward managers were satisfied with the timeliness of response from maintenance staff.

Clinical areas inspected were clean. Clinical nurse managers who spoke with inspectors were satisfied by the level of and access to cleaning resources. Designated cleaning teams for each ward were onsite until 5pm daily, with access to cleaners 24/7. Cleaning schedules for daily, weekly, and deep cleaning tasks were in place. Cleaning checklists for the environment and equipment, checked by inspectors

‡‡‡ Infection Prevention and Control (IPC) National Clinical Guideline No. 30, Department of Health (2023). NCEC National Clinical Guideline No. 30 Infection Prevention and Control Volume 1. Available at: http://health.gov.ie/national-patient-safety-office/ncec/

in both wards were up to date. Sink flushing records used on St Joseph's ward at the time of inspection did not accurately reflect the required flushing frequency. On St Joseph's ward a cleaning checklist for the fridge was not up to date, however, the fridge was observed to be clean.

Cleaners who spoke with inspectors were knowledgeable about the cleaning processes in place. On day two of inspection, a deep clean was being carried out in a four-bedded bay on St Joseph's ward. The beds of two patients that were still in bed were moved close together to facilitate cleaning.

Inspectors observed that there was a lack of storage space in both wards for equipment and patient belongings. Corridors were cluttered with equipment, multi-occupancy rooms were cluttered and patients' belongings were observed on the floor. Inappropriate storage was observed in St Joseph's ward with ward supplies such as gloves and wipes stored in a wardrobe. Additionally, commodes and shower chairs were being stored in one of the bathrooms on this ward. A lack of storage space was also a finding from hospital environmental audits and quality and safety walk-rounds which are discussed in more detail in national standard 2.8.

In summary, the physical environment in clinical areas visited did not fully support the delivery of high-quality, safe and reliable care that protects the health and welfare of service users. The following was identified:

- infrastructural issues observed on inspection included open rooms with no doors, limited showers and toilets for the number of patients using them, and single rooms with no en-suite toilet and shower facilities where patients were isolated with transmissible infections
- wear and tear on painted surfaces and damaged flooring
- corridors and multi-occupancy rooms were cluttered, storage was limited, and patients' belongings were observed on the floor
- sink flushing records for St Joseph's did not reflect the required flushing frequency.

Judgment: Partially Compliant

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

There were systems in place at the hospital to systematically monitor, evaluate, and continuously improve the effectiveness of the healthcare provided there.

Noticeboards displaying audit results were in place in both St Joseph's and Lourdes wards. Nursing and midwifery quality care-metrics were measured at the hospital. Metrics measured relevant to this inspection included medication safety, health care associated infection prevention and control, and monitoring and surveillance of patients' vital signs. Inspectors reviewed results from June, July and August 2025, which showed that both wards had achieved the target of 90% each month.

Quarterly quality and safety walk-rounds by senior management were carried out in the hospital. A recent walk-round had been carried out on St Joseph's ward in May 2025. A copy of the findings was provided to inspectors. Issues included an overgrown outdoor garden, a lack of storage space for patient belongings, and an isolation room with no en-suite toilet or shower. Issues identified had been assigned time-bound actions, however the actions were not adequately addressing the issues identified. Lourdes ward's last walk-round was in 2023, an opportunity for improvement identified was 'all patients encouraged to send home property as the ward does not have capacity'. There was no accompanying action to address this finding. The schedule provided to inspectors showed that a walk-round was scheduled for Lourdes ward in quarter four 2025. This significant gap in the walk-around did not provide senior management with the assurances required that actions had been implemented and sustained.

Infection prevention and control (IPC) practice audits for St Joseph's and Lourdes ward were carried out by the IPC team. Audits covered fifteen distinct areas, including hand hygiene, the general environment, patient equipment, waste management, and isolation facilities. In April 2025, Lourdes ward achieved an overall score of 90%, and St Joseph's ward scored 91% (target 85%). The general support services team also carried out environmental audits. Results for St Joseph's ward for September 2025 were 97%. Lourdes ward scored 84% in April 2025 which was just below the target of 85%. Findings from both IPC and environment audits included insufficient storage space, clutter and patient belongings stored on the floor. Similar to quality and safety walk-rounds, actions were identified and were documented as implemented. However, they were not sustained as inspectors had similar findings as discussed under national standard 2.7.

