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 John's Community Hospital Benbulben Rehabilitation Unit
Address of healthcare service:	Ballytivan Sligo F91 H224
Type of inspection:	Announced
Date(s) of inspection:	18 and 19 February 2025
Healthcare Service ID:	OSV-0001469
Fieldwork ID:	NS_0123

About the healthcare service

Model of hospital and profile

St John's Community Hospital Benbulben Rehabilitation Unit is a model one* rehabilitation and community inpatient healthcare service owned and managed by the Health Service Executive (HSE). At the time of inspection, it was part of HSE Community Healthcare Organisation 1 (CHO 1)† and was transitioning to the new HSE regional health structures under the governance of Integrated Healthcare Area, Sligo, Leitrim, West Cavan and South Donegal within the HSE West and North West Regional Health Area (RHA). At the time of inspection, CHO 1 and Community Healthcare Cavan, Donegal, Leitrim, Monaghan, Sligo (CH CDLMS) were terms that were used interchangeably for the same geographical area.

Services provided by the hospital include:

- Rehabilitation

The following information outlines some additional data on the hospital.

Number of beds	19 inpatient rehabilitation beds

The hospital had contracted additional beds in four private nursing homes for patients requiring periods of convalescence or emergency respite.

St John's Community Hospital also accommodated four residential units designated as centres for older persons. Sligo University hospital had also recently opened a 26-bed medical ward within the campus of St John's Community Hospital which remained under the governance of the acute hospital. Both of these services were outside the scope of this inspection.

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.

* The National Acute Medicine Programme's model of hospitals describes four levels of hospitals. Model-1 hospitals are community and or district hospitals and do not provide surgery, emergency care, acute medicine (other than for a select group of low risk patients) or critical care.
† CHO 1 serves the populations of Cavan, Donegal, Leitrim, Monaghan, and Sligo, delivering a range of community health services.

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 publicly 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.

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

[‡]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.

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
18 February 2025	13:10 – 17:15hrs	Robert McConkey	Lead
		Patricia Hughes	Support
19 February 2025	09:00 – 15:00hrs		

Information about this inspection

An announced inspection of the Benbulben Rehabilitation Unit (BRU) at St John's Community Hospital was conducted on 18 and 19 February 2025.

The rehabilitation unit comprised a single ward with 19 beds located in five three-bedded rooms and one four-bedded room. These acute step-down beds were used for patients requiring rehabilitation after a stroke, orthopaedic surgery or for reconditioning after an episode of delirium.

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

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

The inspection team visited one clinical area:

- Benbulben Rehabilitation Unit

[§] HIQA has presented the 45 National Standards for Safer Better Healthcare under eight themes and these are arranged under the two dimensions 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 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, and shift and interdepartmental handover.

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

- Representatives of the hospital's Executive Management Team:
  - Director of Nursing (DON)
  - Service Manager for Older Persons Services (OPS) CHO 1 (Sligo and Leitrim)
  - General Manager OPS CHO 1
- Quality and Patient Safety Advisor OPS CHO 1
- Consultant geriatricians and representatives for the non-consultant hospital doctors (NCHDs)
- Interim Human Resource Manager for CHO 1 (Donegal, Sligo and Leitrim)
- Infection Prevention and Control - Assistant Director of Nursing (ADON) OPS CHO 1
- Discharge Liaison Officer OPS CHO 1 (Sligo and Leitrim)
- A staff representative from each of the following areas:
  - Medication Safety and Drugs and Therapeutics
  - Complaints Management
  - The Deteriorating Patient

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 spoke with several patients about their care experiences. Patients expressed satisfaction with the care they received and praised the hospital staff.

When asked to describe what had been good about their stay in the rehabilitation unit, patients commented that "we go to the canteen here and staff are very friendly. Great laughs here too", "great staff, good for patients, makes a great place to recover, good food", "staff are very nice", "they are little angels", "I feel safe here" and "it's the cleanest hospital I have ever been in".

In the clinical area, a patient 'board at a glance' was seen by inspectors. Patients' names were concealed to protect their privacy and confidentiality. The board included a colour code to indicate which consultant had overall responsibility for each patient's care. Each patient had assigned and named health and social care professionals, including the nurse allocated for the shift, an occupational therapist, a physiotherapist, a speech and language

therapist, a tissue viability nurse, a dietician and a social worker. Additionally, the predicted date of discharge (PDD), date of multidisciplinary team meeting and destination at discharge was included for all patients.

Nurses were observed answering patient call bells promptly. Curtains were drawn when staff attended to the personal care needs of patients, protecting their privacy and dignity. Staff interacted with patients in helpful, kind, and respectful ways.

Inspectors observed seven patients having their meal in the dining room, supported by a healthcare assistant (HCA). Clear pictures of a variety of meal options were on display. Speech and language therapy services had a dysphagia information board on display providing essential details about swallowing difficulties, including symptoms, management, and safety tips for patients and caregivers.

When asked by inspectors if anything could be improved in the way service or care was delivered in the hospital, one patient commented, "no broadband here – that's an awful loss". Management informed inspectors of the challenges related to this due to the thickness of the walls and mentioned that the facilities team was conducting a survey to see if improvements could be made.

Multi-denominational religious services were available on-site in a large chapel. A large social board contained the hospital's quarterly newsletter as well as photographs of staff and patients enjoying social activities in the hospital.

Inspectors observed a well-stocked, wall-mounted patient information leaflet holder containing leaflets on various services, conditions, and safety topics. These included patient advocacy services, how to make a complaint, stroke action, social prescribing, bereavement support, medication lists, and delirium.

When asked if they knew how to make a complaint if needed, patients said they would speak with a nurse or "find who was in authority and tell them". A HSE *Your Service Your Say*[§§] information poster, which explained how to make a complaint, concern, or compliment, was seen on display in the rehabilitation unit, along with suggestion boxes for patients to provide feedback. Posters about patient advocacy services and information on assisted decision-making were observed in the corridors of the patient areas.

Inspectors observed the delivery of a gift hamper to the staff from a patient who had been discharged the previous day, along with a card complimenting the staff on the care provided.

[§§] 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

It was clear to inspectors that management and staff supported and cared for patients in a person-centred manner, consistent with the human rights-based approach to care promoted by HIQA.

Capacity and Capability Dimension

This section discusses the themes and standards relevant to the dimension of capacity and capability. Inspection findings in relation to the capacity and capability dimension are presented under four national standards (5.2, 5.5, 5.8 and 6.1) from the two themes of leadership, governance and management, and workforce.

The Benbulben Rehabilitation Unit at St John's Community Hospital was found to be substantially compliant with NS 5.2 and 6.1, and compliant with NS 5.5 and 5.8.

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

Inspectors reviewed organisational charts that illustrated the rehabilitation unit's corporate and clinical reporting structures. These charts specified the direct reporting lines for hospital management and the governance and oversight committees, clearly outlining the reporting and accountability relationship to CHO 1.

The DON was the senior accountable officer for both the Benbulben Rehabilitation Unit and the older persons residential units within St John's Community Hospital. The DON was responsible for the operational management of the hospital and reported to the service manager for older persons (Sligo and Leitrim), who in turn reported to the general manager for older persons in CHO 1. The general manager reported to the head of service for older persons services (OPS) in CHO 1. The DON was responsible for the organisation and management of all staff at the hospital apart from the medical consultants and NCHDs. Medical consultants working in the hospital were operationally accountable to the DON and clinically accountable to the associate clinical director of medicine in Sligo University Hospital (SUH).

Management at the hospital informed inspectors that, in line with ongoing changes in the overall HSE governance structures, acute and community care were being integrated under the management of six regional health areas. Governance arrangements were still being finalised and could be subject to change. Inspectors were informed that this transition was expected to be completed for CHO 1 by the end of quarter two 2025.

Two consultant geriatricians provided clinical oversight and leadership at the rehabilitation unit. All patients admitted to the rehabilitation unit were under the care of one of these consultants. Out-of-hours medical services were provided by an on-call medical officer, whose periods of leave were covered by a locum on-call doctor. A previous HIQA inspection in 2020 identified a risk due to the lack of arrangements for covering the on-call medical officer leave. During this inspection, it was noted that management at the hospital had implemented arrangements to address this risk.

