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:	Clifden District Hospital
Address of healthcare service:	Tullyvoheen Clifden Co. Galway
Type of inspection:	Announced
Date(s) of inspection:	11 and 12 December 2024
Healthcare Service ID:	OSV-0007268
Fieldwork ID:	NS_0106

Model of hospital and profile

About the healthcare service

Clifden District Hospital is a seven bedded publicly funded Health Service Executive (HSE) Rehabilitation and Community In-patient hospital. At the time of inspection, it was part of HSE Community Healthcare West (CHW)* and was in the process of transitioning to the new HSE regional health structures under the governance of Integrated Healthcare Area, Galway, within the HSE West and Northwest health region.

Services provided by the hospital included:

- convalescence care
- respite care
- palliative care

The following information outlines some additional data on the hospital.

Model of Hospital	HSE Rehabilitation and Community In-patient Hospital (RCIH)
Number of beds	Seven inpatient beds

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* 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

* CHW comprises 16 community nursing units (residential care) and four district hospitals (rehabilitation and in-patient community hospitals).
† 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 (2012)

previous inspection findings (where available), information submitted by the provider, unsolicited information and other publically available information since last inspection.

During the inspection, inspectors:

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

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with the national standards monitored during this inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
11 December 2024	13:30 – 17:05hrs	Éilish Browne	Lead
12 December 2024	09:00 – 16:50hrs	Robert McConkey	Support

Information about this inspection

Clifden District Hospital comprised seven inpatient beds at the time of inspection. This was a reduction of 14 beds on the original 21 beds at the time of the previous inspection in August 2020. Inspectors were told that the reduction in beds was due to staffing shortages in the hospital. Historically, the hospital had separate wards for male and female patients. However, due to bed closures, both male and female patients were now accommodated together in a single seven-bed ward.

Inspectors were told that the HSE had approved plans to construct a 40-bed community nursing unit in Clifden. This new facility will amalgamate the services currently provided by Clifden District Hospital and the local community nursing unit. The project is now in the design phase and will be built on the existing grounds of St. Anne's Community Nursing Unit.

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 the clinical area that was currently open, which had seven beds.

[‡] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.
[§] The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.
[**] 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. World Health Organization. Transitions of Care. Technical Series on Safer Primary Care. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

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

- Director of Nursing (DON)
- General Manager of Older Peoples Services (CHW)
- A GP who provides Medical Officer cover to the hospital
- Clinical nurse manager grade 2 (CNM 2) who was the infection prevention and control link nurse
- Staff working in the clinical areas visited.

During this inspection, inspectors reviewed documentation and data on site and requested additional documentation and data from hospital management which was reviewed following the inspection.

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

Over the course of the inspection, inspectors had the opportunity to speak with several patients receiving care at the hospital. The patients expressed satisfaction with the care they received and praised the staff. Patients described staff in the clinical area as "lovely, beautiful, kind and caring". Patients explained that staff "take the time to talk even though they are busy". Patients were also complimentary of the food provided in the hospital. A thank you card was displayed at the nurses' station thanking all staff for their kindness and the care provided to a patient during their recent respite stay.

Inspectors observed that staff engaged with patients in a respectful and kind manner and were responsive to patient's needs. Staff were observed to answer patients call-bells in a timely manner, this was validated by patients who told inspectors "if you call they come".

The hospital had a chapel on site which patients could access freely, and inspectors were told that religious services were held on alternate weeks.

Patients had access to the day-room during their stay and were observed relaxing and watching television in this room on both days of the inspection. Patients also had access to 'The Magic Table' in this room. Inspectors were told that it featured a series of vibrant and engaging interactive light games projected onto a table surface. These games

respond to hand and arm movements, staff reported that patients thoroughly enjoyed partaking in these games.

Patients spoken with explained that if they wanted to make a complaint, they "would go to staff' or "speak to the nurse in charge". A suggestion box was located at the hospital entrance, allowing patients to leave any comments they desired regarding their stay in the hospital. Inspectors observed a suite of information leaflets available to patients regarding how to submit a complaint, concern or compliment and how to access advocacy services at the entrance of the hospital. These included '*Your Service Your Say*'[‡‡], '*Patient Advocacy Service*' and *'SAGE'* advocacy service. In addition, the hospital's complaints management pathway was displayed along with the contact details of the hospital's complaints officer.

Capacity and Capability Dimension

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

Clifden District Hospital was found to be partially compliant with national standard (NS) 5.2, substantially compliant with 5.5 and 6.1, and compliant with NS 5.8.

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

Inspectors were provided with organisational charts, setting out clear lines of accountability and responsibility in relation to reporting structures within Clifden District Hospital. The organisational charts also clearly outlined the reporting and accountability relationship to HSE Community Healthcare West (CHW).

The DON was responsible for the operational management of Clifden District Hospital and reported to the Manager for Older Persons' Services, CHW, who reported to the General Manager for Older Persons' Services, and upwards to the Head of Service for Older People and to the Chief Officer for CHW. The DON was accountable for the organisation and management of all staff members at the hospital.

‡‡ 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.

The medical officer role provided clinical oversight and leadership at Clifden District Hospital. One whole-time equivalent (WTE)[§§] medical officer role was filled by two local GPs. During the inspection, the medical officer informed inspectors that they reported operationally to the DON. Patients that were admitted to Clifden District Hospital were from the local area and typically attended one of the medical officers as their GP. Throughout their time in the hospital, patients were under the ongoing care of their own GP. The medical officer was responsible for the care of their own patients from Monday to Friday, during the hours of 8am to 5pm. The medical officers provided cover on alternating weeks to resume care over any patient who was admitted to the hospital from outside the area and was not a patient of either medical officer.

Inspectors found that arrangements were in place for the provision of medical cover for the out-of-hours period, Monday to Friday and for 32 weekends each calendar year through the use of a rota involving GPs from neighbouring practices. Out-of-hours cover at weekends for the remaining 20 weekends in the year was provided by the regional doctor on-call scheme, known as West-Doc.

The DON was also responsible for the local community nursing unit. Inspectors were informed that both sites functioned as one unit and shared staff where the need arose. The DON was supported in their role by a CNM2 based in Clifden District Hospital. At the time of the inspection, the CNM2 was on leave, and therefore all nursing and support staff within the hospital reported directly to the DON.

