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

Name of healthcare service provider:	Peamount Healthcare
Address of healthcare service:	Newcastle Road Newcastle Co. Dublin D22 Y008
Type of inspection:	Announced Inspection
Date(s) of inspection:	27-28 August 2024
Healthcare Service ID:	OSV-0007266
Fieldwork ID:	NS_0092

About the healthcare service

Peamount Healthcare is an independent voluntary organisation funded under Section 38 of the Health Act 2007 (as amended). The organisation is governed and led by a Board of Directors and provides healthcare services on behalf of the Health Service Executive (HSE). This arrangement is formalised in a service level agreement and involves formal reporting arrangements to the general manager of the community healthcare organisation 7 (CHO 7) and the chief executive officer (CEO) of the Dublin Midlands Hospital Group (DMHG). At the time of inspection, six new regional health areas were being established by the HSE and as part of that process, the CHO 7 and DMHG were to be realigned into HSE Dublin and Midlands's health region. The organisation also comprises designated centres in intellectual and disability services and older person services.

This inspection focused on the rehabilitation services provided by the organisation.

Number of beds	Rehabilitation services comprise 100 inpatient beds: -50 age related rehabilitation beds -25 respiratory rehabilitation beds -15 neurological rehabilitation beds -10 rheumatology rehabilitation beds.

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors* reviewed information which included any previous inspection findings, information submitted by the service provider, unsolicited information and other publically available information since HIQA's last inspection in 2020.

During the inspection, the inspectors:

- spoke with people who used the rehabilitation healthcare services in two rehabilitation units to ascertain their experiences of receiving care and treatment

*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.

- spoke with staff and management to find out how they planned, delivered and monitored the rehabilitation services provided to people who received care and treatment in Peamount Healthcare
- observed care being delivered, interactions with people who used the rehabilitation services 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 11 national standards monitored during the inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

A full list of the 11 national standards assessed as part of the 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
26 August 2024	13:20-18:00hrs	Cathy Sexton	Lead
		Denise Lawler	Support
27 August 2024	08:45-15:00hrs	Robert Mc Conkey	Support

Information about this inspection

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

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

The inspection team visited two clinical areas:

- Age Related Rehabilitation Unit (ARRU) (a 50-bedded unit for patients over 65 years of age requiring rehabilitation care)
- Respiratory Rehabilitation Unit (RRU) (a 25-bedded unit for patients with respiratory disease).

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

- Representatives of the hospital's Executive Management Team (EMT)
  - Director of Rehabilitation Services
  - Director of Nursing and Social Services (DON)
  - Clinical Lead
- Quality and Continuous Improvement Manager
- Lead Representative for the Non-Consultant Hospital Doctors (NCHDs)
- Interim Human Resource Manager
- A representative from the:
  - Infection Prevention and Control Committee
  - Drugs and Therapeutics Committee
  - Complaint Officer
  - Patient Flow Manager.

Acknowledgements

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

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

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

Throughout the inspection, the inspectors spoke with patients and observed how staff actively engaged with patients in a respectful, kind manner and ensured patients' needs were promptly addressed. Patients receiving care in ARRU and RRU who spoke with inspectors described their experiences as "*a good experience*" and the care "*was very good, staff were kind and caring* "and "*very helpful*". Inspectors observed effective communication used by staff when interacting with patients. Staff engaged in a positive manner with patients, patient's relatives and with other staff. Patients told inspectors they did not receive information on how to make a complaint, but said if they wanted to raise an issue or make a complaint they would speak with a staff member. The inspectors observed information leaflets on how to make a complaint available at the entrance to ARRU and RRU.