Staff on the ward reported to the clinical nurse manager (CNM) on duty, who in turn reported to the ADON, and then to the DON. Safety pauses were held three times daily and attended by all multidisciplinary staff on the ward, providing opportunities to raise any risks or issues of concern.

Local governance meetings were held to review all aspects of quality and safety activities in the rehabilitation unit. Minutes of the three most recent 'BRU Monthly Governance Meeting' and 'BRU Weekly QPS Meeting' were reviewed and found to be action-oriented, with evidence of follow-up on actions from meeting to meeting. However, actions were not always clearly time-bound.

Agenda items discussed included occupancy and discharge planning, incident review, falls, tissue viability, pressure sores, bruising and skin tears, medication safety, infection prevention and control, safeguarding, complaints and compliments, staffing, training, and other business. The meetings also included a log of staff training, which was updated from meeting to meeting.

Inspectors were informed about community-wide committees involved in the governance of the rehabilitation unit. Minutes of these committees were reviewed, and inspectors spoke with management at both the hospital and CHO 1 levels to ensure consistency with the documented governance arrangements. The committees involved in the governance of the rehabilitation unit as described below.

CH CDLMS Older Persons Quality & Safety Review Committee

This committee, as outlined in its terms of reference (TOR) dated 06 December 2023, was scheduled to meet four times per year to ensure quality and safety structures, processes, and standards throughout CHO 1 older person services are maintained to a good standard. The TOR had not yet been updated in line with the annual review schedule outlined in the document. This multidisciplinary committee, chaired by the head of service OPS, included key stakeholders such as the general manager OPS, service managers (Cavan Monaghan, Sligo Leitrim, and Donegal), home support managers, quality and risk manager, health and safety manager, consumer services manager, safeguarding manager, infection control representative, and administrative support. The committee's role was to assure the head of service OPS that effective systems were in place for delivering person-centred, safe, and effective care. Key activities included risk management, compliance, incident management, reviews and investigations, regulatory

compliance, audits, monitoring of quality improvement plans, service user experience, quality metrics, feedback, policies and guidelines, trends, and learning. The committee invited internal and external experts to inform deliberations and decision-making. The chairperson was operationally accountable to the chief officer. Subcommittees reporting to the local CHO 1 Quality and Safety Committee included the Infection Prevention and Control Committee, Drugs and Therapeutics Committee, Health and Safety Committee, and the Medical Devices Committee.

Minutes from the meetings held on 9 May, 1 August, and 14 November 2024 were reviewed by inspectors and discussed with management at the hospital and CHO 1 level. The meetings were well attended, with action-oriented discussions and responsible persons assigned to actions, although these were not always time-bound. Key topics included quality and safety governance committees throughout CHO 1, safety incidents, safeguarding, acquired infections, complaints, compliments, HIQA inspections, and mandatory training. While it was clear that the Service Manager for Sligo and Leitrim provided updates on issues relevant to Sligo and Leitrim OPS, such as complaints, policies, and medication errors, it was sometimes unclear if issues discussed were specifically related to the rehabilitation unit or residential units in the hospital.

Older Persons Quality & Patient Safety Meeting (CHO 1 Sligo and Leitrim)

According to its TOR, dated May 2024, this committee met every four weeks to oversee the development and implementation of quality and safety structures across services. The committee, chaired by the service manager and comprising key stakeholders such as the quality and patient safety lead, directors of nursing, and health & safety representatives, focused on risk management, incident reporting, and continuous improvement. The minutes of the three most recent meetings reviewed by inspectors indicated that the meetings were well attended, with the Director of Nursing for St John's Community Hospital present at all three meetings. Key areas discussed included infection prevention and control, medication safety, transitions of care, incidents and complaints. Notable discussions involved the implementation of the dementia strategy, updates on infection prevention, and the management of risk registers. Health and safety and safeguarding meetings were incorporated into the committee meetings and recorded in the minutes, with relevant issues related to St John's Community Hospital discussed. While it was clear that issues related to St John's Community Hospital were raised and discussed, it was sometimes unclear if items discussed were specifically related to the rehabilitation unit, the residential units, or both. Additionally, the minutes revealed gaps in the follow-up of actions from previous meetings and the assignment of responsibilities.

CHO Area 1 Infection Prevention and Control and Antimicrobial Stewardship Committee

According to its terms of reference, dated February 2024, the CHO Area 1 Infection Prevention and Control and Antimicrobial Stewardship (AMS) Committee was scheduled to meet every three months. The committee, comprising key interested parties, included the

chief officer (who acted as chairperson), quality safety and service improvement lead (QSSI) (who may act as co-chairperson), CHO 1 infection prevention and control lead, CHO 1 antimicrobial stewardship pharmacist, director of public health medicine from both the northwest and northeast public health medicine departments, quality patient safety and risk manager representative, and a consultant microbiologist or a consultant infectious disease physician. The committee focused on reducing healthcare-associated infections and improving antimicrobial use. The three most recent meeting minutes reviewed by inspectors indicated that the meetings were action-oriented, with responsible persons assigned and follow-up actions from previous meetings. Notable discussions included updates on the infection prevention and control link practitioner programme, antibiotic consumption data, quality improvement initiatives and the development of national audit tools.

The minutes provided evidence of a strong commitment to quality and safety, with outbreaks discussed at all meetings. However, the distinction between residential services and the rehabilitation unit was not always clear in discussions. For example, the older persons services update in the December minutes referred to quality improvement plans being actioned by PICs (person in charge) on site, which is a term used to identify the responsible person in a residential care facility, whereas a DON can be the responsible person in both residential care facilities and in rehabilitation and community hospitals.

Issues related to infection prevention and control at ward level were discussed in weekly quality and patient safety and monthly governance ward meetings in the hospital. Infection prevention and control was also noted to be a standing agenda item in the monthly CHO 1 services for older persons quality and safety committee (Sligo and Leitrim) and quarterly CH CDLMS older persons quality & safety review committee meetings. Minutes from the three most recent meetings of each of these committees confirmed that infection prevention and control issues, including audits, outbreaks, and shared learning, were reviewed and discussed.

Medication Safety

Inspectors spoke with the hospital's lead representative for medication safety, a pharmacist (Chief II) who was based in Sligo University Hospital (SUH). This pharmacist was employed one day per week in St John's Community Hospital, and assumed overall accountability for medication safety in the hospital. The hospital had access to the CHO 1 drugs and therapeutics committee (DTC), which functioned in an advisory capacity only.

Inspectors reviewed documentation of communication between hospital management and the chair of the DTC at SUH seeking to formalise membership and representation of St John's Community Hospital on their DTC. While the hospital informally received bulletins and ad-hoc guidance from the SUH DTC, inspectors were informed that formalising this relationship would enhance governance and overall medication safety within the hospital.

Guidance on antimicrobial stewardship was available through the antimicrobial pharmacist at SUH, and staff at the rehabilitation unit had access to the microbiologist at SUH when needed. Microbiology results were accessible to staff via the hospital's computer system. Medication safety concerns such as medication incidents were reported to and discussed at the Older Persons Quality & Patient Safety Meeting (CHO 1 Sligo and Leitrim) as seen in the minutes reviewed by inspectors. Medication safety in the hospital was supported by up-to-date policies reviewed by inspectors.

Deteriorating Patient

Management at the hospital and CHO 1, along with clinical staff including nursing and medical personnel, outlined the process in place to recognise and manage a patient whose condition deteriorates, although there was no policy in place to support this. The process will be outlined under national standard 5.5.

Transitions of Care

Transitions of care to and from the hospital were overseen by management in the hospital and at CHO 1, and were supported by an admissions protocol and discharge policy seen by inspectors. The DON acted as the admitting officer and worked closely with the discharge liaison officer for OPS (Sligo and Leitrim). The discharge liaison officer participated in discharge committees and forums at SUH, where most patient admissions to the rehabilitation unit originated, to ensure patients met the admission criteria.