Inspectors were informed that there was regular communication between management in Clifden District Hospital and senior management in CHW, however, these communications were often informal, through emails or telephone calls. This is an area for improvement to ensure hospital matters are formally and regularly documented.

Inspectors were told about community-wide committees involved in the governance of Clifden District Hospital as follows:

Community Healthcare West Older Persons' Services Quality and Safety Committee

The CHW Older Persons' Quality and Safety Committee was a multidisciplinary team with the purpose of establishing, developing and implementing Community Healthcare Organisation (CHO) wide quality and safety structures, processes, standards and oversight of quality and safety across the service. Membership included Head of Service for Older Persons as chair, General Manager (GM) for Older Persons Services, quality and safety risk advisor, a DON as the district hospital representative and home support manager for the Integrated Care Programme for Older People (ICPOP). Representatives from the following areas were listed as members on a 'as required' basis: infection

[§§] Whole-time equivalent - allows part-time staff working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to staff working full-time while 0.5 refers to staff working half full-time hours.

prevention and control (IPC), antimicrobial resistance (AMR), health and safety officer, medical advisor, nursing and midwifery planning development unit (NMPDU) and policies, procedures and guidelines (PPGs) representatives.

The second version of the Terms of Reference (TOR) was approved in February 2020 and was provided in draft form. The TOR stated it was to be reviewed annually, however, it was most recently reviewed in March 2022. According to the TOR, meetings took place every four weeks and the committee was noted to be meeting in line with this.

Inspectors reviewed the agenda and minutes of the last three meetings of the QSC held in August, September and October 2024. Review of the listed agenda items included 'Q & S Monthly Report', 'Risk Register & New Risk Assessments', 'IPC Update' and 'PPPGs'. Meetings were well attended, with the DON of Ballina District Hospital representing the district hospitals in both the September and October meetings. The DON in Clifden District Hospital confirmed that the minutes of meetings were circulated by the DON from Ballina District Hospital. The meeting minutes indicated that the meetings adhered to a structured format and were action-oriented with a responsible person identified, however, they lacked specific time constraints.

Inspectors were informed by management in Clifden District Hospital that quality, patient safety, and risk issues were reported to the Manager for Older Persons' Services and upwards to the General Manager for Older People.

Director of Nursing Governance Meeting CHW

According to TOR of the Director of Nursing Governance Meeting, the chair of this meeting alternated monthly between the two managers for Older Person Services. Membership included the DON of each residential unit in the CHW area. Although the DONs of the district hospitals were not specifically listed as committee members in the TOR, meeting minutes reviewed showed they or their representatives attended these meetings. The frequency of the meetings was monthly.

The TOR outlined the committee's vision, purpose, and accountability. However, the TOR lacked a date and signature, and did not specify the approval mechanism.

Inspectors found that the committee had not been adhering to its TOR with regard to the frequency of meetings. Three meetings were held between December 2023 and August 2024. The meetings were well attended with the DON from Clifden District Hospital in attendance at two of the three meetings. Two of these meetings were conducted in person, while one was held virtually on an online meeting platform.

Minutes reviewed showed safeguarding, quality and risk, flu and COVID-19 vaccinations and health and safety as items discussed at the forum. Medication management was a topic of discussion in the April 2024 meeting, where the formation of a Drugs and Therapeutics Committee was documented as being a priority. The minutes reviewed indicated that the meetings followed a structured format and were action-oriented,

however inspectors noted that they would benefit from having clearly defined time-bound actions in the minutes.

Community Healthcare West, Infection Prevention and Control and Antimicrobial Stewardship Committee

The TOR for the Community Healthcare West, Infection Prevention and Control (IPC) and Antimicrobial Stewardship (AMS) Committee outlined the committee's purpose as an advisory body. Governance in relation to IPC and AMS was through the Chief Officer of CHW and the Senior Management Team. The committee supported the Chief Officer and the Senior Management Team in ensuring the development of IPC and AMS services and structures in the community and to prioritise the use of these resources in line with national strategic objectives for both IPC and AMS.

The Head of Quality, Safety & Service Improvement (QSSI) was the committee chair. Membership comprised a consultant microbiologist, an antimicrobial pharmacist, IPC Assistant Director of Nursing (ADON), quality and risk manager, Patient and Service User Engagement Officer, an epidemiologist and representatives from public health, disability services, older persons services, mental health, health and wellbeing, dental, social inclusion, estates management, Antimicrobial Resistance and Infection Control (AMRIC), the hospital group, and a medical representative or General Practitioner. The frequency of meetings was quarterly and review of the meeting minutes confirmed that the committee were meeting in line with this.

The TOR reviewed by inspectors was in draft form and lacked a date and signature, and did not specify the approval mechanism.

DON of Ballina District Hospital started attending these meetings in September to represent the district hospitals on the committee. Inspectors were informed by the DON in Clifden District Hospital that they received updates from these meetings from the representative DON and meeting minutes were circulated shortly after the meetings.

Inspectors reviewed the minutes from the last three meetings from March 2024 to September 2024. The committee had a standing agenda which included updates from each service area, IPC and AMS updates. The minutes were also action-orientated with an assigned responsible person, however not all actions appeared to be time-bound.

Medication Safety

Inspectors were told that following a CHW-wide audit into medication safety in 2023, it was recommended that a drugs and therapeutics committee be established to provide oversight. Inspectors were informed a drugs and therapeutics committee met for the first time on 20 November 2024 to look at the TOR and membership of the group. However, the decision was made that the CHW did not have the necessary expertise within its resources to form a committee. Inspectors were informed by senior management that they had made contact with the chairperson of the current drugs and therapeutics

committee hospital at group level to seek CHW representation on the existing drugs and therapeutic committee.