Hand hygiene audit results for Lourdes ward in August 2025 was 96.7% and for St Joseph's ward in quarter two 2025 was 97% (the target of 90% was achieved). However, IPC practice audits had identified that not all staff had completed hand hygiene training, which was also a finding by inspectors as discussed under national standard 6.1. Quarterly indicators for quarters one and two 2025 showed that all patients requiring contact precautions had been isolated within 24 hours of admission. An audit of compliance with CPE screening procedures had last been carried out in August 2024 with a score of 99% achieved. Inspectors were told by

the IPC team that the next CPE screening audit was scheduled for October 2025. The IPC audit schedule reviewed by inspectors confirmed this.

Antimicrobial prescribing (AMS) process indicators were measured and compared on a quarterly basis in the hospital. A review of infection prevention and control team committee minutes indicated that the AMS quarter two report was discussed. All targets had been achieved with the exception of patients on intravenous therapy eligible to switch to oral antibiotics. St Joseph's ward had won the 'ward of the quarter' award for high compliance with AMS prescribing practices. A 'gold star' initiative to recognise good antimicrobial prescribing practice had been implemented in the hospital. Inspectors found evidence of a gold star being awarded in two prescription and administration records reviewed on Lourdes ward.

Nursing and midwifery quality care-metrics measured included medication safety and medication storage and custody. Overall metric results for June, July and August for all hospital wards showed that scores of 96.2% and above had been achieved for medication safety and 100% had been achieved for medication storage and custody. Medication related patient-safety incidents were analysed on a quarterly basis which is discussed in more detail in national standard 3.3.

Quarterly sepsis audits overseen by the deteriorating patient committee had been carried out in quarter one and two of 2025. A suite of five key performance indicators were measured as part of these audits, with a target compliance of 70%. Performance was benchmarked between each quarter. Results showed that the target for appropriate implementation of sepsis 6[§§§] and patient review had been achieved in both quarters. In quarter two 2025, 90% of eligible sepsis forms had been commenced. However, target compliance for completion of all relevant sections of the sepsis form had not been achieved in either quarter. A time-bound quality improvement plan to address findings was in place.

The deteriorating patient committee also oversaw compliance with the Irish National Early Warning System (INEWS). A suite of six key performance indicators was measured and compared in quarter one and quarter two 2025. This included correct calculation of INEWS score, observations carried out at the correct frequency, escalation to the medical team and medical review within the recommended time. Results reviewed by inspectors showed that the target compliance for all indicators was reached in both quarters. A time-bound quality improvement plan to address findings was in place.

The Identify, Situation, Background, Assessment, Recommendation (ISBAR) communication tool was used in the hospital to facilitate nursing handover. This

[§§§] Sepsis 6 is a bundle of six critical care actions—Give three (oxygen, IV fluids, and IV antibiotics) and Take three (blood cultures, lactate blood tests, and urine output monitoring)—that should be completed within one hour of suspecting sepsis.

practice was audited and results from quarter one and quarter two 2025 compared. Results showed that the situation and background sections were partially complete with compliance of 60% in quarter two 2025. An action plan was developed to address findings.

Data was collected on a daily basis to inform the daily bed status overview, a copy of which was provided to inspectors, this gave an overview of bed usage and bed capacity. Routine data was also collected by the patient flow team in relation to delayed transfers of care and length of stay.

While there were systems in place at the hospital to systematically monitor, evaluate, and continuously improve the effectiveness of the healthcare provided there, the following was identified:

- recurring issues such as clutter and a lack of storage space were found on walk-rounds, environmental audits, and IPC audits. While evidence was provided that actions in response to findings had been implemented, these actions had not been sustained as inspectors found similar findings.