The transfer of patients back to the acute setting was supported by a 'Safety Alert Form' which was reviewed by inspectors and is discussed under national standard 3.1.

Serious Incident Management Team Older Person Services, CH CDLMS

According to the terms of reference (TOR) dated December 2023, the Serious Incident Management Team (SIMT) for older persons services in CH CDLMS oversaw the review of adverse events classified as category 1 (clinical and non-clinical incidents rated as major or extreme) or Serious Reportable Events (SREs) (serious, largely preventable patient safety incidents that should not occur if the available preventative measures are implemented). It was noted by inspectors that the TOR did not reflect the annual review cycle outlined within the document. The SIMT aimed to ensure that incident reviews followed a standardised process in line with the HSE Incident Management Framework (IMF) 2020, and to meet the needs of service users, their families, and the organisation. Key objectives included reviewing incidents, ensuring appropriate investigations, monitoring review progress, maintaining accountability and communication, supporting affected staff, and ensuring open disclosure.

Chaired by the head of service for older persons services, with the general manager as vice chair, the SIMT included representatives from various disciplines such as advanced nurse practitioners, clinical coordinators, quality and patient safety advisors, and infection control specialists. The SIMT could invite internal and external experts as needed. The

SIMT reported to the executive management team and was accountable to the chief officer. Meetings were held monthly, with the quality and patient safety department managing the serious incident tracker log and overseeing the implementation of recommendations.

Minutes from the meetings held on 9 July, 8 November, and 3 December 2024 were reviewed by inspectors and discussed with management at the hospital and at CHO 1 level. The meetings were well attended and contained action-oriented discussions. There was one category 1 incident reported in the rehabilitation unit in 2024 which was reviewed by the SIMT and was closed at the time of inspection.

In summary, the hospital has established formalised governance arrangements that effectively supported the delivery of high-quality, safe, and reliable healthcare. The organisational charts and committee structures clearly demonstrate well-defined reporting lines and accountability mechanisms. The hospital demonstrated a strong commitment to quality and safety through regular, action-oriented governance meetings. However, not all TORs were reviewed in accordance with the stated review process. Additionally, there were opportunities to enhance the clarity of meeting minutes by clearly distinguishing between the Benbulben Rehabilitation Unit, which was the focus of this inspection, and the older persons' residential units within the hospital. It should be evident when an item discussed pertains specifically to the rehabilitation unit. Given the distinct differences in care philosophies between a rehabilitation unit and a residential unit for older persons, the language used should reflect the relevant services to maintain this distinction. Nonetheless, the minutes reflected a strong and clear commitment to quality and safety for people using services in the hospital. Additionally, ensuring that actions from governance meetings are consistently time-bound will further strengthen the hospital's governance framework.

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.

At the time of inspection, management arrangements were in place in the hospital to support the delivery of safe and reliable healthcare in the rehabilitation unit, which inspectors found were functioning well.

The management arrangements in place for the rehabilitation unit in relation to the four areas of known harm were as follows:

Infection Prevention and Control (IPC)

The hospital had two infection prevention and control link practitioners who provided guidance and training to hospital staff on matters concerning infection prevention and control. These link practitioners attended meetings of the CHO 1 infection prevention and control team every six weeks, sharing learning from audits across the services. The infection prevention and control team at CHO 1 level included a clinical nurse specialist as a dedicated resource available to Sligo and Leitrim OPS.

Management at the hospital had recently introduced a cloud-based digital quality management system to help monitor and measure care quality, drive improvement, and support quality assurance. Training was provided to staff in the rehabilitation unit on its use. Audit reports were reviewed by the DON and the ADON for infection prevention and control in CHO 1, who had oversight of the reports with a focus on developing and implementing resulting quality improvement plans. Nursing staff on the ward confirmed supportive and collaborative links with the infection prevention and control team.

Medication safety

A clinical pharmacy service was provided to the hospital, led by a pharmacist (Chief II) based in SUH, who attended the hospital one day per week. The pharmacist was supported by visiting pharmacy technicians from SUH two days per week. Medications were delivered to the pharmacy daily from SUH and stored in the dispensing pharmacy under the oversight of a dispensing pharmacist. The pharmacist conducted medication reconciliation for all patients and oversaw the medication safety audits. Pharmacy services, such as reviewing the supply of medications and highlighting any clinical pharmacy issues to the pharmacist, were supported by the pharmacy technicians.

Deteriorating Patient

Medical and nursing staff in the rehabilitation unit outlined key measures employed for the identification and management of deteriorating patients as follows:

- Monitoring for changes against baseline assessments documented on the admission documentation, including signs of infection or delirium
- Daily vital signs monitoring and clinical judgment
- Liaising with medical staff using 'Identify, Situation, Background, Assessment and Recommendation' (ISBAR) to communicate concerns
- Clinical patient reviews by either the consultant, NCHD, or medical officer on-call at the request of nursing staff for any patient
- Transfer via ambulance to either the acute medical assessment unit or the emergency department in Sligo University Hospital based on the level of deterioration as assessed clinically

- Inclusion of a 'safety alert form' in the documentation accompanying the patient to support safe transfer.

Management, medical and nursing staff were consistent in their knowledge about the response to a deteriorating patient and reported no issues in transferring patients to SUH when necessary. Documentation reviewed by inspectors confirmed that management at the hospital were tracking data on patient discharges, including transfers back to Sligo University Hospital.

Management on the ward informed inspectors of in-person and online training provided to staff in the unit related to the deteriorating patient, which commenced in January 2025. Inspectors were told that the onsite training was provided by the Centre for Nursing and Midwifery Education (CNME) and was supplemented by staff completing the online Irish National Early Warning System (INEWS) training modules on HSeLanD. Inspectors noted the discussion of the deteriorating patient training for staff in the minutes of the ward meetings reviewed.

Transitions of care

Inspectors reviewed documentation and spoke with management in the rehabilitation unit and from CHO 1 regarding safe transitions of care. It was evident that robust management arrangements to ensure effective transitions of care had been implemented in the hospital. Admitted patients had access to a multidisciplinary team, including consultants and NCHDs, nursing staff, physiotherapists, a dietician, speech and language therapy, occupational therapy and medical social worker services. All admissions were consultant-led and planned in advance. The majority of patients were admitted from SUH, with smaller numbers of patients admitted from the National Rehabilitation Hospital, home or community facilities.

All admissions were discussed in advance with the team in the rehabilitation unit to ensure they met the criteria for admission and that a patient's maximum potential could be met. Patients admitted from SUH were either already under the care of one of the two consultant geriatricians or had been assessed and accepted by them for admission to the rehabilitation unit. Admissions from home were coordinated through the GP and accepted by one of the consultants. Patients from other hospitals or community facilities were assessed in advance to ensure they met the criteria for the rehabilitation unit.

A clinical handover form, following the ISBAR format, supported the admission process, and all necessary documentation was provided. For example, home admissions included a medication prescription, discharge letter from the previous hospital, GP letter, and a public health nurse letter. SUH admissions included a completed drug kardex, nursing transfer letter, safety alert form and the full medical chart. Admissions from other community facilities or hospitals included a discharge letter, prescription, nursing transfer letter and relevant reports such as speech and language or occupational therapy.

The DON collaborated daily with the discharge liaison coordinator for OPS (Sligo and Leitrim) to facilitate discharge planning, admissions, and transfers. The discharge liaison coordinator had strategic involvement in committees and forums related to transitions of care, including the Delayed Transfer of Care (DTOC) meetings and the Unscheduled Patient Pathway Group in SUH, and with the home support services. Additionally, the discharge liaison coordinator worked closely with the discharge coordinator at SUH.

Staff at the hospital maintained ongoing liaison with home support services to ensure timely applications for safe discharge planning. The discharge liaison coordinator and the DON employed a patient-centred approach to discharge planning, supporting patients and their families in identifying the most appropriate placement and progressing the appropriate route for discharge, the majority of which were to home. Weekly home support governance meetings were chaired by the service manager for OPS.