Capacity and Capability Dimension

Inspection findings related to the capacity and capability dimension are presented under four national standards from the themes of leadership, governance and management and workforce. The service were found to be compliant with three national standards (5.2, 5.5 and 5.8) and substantially complaint with one national standard (6.1) assessed. Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

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

Peamount Healthcare had robust corporate and clinical governance arrangements in place to assure the delivery of safe, high-quality rehabilitation services in ARRU and RRU. Decision-making, responsibility and accountability about the delivery of rehabilitation services was devolved to senior managers who had a clear understanding of their reporting arrangements. These reporting arrangements were integrated, clearly defined and formalised in the hospitals organisational charts. The governance arrangements outlined to the inspectors during the inspection were consistent with those in the hospital's organisational charts. The chief executive Officer (CEO) was appointed by the Board of Directors and was the accountable officer with overall responsibility and accountability for the governance and quality of the rehabilitation services provided in the organisation. The EMT supported the CEO in carrying out this function. The CEO reported on the rehabilitation services' performance and outcomes to the Board of Directors six times a year. The CEO also

reported on the quality of rehabilitation services provided in the ARRU to the Head of Services for Older Persons Services via the general manager in CHO 7 and on the quality of the rehabilitation services provided in RRU to CEO of the DMHG. The services' compliance with key performance indicators (KPIs) and quality metrics, service activity and staffing levels was reviewed at meetings with the CHO 7 and DMHG. The CEO, director of rehabilitation services and finance manager attended the monthly meetings with the DMHG. A consultant geriatrician was the appointed clinical lead for the ARRU. The chair of the Medical Advisory Committee (MAC) is shared between the specialities on a rotational basis and had a dual reporting arrangement with the CEO of Peamount Healthcare and the Clinical Director in Tallaght University Hospital. The clinical lead chaired the MAC who provided advice on clinical practice and reported on performance with KPIs and quality metrics to the Board of Directors. The DON oversaw the management and organisation of the nursing services and reported to the CEO. The director of rehabilitation services oversaw the management, organisation and quality of the rehabilitation services and reported to the CEO.

Two committees ensured the effective management of infection prevention and control and medication safety practices across the service — Infection Prevention and Control Committee (IPCC) and Drugs and Therapeutics Committee (DTC). Although there was no formalised committee overseeing the management of the deteriorating patient, or the safe transitions of care, there was evidence of good systems and processes in place to effectively manage these areas. It was clear from documentation reviewed by inspectors and meetings with relevant staff during the inspection that the IPCC and DTC functioned well and in accordance with their terms of reference. Committee meetings were action oriented and the implementation of agreed actions to improve the quality of healthcare services was monitored. The services' chief pharmacist was also a member of the DTC in Tallaght University Hospital and provided feedback from that committee to the local DTC. The IPPC and DTC had defined and formalised reporting arrangements to the Quality and Safety Steering Group (QSSG) and upwards to the EMT. The QSSG provided the EMT with assurances about the quality and safety of healthcare services provided in ARRU and RRU. The CEO chaired meetings of the QSSG and clinical nurse managers (CNMs), and senior managers attended meetings of the QSSG. The QSSG functioned well in accordance with its terms of reference. The QSSG reported to the EMT and a subcommittee of the Board of Directors that had responsibility for overseeing the quality and safety of healthcare services —Quality and Safety Committee (QSC). Overall, inspectors found that the service had integrated corporate and clinical governance arrangements, which clearly defined the roles, accountability and responsibilities throughout the services for assuring the quality and safety of the service. The governance arrangements were robust and functioning well in accordance with their terms of reference.

Judgment: Compliant

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

At the time of inspection, there were defined management arrangements in place to support and promote the delivery of safe, high-quality healthcare services in ARRU and RRU and these arrangements were functioning well. It was evident that the EMT were responsive, reactive and had good oversight and operational grip on the issues that effected the quality and safety of rehabilitation services in ARRU and RRU. The IPCC, chaired by the DON, developed a work plan for 2024 that identified the infection prevention and control priorities for that year. The services' infection prevention and control team (IPCT) was responsible for implementing the infection prevention and control work plan. The team provided an update on the progress in implementing the plan at the three-monthly meetings of the IPCC. A quarterly performance report devised by the IPCT was submitted to the IPCC and the QSC. These performance reports included information on surveillance and monitoring, compliance with relevant infection prevention and control national standards and KPIs.