The Deteriorating Patient

All admissions to Clifden District Hospital had been 'medically discharged from acute services and had additional needs prior to returning home'. These needs may include a period of convalescence after an acute episode of illness, or time may be required for home adaptations before discharge. Inspectors were informed of the processes in place in the hospital in relation to the early detection of a deteriorating patient. On admission, patients' baseline vital signs were established. Daily monitoring was then conducted to identify any deviations from these baseline observations. There was a medical officer in place who was responsible for the initial admission process in the hospital and reviewed patients' conditions as the need arose. Out-of-hours arrangements were in place as previously discussed, and staff could also use their clinical judgment to transfer a patient by ambulance to the nearby acute general hospital when needed.

Transitions of Care

Matters in relation to transitions of care were managed through the recently established CHW Integrated Discharge Management (IDM) Team. The IDM team reported to the General Manager for Older Persons' Services, and to the Head of Service for Older People through the team lead. Inspectors were informed that the discharge co-ordinator in University Hospital Galway linked in directly with the DON in Clifden District Hospital regarding bed availability for any admissions local to the area. The IDM team leader also linked in directly with the DON as necessary, especially in cases where a patient from the locality required admission.

In summary, inspectors observed that while the CHW had some formal corporate and clinical governance arrangements in place for Clifden District Hospital, there were several areas identified for potential improvement.

Although the CHW were in the process of establishing a formal medication safety committee as previously discussed, there was an absence of a specific forum to escalate, manage and monitor issues relating to medication safety at the time of inspection.

Not all committees were meeting in line with their TOR. Some committees did not have an up-to-date TOR. Committee minutes would benefit from having clearly defined, time-bound actions. In addition, while there was regular communication between management in Clifden District Hospital and senior management in CHW, these communications were often informal and not recorded. This is an area for improvement to ensure that discussions and decisions in relation to the hospital are formally documented.

Judgment: Partially 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 Clifden District Hospital.

The hospital had management arrangements in place in relation to the four areas of known harm.

Infection, prevention and control

The hospital had an IPC link practitioner, a role that was integrated into the CNM2 position. At the time of inspection, the CNM2 had been on leave. In their absence, the link practitioner from St. Anne's CNU provided guidance and training on matters concerning infection prevention and control to staff.

The IPC link nurse attended bi-monthly meetings with the IPC team from CHW, which offered updates, education, and opportunities to seek advice and guidance on clinical matters. Minutes reviewed from January 2024 to November 2024 noted that there was no representative present from either Clifden District Hospital or St. Anne's CNU. Inspectors were informed that this was due to leave, however, minutes from these meetings were circulated to the DON at this time. Hospital management and staff spoken with in the clinical area, informed inspectors that there were close links with and IPC support from the CHW IPC team. Staff also had access to a microbiologist in the acute hospital through telephone contact and could access laboratory reports directly from the acute hospital.

Medication safety

The hospital or CHW did not employ a pharmacist for oversight and support of medication management. Inspectors were informed by management that the hospital had access to both a clinical pharmacist and an antimicrobial pharmacist through CHW.

Clifden District Hospital implemented a practice which required patients to bring their own medications in their original packaging for the entirety of their hospital stay. The process was put in place with the aim of ensuring patients who had transferred for respite (from the acute hospital or from home) received their correct medication. For patients admitted from the acute hospital, the discharging hospital was required to email the patient's medication list to Clifden District Hospital prior to admission. For patients being admitted from home for respite care, a respite transition form was sent to the family before admission, in which the family detailed the patient's medications. Nursing staff then undertook medication reconciliation by checking the medication lists against the medications the patient presented with, on admission. Inspectors spoke with nursing staff who demonstrated comprehensive knowledge of this process. However, inspectors noted

a lack of documented evidence in the patients' drug kardex to confirm that medication reconciliation had been completed.

The hospital maintained a stock of emergency medications, with a nurse conducting weekly checks of each medication and documenting their expiry dates. If required, pharmacy supplies were provided to the hospital by University Hospital Galway. Inspectors were informed that no medication orders had been placed since patients commenced bringing their own medications for the duration of their hospital stay.

Deteriorating patient

Inspectors spoke with management and staff who detailed the key measures implemented for the identification and management of deteriorating patients in the hospital as follows:

- review of patient referral by the nurse-in-charge to determine patient suitability
- if the patient is deemed suitable, a clinical handover was conducted prior to admission
- admission by medical officer (from Monday to Friday)
- baseline observations established on admission through the nursing assessment and care planning process
- daily monitoring of observations against baseline assessment for changes
- if changes noted, the appropriate interventions were implemented, for example commence vital signs, reposition, escalation to medical officers as appropriate
- review by medical officer or out-of-hours doctor, as previously discussed
- in acute situations, nurses exercised clinical judgment to transfer patients to the acute hospital by calling 999
- transfer via ambulance to the acute hospital
- notification to the National Incident Management system[***] (NIMS) as appropriate.

Transitions of care

The DON had oversight over all patient transitions of care. The hospital had established effective processes to manage transitions of care, both into and out of the hospital. All admissions were planned in advance and came from the following sources; referral from acute hospitals, referral from community for respite; or referral from palliative care from the community. Inspectors reviewed the referral and admission pathways for patients

[***] The State Claims Agency National Incident Management System is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation.

admitted for convalescent care from the acute setting, as well as for those admitted from home for respite care.

Inspectors were informed that referrals for convalescent care from the acute hospital were received several days prior to admission. On the advice of the DON, the referral was forwarded to the nurse-in-charge for review. Once the referral was accepted, a verbal handover was conducted between the nurse-in-charge and the nurse from the acute hospital. The hospital used a standardised template for the verbal handover to ensure all relevant information was handed over.

In the case of patients being admitted for respite care, a referral was received from the patients GP, public health nurse or from the ICPOP. The DON and the nurse-in-charge reviewed the referral to determine the patient's eligibility for admission. A respite transition form was subsequently sent to the patient's family for completion prior to admission, ensuring that all clinical details were provided to the hospital.

The HSE contracted two GPs as medical officers to provide clinical care to patients. These medical officers visited the hospital from Monday to Friday, to complete patient admissions and were also available by phone from 8am to 5pm.

The hospital also facilitated extensions of stay for patients in some instances. Patients or their families were required to complete a form detailing the reasons for their extended stay, which was then reviewed and either approved or declined by the DON.