Judgment: Substantially Compliant

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

The systems in place in the hospital to protect patients from the risk of harm associated with the design and delivery of healthcare services were not fully effective. Gaps identified included staff access to policies, procedures, protocols and guidelines.

A daily operational safety huddle took place each morning at 10am. Minutes of this meeting for the days of inspection were provided to inspectors. Meetings were attended by representatives from key areas such as patient flow, infection prevention and control, pharmacy, quality and safety, and clinical areas. Key updates and important information was shared at this meeting. Inspectors were told that daily huddles also took place locally in both St Joseph's and Lourdes ward. There were local risk registers in place in both wards. A risk relevant to the focus of this inspection included ward infrastructure.

Patients were screened for Multi-drug resistant organisms (MDROs) in the hospital. All admitted patients were screened for Methicillin Resistant *Staphylococcus aureus* (MRSA) and Carbapenemase Producing *Enterobacterales* (CPE). Patients requiring transmission-based precautions were isolated as per the advice of the infection prevention and control team in line with the 'Infection prevention and control

management of patients with infectious disease' policy. The infection prevention and control team told inspectors that they visited clinical areas daily and this was confirmed by staff who spoke with inspectors.

At the time of inspection there was an open outbreak of *Clostridium difficile* infection on Lourdes ward. The outbreak which had affected a small number of patients had been declared on 13 July, with the last case detected at the end of July. While the outbreak remained open, there were no patients at the time of inspection with this infection. The outbreak was due to close at the end of September if no new cases were detected. The most recent outbreak control team meeting minutes from 11 September 2025 was reviewed by inspectors. Measures implemented in response to the outbreak included infection prevention and controls audits of the dirty utility, patient equipment and hand hygiene.

A clinical pharmacy service was provided to ward areas daily, with a senior pharmacist providing antimicrobial stewardship services. Weekly antimicrobial stewardship rounds were carried out in clinical areas by the consultant microbiologist and antimicrobial stewardship pharmacist. Medication reconciliation was undertaken for all patients on admission. A sample of medication prescription and administration records reviewed by inspectors showed that medication reconciliation and clinical pharmacy review had been undertaken for those patients. One instance of a patient's weight not being recorded was observed by an inspector. Additionally, one instance of a medication that was stopped but not signed or dated was observed by an inspector and this was highlighted to the ward manager.

Access to medicines information at the point of prescribing and administration was available through an information technology application. Inspectors observed that paper-based prescribing guidelines in clinical areas were not up to date, this was highlighted to senior management. Staff explained risk reduction strategies relating to medicines to inspectors. Information on sound-alike-look-alike medicines was available on Lourdes ward but not on St Joseph's ward. Nurses carrying out medicines rounds were observed wearing red aprons to alert staff and patients of their need to concentrate and not be disturbed.

Irish National Early Warning System (INEWS) and sepsis guidelines were implemented in the hospital. Staff who spoke with inspectors were knowledgeable about responding to signs of clinical deterioration and escalating care. Inspectors reviewed a sample of INEWS charts. Observations were carried out at the required frequency with one exception, which was highlighted to the ward manager. An INEWS event log was in place to note actions taken in response to low scores of one to two, and inspectors observed this in use. Staff could access laboratory results on computers in clinical areas and were knowledgeable in relation to the process for

communication of critical laboratory results, which was underpinned by a formalised policy.

Emergency equipment was available in the wards inspected. Phone numbers to use in an emergency were displayed, this included the number to call in the event of a cardiac arrest and a separate number to contact the medical emergency team (MET). Staff who spoke with inspectors understood the difference between these phone numbers and when to use them. The role of the multidisciplinary MET team, which comprised doctors and nurses, was to respond rapidly to acutely deteriorating patients. Patients requiring a higher level of care were transferred to the observation unit in Lourdes ward or transferred out of the hospital by ambulance using Protocol 37.[****] The observation unit was not at full capacity on the day of inspection, with a nurse to patient ratio of 1:1.