Inspectors were informed by staff in the hospital and management at CHO 1 that every patient was assigned a predicted date of discharge (PDD) upon admission to the rehabilitation unit. The rehabilitation unit updated their 'bed app' daily by 9:00am to manage discharges and admissions efficiently. Inspectors were informed that the hospital typically maintained a bed occupancy rate in excess of 90%, which was confirmed in the documentation reviewed during the inspection.

Overall, the management arrangements in place demonstrated a commitment to maintaining high standards of care and ensuring patient safety.

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.

Management and staff at the hospital and at CHO 1 level had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety, and reliability of the healthcare services provided, relevant to the size and scope of the hospital.

Monitoring service performance

Staff in the hospital, in collaboration with CHO 1, systematically collected data on a range of clinical metrics related to the quality and safety of healthcare services provided. This included the number and source of admissions, the number and destination of discharges, including transfers to acute hospitals, length of stay, patient safety incidents, infection prevention and control data, workforce statistics, and risks that could potentially impact service quality and safety. The collated performance data was reviewed during relevant

committee meetings, as outlined under National Standard 5.2, and at performance meetings held between staff at the hospital and CHO 1.

Risk management

Risks identified by staff on the ward were escalated through management in the hospital. Management at the hospital maintained a local risk register. Risks requiring oversight and management beyond the capacity of the hospital were escalated through appropriate channels in CHO 1. Risks on the hospital risk register related to infection prevention and control, medication safety, the deteriorating patient, transitions of care, and workforce were reviewed by inspectors. The risks included details such as the risk description, date of entry, owner, controls, risk rating, and review date. Inspectors were informed that the risk register was reviewed bi-monthly, and updated sooner if new risks were identified or if circumstances relevant to existing risks changed.

It was evident from meeting minutes reviewed at the hospital and CHO 1 level, as well as from discussions with staff on the ward, hospital management, and CHO 1 representatives, that there was a positive culture of risk identification and risk management. Risk management training was provided to hospital staff by the QPS advisor in CHO 1 and through online modules on HSeLanD. Both local and national risk management policies seen by inspectors supported the hospital's risk management processes.

Audit activity

The hospital had an annual audit schedule outlining the type of audit, frequency, completion dates, and the responsible person for each audit. For example, monthly audits were conducted on medication safety and transitions of care, including admissions and discharges to and from the rehabilitation unit. Infection prevention and control audits included monthly environmental, patient equipment and hand hygiene compliance audits. It was clear from speaking with staff on the ward that they were engaged with the auditing process, and the findings from audits requiring improvement were discussed at ward meetings. Actions to address these findings were implemented within the relevant area, supporting continuous quality improvement.

Management of patient safety incidents

Incidents occurring in the rehabilitation unit were logged on the National Incident Management System (NIMS) in line with the HSE's Incident Management Framework. Incidents were reviewed and discussed at governance meetings in the hospital and at CHO 1 level, as evidenced by minutes reviewed by inspectors. Feedback on incidents was provided to staff at weekly and monthly governance meetings.

The process for reporting and managing different categories of incidents in the rehabilitation unit was supported by reference guides and flow charts seen by inspectors. Incidents categorised as major or extreme (category 1) or Serious Reportable Events

(SRE) were escalated to the CHO 1 Serious Incident Management Team (SIMT). One incident in 2024 was escalated to SIMT and closed out in July 2024, as evidenced by SIMT minutes reviewed by inspectors. The minutes also confirmed that recommendations from incident outcomes discussed at the SIMT were uploaded to a 'recommendations app'. Management at CHO 1 informed inspectors that these recommendations were assigned to a responsible person for implementation and were time-bound.

Feedback from people using the service

The hospital had several mechanisms in place to gather feedback from people using the service. A suggestion box was available on the ward, allowing patients and visitors to provide anonymous feedback. Additionally, HSE *Your Service Your Say* information leaflets were readily accessible, and posters outlining the process for making a complaint were clearly displayed. Results of a recent patient experience survey were also prominently displayed on the ward, demonstrating the hospital's commitment to transparency and continuous improvement based on patient feedback.

Overall, the hospital had systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety, and reliability of healthcare services, reflected in effective risk management processes, regular audits, and robust feedback mechanisms.

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.

Management at the hospital informed inspectors that the approved staffing complement for the rehabilitation unit was 37.4 whole-time equivalents (WTEs). Of these, 32.4 WTE posts were filled, with a further five WTE staff on various types of leave. This comprised four WTE nursing staff and one WTE healthcare assistant (HCA). The use of agency staff to cover shortages due to long-term leave was approved and effectively utilised for both nursing and HCA cover. Additionally, management assured inspectors that the rehabilitation unit maintains safe staffing levels through cross-cover from staff in the hospital's residential units if and when required. A review of the previous four weeks' rosters confirmed alignment with this information.

Management at the hospital and CHO 1 also outlined an ongoing initiative to address short-term sick leave rates within the rehabilitation unit. Inspectors noted anecdotal improvements, though official results were not yet available as the initiative was still in progress.

Management at the hospital and at CHO 1 outlined to inspectors the process of escalating issues related to workforce and workforce planning via the service manager for older persons (Sligo and Leitrim). Risks related to workforce were recorded on the risk register and were discussed at the monthly governance meeting. Absence templates were returned monthly to the service manager.

The clinical pharmacy service was provided by a 0.2 WTE pharmacist (Chief II) who worked one day a week in the hospital. There was no cover for this service during periods of absence or leave. A risk register entry highlighted the lack of cover for the pharmacist during periods of annual leave or other absences, noting the potential for medication errors and patient harm. It included an action to request cover from the Sligo University Hospital (SUH) pharmacy department. Inspectors were informed by management at the hospital that the request had been actioned and a response was awaited. The service was supported by visiting pharmacy technicians two days per week from SUH and a dispensing pharmacist.

The hospital's medical cover was provided by 0.4 WTE posts shared equally (0.2 WTE each) between two consultant geriatricians from SUH. Each consultant visited the hospital for patient rounds one day per week, and an NCHD visited the hospital daily from SUH. Out-of-hours and on-call arrangements were in place through a 0.4 WTE medical officer, whose service was covered during periods of leave or absence.

Staff Training and Education

Hospital staff, including nursing and health and social care professionals (HSCPs), had their attendance at mandatory and essential training monitored by the DON. The DON had systems in place to monitor and record attendance. Mandatory training programmes included infection prevention and control, basic life support, medication safety, deteriorating patient management, clinical handover, complaints management and positive behaviour support.

Training records reviewed indicated high levels of compliance with mandatory and essential training for all staff at the hospital, with few exceptions. Attendance at infection prevention and control training was recorded at 100% for nursing staff, healthcare assistants, and HSCPs, and at 87.5% for medical staff. Basic life support training attendance was also recorded at 100% for nursing staff, HCAs, and HSCPs, and at 68% for medical staff. Clinical handover training was attended by 50% of nursing staff. Complaints management training was attended by 100% of nursing staff, HCAs, and HSCPs.

Theoretical components of infection prevention and control and medication management were delivered on HSeLanD[***], with face-to-face training provided by the CHO 1 infection prevention and control antimicrobial stewardship team. An antimicrobial pharmacist, part of

[***] HSeLanD is the HSE's online learning portal, offering eLearning courses, CPD resources, and training materials for health and social care staff.

the CHO 1 infection prevention and control antimicrobial stewardship team, delivered training on antimicrobial stewardship to staff in the hospital.

Employee Supports

Staff in the hospital had access to a staff welfare officer, occupational health services, and the HSE employee assistance programme (EAP). Management informed inspectors that staff could access these programmes by self-referral or be referred by management, although there were no information posters seen in the hospital informing staff of how to access the EAP.

Inspectors reviewed a report of a staff satisfaction survey conducted in January 2025. The survey reported high levels of job satisfaction, with 82% of staff very satisfied with their roles and 73% optimistic about their future in the organisation. Key strengths included effective communication, clarity of roles, and strong support from management. Additionally, 91% of staff reported that they would recommend the organisation as an employer. Notably, 73% of staff reported feeling encouraged to report errors, near misses, and incidents, with 82% agreeing they had clear guidance on reporting. These findings were consistent with the positive feedback inspectors received from staff on the ward. The report indicated that an action plan would be developed to address these findings, with a follow-up survey planned in six months.