In summary, HIQA was satisfied that the hospital had established local management arrangements to effectively manage, support, and oversee the delivery of high-quality, safe, and reliable healthcare services in medication safety, infection prevention and control, the deteriorating patient and transitions of care. One area identified for improvement was the need to document when medication reconciliation has been completed in the patient's prescription chart.

Judgment: Substantially Compliant

Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Clifden District Hospital and CHW management had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of services provided. Inspectors viewed minutes of meetings which reflected that performance data was reviewed at meetings internally and at CHW level.

Monitoring service's performance

Clifden District Hospital collected data on a range of measurements related to the quality and safety of healthcare services. Data was collected by the DON on the number of

admissions, discharges, transfers from the acute hospitals, transfers back to acute hospitals, average lengths of stay, patient-safety incidents and workforce. It was evident that collated performance data was reviewed at meetings of the relevant committees as outlined under NS 5.2.

Risk management

The hospital had risk management structures and processes in place to proactively identify, manage and minimise risks in the clinical area. The hospital's risk register was prepared by the DON in the absence of the CNM 2 and risks were escalated to the Manager for Older Persons' Services in CHW as required. The DON told inspectors that the risk register underwent an annual review, with additional reviews conducted as necessary. The hospital's risk register relating to the four key areas of known harm was reviewed by inspectors. It included date of assessment, name of risk owner, hazard and risk identification, additional controls required, responsible person for action and due date.

Audit activity

Although the hospital was conducting audits, there was no schedule of audit in place. The DON was aware of this and at the time of inspection had begun work in identifying when each audit was due to be completed in 2025. This is discussed further under NS 2.8.

Management of patient-safety incidents and serious reportable events

Management and staff informed inspectors that incidents were logged on the NIMS, in line with the HSE's Incident Management Framework. Staff recorded incidents in paper format which were then escalated to the DON for review in the absence of the CNM 2. Incidents were inputted on the NIMS by on-site administrative staff. The summary of NIMS Report for 2024 provided by management, showed that all 15 incidents were inputted to NIMS within 30 days of date of notification, thereby meeting the HSE's national target of 90%. Patient-safety incidents are discussed further under national standard 3.3.

The CHW Serious Incident Management Team for Older Persons Services had oversight of the management of Serious Reportable Events (SRE) and serious incidents which occurred under the remit of the older person's services within CHW. The committee reported to the Older Persons' Services Quality and Safety Committee. Membership of this committee included the Head of Service for Older Persons', General Manager for Older Persons' Services as well as a service representative from where the incident occurred. Committee meetings were held on a weekly basis. The DON and senior management in CHW confirmed that no SREs had occurred in the hospital in the previous 12 months.

Overall, inspectors were assured that hospital management were identifying and acting on all opportunities to continually improve the quality and safety of healthcare services at the hospital.
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.

Staffing Levels and Recruitment

Clifden District Hospital had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. All staff in the hospital reported directly to the DON in the absence of the CNM2 on the ward. The DON in turn reported to the General Manager for Older Persons CHW.

Inspectors were informed that as there were plans for Clifden District Hospital and St. Anne's CNU to amalgamate their services in the near future, they operated as a single unit, sharing staff as necessary. Consequently, distinguishing between the approved and actual WTEs for each site proved challenging. The DON delineated the necessary WTEs required for hospital operations, in comparison to the actual WTEs present at the time of inspection. There was a deficit of 1.14 WTEs for nursing staff, 0.59 WTEs for healthcare assistants (HCAs), and 0.48 WTEs for multi-task assistants (MTAs). At the time of inspection, the hospital did not have approval for a social worker post, an occupational therapist post, speech and language therapist post or physiotherapist post. Inspectors were informed that these deficits had minimal impact on the care and support provided to patients, with the exception of physiotherapy, however, this service was supplemented by an agency physiotherapist with a WTE of 0.5.

Management informed inspectors that regular agency, redeployment from St. Anne's CNU and existing staff were effectively employed to address staffing shortages across the various disciplines. This was confirmed through review of staff rosters for the month prior to the inspection, as all shifts had been covered for each discipline. Regular agency staff covered 8.9% of nursing shifts, while 1.8% were managed through redeployment. Inspectors noted that 35.7% of HCA shifts were covered by regular agency and 3.6% were redeployed from St. Anne's CNU. Additional agency HCA staff were also rostered during this period to compensate for core staff attending mandatory training, and further staff were rostered in response to the increased patient admissions during a weather alert. Redeployment from St. Anne's CNU covered 3.6% of the unfilled MTA shifts.

One WTE medical officer role was filled by two local GPs. A medical officer provided cover for the hospital (from Monday to Friday from 8am to 5pm) attending the hospital for

patient admissions and as required. There were also appropriate arrangements in place for night cover during out-of-hours times.

Staff training

The DON had oversight of staff training and had systems in place to monitor and record staff attendance at mandatory and essential training. It was evident from staff training records reviewed by inspectors and from speaking with staff, that they were up to date with the appropriate training. Good compliance rates were identified as 100% of staff had completed training in standard and transmission-based precautions, hand hygiene, basic life support and open disclosure training. All nurses had attended medication safety training. In addition, all nurses and all MTAs had completed complaints management training, while 83.3% of HCAs had completed the training.

Employee Supports

Staff demonstrated awareness of the available supports, including access to the Employee Assistance Programme (EAP) and occupational health services. Informational signage regarding EAP resources and access procedures was observed in the staff office.

Overall, inspectors found that hospital management had effective arrangements in place to plan, organise and manage their staffing levels to support the provision of high-quality, safe healthcare. While all shifts were currently being covered, the reliance on agency staff to cover staffing shortages is an area that requires improvement.

Judgment: Substantially compliant

Quality and Safety Dimension

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

Clifden District Hospital was found to be partially compliant with NS 2.7, substantially compliant with NS 2.8 and 3.1 and compliant with NS 1.6, 1.7, 1.8 and 3.3.

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

It was evident through observation of care provided, and through discussions with both staff members and patients that staff in Clifden District Hospital were aware of the need to respect and promote patients' dignity, privacy and autonomy. Patients were cared for in an environment that not only protected, but also promoted their dignity and privacy. For example, staff were observed to use privacy curtains when providing assistance and personal care to patients.