Staff told inspectors about the inclusion and exclusion criteria for admission to the observation unit (room 3) in Lourdes ward. Staff provided a document 'Admission criteria to room 3' to inspectors, however the document, which was dated November 2022, was incomplete and did not contain the criteria. A full copy of this document was provided to inspectors by senior management. The document contained operational guidelines, however, it was unclear from the document what ceilings of care applied to the patients being cared for there, and which procedures, for example intravenous drug administration, were permitted. Additionally, it was unclear from the document what competencies and training staff required in order to work in the unit. This was discussed with senior management, who outlined that staff working in the unit attended a mandatory medical emergency management course. Inspectors were told that nursing competencies were overseen by a clinical facilitator and the roster was managed to ensure trained staff were on duty.

Patient flow, including transfers into and out of the hospital, and factors impacting on discharges were discussed at a number of meetings. Daily meetings included the bed management meetings and the operational safety huddle mentioned earlier in this national standard. Multidisciplinary team meetings to discuss patient flow and discharge took place twice a week on both wards inspected. It was observed by inspectors that infection status was not recorded on patient discharge summaries.

Policies, procedures, protocols and guidelines (PPPGs) reviewed by inspectors that had been formally signed off by the clinical governance committee were up to date. 'Admission criteria to room 3' had not been formalised or ratified for use. A protocol for bi-directional patient transfers between St Columcille's Hospital and St Vincent's University Hospital was in draft format at the time of inspection. Inspectors observed

[****] The Emergency Inter-Hospital Transfer Policy Protocol 37 was developed for emergency inter-hospital transfers for patients who require a clinically time critical intervention which is not available within their current facility.

and were informed by a number of staff in both St Joseph's and Lourdes ward that they had difficulty in accessing PPPGs on ward computers. This was escalated to senior management by inspectors.

In summary, while the hospital had systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services these systems were not fully effective with the following identified:

- staff had difficulty in accessing PPPGs in both wards inspected
- a document outlining admission criteria to high-observation beds in room 3 in Lourdes ward was not formalised or ratified for use
- a protocol for bi-directional patient transfers was in draft format.

Judgment: Partially Compliant

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

Systems and processes were in place at the hospital for identifying, reporting, managing and responding to patient-safety incidents.

As discussed under national standard 5.8, discussion of patient-safety incidents took place at the hospital's serious incident management team (SIMT) meetings. The executive management committee, quality safety executive committee, and clinical governance committee had effective oversight in relation to patient-safety incidents.

Staff who spoke with inspectors were knowledgeable about how to report and manage patient-safety incidents. Electronic point of entry of patient-safety incidents onto the National Incident Management System (NIMS)[††††] had been implemented in the hospital since the previous inspection in May 2024. Documentation reviewed by inspectors showed that the HSE target of 70% for incidents created in NIMS within 30 days of date notified, had been achieved. The compliance for quarters one and two 2025 was 100%.

Staff who spoke with inspectors told them that patient-safety incidents were discussed before handover in St Joseph's ward and at team safety briefings on Lourdes ward. An example of an improvement in response to a medication safety incident included staff wearing red aprons on medicine rounds to avoid disturbance. As discussed under national standard 3.1 this practice was observed by an inspector.

[††††] An incident management tool developed to improve patient and service user safety. The system also supports reviews into incidents, the monitoring of recommendations and records complaints.

An incident summary dashboard overseen by staff in the quality, risk and patient safety department provided an overview of the number and type of incidents that had occurred in the hospital. Medication-related patient-safety incident summary reports were produced on a quarterly and yearly basis, and discussed monthly at the drugs and therapeutics committee. The annual medication safety incident report for 2024 was reviewed by inspectors. Medication-related incidents were categorised using a formal classification system. High risk medications accounted for 25% of all reported errors in 2024. In response to insulin-related patient-safety incidents, a quality improvement plan to update the insulin medication prescribing and administration record was progressing. Staff in clinical areas who spoke with inspectors were aware of this plan.