Peamount Healthcare's chief pharmacist led the pharmacy service across the organisation. The DTC, chaired by clinical lead for ARRU, devised the services' medication safety strategy that set out the priorities to be focused on to ensure safe medication practices. Implementation of the priorities was monitored by the chief pharmacist and pharmacy department and progress on implementing the strategy was reported to the DTC. A subcommittee of the DTC — Medication Incident Review Group oversaw the management of medication related patient safety incidents reported in AARU and RRU. Peamount Healthcare did not have an antimicrobial stewardship programme and the lack of an antimicrobial pharmacy post was a high rated risk recorded on the corporate risk register.

There was no formalised deteriorating patient improvement programme in Peamount Healthcare, but there were systems in place to ensure the timely recognition and management of the clinically deteriorating patient. The Irish National Early Warning System (INEWS) was used in ARRU and RRU.

There were management arrangements in place to monitor hospital activity and issues that impacted on the demand for rehabilitation services in ARRU and RRU and on the effective and safe transitions of care. The service had a formalised transfer policy and handover process. The bed flow manager, in consultation with the clinical teams, coordinated the admission and discharge of patients from ARRU and RRU. There was a defined criteria for admission of patients to ARRU and RRU, with priority given to patients from Tallaght University Hospital for RRU beds. The bed flow manager reported to the director of rehabilitation services. The average length

of stay of patients was reported quarterly to the director of rehabilitation services and the CEO. Overall, at the time of inspection, it was evident that there was clear, responsive and effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable rehabilitation services in ARRU and RRU. These arrangements supported the effective management and operational functioning of both units.

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.

There were systematic monitoring arrangements in place in Peamount Healthcare to identify and acting on opportunities to continually improve the quality, safety and reliability of the rehabilitation services. Information from a range of different clinical and quality data sources provided the EMT with assurances about the quality of rehabilitation services in ARRU and RRU. The services' quality and continuous improvement manager oversaw the hospital's quality and risk management function and provided assurances in that regard to the EMT. The services' risk management structures aligned with the HSE's risk management framework and they supported the identification, analysis, management, monitoring and escalation of reported clinical and non-clinical risks. Risks identified at ARRU and RRU level were managed and monitored by the CNMs and DON. The CNMs implemented corrective measures to mitigate any actual and potential risks to patients. When required, significant risks were escalated to the EMT and recorded on Peamount Healthcare's corporate risk register. The EMT monitored and managed any risks escalated to the corporate risk register. Significant high-rated risks and the corresponding mitigating actions were reviewed at meetings with the DMHG and at quarterly meetings of the QSC.

The QSSG and Serious Incident Management Team (SIMT) was responsible for ensuring that all serious reportable events and serious incidents reported in ARRU and RRU were reported to the National Incident Management System (NIMS) and managed in accordance with the HSE's Incident Management Framework. The EMT had oversight of the timeliness and effectiveness of the management of adverse events and patient-safety incidents. The quality and patient safety team monitored and oversaw the implementation of recommendations and the sharing of learning from the review of adverse events and patient-safety incidents.

The service did not have an overarching quality and safety programme, but there were arrangements in place to ensure there was a coordinated approach to the monitoring and improvement of the rehabilitation services. The effectiveness and outcome of the monitoring arrangements was overseen by the QSSG, who in turn

provided assurances to the EMT. Patient feedback and complaints were managed by the complaints officer and reported as required at meetings of the EMT. In summary, there was a proactive approach to the identification, evaluation and management of actual and potential risks to patients receiving care in ARRU a RRU.