As there was only one clinical area in use in the hospital, male and female patients were accommodated in the same ward. On the day of inspection there was no gender mix observed and instead male and female patients were separated into different bays to maintain their dignity and privacy. The DON informed inspectors that mixed-gender bays were not permitted in the hospital.

Inspectors observed that the physical environment promoted the privacy, dignity and confidentiality of patients receiving care. There were three single rooms within the clinical area, inspectors were informed that these were allocated based on clinical need. For example, patients in receipt of palliative care and patients who required isolation were prioritised for accommodation in these rooms. The three single rooms were spacious and had en-suite facilities. The visitors' room also facilitated confidential discussions between patients and medical officers, ensuring privacy.

Patients' personal information in the clinical area visited was observed to be protected and stored appropriately. Patients' healthcare records were securely stored behind a key-code-protected door in the nurses' office.

Inspectors observed that staff consistently interacted with patients throughout the inspection, demonstrating kindness, care and respect. Patients who spoke with inspectors were very complimentary of the staff, as described at the beginning of this report.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital and this is consistent with the human rights-based approach to care promoted by HIQA.

Judgment: Compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.
Inspectors observed that a culture of kindness and consideration was actively promoted by all staff in the clinical area visited by inspectors. Staff were observed to communicate and engage with patients in an open, caring and respectful manner. This was validated by patients who spoke with inspectors, as they expressed their satisfaction with the care provided by staff, and praised staff for their kindness as outlined at the beginning of the report. The hospital welcomed feedback from people using the service and it was evident that patients were comfortable raising issues or concerns with staff. Three patients outlined that if they had a concern or wanted to make a complaint, they would talk to a member of staff. The hospital had provisions to facilitate patient access to independent advocacy services when needed, with information leaflets about these services on display. Patients' views, values and preferences were actively sought and taken into account by staff. This was observed through different food options at meal times. Two patients who spoke with inspectors, expressed their satisfaction with the food provided at the hospital. Overall, it was clear that hospital management and staff fostered a culture of kindness, consideration, and respect for people accessing and receiving care at the hospital.
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 DON was the designated Complaints Officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints within the hospital. Inspectors were informed that the DON could also access a complaints manager within CHW if support was required. The hospital did not have its own local complaints policy but followed the HSE's '*Your Service, Your Say' to* manage complaints.

It was evident there was a culture of local complaints resolution in the clinical area visited. Staff members who spoke with inspectors, explained that they would address a verbal complaint by seeking to resolve it locally. If the issue could not be resolved locally, it would be escalated to the DON and subsequently to the Older Persons Manager. Staff were familiar with the '*Your Service, Your Say'* policy and demonstrated to inspectors how to access it. Minutes of staff meetings that were viewed by inspectors, showed that complaints management was a standing item on the agenda. There was evidence of management directing staff to the '*Your Service, Your Say'* policy and discussions of how to resolve complaints, at a local level. Staff also attended training on how to assist people in making a complaint. At the time of inspection, 100% of nursing staff, 100% of HCAs and 100% of housekeeping and cleaning staff had attended this training.

Inspectors observed a suggestion box at the hospital entrance, along with posters detailing how to make a complaint, including contact information for the HSE's '*Your Service Your Say*'. Additionally, information about advocacy services and how to contact them was prominently displayed in the foyer of the hospital.

The DON was responsible for maintaining a log of all written and verbal complaints. The DON also formally tracked and analysed complaint trends annually. In 2024, up to the date of inspection, the hospital had received four informal verbal complaints, all of which were resolved at point-of-contact, and therefore, within the HSE target timeline of 30 days. There were no trends observed for this time period and therefore no quality improvement plans implemented as a result.

Patients who were asked if they knew how to make a complaint, indicated that they were not aware of the process but would seek information from a staff member if needed. Inspectors were informed that feedback in relation to complaints was provided to staff at staff meetings and staff handovers. The DON explained that patients' care is not affected as a result of them having made a complaint, as the patient's name is never highlighted when learning is shared with staff.

Overall, HIQA were assured that the hospital had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service.

Judgment: Compliant

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.

Inspectors visited the clinical area which was a seven-bedded ward comprising one open ward which could accommodate up to 12 patients and three single rooms with en-suite

facilities. Inspectors were told by hospital management that the number of beds in the open ward were adjusted according to the needs and number of admitted patients. None of the single rooms had anterooms. At the time of inspection, seven beds were occupied on the open ward and none of the single rooms were in use. Inspectors were informed that there were no neutral or negative pressure rooms in the hospital.

Wall-mounted alcohol based hand sanitiser dispensers were located strategically throughout the hospital with hand hygiene signage clearly displayed throughout the clinical area. Inspectors noted that hand hygiene sinks conformed to requirements[†††]. However, there was no clinical hand-wash sink installed in the clinical treatment room. The last HIQA inspection, identified there was no dedicated cleaning room in the hospital resulting in inappropriate storage of cleaning equipment in the dirty utility room. On the day of inspection, inspectors observed that the provider had not addressed this issue. This had also been identified as a non-compliance in a recent HSE Community Nursing audit completed by an IPC Clinical Nurse Specialist (CNS) from CHW. Management informed inspectors that there were plans to reconfigure the dirty utility room to partition part of it as a dedicated space for cleaning equipment. Inspectors observed clean equipment being stored alongside laundry skips in the anteroom of the dirty utility room. This was brought to the attention of the DON and a risk assessment was completed while inspectors were on site.

Physical distancing of one metre was observed between beds in multi-occupancy rooms. Inspectors observed that overall, the physical environment was free from clutter, clean and well maintained, with a few exceptions. There was evidence of minor wear and tear observed, with a few areas of paint work and wood finishes chipped.

On the day of inspection, there were no inpatients that required isolation. However, inspectors were told that if patients required isolation, they would be accommodated in one of the single rooms. The DON reported that if an isolation room was not available, then relevant patients were managed in line with the isolation prioritisation policy. Appropriate signage was available to place outside of the patient's door to alert healthcare workers of the need to apply transmission-based precautions. While none of the single rooms were in use on the day of inspection, inspectors noted that the wardrobes were being used as storage space for some linen and equipment. This was brought to the attention of the DON and addressed on the day of inspection.