In summary, the hospital effectively managed staffing levels despite temporary vacancies, ensuring continuity of care through the use of agency staff. High compliance with mandatory training was observed for most programmes, supported by robust monitoring systems. However, areas for improvement were identified in attendance at some mandatory training sessions, such as clinical handover for nursing staff, and basic life support for medical staff. In addition, while employee support mechanisms were in place, visibility of information on how to access these supports could be improved. The absence of cover for the clinical pharmacy service during periods of leave was noted as a potential risk. Overall, the hospital demonstrated commitment to workforce planning and management practices.

Judgment: Substantially compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. Inspection findings in relation to the quality and safety dimension are presented

under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support.

The Benbulben Rehabilitation Unit at St John's Community Hospital was found to be substantially compliant with NS 1.6, 2.7, 2.8 and 3.1, and compliant with NS 1.7, 1.8 and 3.3.

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

During the inspection, several measures were observed that ensured the dignity, privacy, and autonomy of service users, consistent with HIQA's human rights-based approach to care.

Staff on the ward informed inspectors that patient confidentiality was maintained in accordance with the General Data Protection Regulation[†††] (GDPR). The hospital maintained a policy on records management, reviewed by inspectors, that covered best practices and legal requirements for creating, accessing, retaining, and destroying records, ensuring data privacy, confidentiality, and regulatory compliance.

Patient needs were assessed at the referral stage to ensure appropriate accommodation, including gender-specific bays and access to bathrooms. Privacy was maintained using curtains, and patients' personal items were carefully managed. Care was patient-centred, addressing individual needs such as continence care and emotional support.

Every patient had access to a call-bell, and staff were observed responding promptly when patients used the system. Inspectors were informed that interpreters and telephonic translators were used to support patients with language barriers.

The physical environment promoted dignity, privacy, and autonomy, with spacious and tidy rooms that were visibly clean. Personal information was handled discreetly, with patients' names covered on the 'patient at a glance' whiteboard. Colour codes were used over patients' beds to identify care needs such as dietary assistance, cognitive support and fall prevention.

Patients' privacy was protected during personal care activities by drawing curtains when needed. Patients' photographs were taken on admission and placed on their records with their consent. Although patients' names were also displayed over their beds without explicit consent, inspectors were informed that there were no complaints about this practice.

[†††] General Data Protection Regulation is a European Union (EU) law that sets guidelines for the collection and processing of personal information from individuals within the EU and the European Economic Area.

Notwithstanding, management at the hospital should seek to assure themselves that patients have consented to this practice.

The hospital conducted patient experience surveys, with results displayed on the ward. Staff received positive behaviour support[‡‡‡] training to help identify and address issues patients may face due to life changes during rehabilitation. This training typically includes communication elements aligned with promoting dignity, privacy, and autonomy.

Overall, there was evidence that hospital management and staff were committed to respecting and promoting patients' dignity, privacy, and autonomy. This commitment was evident through respectful communication, secure handling of patient information, and the use of curtains and colour codes. However, the practice of displaying patients' names over their beds without explicit consent provides an opportunity for improvement.

Judgment: Substantially compliant

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

A culture of kindness was actively promoted by staff in the hospital, who were observed engaging meaningfully with patients in a kind, caring, and respectful manner.

One patient shared their enjoyment of a recent birthday celebration in the rehabilitation unit, while others spoke highly of their care experiences, with one noting that in the rehabilitation unit, "strangers become friends". The nursing admission documentation included a section to record 'Important people in my life', ensuring that patients' personal and emotional needs were acknowledged and respected. Photographs of patients enjoying the recent Christmas party were on display, and a patient commented on the "great entertainment at Christmas".

Patients had access to a large family room and meals could be served in a dining room located within the rehabilitation unit. Patients praised the variety and quality of the food, with one commenting, "I got choice every day here".

Patient information leaflets on various health topics, including 'We Care About Continence,' 'Mealtimes Matter,' and 'Safe Swallowing,' were readily available and accessible. Additionally, patient-friendly signage was observed outside various rooms on the rehabilitation unit, such as a picture representing a bathroom on display outside the

[‡‡‡] Positive Behaviour Support (PBS) training involves strategies to improve quality of life and reduce challenging behaviours by teaching new skills and enhancing communication, tailored to individual needs.

bathroom and a picture of a dining room on display outside the dining room, making them easy to identify.

Inspectors noted the availability of an equipped hair salon in the unit. Inspectors were told by staff on the ward that patients could hire private hairdressing or chiropody services, and were facilitated to attend dental appointments when needed.
Patients communicated confidently with staff, and reported feeling comfortable raising concerns, and were empowered to ask for help when needed. Inspectors spoke with numerous patients, all of whom expressed overall satisfaction with the staff, care and services provided. Staff on the ward reflected on compliments they received from patients, and multiple cards from patients complimenting staff for the care they received were observed on the ward. The large number of compliments received by the hospital was also acknowledged in the minutes of a meeting of the CHO 1 OPS quality and safety review committee.

The hospital had an onsite chapel offering weekly multi-denominational religious services, providing a peaceful environment for patients to spend quiet time and engage in personal reflection.

Inspectors observed HSE *Your Service Your Say* (YSYS) patient information leaflets and various posters detailing YSYS, complaints and compliments, patient advocacy services, and the identification of the hospital's complaints officer. All patients interviewed stated they would speak to a staff member if they needed to make a complaint.

Upon admission to the rehabilitation unit, all patients received a welcome pack, which included resources such as information on the Office of the Confidential Recipient,[§§§] Know Check Ask[****], SAGE Advocacy[††††] and a patient experience survey questionnaire.

In summary, the hospital promoted a culture of kindness, consideration, and respect, as evidenced by patient interactions, satisfaction, the availability of supportive resources, and initiatives to meet patient needs and preferences.

Judgment: Compliant

[§§§] The Office of the Confidential Recipient is a national free service that acts as an independent advocate for vulnerable adults with disabilities and older persons receiving various health services. Although appointed by the HSE, the Confidential Recipient operates independently to provide a confidential service for reporting concerns or making complaints.
[****] The 'Know, Check, Ask' campaign promotes safe medication use by encouraging patients to know their medications, check for accuracy, and ask questions if unsure
[††††] Sage Advocacy acts on behalf of older people who need support in fulfilling their wish to remain living in their own homes and communities.

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 DON reported complaints to the service manager for older persons in CHO 1 (Sligo and Leitrim), the designated complaints officer for the hospital. The rehabilitation unit fostered a culture of resolving complaints locally.

Inspectors reviewed the hospital's local complaints policy which was adapted from and aligned with the HSE *Your Service Your Say* complaints management policy. The policy also incorporated the national patient advocacy service, which provided support and guidance to any resident wishing to make a complaint.

Staff on the ward outlined the process for managing complaints locally and escalating them through line management. Management on the ward provided feedback from compliments and complaints and shared learning during safety pauses and at weekly and monthly ward meetings. Senior management in the hospital recorded and tracked complaints locally using an electronic spreadsheet. A review of the monthly minutes of the CHO 1 services for older persons (Sligo and Leitrim) quality and safety committee demonstrated that complaints were discussed here and at the quarterly CHO 1 OPS quality and safety review committee meetings.

In 2024, the hospital received two complaints, both resolved at 'stage one' point of contact. No 'stage two' complaints (a written complaint formally investigated by a complaints officer) were received in 2023, 2024, or year to date in 2025. The hospital tracked the small number of complaints received, which were related to communication. In response, the hospital provided staff with training on age-friendly communication. Additionally, several staff members were trained as age-friendly communication facilitators to provide ongoing updates.

During the inspection, posters and leaflets about *Your Service Your Say* and patient advocacy services were prominently displayed and easily accessible to patients throughout the hospital. Two suggestion boxes were located within the rehabilitation unit. The admission pack for new patients included comprehensive information on making and being supported to make a complaint.

In summary, the hospital effectively managed complaints through local resolution, staff training, and clear communication. Complaints were tracked and discussed at various committee meetings, ensuring continuous improvement. Information on complaints procedures was readily available to patients.