Judgment: Compliant

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

The inspectors found there were arrangements in place to plan organise and manage the workforce to support the delivery of high-quality, safe rehabilitation services in ARRU and RRU. All the rehabilitation services were funded for 74 whole-time equivalent (WTE)[††] nursing positions (inclusive of management and other grades), with 66.42 WTE (90%) of these positions filled at the time of inspection. Agency staff filled the 10% nursing staff shortfall as per the HSE's arrangements for employing agency staff. The IPCT consisted of 1.0 WTE CNM3 and 0.5 staff nurse who supported and advised staff across Peamount Healthcare on infection prevention and control practices. Both positions were filled at the time of inspection. RRU and ARRU units had full staffing complement for nurses and HCAs at the time of inspection.
Peamount Healthcare was funded for a total of 13 WTE occupational therapists, with 10.5 WTE positions filled at the time of inspection. The shortfall in occupational therapists was escalated to the DMHG and CHO 7 and was recorded as a high-rated risk on the corporate risk register. The rehabilitation services was funded for 1.85 WTE pharmacists and 0.5 WTE pharmacy technician. All positions were filled at the time of inspection. Pharmacist-led medication reconciliation was completed on all patients admitted to ARRU and RRU.

Medical consultants to ARRU and RRU were employed by Tallaght University Hospital and or Naas General Hospital with sessional commitments to Peamount healthcare. The medical consultants reported to the clinical lead in ARRU. There was seven WTE NCHDs (two at registrar grade, five at SHO's) provided 24/7 cover to ARRU and RRU. In addition, three WTE NCHDs at registrar grade rotated into the rehabilitation services, with two assigned to ARRU and one assigned to RRU. Outside core working hours, two NCHDs and a medical consultant was available per specialty. One NCHD at SHO grade was available on site and the one registrar and a medical consultant was available off site per speciality.

[††] Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.

Workforce planning was managed via the business partners and heads of department. Business partners met with nursing management every two weeks to review workforce planning and recruitment needs. Recruitment campaigns for nursing and household staff was ongoing at the time of inspection. Heads of departments were responsible for the monitoring and managing of staff absenteeism rates. Staff absenteeism rates were reported to the HSE monthly. Back to work interviews were conducted and staff who spoke to the inspectors were aware of the employment assistant programme and the onsite occupational health services.

There was a centralised mechanism in place to record and monitor the uptake of staff attendance at mandatory and essential training. Attendance at essential and mandatory training by NCHDs was recorded on the National Employment Record (NER) system. The clinical lead and consultants monitored and had oversight of NCHD uptake of training. Attendance at mandatory and essential training by nurses and healthcare assistants in ARRU and RRU was monitored by the CNMs in each unit, the DON and director of rehabilitation services. Information on the uptake of mandatory training was reported at meetings of the EMT and included in the quarterly reports submitted to the QSC. Staff who spoke with inspectors confirmed that they had received formal induction training on commencement of employment in ARRU and RRU. All staff had access to and were required to complete essential and mandatory training in infection prevention and control, medication safety and the early warning systems on the HSE's online learning and training portal (HSELanD). Overall, workforce arrangements were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare and staff shortfalls across the different professions were relatively small. Notwithstanding this:

- There was a reported shortfall in occupational therapists, which could potentially impact on the delivery of rehabilitation services in ARRU and RRU.

Judgment: Substantially compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards from the three themes of person-centred care and support, effective care and support, and safe care and support. The service was found to be compliant with five national standards (1.6, 1.7, 1.8, 3.1, 3.3) and substantially compliant with two national standards (2.7, 2.8) assessed. Key inspection findings informing judgments of compliance with these seven national standards are described in the following sections.

Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.
Inspectors observed how staff in ARRU and RRU were committed and dedicated to promoting a person-centred approach to care. Staff were observed to be kind and caring towards patients and responded to their individual needs. The privacy, dignity and autonomy of patients using the service was promoted and protected. This was consistent with the human rights-based approach to care promoted by HIQA. There was clean, adequate showering and toilet facilities accessible and in close proximity to patients. Patients wore their own clothes and there was a designated dining area for patients. This provided patients with an opportunity to socialise with other patients, if they wished. Patient's personal information was protected and stored securely during the inspection.
Judgment: Compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.
Staff in ARRU and the RRU promoted a culture of kindness, consideration and respect. Inspectors observed staff engaging with patients in an open and sensitive manner. Staff listened to, communicated respectfully and supported patients to express their individual needs and preferences. This was confirmed by patients who described staff as "*good,*" "*wonderful*", "*pleasant*" and "very kind". Patients was provided with patient experience surveys on admission. Survey responses and other feedback from patients were reviewed monthly by the clinical nurse specialist (CNS) for the older person's services. Patient's feedback was shared with staff in both ARRU and RRU. Staff were responsive in attending to the individual needs of patients. A number of validated assessment tools were used to assess patient's needs and to determine any individual supports needed. Staff and patients receiving care in ARRU and RRU could avail of advice and support from the CNS and advanced nurse practitioner (ANP) in respiratory medicine. A patient forum was established by Peamount Healthcare, this provided patients with an opportunity to share their experiences of receiving care in the organisation. Overall staff in ARRU and RRU promoted a culture of kindness, consideration and respect for people receiving care at the units.
Judgment: Compliant

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

The inspectors found there was a clear, transparent, open and accessible complaints procedure in place to manage complaints from patients and or their families. The service had a complaints management system. The HSE's complaints management policy *'Your Service Your Say'* was adapted. The complaints officer provided staff with training on complaints management. There was a culture of resolving complaints at the point of contact. Stage 1 complaints were managed in ARRU and RRU by the CNMs. Stage 2 complaints were assessed and managed by the complaint officer with support from the services' quality and continuous improvement manager, CNMS and department managers. Staff who spoke with the inspectors were aware of the services' complaints policy and knew how to resolve a complaint. Information about independent advocacy services was available for patients in the ARRU and RRU, and staff knew about these services. Compliments and complaints received in ARRU and RRU were logged by the CNMs on a register of complaints. Complaints were tracked and trended by the complaints officer to identify emerging themes, categories and departments involved. Information from the tracking and trending process was shared with CNMs. The CNMs shared this information with staff at ward meetings, safety huddles and it was also discussed in quality walk-about carried out by members of the executive management team. Information on the numbers and types of complaints received, the timeliness of response, outcomes and recommendations from the complaints resolution process was presented at meetings of the QSSG. A report on the outcomes of the complaints resolution process was provided by the QSSG three monthly to the EMT and the QSC. Peamount Healthcare was compliant with the HSE's timelines for complaints acknowledgement (five days) and resolution (30 days). Quality enhancement plans were devised to implement recommendations from the complaints resolution process. The CNMs, with oversight by the complaint officer were responsible for ensuring the recommendations from the complaints resolution process were implemented. Overall, Peamount Healthcare had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the rehabilitation services in ARRU and RRU.

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 inspectors observed the physical environment in ARRU and RRU was secure, generally well maintained and clean. There was evidence of some general wear and tear, with the woodwork and paintwork chipped in some areas. This did not always facilitate effective cleaning and posed an infection prevention and control risk. Staff who spoke to the inspectors were satisfied with the level of cleaning resources available and the timeliness of maintenance services for ARRU and RRU 24/7.The ARRU and RRU had dedicated cleaning staff during core working hours. Additional cleaning staff were available and employed outside core working hours. Cleaning staff who spoke with the inspectors confirmed they had received relevant training on discharge and terminal cleaning[‡‡] and were knowledgeable about their role and cleaning processes in ARRU and RRU. The CNMs and the cleaning supervisor had oversight of the standard of cleaning in both rehabilitation units. Cleaning of patient equipment was assigned to healthcare assistants. Healthcare assistance who spoke with the inspectors were knowledgeable about their role and responsibilities. Patient equipment in the RRU and ARRU was observed to be clean and there was a system in place to identify cleaned equipment. Environmental and patient equipment audits were carried out monthly, these are discussed further in national standard 2.8. Hazardous material and waste was observed to be stored safely and securely. There was appropriate segregation of clean and used linen and used linen was stored appropriately. Supplies and equipment were stored appropriately in ARRU, but storage was an issue in RRU, as the storage space was limited.