MTAs were responsible for environmental cleaning while equipment cleaning was carried out by the HCA and the nurse on duty. Out-of-hours cleaning was performed by the HCA. On the day of inspection equipment was observed to be clean. Inspectors observed that checklists and lists of cleaning duties were maintained, all of which were complete with no gaps. The DON in the absence of the CNM2 was responsible for monitoring the

[†††] Department of Health, Warded Kingdom. Health Building Note 00-10 Part C: Sanitary Assemblies. Warded 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

cleanliness, quality and oversight of the cleaning schedules on the ward. The DON informed inspectors that there were sufficient cleaning resources in place, and advised that the hospital brings in additional agency cleaners to conduct a thorough cleaning on a quarterly basis.

Hazardous material and waste was safely and securely stored in each clinical area visited. Inspectors observed appropriate segregation of clean and used linen.

The appropriate measures were in place to ensure the security of the hospital. The hospital main entrance door was locked at all times, to accommodate the needs of the patients and ensure their safety. Upon making a request to staff, patients were permitted to go outside.

In summary, HIQA was not fully assured that the physical environment comprehensively supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care, due to:

- the lack of a dedicated cleaning room, resulting in the improper storage of cleaning equipment in the dirty utility room
- the absence of a clinical hand-wash sink in the clinical treatment room
- linen and equipment were inappropriately stored in wardrobes within single rooms
- there was a mix of clean and dirty items in the dirty utility room, where clean equipment was stored alongside laundry skips.

Judgment: Partially Compliant

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

Hospital management were proactively and systematically monitoring, evaluating and responding to information from multiple sources to inform improvement, and provide assurances to CHW on the quality and safety of the service provided to patients. While there was no annual audit schedule in place for the hospital, there was evidence that audit results were reviewed or evaluated by the DON.

Hospital management monitored and regularly reviewed performance indicators in relation to infection prevention and control. The IPC link nurse was responsible for monitoring and evaluating infection prevention practices in the clinical area. This position was temporarily assumed by the IPC link nurse in St. Anne's CNU, during the absence of the IPC link nurse in Clifden District Hospital. The IPC link nurse was responsible for overseeing the findings from audits related to environment, equipment, sharps management, waste management, and hand hygiene.

Inspectors reviewed a range of environmental audits completed from August to December 2024. Although non-compliances were detected, no overall score was assigned to the completed audits. For each audit where non-compliances were identified, the DON ensured the implementation of a detailed, time-bound action plan, with designated responsible individuals. Peer-to-peer hand hygiene audits were also conducted bi-monthly.

An IPC CNS from CHW had undertaken an IPC environmental audit in the clinical treatment room in August 2024 using the HSE Community IPC Nursing Healthcare Audit Tool. The audit report identified multiple environmental non-compliances, such as the absence of a clinical hand-wash sink in the treatment room, damaged furnishings, and the need for repairs to walls, ceilings, floors, and paintwork. A quality improvement plan had been developed by the unit, using the findings and recommendations of this audit. There was evidence that the recommendations were being implemented and monitored. Only one recommendation remained pending at the time of inspection, which was the installation of a clinical hand-wash sink. This issue was under continuous discussion, as the room was awaiting refurbishment. Inspectors observed that a re-audit had not been conducted within the recommended one-month timeframe, as advised by the auditor.

It was evident that the hospital lacked a structured audit schedule, as only a single audit was made available to inspectors concerning sharps management and waste management. This infrequency of audits highlights a significant gap in the hospital's oversight and quality assurance processes. Inspectors noted that time-bound action plans were established to address areas requiring improvement. However, one area identified for improvement was the lack of an overall score in the audits.

The hospital submitted a monthly healthcare-associated infection surveillance report to the IPC and AMS committee. This provided an ongoing level of assurance to management in CHW, in relation to the quality and safety of services, in particular the burden of healthcare associated infection and antimicrobial resistance in the hospital and the effectiveness of IPC and AMS measures.

In accordance with CHW reporting requirements, the hospital provided reports on incidents of:

- *clostridioides difficile*
- *carbapenemase-producing enterobacterales (CPE)*
- outbreaks.

Inspectors reviewed CHW quarterly reports received from the hospital for quarters one, two and three in 2024 for the '*Monthly Monitoring of a Healthcare Associated Infection - Antimicrobial Resistance (HCAI/AMR) and Antimicrobial Consumption minimum dataset'.*

The three reports for 2024 documented a single case of CPE within that year, with no outbreaks reported. The *'Skip the Dip'* initiative was implemented at the hospital in 2024, leading to a significant reduction in antibiotic prescriptions for urinary tract infections.

There was evidence of monitoring and evaluating medication safety practices at the hospital. Medication chart audits were conducted, however, the evidence presented to inspectors indicated that only three audits had been completed between September 2022 and December 2024. When non-compliance was identified in the audits, an action plan was developed with specific timeframes and a designated responsible person. Inspectors noted that no overall score was allocated to the audit.

Staff were knowledgeable about the procedures for managing and escalating care for patients who deteriorated and required transfer to an acute care facility. There was no evidence of audit or evaluation of the escalation process. Although there were no audits being conducted in the hospital regarding transitions of care at the time of inspection, a document was presented to inspectors which outlined a plan for audits in 2025, indicating that admission and discharge practices would be audited in January 2025.

While inspectors found that the effectiveness of healthcare was broadly being systematically monitored, evaluated and continuously improved, there were opportunities to make further improvements. In particular, the application of attention to more frequent and regular audit and by completion of audit with the use of an overall score which could have provided a more comprehensive assessment of compliance and performance. Additionally, management needed to ensure that re-audits were conducted as necessary.

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 hospital had systems in place to identify and manage risks. Risks in relation to the service were recorded on a risk register and reviewed annually by the DON in the absence of the CNM 2. Inspectors were informed that any risks that could not be managed locally were escalated to the Manager for Older Persons' Services in CHW for further review and action. Inspectors reviewed the hospital's risk register, risks had owners assigned and controls, and actions in place to manage and reduce recorded risks. There was evidence that risks and associated controls were being regularly updated by the DON. Inspectors observed that one of the reviewed risk assessments lacked a specified due date for the implementation of additional controls. This issue was brought to the attention of the DON and was rectified on the day of the inspection. Inspectors were informed that risk registers were a standing agenda item at the CHW

Older Persons' Services Quality and Safety Committee monthly meetings, this was evidenced in the meeting minutes reviewed by inspectors.