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.

During the inspection, the rehabilitation unit, which had been relocated to a newly renovated ward in February 2024, was visually clean, well-maintained and was spacious. The ward comprised a total of 19 beds, located across five three-bedded rooms and one four-bedded room, all with en-suite facilities. A large shower room with an overhead hoist system was located at the end of the ward.

At the time of inspection, there were no single rooms on the rehabilitation unit. This was identified as a risk on the hospital's risk register due to constraints in infection prevention and control and maintaining dignity during end-of-life care. Inspectors were informed that cohorting of patients was used if transmission-based precautions were required. Patients receiving end-of-life care were transferred to hospice care.

There were no specific actions recorded on the risk register to address the provision of single rooms or isolation facilities in the rehabilitation unit. Management in the hospital and at CHO 1 level explained that there was an expectation for the rehabilitation unit to eventually return to its original location within the hospital, which had single rooms. However, the timeframe or certainty of this move was not known.

Despite these challenges, both staff on the ward and management at the hospital outlined the policies and procedures that supported the delivery of high-quality, safe, and reliable care. These measures protected the health and welfare of service users within the current configuration of the rehabilitation unit.

There were no patients requiring isolation facilities at the time of inspection. However, staff at the hospital demonstrated knowledge of the indications for cohorting patients if transmission-based precautions were required.

Infection prevention and control signage related to transmission-based precautions was observed in the areas visited. This included point-of-care risk assessment posters on the ward walls, outlining a simple point-of-care risk assessment that healthcare professionals can carry out before each interaction with a patient.

All patient rooms on the rehabilitation unit were spacious, with physical distancing of greater than one metre observed between beds. There was no clutter or inappropriate storage of equipment observed on the ward. All hand hygiene sinks in clinical areas observed were compliant with Health Building Note[‡‡‡‡] (HBN) requirements and were stocked with non-antimicrobial soap. Alcohol-based hand sanitiser dispensers were

[‡‡‡‡] An HBN compliant sink is a sink that meets the standards outlined in Health Building Note (HBN) 00-10 Part C. These standards ensure the sink supports hygiene and infection control in healthcare settings through features like non-touch operation, integrated splashbacks, smooth surfaces, and efficient drainage.

strategically placed throughout the rehabilitation unit, accompanied by clearly visible hand hygiene signage.

Inspectors spoke with household staff responsible for environmental cleaning. Environmental cleaning schedules, checklists, and duty rosters were reviewed by inspectors. No gaps were identified. Bedside curtains were dated with the date of last change and were changed at six-monthly intervals or sooner if required. Healthcare assistants were responsible for equipment cleaning and outlined to inspectors the appropriate cleaning products used for equipment that was soiled or exposed to infection, as well as the process for managing a spillage. Equipment observed by inspectors, such as blood pressure monitors and the electrocardiogram (ECG) machine, contained no visible dirt or dust. A green tagging system and an equipment cleaning checklist were both used to identify patient equipment that had been cleaned.

Waste was managed and stored in line with hospital policy. Used and or soiled linen was stored appropriately. Alginate bags and colour-coded bags were used for laundry to safely contain soiled or contaminated items, minimising direct contact and reducing the risk of cross-contamination. Any laundry bags observed were no more than two-thirds full. The laundry bag policy was laminated and on display to guide and support staff. The 'dirty utility' room contained no inappropriate storage of clean or sterile items, and the bed-pan washer service tag was in date.

In summary, the rehabilitation unit appeared to be clean, spacious, and well-maintained, with strong infection prevention and control measures. However, the absence of single rooms remains a risk, impacting the unit's ability to fully support high-quality care and limiting access for patients needing isolation due to infection prevention and control reasons.

Judgment: Substantially compliant

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

Hospital management were actively and systematically monitoring, evaluating, and responding to information from multiple sources to drive improvements and provide assurances regarding the quality and safety of the services provided to patients. Inspectors spoke with staff in the hospital and at CHO 1 level and reviewed documentation in relation to the monitoring and evaluation of care and delivery of services in the hospital. The hospital had recently introduced an electronic quality management system which it used to manage audit and quality improvement planning. Monitoring in relation to the four key areas of harm (infection prevention and control,

medication safety, the deteriorating patient and transitions of care) which were the focus of this inspection are presented.

The hospital regularly audited infection prevention and control practices, encompassing the environment, equipment, and hand hygiene. Overall, compliance levels were high. Quality improvement plans were consistently formulated to address any identified deficits. For instance, an environmental audit conducted in early February 2025 initially scored 69% compliance. Following the implementation of an action plan and a subsequent re-audit in mid-February, the compliance score improved significantly to 95.8%.

Infection prevention and control and antimicrobial stewardship practices were monitored and reported to CHO 1. The hospital participated in the national *Skip the Dip*[§§§§] campaign, aimed at reducing inappropriate antibiotic prescribing driven by urine dipstick testing. This project involved education and workshops across older person services (OPS) which was delivered by the infection prevention and control team and an antimicrobial stewardship pharmacist. Management at the hospital and a CHO 1 level outlined details of the campaign to inspectors and a poster promoting the campaign was seen in the clinical area.

The campaign resulted in a downward trend in antibiotic consumption and a reduction in prophylactic antibiotic use (preventive use) through the promotion and adoption of best practices for assessing urinary tract infections (UTIs). Inspectors reviewed the 'Monthly Monitoring of HCAI/AMR/Antibiotic Consumption in HSE RCFs for Older Persons' dashboard report for 2024. It reported that the proportion of patients in the Benbulben Rehabilitation Unit taking antibiotics for the treatment of a UTI was consistent with the national average, and lower than the CHO 1 average. Additionally, the proportion of patients in the rehabilitation unit taking antibiotics for the prophylaxis (prevention) of a UTI was significantly lower than both the national and CHO 1 averages, with no patients recorded on prophylactic antibiotics since March 2024. The rehabilitation unit did not record any cases of *Clostridium difficile* (*C. difficile* or carbapenemase-producing *Enterobacterales*[*****] (CPE) infection in 2024. These findings are commendable and suggest a strong commitment to infection prevention and control and antimicrobial stewardship practices by staff in the rehabilitation unit.

Staff at the hospital demonstrated a culture of monitoring and evaluating medication safety. Audits related to medication safety were seen by inspectors including those conducted at transfers of care involving discharge prescriptions and medication reconciliation, as well as audits of controlled drugs and medication administration.

[§§§§] The 'Skip the Dip' campaign promotes best practices for assessing UTIs in people aged 65+ in care facilities. It highlights that not using antibiotics for bacteria in urine without symptoms is safe and helps prevent antibiotic resistance, based on best-practice guidelines and evidence.
[*****] CPE are a type of superbug. These are bugs that are resistant to many antibiotics. This means that some antibiotics that were used to treat them no longer work very well.

For example, in November 2024, a three-month follow-up audit was conducted to assess the management of Misuse of Drugs Act[†††††] (MDA) Schedule 2 medicines. The audit revealed five instances of compliance and four instances of non-compliance. The non-compliances were related to the receipt of medicines (one instance), administration (two instances), and stock balance checks (one instance). A quality improvement plan was developed to address all identified non-compliances, however it was not time-bound and did not have a responsible person assigned.

Another medication safety audit conducted in November 2024 and reviewed by inspectors examined the safety checks performed both prior to the administration of medication and during the administration of medication. The audit demonstrated a compliance score of 92% for Section A (prior to administration) and 100% for Section B (during the administration). A quality improvement plan was developed to address the 92% score in Section A, with the identified item assigned to a responsible person and given a time-bound deadline.

Inspectors were informed by the lead for pharmacy in the hospital that learning from audits was shared with NCHDs via feedback to consultants, and to nursing staff via feedback to the CNMs on the ward.