Judgment: Compliant

## Conclusion

An announced inspection of St Columcille's Hospital was carried out to assess compliance with the *National Standards for Safer Better Healthcare Version 2* (2024). The inspection focused in particular, on four key areas of known harm, these being infection prevention and control, medication safety, the deteriorating patient and safe transitions of care.

Overall, the hospital was compliant in four national standards (5.5, 5.8, 1.7, 3.3), substantially compliant in four national standards (5.2, 1.6, 1.8, 2.8), and partially compliant in three national standards (6.1, 2.7, 3.1) assessed on inspection.

### Capacity and capability

Formalised governance arrangements were in place in the hospital and accountability arrangements were clearly described to inspectors. The general manager position which had been filled on an interim basis at the time of the last inspection was now filled on a permanent basis. Filling of the operations manager and quality and safety manager roles were progressing, and a consumer affairs manager was now in place. Additionally, the appointment of an additional anaesthesiologist for the hospital was progressing. Quality and safety walk-rounds were infrequent in the clinical areas visited and actions identified to address findings were not sustained.

### Quality and Safety

There were systems and processes in place in the hospital to respond effectively to complaints and concerns from those using the service. Inspectors found that not all

patients were satisfied that informal complaints had been effectively resolved. Aging infrastructure in the hospital posed challenges for management and was a high-rated risk on the hospital's risk register. Overall, clinical areas inspected were clean, some evidence of wear and tear was observed. Recurring issues that had not been adequately addressed such as a lack of storage, including for patient belongings, were identified through walk-rounds, audit, and by inspectors. Staff had difficulty in accessing policies, procedures, protocols and guidelines on computers in both wards inspected.

HIQA will, through the compliance plan submitted by hospital management as part of this monitoring activity, continue to monitor the progress in implementing actions to address compliance with areas identified under national standards 6.1, 2.7 and 3.1.

## 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.

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| **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. | 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** | |
| Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare. | Partially Compliant |
| **Dimension: Quality and Safety** | |

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| **Theme 1: Person-centred Care and Support** | |
| 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. | Substantially Compliant |
| **Theme 2: Effective Care and Support** | |
| Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users. | Partially Compliant |
| Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved. | Substantially Compliant |
| **Standard** | **Judgment** |
| **Dimension: Capacity and Capability** | |
| **Theme 3: Safe Care and Support** | |
| Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services. | Partially Compliant |
| Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents. | Compliant |

**Compliance Plan for St Columcille's Hospital**

**Inspection ID: NS_0166**

**Date of inspection: 22 and 23 September 2025**

## Compliance plan provider's response:

| 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. | Partially Compliant |
| Outline how you are going to improve compliance with this national standard.<br><br>The rosters for the 2 days of the inspection demonstrated that on that on first day, there were no staff shortages. CNM2, 6 Staff Nurses, and a HCA were present. Also, additional agency HCAs provided to cover the 1:1 patient specials that were in place.<br><br>On the second day of the inspection, there was a CNM2, 5 Staff Nurses, and 1 Staff Nurse deficit. Staff nurse had been replaced with an agency Staff Nurse. There was a HCA present. Also, additional agency HCAs provided to cover the 1:1 patient special that were required.<br><br>Every reasonable effort is always made to secure replacement staff, when unexpected leave occurs, through either overtime or agency. Aspects of care, such as showers, were completed during this time and staff worked diligently to support patients and maintain good and safe standards of care that were individualised and not task focused.<br><br>IPC Training records on the day did not reflect the true accuracy around compliance. Actual training records for combined Transmission based precautions and Hand Hygiene noted at 88% compliance for St Joseph's ward. | |
| **Timescale:** Complete | |
| 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. | |

1. Infrastructural issues observed on inspection included open rooms with no doors, limited showers and toilets for the number of patients using them, and single rooms with no en-suite toilet and shower facilities where patients were isolated with transmissible infections.

2. Wear and tear on painted surfaces and damaged flooring

An extensive mechanical and infrastructure audit has been conducted in St Josephs.