Infection prevention and control

All admissions were planned in advance. Patient referrals to the hospital were reviewed by the nurse-in-charge before acceptance, with the referral form documenting any known infections. Patients admitted to the hospital were not routinely screened for Multi-Drug Resistant Organisms (MDRO) or transmissible infections, however, patients identified as having a MDRO in the pre-assessment document were managed according to the HSE community infection prevention and control guidelines. A prioritisation system was in place in the hospital to allocate patients to single rooms. Both staff and management confirmed that terminal cleaning was conducted following suspected or confirmed infectious cases.

The hospital had an IPC link practitioner who was available to staff for IPC advice. The IPC link practitioner also had access to the CHW IPC and AMS team. Inspectors were informed that an outbreak had never occurred in Clifden District Hospital. Management staff demonstrated a thorough understanding of the procedures to follow in the event of an outbreak, including the necessity to complete an outbreak report to facilitate future learning.

As discussed under national standard 2.7, inspectors noted that the risks associated with storing clean equipment alongside laundry skips in the anteroom of the dirty utility room had not be recognised, prior to the inspection. This issue was brought to the attention of the DON, and a risk assessment was produced while the inspectors were on site. The DON promptly addressed the issue, resulting in the removal of all clean equipment from the room.

Medication safety

As discussed under national standard 5.5, the hospital or CHW did not employ a pharmacist for oversight and support of medication management. The hospital implemented a medication practice requiring patients to bring their own medications in original packaging, upon admission. For patients transferred from an acute hospital, the discharging hospital was required to email the patient's medication list to the receiving hospital, prior to admission. In cases where patients were admitted from home for respite care, a respite transition form was provided to the family in advance, requesting detailed information on the patient's medications. Upon the patient's admission, nursing staff performed medication reconciliation by verifying the provided medication lists against the medications with which the patient presented. Staff who spoke with inspectors were knowledgeable and confirmed that these processes were being followed. A sample of medication prescribing and administration records were reviewed, however there was no evidence of medication reconciliation being completed. Inspectors observed that the medication trolley was locked and securely stored in the nurse's office.

Medications within the trolley were organised with each patient's medication stored in individual bags. An up-to-date British National Formulary (BNF) was available to staff for reference regarding administration of medications. A list of high-risk medicines in the form of APINCH‡‡‡ and sound-alike, look-alike drugs (SALADS) were also available on the drug trolley.

Inspectors observed that the temperature for the medication fridge was checked daily and was within the recommended temperature parameters. Inspectors observed that there was an open insulin pen being stored in the fridge without patient identification. This was brought to the attention of the nurse-in-charge and the insulin pen was discarded. Inspectors spoke with staff who demonstrated an understanding of the risk-reduction strategies for high-risk medications.

Deteriorating Patient

Management and nursing staff outlined the processes in place to support the early detection, escalation and management of a deteriorating patient in Clifden District Hospital. On admission of patients, baseline vital signs were established using a standard vital observation chart. Daily vital signs were recorded for each patient, and any changes or signs of deterioration were promptly acted upon with a review by the medical officer. As discussed under national standard 5.2, the hospital had arrangements in place to ensure the medical officer role was covered during out-of-hour periods. In the event that a patient became acutely unwell, nursing staff could arrange a transfer to the acute hospital by ambulance. An ambulance base was located on the grounds of Clifden District Hospital. The DON also maintained comprehensive records of data pertaining to patients who were transferred back to the acute hospital.

Transitions of care

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services, and support safe discharge planning. It was evident to inspectors, from reviewing a sample of patient healthcare records, that the patient's personal details, medical history, current medications and infection status were recorded on the discharge and transfer forms. To ensure all relevant information regarding the patient's care was handed over in advance of a transfer, a verbal handover using a standardised template took place between the acute hospital and the rehabilitation and community inpatient hospital. Clinical notes from the acute hospital were photocopied and accompanied those patients with a complicated medical history. Patients referred for respite care, were provided with a cover letter and a respite transition form (to be completed prior to admission), ensuring the comprehensive transfer of all relevant details regarding the patient's care.

‡‡‡ APINCH is an acronym used to identify high risk medicines and includes anti-infective agents, potassium, insulin, narcotics and sedatives, chemotherapy and heparin and other anti-coagulants.

Policies, Procedures, Protocols and Guidelines (PPPGs)

The hospital did not have an electronic document management system, instead it maintained a collection of hard copy PPPGs that were available to guide and inform staff. The 'Missing Person Guideline' was observed to be outdated. In addition, a number of policies had been adapted from the community nursing units which have a different philosophy of care based on the status of the person using the service, than the rehabilitation and community inpatient hospitals, for example a resident or a patient. This was discussed with the DON and the General Manager of Older Persons Services in CHW who confirmed that work was in progress at the CHW level to develop a region-wide database aimed at centralising and developing PPPGs. Additionally, the General Manager of Older Persons Services in CHW confirmed their intention to formulate policies specifically tailored to the rehabilitation and community inpatient hospitals.

Overall, the hospital had systems in place to identify and manage potential risks associated with the four areas of harm, however a number of areas were identified for improvement. The risks of storing clean equipment alongside laundry skips in the anteroom of the dirty utility room were not identified prior to the inspection, however this was promptly addressed by management on the day of inspection. Additionally, there was a need for improved monitoring of PPPGs due for revision and ensuring that policies are appropriately adapted for the district hospital.

Judgment: Substantially Compliant

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

Clifden District 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. Clinical incidents were reported by staff on a paper-based system and then escalated to the DON for review in the absence of the CNM 2. Onsite administrative staff were then responsible for inputting these on NIMs. Inspectors spoke with staff in the clinical area who were knowledgeable about how to report an incident, and were able to describe incidents that they had previously reported and the process for reporting them.