In relation to the deteriorating patient, inspectors reviewed a quality improvement plan focused on the screening, assessment, and management of delirium. Delirium often presents as confusion, disorientation, and difficulty focusing. It is common among older adult patients and those with underlying conditions. Monitoring delirium is important as it can indicate issues like infections or medication side effects. Early detection and management can prevent complications, reduce hospital stays, and improve patient outcomes. The documentation submitted for this quality improvement plan included a staff survey evaluating knowledge of delirium and the tools used for its assessment. Additionally, it featured an audit of the screening, assessment, and management of delirium in the rehabilitation unit. The plan also included a copy of the '4AT Delirium Screening Tool', and the minutes from the December 2024 delirium project meeting.

The minutes from the quality improvement meeting were notably action-oriented, detailing responsible persons and time-bound deadlines to progress and deliver the project. Key topics discussed included the governance of the quality improvement project, review of documentation, education sessions, screening tools and signage for delirium.

On the rehabilitation unit, inspectors also observed a poster related to the quality improvement plan displayed on a quality board with the acronym 'PINCHME' (pain, infection, nutrition, constipation, hydration, medication, environment). This served as a

[†††††] MDA Schedule 2 medicines are controlled substances regulated under the Misuse of Drugs Act. These medications are strictly regulated to ensure they are prescribed and administered safely, and their management involves stringent record-keeping, secure storage, and regular audits to prevent misuse and diversion.

guide to healthcare professionals to identify and address common reversible causes of delirium. It was evident from engaging with hospital staff, including medical, nursing and pharmacy, and management in the hospital and at CHO 1 level that the project was multidisciplinary in nature. The staff demonstrated a clear understanding and active involvement in the quality improvement plan, reflecting a committed effort to enhance the screening, assessment, and management of delirium within the hospital. Inspectors noted that the quality improvement plan was in progress at the time of the inspection and were informed that management in the hospital planned to audit its outcomes after a period of implementation.

Management at the hospital had been actively monitoring and evaluating transitions of care, focusing on areas such as bed occupancy rates, length of stay, discharge planning, and the admission processes. Bed occupancy rates for the 19 available beds were consistently high, with rates of 97.2% in November 2024, 98.3% in December 2024, and 95.08% in January 2025, indicating effective use of resources and bed management. Management at the hospital and at CHO 1 informed inspectors that improvements in delayed discharges had been realised since moving to the fully consultant-led bed unit in January 2024.

A review of the length of stay records from August 2024 to January 2025 showed monthly variations, with an overall average of 31.41 days.

The discharge planning process audit conducted in January 2025, which reviewed five patient discharges over the previous three months, revealed that 80% of records audited had a predicted date of discharge (PDD) documented. However, the report indicated that three out of the five PDDs were not met due to several reasons. While some of these reasons were beyond the control of hospital management, such as incomplete building works at a patient's home, others included a delay in processing a home care package and additional home support not being in place. These delays resulted in patients spending an additional seven to 19 days in the rehabilitation unit. A time-bound quality improvement plan was developed to address the delays, although it lacked a designated responsible person. Ongoing monitoring and evaluation of actions to improve timely discharges are commendable given the impact of delayed discharges on patients access to care in both the acute facility and the rehabilitation unit.

Audits of the admission process in January and February 2025 demonstrated 100% compliance across key areas, including documentation, medication safety, and healthcare-associated infections. However, an issue with an undated prescription chart was identified and addressed through a quality improvement plan with a time-bound deadline and an assigned responsible person.

It was evident that management at the hospital maintained oversight of the audits and the implementation of action plans. Quality improvement plans, audit results, corresponding actions and learnings were discussed at ward and management meetings. Recommendations and actions were developed when any non-compliances were

identified. Most but not all actions were time bound and assigned to a responsible person for completion.

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 rehabilitation unit had systems in place to identify and manage risks. Risks in relation to the service were recorded on a local risk register and reviewed at least bi-monthly, or sooner if required. Local risk management was overseen by the DON. Although risk management did not appear as an item on the agendas in minutes of local weekly and monthly performance meetings, discussions with ward management revealed familiarity with the risk register and risk management processes. Inspectors were informed by members of the management team at the hospital and at CHO 1 level that risks that could not be managed at local level were escalated to the service manager for older persons services in Sligo and Leitrim. Evidence from minutes of the monthly Sligo and Leitrim CHO 1 services for older persons quality and safety committee meetings and quarterly CHO 1 OPS quality and safety review committee meetings confirmed that risks and risk management were discussed.

Infection prevention and control

Patients being admitted to the hospital were not routinely tested for multi-drug resistant organisms (MDRO) or transmissible infections. However, a screening process was in place. This process involved collecting the patient's infection status from the discharging facility using a healthcare-associated infection (HCAI) and MDRO surveillance form, which was reviewed by inspectors. Patients' healthcare records reviewed by inspectors confirmed this.

For patients being admitted from Sligo University Hospital (SUH), there was frequent communication with the discharge coordinator and bed management team regarding the infection status of all patients prior to admission. Additionally, the infection prevention and control link practitioner, supported by infection prevention and control staff, including the CNS and ADON in infection prevention and control at CHO 1, provided further support as needed.

As outlined in national standard 2.7, the rehabilitation unit did not have any single rooms for isolation of patients with a confirmed or suspected transmissible infection. Inspectors were informed that if a patient developed signs or symptoms of infection, testing would be initiated, and the entire room was cohorted as an isolation area until test results were negative or the infection was resolved.

Inspectors observed that adequate supplies of personal protective equipment were available to staff as needed, and patients had access to face coverings if they chose to wear them.

The environment and patient equipment was visually clean with no dirt or dust observed. Cleaning checklists and a green tagging system both supported the identification of areas and items that had been cleaned.

Documentation was reviewed, and staff on the rehabilitation unit and at CHO 1 level outlined the processes for identifying, reporting and managing infection outbreaks. Staff in the rehabilitation unit were guided by national infection prevention and control policies. Inspectors were informed of three COVID-19 outbreaks that occurred in the rehabilitation unit in 2024. Patients were cohorted in each instance. None of the outbreaks resulted in onward transmission. This was confirmed in the minutes of infection prevention and control committee meetings, along with evidence of discussions and sharing of learnings from outbreaks in relevant CHO 1 meetings and at ward level. An outbreak report from a COVID-19 outbreak in December 2024 was reviewed, which comprehensively detailed the outbreak, its outcomes for patients, involvement of stakeholders including the infection prevention and control team, public health, cleaning staff, and a risk review with follow-up actions clearly outlined.

Medication safety

Medications in the rehabilitation unit were securely stored in locked drug cupboards within a room accessed by a key code. Inspectors confirmed that medicine information was readily available at the point of prescribing and administration. Although one current edition of the British National Formulary was available, two outdated copies were also observed on the medicine trolleys. This was brought to the attention of the ward manager. Additionally, an open bottle of patient antibiotic eye drops was found in the fridge without a patient label, although staff on the ward indicated that there was only one patient on the ward at that time who was prescribed these drops. Medications designated for single-patient use should be clearly labelled with the patient's identifiers, the date of opening and expiration period to ensure safe care. Medicines in the fridge were otherwise stored appropriately, and records reviewed by inspectors confirmed that temperature checks were conducted at scheduled intervals.

Safe medication practices were observed during the medication round, including staff wearing red aprons to signal that they should not be interrupted, thereby reducing the risk of medication errors. A patient with a known allergy was observed wearing an allergy alert bracelet. Posters supporting safe medication practices were displayed in the drug room, which included two posters related to antimicrobial guidance and intravenous drug administration.

The hospital maintained a list of high-risk medications and displayed an A-PINCH (antimicrobials, potassium, insulin, narcotics, chemotherapy, and heparin) poster to

highlight these to staff. Nursing staff described the use of various risk reduction strategies for these high-risk medications. Additionally, the hospital had a list of 'sound-alike, look-alike' (SALADs) medications to help prevent medication errors.

Inspectors were informed by both the lead pharmacy representative and nursing staff about the medication reconciliation process carried out for all patient admissions and discharges in the rehabilitation unit. On admission, nursing staff conducted the initial medication reconciliation against three sources, including the transfer letter and the prescription or drug kardex for patients from SUH. Additionally, NCHDs checked patient medications, and the pharmacist conducted medication reconciliation for all new admissions and discharges on Fridays.

Deteriorating patient

Nursing and medical staff described the process for recognising and managing a deteriorating patient. Baseline observations were recorded for all patients on admission and monitored daily. Staff indicated that if there was clinical judgment or suspicion of deterioration from a patient's baseline, the NCHD or consultant was contacted for a patient review. Out-of-hours, the medical officer was contacted, or if nursing staff were concerned about the patient's condition, they would call an ambulance to transfer the patient to SUH. Documentation and staff discussions provided evidence of the introduction of the ISBAR tool which was used by nursing staff to communicate patient concerns to medical staff. At the time of inspection, management were in the process of implementing an early warning system to enhance monitoring and response to deterioration, with staff undergoing training in its use.

As outlined under national standard 2.8, in response to the risk of deterioration associated with delirium, inspectors reviewed a quality improvement plan focused on the screening, assessment, and management of delirium. The plan included a staff survey, an audit and the use of the 4AT Delirium Screening Tool. Inspectors observed a poster detailing the PINCHME acronym (pain, infection, nutrition, constipation, hydration, medication, environment) on display in the clinical area, which supports staff in identifying and managing potential causes of delirium. The project was ongoing and inspectors were told that management planned to audit outcomes after a period of implementation.

Transitions of care

The hospital had systems in place to minimise the risk of harm during patient transfers within and between healthcare services, and to support safe discharge planning.

Staff on the ward and management at the hospital and CHO 1 clearly articulated the process for admissions and discharges to and from the hospital with established criteria. Admissions were planned to support optimal patient outcomes, using detailed handover forms and comprehensive documentation. The DON and the discharge liaison coordinator

worked together to facilitate patient-centred discharge planning and transitions of care, maintaining effective collaboration with home support services and relevant committees.

A clinical handover form used at shift handover, observed by inspectors, was based on the ISBAR format. Staff on the ward explained that the ISBAR format was also utilised when communicating clinical details of patients to other team members by telephone. However, inspectors were informed that the use of ISBAR was not audited.

The transfer of patients back to the acute setting was supported by use of a 'safety alert form,' which was reviewed by inspectors. Nursing staff indicated that the form highlights key patient risks during transfer, ensuring critical safety concerns such as falls risk, sensory or communication difficulties, cognitive impairment and allergies, are immediately visible to the receiving team. This, along with the patient's full chart and notes, supported safe transitions of care, enabling timely and informed clinical decision-making.

Policies, procedures, protocols and guidelines (PPPGs)

Inspectors reviewed a variety of PPPGs that supported staff in delivering safe care within the rehabilitation unit. Regional and national policies were utilised where available, including those for infection prevention and control, incident management, and risk management. Local policies, such as the complaints policy, incorporated the national HSE *Your Service Your Say* policy, and the rehabilitation unit admission protocol and discharge policy was used in conjunction with the HSE *Integrated Care Guidance: A practical guide to discharge and transfer from hospital*.

Documents were tracked using version control, and the DON monitored PPPGs due for revision. All policies reviewed were current and up-to-date. The update, revision, and approval of multi-disciplinary local or community-wide policies were coordinated by the practice development coordinator for CHO 1 Sligo and Leitrim, along with the service manager for CHO 1.

In summary, the rehabilitation unit had effective systems for risk management, infection prevention and control, medication safety, the deteriorating patient, and safe transitions of care. Comprehensive infection outbreak reports with shared learning and the quality improvement plan on delirium demonstrated proactive approaches to patient safety. Processes for managing deteriorating patients and transitions of care were in place, though areas for improvement include the lack of auditing for ISBAR usage, and labelling of single-patient-use medication in the fridge. Overall, the hospital showed dedication to safeguarding service users from risks associated with healthcare delivery.

Judgment: Substantially compliant

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

The hospital had patient safety incident management systems in place to identify, report, manage, and respond to patient safety incidents in line with national legislation, policy and guidelines. Nursing staff on the ward and management at CHO 1 level informed inspectors that a National Incident Report Form (NIRF) was completed at the point of occurrence of an incident. The NIRF was then reviewed by the DON or ADON to review actions and ensure its completion before a clerical officer in the hospital input the report into the national incident management system (NIMS).

In 2024, there were a total of 114 incidents reported in the rehabilitation unit. This included one major or extreme (category 1) Serious Reportable Event (SRE), which was discussed at the Serious Incident Management Team (SIMT) and subsequently closed. The remaining incidents comprised one moderate (category 2) and 112 minor or negligible (category 3) incidents.

The incidents were trended and included categories such as medication, virus, slips, trips, falls, and injuries like grazes, bruises, and cuts. Inspectors were informed that the hospital responded to trends observed in incidents. For example, inspectors were told that communication issues were identified and addressed by instituting 'age-friendly communication' training for staff, which was also recorded in the meeting minutes reviewed by inspectors.

Inspectors also reviewed the last three quarterly OPS CHO 1 quality & patient safety service manager reports for 2024, covering the periods from April to December 2024. The reports contained reviews of monthly safety incidents, including serious incidents (SIs) and SRE's, safeguarding incidents, acquired infections and complaints. For any issues arising, an action table was developed and recommendations were listed. For example, in relation to a medication error in May 2024, the actions taken included reviewing and discussing the medication error with staff, completing individual reflection following the incident, completing medication management training on HSeLanD and facilitating medication information sessions on-site by the pharmacist.

The data reported for 2024, submitted to HIQA, included the percentage of reported incidents entered onto the NIMS within 30 days of notification. The HSE key performance indicator (KPI) is 70%. The actual figure for the rehabilitation unit in 2024 in was 43%. This was discussed with hospital management who explained that the delay in reporting incidents to NIMS was due to a staff absence. Inspectors were informed that the staffing issue had since been resolved and an additional member of staff had been trained to prevent a recurrence of delayed reporting. Inspectors reviewed documentation confirming that the reporting of incidents to NIMS within 30 days had improved to 71% by December 2024 and had reached 100% for January 2025.

Overall, staff in the rehabilitation unit effectively identified, managed, and responded to patient safety incidents.
Judgment: Compliant

Conclusion

HIQA carried out an announced inspection of the Benbulben Rehabilitation Unit at St John's Community Hospital to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare*. The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient, and transitions of care.

Overall, the hospital was judged to be:

- Compliant with five national standards (5.5, 5.8, 1.7, 1.8, 3.3)
- Substantially compliant with six national standards (5.2, 6.1, 1.6, 2.7, 2.8, 3.1)

Capacity & Capability

The hospital demonstrated strong governance arrangements with well-defined reporting lines and accountability mechanisms, supported by regular, action-oriented governance meetings. However, there were opportunities to enhance the clarity of meeting minutes and ensure time-bound actions from governance meetings. Management arrangements were effective, reflecting a commitment to maintaining high standards of care and patient safety. Systematic monitoring arrangements were in place, with effective risk management processes, regular audits, and robust feedback mechanisms. Workforce planning and management practices were generally effective, despite five WTE members of staff being on long-term leave. High levels of compliance with attendance at most mandatory training programmes was observed. Areas for improvement included attendance at some mandatory training and visibility of employee support mechanisms.

Quality & Safety

The hospital was committed to respecting and promoting patients' dignity, privacy, and autonomy, with respectful communication and secure handling of patient information. Nonetheless, there are opportunities to enhance privacy measures in patient identification practices. A culture of kindness, consideration, and respect was evident, supported by patient interactions and satisfaction. Complaints were managed effectively, with clear communication and continuous improvement processes in place. The physical environment of the rehabilitation unit was clean, spacious, and well-maintained, though the absence of single rooms posed a risk for infection prevention and control. The effectiveness of

healthcare was systematically monitored and continuously improved, with oversight of audits and implementation of action plans. Effective systems for risk management, infection prevention and control, medication safety, the deteriorating patient, and safe transitions of care were in place, though areas for improvement included auditing ISBAR usage and labelling of single-patient-use medication in the fridge. Efforts to address delayed discharges and improve timely discharges were noted. Patient safety incidents were effectively identified, managed, and responded to by staff.

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

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the 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
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.	Substantially compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient safety incidents.	Compliant