Adequate physical spacing was observed to be maintained between beds in multi-occupancy rooms in ARRU and RRU. Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available for staff and visitors. Hand hygiene signage was clearly displayed throughout ARRU and RRU, but the hand hygiene sinks did not conform to required specifications.[§§] When the inspectors discussed this with members of the EMT, they were told that the organisation was waiting on approval of funding to continue with the programme of refurbishment, which included replacing hand hygiene sinks, providing additional storage space and replacing damaged surfaces.

There was a formalised process in place to ensure appropriate placement of patients requiring transmission-based precautions in ARRU and RRU, and this process was overseen by the patient flow manager and IPCT. Staff could access laboratory

[‡‡] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.
[§§] Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf.

results from Tallaght University Hospital, when required. All admitted patients to ARRU and RRU were screened for *Carbapenemase-Producing Enterobacterales* (CPE) and *Methicillin-resistant Staphylococcus aureus* (MRSA). Patients were not routinely screened for COVID-19, but were risk assessed to determine the risk of exposure to COVID-19. If a patient had respiratory symptoms or had contact with a patient with COVID-19, the patient's movements were restricted. If staff suspected signs and symptoms of COVID-19, the patient was tested and isolated until test results were received. On the day of inspection, a number of patients in RRU required standard-based precautions. All were located in single rooms with appropriate precautions and infection prevention and control signage applied. Staff were also observed wearing appropriate personal protective equipment in line with national guidelines in place at the time of inspection. In summary, at the time of inspection, the environment and patient equipment in ARRU and RRU was observed to be generally clean and well maintained. The physical environment supported the delivery of high-quality, safe care for patients receiving care in ARRU and RRU, but:

- some hand hygiene sinks did not conform to required specifications
- the storage space in RRU was limited
- some surfaces were chipped and in need of repair.

Judgement Substantially compliant

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

The inspectors found that there were assurance systems in place in Peamount Healthcare to monitor, evaluate and continuously improve the rehabilitation services provided in ARRU and RRU. Information from a variety of sources (including KPIs, findings from audit activity, risk assessments, patient-safety incident reviews, complaints and patient experience surveys) to compare and benchmark the quality of their rehabilitation services. ARRU and RRU used a range of audit tools developed by CHO 7 to assess the unit's environmental hygiene standards monthly. The rate of compliance set by the CHO 7 was 85% and any non-compliance (less than 85%) required the development of a quality improvement plan. Hand hygiene audits were carried out regularly in ARRU and RRU and recent audit findings (May 2024), showed the service was complaint with the HSE's target of 90%. There was sufficient evidence that quality enhancement plans were developed and implemented when environmental, patient equipment and hand hygiene standards fell below the expected standards. Antibiotic prescribing practices were audited in ARRU and RRU in February 2024 and the findings indicated good compliance with prescribing guidelines. A quality enhancement plan was develop to further improve

compliance, which included instruction on antibiotic prescribing practices during induction training for NCHDs. Clinical audit findings were reported to the IPCC, DTC, QSSG, QSC and shared with CNMs. The CNMs shared audit findings with clinical staff at staff meetings. Audits findings were also shared and discussed with clinical staff during the quality walkabouts, carried out by members of the EMT. During the quality walkabouts, members of the EMT also received feedback on outcomes used to measure the effectiveness of rehabilitation services provided in ARRU and RRU. The CNMs oversaw the implementation of quality enhancement plans to improve hygiene standards and medication practices. In some of the quality enhancement plans reviewed by the inspectors, some actions were not time bound and or did not have an assigned person responsible for implementing the action. Overall, there were assurance systems in place in ARRU and RRU to monitor, evaluate and continuously improve the rehabilitation services. Notwithstanding this:

- there was no timeline and or assigned person responsible for implementing actions to improve hygiene standards in some quality enhancement plan reviewed by the inspectors.