The DON tracked and trended patient-safety incidents for the hospital, a total of 17 incidents were reported to NIMS in 2023 with 88% (15 incidents) recorded within 30 days. The majority of these incidents were related to slips, trips, and falls (53%), followed by self-injurious behaviour (17%), medication accounted for 12% of incidents, while 6%

were related to violence, harassment and aggression, 6% were related to ergonomics and the remaining 6% were in relation to work equipment.

A total of 15 incidents were reported from January to December 2024, the majority (60%) were related to slips, trips and falls, 20% were related to care management, 7% were related to violence, harassment and aggression, and 7% were related to systems or installations while the remaining 6% were in relation to HSA dangerous occurrences. The summary of incidents reported to NIMS for 2024 provided by management, indicated that all 15 incidents were entered into NIMS within 30 days of notification, thereby meeting the HSE national target.

Inspectors were informed of a patient safety incident that occurred on the first day of the inspection. This incident was observed to have been managed appropriately by staff and management, in accordance with the hospital's relevant guideline, although the specific guideline was noted to be out-of-date at the time of inspection. Category 1 incidents and SREs were escalated to the SIMT. The SIMT held a weekly meeting to discuss incidents which fell under the remit of the Older Persons' Services within CHW to formulate recommendations, and review the outcomes.

Both ward staff and management reported that incident feedback is disseminated during staff handovers and ward meetings. The minutes of the general staff meeting reviewed by inspectors indicated that incidents were a recurring agenda item, and it was evident that staff were encouraged to report incidents, as deemed appropriate.

Overall, HIQA was satisfied that the hospital had a comprehensive system in place for identifying, reporting, managing, and responding to patient-safety incidents, particularly concerning the four key areas of harm, and ensuring that learnings were disseminated among staff.

Judgment: Compliant

Conclusion

An announced inspection of Clifden District Hospital was carried out 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

Inspectors observed that while the CHW had some formal corporate and clinical governance arrangements in place for Clifden District Hospital, several areas were identified for potential improvement. For example, although inspectors were told that the CHW were in the process of establishing a formal medication safety committee, there was an absence of a specific

forum to escalate, manage, and monitor issues related to medication safety at the time of inspection. Not all committees were meeting in line with their terms of reference (TOR) and some committees lacked up-to-date TORs. Additionally, committee minutes would benefit from having clearly defined, time-bound actions.

HIQA was satisfied that the hospital had established local management arrangements to effectively manage, support, and oversee the delivery of high-quality, safe, and reliable healthcare services in areas such as medication safety, infection prevention and control, the deteriorating patient, and transitions of care. One area identified for improvement was the need to document when medication reconciliation has been completed in the patient's prescription chart.

Inspectors found that hospital management had effective arrangements in place to plan, organise, and manage their staffing levels to support the provision of high-quality, safe healthcare. However, the reliance on agency staff to cover staffing shortages was identified as an area requiring improvement. While all shifts were currently being covered, this approach may not have long-term sustainability.

Quality and Safety

Hospital staff promoted the dignity, privacy and autonomy of people receiving care at the hospital, and this was consistent with the human rights-based approach to care promoted by HIQA. People who spoke with inspectors were positive about their experience of receiving care in the hospital, and were very complimentary of staff. The hospital also had systems and processes in place to respond promptly, openly and effectively to complaints and concerns raised by people using the service.

Inspectors found that the hospital's physical environment did not adequately support the delivery of high-quality, safe, reliable care to protect the health and welfare of people using the service. A number of issues identified in the clinical area had the potential to impact on infection prevention and control measures in the hospital. For example, the storage of clean equipment in proximity to contaminated items in the anteroom of the dirty utility room. This issue was promptly addressed by management on the day of inspection through the completion of a risk assessment, and the removal of all clean equipment from the room.

The hospital was systematically monitoring and evaluating healthcare services provided at the hospital which were appropriate to the size and scope of the hospital. Areas identified for improvement included an increase in the frequency of audits and completion of audits through use of an overall score, which will help provide a more comprehensive assessment of compliance and performance.

The hospital had systems in place to identify and manage potential risks of harm associated with infection prevention and control, medication safety, the deteriorating patient and transitions of care. Inspectors observed the need for improvement in relation to the

monitoring of PPPGs due for revision and ensuring that policies are appropriately adapted for the rehabilitation and community inpatient hospital. The hospital also had a system in place to identify, manage, respond to and report patient-safety incidents, in line with national legislation and standards, policy and guidelines.

Following this inspection, Clifden District hospital submitted their compliance plan and have provided updates on the findings outlined in this report. The hospital management has also indicated what further steps are being taken to bring the hospital into compliance with the standards where they were found to be partially compliant. HIQA will, through the compliance plan (see Appendix 2), continue to monitor the progress in relation to these outstanding actions and standards.

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	Partially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
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.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially Compliant
Theme 3: Safe Care and Support	
National Standard	**Judgment**
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Appendix 2

Service Provider's Response

National Standard	Judgment
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Partially Compliant
Outline how you are going to improve compliance with this national standard. This should clearly outline: (a) details of interim actions and measures to mitigate risks associated with non-compliance with national standards.	

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

- A record of remote and in person meetings between Director of Nursing and Older Persons Management will be maintained , in addition to existing email records that issue post regular consultations on matters arising.
- The need for time bound actions to be recorded in the various governance meetings reviewed by the inspectors is being communicated to the relevant committees for action.
- The need for updated Terms of Reference for the various governance meetings reviewed by the inspectors is being communicated to the relevant committees for action.
- The need for meeting in line with existing TOR's for the various governance meetings reviewed by the inspectors is being communicated to the relevant committees for action.
- Access to a formal medication safety to committee is under review at present as advised during the inspection and reported on in this report. It is expected this will be in place by the end on September 2025.

Timescale:

All actions identified will be complete on or before 30/9/2025

National Standard	**Judgment**
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant

Outline how you are going to improve compliance with this national standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with national standards.

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

- A dedicated cleaning room will be provided in the hospital on or before 30th June 2025

- A clinical washand sink will be provided in the Clinical Treatment room on or before 30th June 2025
- The storage of linen and equipment inappropriately in single rooms has ceased.
- The storage of a mix of clean and dirty items in the dirty utility room has ceased