This audit included but was not limited to.

- All bathing facilities and washing facilities.
- Mechanical provisions in the ward - Heating & Ventilation
- Medical Gas provision
- Electrical Infrastructure
- Bedside provisions
- Ward decoration and condition.

Actions derived from the audit

Extensive electrical (board mapping and TEGG) testing on the main distribution boards serving the ward.

- Recommended actions following this are underway

Several submissions for funding to improve patient care in the Ward, AMRIC submissions, minor capital and sustainability projects are being developed.

- Patient isolation ensuite
- Peeling and flaking paint
- Replacement floor coverings
- New radiator covers
- New WHB units
- New AVSU and alarms for piped Oxygen

Review of St Joseph's Ward has been conducted with capital and estates office, and an improvement plan is being developed.

The hospital acknowledges that clutter in corridors and multi-occupancy rooms, and the placement of patients' belongings on the floor arose due to limited storage capacity associated with the older hospital infrastructure.

In response to the inspection findings, measures have been implemented to reduce clutter in corridors and multi-occupancy rooms to mitigate patient safety, infection prevention and fire safety risks. Patients' belongings are now stored off the floor wherever possible, excess items are returned home, and environmental checks have been incorporated into daily Nursing records of each patient. The Person in charge will monitor compliance through regular documentation and environmental audits, and daily ward safety checks.

To improve storage for patients, sourcing more suitable lockers is essential. This involves identifying durable, secure, and easy-to-clean options that meet hospital standards. This will be included in the hospital's estates development plan. Representatives from different suppliers will be asked for quotes to replace the existing patient lockers for more suitable bigger storage solutions

Decontamination Booklets: issues identified with environmental and decontamination ward booklets, due to delay in ordering bound document booklets. Staff went to single sheets printed and this may have resulted in this issue. We have moved from ordering the booklets from quarterly to yearly orders. This has mitigated this issue and provided contingency on the wards.

**Timescale:** Ongoing - awaiting funding from HSE

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| 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.

1. All staff should have access to the hospital main drive in their profile once a network account has been registered for them. The access to main drive will also give them access to the PPPGS drive with read only access as a result. There are currently 2 improvements in process which will have a clear path to the PPPGS information without additional support.

- Implementation of the SSO project which will facilitate logging into systems using a swipecard and pin on KIOSK devices, these KIOSKS will have a clear path to the hospital main drive (X: drive) by default

- Moving PPGS to an O365 SharePoint environment, this will take more time to implement

Ensure all nursing staff can easily and efficiently access up-to-date PPPGs on the ward to support safe and consistent patient care.

All PPPG's are stored on the x-drive.

A random audit was conducted on the two wards in January 2026 to identify the specific barriers to access. The reasons identified included digital access issues, location of the documents on the x-drive, lack of training and staff knowledge.

Nursing staff need to know where and how to access PPPG's without delay. Short training sessions on how to access and use PPPGs easily will be organised by the Person in charge.

A quick-reference guide/flowchart for staff will be created.

PPPG access will be included as part of new staff induction.

Person in Charge of the ward will repeat the audits every 3 months.

Ensure all ward computers have log-in access to PPPGs. The person in charge will follow this up with external ICT support and in-house ICT support. All Nursing staff should have access to PPPG's anytime and anywhere on the ward.

A PPPG coordinator needs to be identified to ensure documents are current and uploaded promptly.

A review of all PPPG's needs to be completed annually.

2. A document outlining admission criteria to high-observation beds in room 3 in Lourdes ward was not formalised or ratified for use:

A draft form of the document 'Admission criteria to room 3' is in place as an interim measure, with actions and communication ongoing, full approval at relevant committees and full implementation by end of Q2.

3. A protocol for bi-directional patient transfers was in draft format. A draft form of the document is in place as interim measure, reviewed by the Clinical Director, with actions.

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| Communication to be ongoing with full approval at relevant committees and full implementation by end of Q2. |
| **Timescale:** End of Q2 2026 |