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

Information relevant to the provision of high-quality, safe healthcare services in ARRU and RRU proactively monitored, analysed and responded to in Peamount Healthcare. There were systems in place to identify, assess and manage immediate or potential risk for patients receiving care in both rehabilitation units. The QSSG, BQSC and the EMT monitored the effectiveness of controls applied to mitigate identified risks. Staff in ARRU and RRU were trained to identify potential or actual risk to patients in their units and there was a local electronic system to record the risks identified. CNMs applied actions and controls to mitigate the potential and actual risks to patients. The CNMs oversaw the effectiveness of these controls. An electronic copy of all risks was generated and submitted to the risk/health and safety coordinator who reviewed the local risk registers in ARRU and RRU monthly. Any significant risks, not managed at ARRU and RRU level were escalated to the EMT for review and consideration for inclusion on the corporate risk register. Risks related to infection prevention and control, medication safety and the storage of equipment were recorded on the local unit risk register in ARRU and RRU at the time of inspection. Significant high-rated risks were reviewed at quarterly meetings of the QSSG and at meetings with DMHG and CHO 7.
All patients admitted to ARRU and RRU are screened for CPE and MRSA. The Patient Administration System (PAS) alerted clinical staff to patients who were previously

inpatients with confirmed MDROs. Staff confirmed they had access to microbiology support and advise 24/7 from Tallaght University Hospital.

A clinical pharmacy service was provided in ARRU and RRU. Pharmacy-led medication reconciliation was completed on all patients admitted to ARRU and RRU. Medication stock control was carried out by pharmacy technicians. Staff in ARRU and RRU used risk-reduction strategies with high-risk medicines as per the medication policy and when administering medications. For example, staff used red aprons when doing mediation rounds. The hospital's list of high-risk medications aligned with the acronym 'A PINCH' and there was a list of sound alike look alike drugs (SALADs). Prescribing guidelines, including antimicrobial guidelines and medication information were available and accessible to staff at the point of care and the majority of these were up to date.

The INEWS, sepsis 6' care bundle and Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) communication tool[***] was used in ARRU and RRU. Staff were knowledgeable about the INEWS escalation and response protocol and there were processes in place to ensure the timely management of patients with a triggering early warning system. Outside core working hours, a NCHD at SHO grade and consultant for each rehabilitation specialty was available to review patients. When a patient deteriorated there was a 24/7 escalation protocol and transfer process to Tallaght University Hospital and or Naas General Hospital.

Systems and processes were in place to support to safe transfer of patients within and between services during and outside of core working hours. The director of rehabilitation services, bed flow manager and the rehabilitation coordinator in Tallaght University Hospital attended a multidisciplinary huddle meeting daily where bed availability, occupancy and patient acuity was reviewed. The patient flow manager also reported on bed availability twice daily to HSE on predicted date of discharge and bed occupancy. There was a defined criteria for patients referred to RRU and ARRU. Tallaght University hospital accounted for approximately 80% of admissions to the units, with Naas General Hospital accounted for 15% and the remainder of patients came from the local community services. The timely issuing of discharge summaries to general practitioners (GPs) and primary healthcare services further supported the safe transition of care.

Staff in ARRU and RRU had access to a range of up-to-date infection prevention and control and medication policies, procedures, protocols and guidelines. All policies, procedures, protocols and guidelines were accessible to staff via the services' intranet and in hard copy format. In summary, at the time of inspection, there were arrangements in place in Peamount Healthcare to ensure the proactive monitoring,

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

analysis and management of potential and actual risks to patient safety and the delivery of rehabilitation services in ARRU and RRU.

Judgment: Compliant

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

There were arrangements in place to identify, manage and report patient safety incidents in a timely manner and in line with national policy. All patient safety incidents were reported on a local electronic system and the NIMS. Staff who spoke to inspectors were knowledgeable about what and how to report a patient safety incident. The QSSG and SIMT were responsible for ensuring that all serious reportable events and serious incidents were managed in line with the HSE's Incident Management Framework. Patient safety incidents were tracked and trended and a report was generated every three months and shared with clinical staff. Clinical staff in the ARRU and RRU were familiar with patient safety incident reports generated in the months preceding HIQA's inspection. The IPCT reviewed all relevant patient-safety incidents, made recommendations for mitigating actions and these were reported to the IPCC. Medication related patient-safety incidents were reviewed by the Medication Incident Review Group, DTC and the QSC. Staff in ARRU and RRU outlined an example of a quality improvement initiative resulted from a medication related clinical incident. Information on the number and types of reported patient safety incidents, serious reportable events and serious incidents was collated by the services' quality and continuous improvement manager (QCIM) and team. This information was submitted three monthly to the EMT and QSC. The implementation of recommendations from reviews of patient safety incidents, serious reportable events and serious incidents was monitored by the (QCIM), the SIMT and QSC. There was evidence that feedback and the learning from reviews of patient safety incidents, serious reportable events and serious incidents was shared with staff. Feedback on patient safety incidents and review reports were shared with medical consultants and CNMs who in turn shared the information with clinical staff. In summary, there was an effective and robust system in place to ensure the timely reporting and management of patient-safety incidents. There was evidence that recommendations from the review of patient-safety incidents and serious reportable events were implemented and learning was shared with staff to support service improvement.

Judgment: Compliant

Conclusion

An announced inspection of Peamount Healthcare was carried to assess compliance with 11 national standards from the *National Standards for Safer Better Health*. Overall, the inspectors found good levels of compliance with the national standards assessed.

Capacity and Capability

There was evidence of integrated corporate and clinical governance structures and these structures functioned as per their terms of reference. The hospital's executive management team worked collaboratively to ensure there was a concerted focus on the quality and safety of rehabilitation services provided in ARRU and RRU. The management arrangements supported the effective functioning and promoted the delivery of safe, high-quality rehabilitation services IN ARRU and RRU. The systematic monitoring arrangements enabled the identification of opportunities to continually improve the quality, safety and reliability of rehabilitation services in ARRU and RRU. The workforce arrangements were planned, organised and managed to ensure the delivery of high-quality, safe and reliable rehabilitation services. Notwithstanding this, the reported shortfall in occupational therapists had the potential to impact on service delivery.

Quality and Safety

Staff promoted a person-centred approach to care and the inspectors observed staff in ARRU and RRU being respectful, kind and caring towards patients. Staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients, which was consistent with the human rights-based approach to care promoted by HIQA. Patients also spoke positively about their experiences of receiving care in ARRU and RRU. There were systems and processes in place to ensure and support a coordinated approach to the management of complaints and concerns. The physical environment in ARRU and RRU mostly supported the delivery of high-quality, safe, care and protected patients. There were assurance systems in place to monitor, evaluate and continuously improve the healthcare services. Quality enhancement plans were developed when practices fell below expected standards, but some of the actions in the plans were not time bound or had a person assigned to ensure implementation. There was a management system to identify, manage, respond to and report patient safety incidents, in line with national legislation, standards, policy and guidelines. Recommendations from the review of patient safety incidents and serious reportable events were implemented and learning was shared with staff to support service improvement and enable the delivery of safe, quality care.

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 11 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	
National Standard	**Judgment**
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.	Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.	Substantially compliant
Quality and Safety Dimension	
Theme 1: Person-Centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially compliant

Quality and Safety Dimension	
National Standard	**Judgment**
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant