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:	Listowel Community Hospital District Unit
Centre ID:	OSV-0007276
Address of healthcare service:	Greenville Road Listowel Co Kerry
Type of Inspection:	Announced
Date of Inspection:	08/04/2025 and 09/04/2025
Inspection ID:	NS_0135

About the healthcare service

Model of hospital and profile

Listowel Community Hospital District Unit was a Health Service Executive (HSE) Rehabilitation and Community Inpatient Healthcare Service (RCIHS). It is a member of and is managed by the Regional Health Area South West[1] (RHA SW). For the purpose of the report Listowel Community Hospital District Unit will be referred to as the Unit. The Unit comprised of 16 beds including 13 community support beds, two short-stay respite beds and one palliative care bed. The Listowel Community Hospital was also a designated centre for older persons.

The following information outlines some additional data on the hospital.

Number of beds	16

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare Version 2 2024 (National Standards)* as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors[†] reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information[‡] and other publically available information since last inspection.

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[1] The Regional Health Area HSE South West provides health and social care services to Cork and Kerry. HSE South West includes all hospital and community healthcare services in the region. This includes South / South West Hospital Group and Cork Kerry Community Healthcare.

[†]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.

[‡] Unsolicited information is defined as information, which is not requested by HIQA but is received from people including the public and or people who use healthcare services.

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 Unit
- 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 Unit. It outlines whether there is appropriate oversight and assurance arrangements in place and how people who work in the service are managed and supported to ensure high-quality and safe delivery of care.

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector
08/04/2025	09:20 – 18:15	Marguerite Dooley	Maeve McGarry
09/04/2025	09:10 – 14:10	Marguerite Dooley	Maeve McGarry

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, these being:

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

The inspection team visited the District Unit.

During this inspection, the inspection team spoke with staff, representatives of the hospital's management team, regional management, regional infection and prevention and control.

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.

[§] 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

Listowel Community Hospital District Unit was a 16-bedded unit. On the first day of the inspection there were 13 patients present in the Unit. The inspectors were informed that there were no admissions or discharges expected. The clinical area visited included four single rooms. One of the single rooms, available for palliative care patients, was spacious and was equipped with a ceiling hoist. The room had a sofa and a kitchenette for use by patients' family members. There were two three-bedded rooms. There was one six-bedded room with a floor to ceiling divider separating the room into two. All rooms had televisions and call bells.

An enclosed patio area with seating and a water feature, a library, and a dining room with a sofa and a television were available for patient use. Patients also had access to the internet. There was wall mounted art, mosaics, poetry and a 'museum' glass press holding historic items of interest. There was a private room for family meetings and ample seating on the corridor for patients and visitors. There was a kitchenette available for use by patients' family members, with tea and coffee making facilities.

The inspectors spoke with a number of patients and relatives, to ascertain their experiences of receiving care in the Unit. Patients said they get 'help with everything', 'get their tablets on time' and are 'very well looked after'. There is good 'food choice' and staff 'assist with meals'. However one patient noted that while the staff assist with care needs, they are 'too busy'. One relative said the Unit had linked their parent with the Integrated Care Programme for Older Persons (ICPOP). Relatives said the Unit was 'top class' and had a 'very good reputation', this view was supported by feedback to staff.

While patients who spoke with inspectors did not have a complaint, some did not know how to make a complaint but would 'speak to a nurse'. One relative noted their parent had received an admission booklet which gave detail on the HSE '*Your Service, Your Say*'. A wide range of information, appropriate to the profile of patients using the service was on display and this included a statement of purpose, five moments of medication safety, 'know, check, ask' medication leaflet and advanced care directive.

In summary patients and relatives were very complimentary about the staff and the care received in the Unit and this was consistent with what the inspectors observed over the course of the inspection.

Capacity and Capability Dimension

Inspections findings related to the capacity and capability dimension are presented under four national standards from the themes of leadership, governance and management, and workforce. Listowel Community Hospital District Unit was found to be compliant with two national standards (5.5, 6.1) and substantially compliant with two national standard (5.2, 5.8) 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.

Through discussions with senior management and staff the inspectors found that the Unit had formalised corporate and clinical governance arrangements in place to assure the quality and safety of healthcare services.

Organisational charts viewed by the inspectors set out the Unit's reporting structures detailing the direct reporting arrangements. The Director of Nursing (DON) had overall responsibility and accountability for the governance of the Unit and had a direct reporting structure to the General Manager (GM), residential services for older persons, Cork - Kerry. The GM reported to the Head of Service (HOS) for older persons, the Integrated Healthcare Area (IHA) Manager (regional lead older person's services) and the Regional Executive Officer (REO). Administration, groundsman and catering staff reported to the DON. Nursing, Healthcare Assistants (HCAs) and support staff reported to a Clinical Nurse Manager 2 (CNM 2). The CNM 2 reported to the DON. Inspectors were advised that the DON could be contacted at any point by staff, if required out-of-hours.

The GM chaired 'services for older people' DON management team meetings. Inspectors were informed that meetings occurred every two to three weeks or more frequently as required. However terms of reference were not available for this group. Chaired by the GM, attendance included DONs, Clinical Development Coordinator, and the ADON infection prevention and control (IPC) as required. Minutes showed meetings followed a structured format and actions were followed up from meeting to meeting. Actions were not always assigned to an individual. Agenda items included the risk register, IPC, activity and clinical development to include audits, quality improvement initiatives and policies. Minutes included medication safety education, the National Clinical Guideline (NCG) 21 related to the appropriate prescribing of psychotropic medication, IPC updates and assisted decision making. Minutes reflected that risk registers were updated, and the GM had submitted a 'due diligence' template to the RHA SW, which took into account any risks outstanding, investigations and Quality and Patient Safety issues across sites.

A GM chaired quarterly 'services for older people, quality and patient safety (QPS) management team' meetings. Terms of reference (TOR) indicated the frequency of meetings should be monthly as opposed to quarterly and therefore the TOR should be reviewed and the schedule of meetings aligned accordingly. The TOR for the QPS committee Kerry Community Hospitals outlined the aim was 'to ensure that there are appropriate and effective systems in place that cover all aspects of clinical quality and safety in Kerry community hospitals'. Membership included DONs, QPS and the Clinical Development Coordinator. Agenda items included quality improvement, audits, training, risk registers, incidents and policies. Minutes reflected that agenda items were discussed in detail in June 2024 and February 2025. Minutes reflected that the meeting which took place in March 2025 was a 'ratification QPS management team meeting', and inspectors were informed that this meeting was specifically for the ratification of policies. However agenda's indicated that incidents were the only item planned for discussion at the December 2024 and March 2025 meetings.

The DON had oversight of the hospital risk register, and risks were discussed at the fortnightly DON management team meeting, and were an agenda item at the quarterly QPS meetings. Inspectors were informed that a QPS representative was assigned to the Unit to assist with incident reviews if required. Should a serious reportable event (SRE) occur, the DON would be invited to attend a Serious Incident Management Team (SIMT) meeting. The DON was responsible for implementing actions and recommendations arising from the SIMT. At the time of the inspection there were no open SREs and inspectors were informed that any recommendations from previous SREs had been implemented and closed.

Local QPS meetings were conducted quarterly in line with the terms of reference. The objective of these meetings was to ensure that there were appropriate and effective systems in place that covered all aspects of clinical quality and safety in Listowel Community Hospital. Chaired by the DON and attended by the CNM2, HCAs, health and safety representatives and support staff. The committee was directly responsible, and forwarded minutes to the GM older persons. Meetings followed a structured format and agenda items included documentation, incidents, risk register, training, quality improvement, IPC and safeguarding. However, inspectors found that actions were not always assigned to an individual and were not time-bound.

Medical Officer cover was provided by three General Practitioners (GPs) from two local practices. A weekly on-call rota was in place and available in the nurses station. A Medical Officer attended the hospital for one hour on Monday, Wednesday and Friday and inspectors were informed that the Medical Officer could be contacted outside of these hours if required. An out-of-hours GP medical service was contacted should a patients' condition deteriorate out-of-hours. Inspectors were informed that a regional deteriorating patient committee meeting was convened in February 2025 chaired by the Regional Clinical Director. Inspectors were informed that meetings would be scheduled

every two months. Membership included the Clinical Development Coordinator, who was provided with the opportunity to give context and examples of deteriorating patient incidents in community services settings and any variance within. The Clinical Development Coordinator provided feedback from this meeting to the DON.

Drugs and Therapeutic Committee (DTC) meetings for RHA SW, were convened quarterly. Chaired by a GM, emerging trends and risks were discussed. Membership included the Clinical Development Coordinator who provided feedback to the DON.

The Unit had an assigned CNM 2 IPC, RHA SW and staff also had access to an ADON IPC, RHA SW. The DON and staff within the Unit could contact IPC directly or via a generic e-mail for advice. Inspectors were informed that the ADON IPC linked with the Department of Public Health, on a fortnightly basis. Staff had access to advice and education from an antimicrobial pharmacist, and a consultant microbiologist was available to RHA SW ten hours per week. The ADON IPC attended quarterly IPC and antimicrobial stewardship (AMS) meetings with community colleagues. TOR were not provided for this meeting. Minutes reflected membership was multidisciplinary, and items discussed included IPC, AMS, risks, updates from both services and the consultant microbiologist. Actions were assigned to an individual but were not time-bound. Minutes from the DON management team meeting indicated that due to the recent transition to the RHA, the next IPC-AMS meeting would be convened in June 2025 once changes to the governance structures were in place. Hygiene services were provided to the Unit through an external contractor, up to 40 hours per week, in conjunction with the Unit staff.

Overall the inspectors were satisfied that the Unit had formalised corporate and clinical governance arrangements in place appropriate to the size and complexity of the service, but improvements were required to ensure that :

- actions from meetings are assigned to individuals and are time-bound
- ensure the schedule of regional meetings are in line with the terms of reference
- terms of reference are available for all regional meetings.

Judgment: Substantially Compliant

Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.
Inspectors found that there were management arrangements structures and mechanisms in place to support the delivery of safe, high quality and reliable healthcare services at the Unit. The Unit captured daily activity and this will be discussed further under standard 5.8. The Unit had an admission and discharge policy but it did not include admission-exclusion criteria. Admissions to the Unit were through referral and transfer from acute hospital services, referral from Public Health Nurses (PHNs) and the palliative care team Kerry. The DON attended a daily 'older persons delayed transfer of care (DTOC) call' at 9.30am led by the GM. Updates were provided on available capacity, expected discharges, IPC, ICPOP and home support referrals. There was also a weekly DTOC call with the GM and data relating to the number of 'bed days saved' was being collated. There was one DTOC patient in the Unit for a prolonged period of time due to a lack of availability of home support provision. Admission to the Unit required the consent of the patient. Acceptance of patients from acute services was through the Liaison Community Support Team (LCST). Weekend transfers to the Unit from acute settings was through direct communication from the hospitals. The DON reviewed all referrals prior to acceptance. Transfers from acute services generally took place on the same day. Referrals for respite were through the PHN service. All patients had a clinical admission conducted by the Medical officer and evidence of clinical documentation was seen in patient's healthcare records. While a weekly clinical ward round was not conducted, nursing staff could bring a concern to the Medical officer and seek to have a patient reviewed when required. On discharge patients received a nursing discharge letter, a prescription and a letter for their GP. Copies were sent to the Assistant Director of Public Health Nursing (ADPHN), and copies were kept on file in the Unit. The Unit had an approved Medication Management Policy. The PHN provided patients and their families with a medication record or Medicines Prescription and Administration Record (MPAR). The completed MPAR was brought by the patient on admission to the Unit as part of the pre-admission documentation. The medication management PPPG had a list of sound-alike-look-alike-drugs (SALADs) and high-risk medications, and outlined a number of risk reduction strategies. Nurse-led medication reconciliation was conducted prior to admission by two nurses. For respite patients this review took place a number of days prior to admission to allow any queries to be dealt with in advance. For transfers from the acute services, the list of medications was compared to the list provided by the LCST. Inspectors were informed that medications were also checked with the patient on admission or with their next of kin. Inspectors saw evidence of nurse-led medication reconciliation in the admission assessment nursing care plan.

There was an on-site pharmacy, staffed by a pharmacist who worked in the Unit 10 hours a week, during Monday to Friday. There was no cross cover available for periods of leave, but the DON or senior staff had access to the pharmacy outside of hours if required. The pharmacist conducted pharmacist-led medication reconciliation and inspectors saw evidence of this in seven of nine medication records reviewed. The Medical Officer also reviewed the medication of patients from the acute services and evidence of this practice was documented in the healthcare records. Medications for respite patients was not altered unless a query was raised by nursing staff. Changes to patient medications were documented in a discharge letter to the patients GP. Admissions from an acute service required a three-day prescription as part of the pre-admission documentation and in line with the medication management PPPG. Patients for respite or palliative care brought their own medications on admission, blister packs were not accepted to mitigate potential prescription or medication errors. The MPAR, had the patient's name, address and photographic identification. Patients were asked for their consent to have a photograph taken and a patient identification band was also worn.

The Medical Officer and a number of staff had access to diagnostic results and services. A mobile radiology service was available to the Unit and staff acknowledged that the response to requests was within 24 hours. Radiology reports were issued through Healthlink[§§] and inspectors were informed that reports were available promptly, typically within four hours. All diagnostic reports were signed by the Medical Officer. In the event that a patient deteriorated, the Medical Officer was contacted to review the patient while on-site or could be contacted Monday to Friday outside of these hours up to 6pm. An out-of-hours GP medical service operating from Monday to Sunday (6pm – 8am) was contacted should a patient deteriorate out of hours. The identify, situation, background, assessment, recommendation (ISBAR3)[***] communication tool was used, and the inspectors saw evidence of this in a patient's healthcare record. The medical officer or the out-of-hours GP made the clinical decision if a patient required transfer to an acute hospital setting. Transfer was via the National Ambulance Service (NAS) having contacted the national emergency number '999'. The Clinical Development Coordinator supported the development of policies, procedures, protocols and guidelines (PPPGs) in relation to medication safety and the deteriorating patient, with input from relevant stakeholders.

There was not a requirement to screen patients for multi-drug resistant organisms (MDRO) on admission. Staff at the Unit were pre-alerted to patients requiring admission

[§§] Healthlink is the National Health Messaging broker, funded by the HSE, providing a web-based messaging service which allows the secure transmission of clinical information between Hospitals, Health Care Agencies and Medical Practitioners.

[***] ISBAR3 – Identify, Situation, Background, Assessment, Recommendation, Read Back, is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

who had an active or history of an MDRO through review of the admission documentation and had access to the acute hospital inpatient management system which highlighted MDRO alerts. Staff had access to the online IPC and antimicrobial stewardship (AMS) team catalogue that provided information and resources relating to IPC to determine the appropriate precautions required. Patients were accommodated in a single room and on occasions where this was not possible, patients were accommodated in a multi-occupancy room, on appropriate IPC precautions following completion of a risk assessment. The Unit had a 'Respiratory Viral Infections' contingency plan and during an outbreak a 'line list' of patients involved in an outbreak was issued by the Unit to Public Health on daily basis until the outbreak was closed. The most recent outbreak of infection occurred in September 2024 and a 'review of actions following an outbreak of respiratory infection' circulated to the GM, regional IPC and the Department of Public Health (South), outlined the details of the outbreak, IPC advice, what worked well and a number of recommendations. The decision that a patient no longer required isolation following an outbreak was discussed with the regional IPC and Unit staff. The decision that the outbreak could be closed was taken by the Department of Public Health and was communicated to the Unit through IPC.

Overall the inspectors were satisfied that the Unit had effective management arrangements in place to support and promote the delivery of high, safe and reliable healthcare services.

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 proactive identification, documentation, monitoring and analysis of patient safety incidents in the unit.

The Unit captured daily activity, and bed availability was updated on the HSE community bed management system. Annual activity for 2024 showed there were 158 admissions to the Unit to include 100 community support, 52 respite and seven palliative care, with 156 discharges. Fourteen (9%) patients required unplanned transfer to an acute site in 2024. There were 42 admissions to the Unit from January to the third of April 2025 to include 30 community support, 10 respite and two palliative care, with 45 discharges.

Six (13%) patients required unplanned transfer to an acute site. The Unit captured the reason patient's required unplanned transfer to an acute site and inspectors recommended that this detail should be collated and interrogated to ensure there were no trends emerging.

The DON had oversight of the risk register, risks were reviewed quarterly and at the time of inspection there was one risk specific to the four key areas of harm prioritised under HIQA's monitoring programme. Patient safety incidents were reported by type and category onto the National Incident Management System[†††] (NIMS) and while the highest number of incidents was related to falls, inspectors noted a QIP had not been developed in relation to the number of falls reported. Monthly statistics for the Unit were reported to antimicrobial resistance infection prevention and control (AMRIC), and a subsequent healthcare-associated infection (HACI), antimicrobial resistance (AMR) and antimicrobial consumption data set report was issued to the Unit on a quarterly basis.

The inspectors were provided with examples of 18 quality improvement (QI) initiatives to include staff training on world sepsis awareness day September 2024, and medication safety which resulted in the introduction of a patient identification band. Implementation of the NCG 21, 'appropriate prescribing of psychotropic medication for non-cognitive symptoms in people with dementia' was in progress in 2025 with education for staff already provided. Liquid controlled drug accuracy measures initiatives was in progress. There were quarterly 'clinical cuppa' education sessions with Clinical Development and CNM2s and regular 'tool-box' education talks. Initiatives to commence in 2025 include catheter care, and an initiative relating to assisted decision making documentation. The Unit continued to participate in the antimicrobial 'skip the dip' initiative.

Inspectors noted through speaking with management and staff that there were arrangements in place to share learnings from incidents and audits, such as local management meetings, communications book, training and daily safety huddles. However during interview, staff were not aware of shared learnings, for example, recommendations following 'review of actions following outbreak of respiratory outbreak', risks on the risk register relating to the four key areas of harm, and incidents such as a medication incident relating to a drug allergy. Staff noted time constraints as a limiting factor to access shared learnings.

Overall the inspectors were satisfied that the Unit had monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services provided. However an area for focused improvement:

- develop QIPs in relation to incident reports

[†††] The National Incident Management System is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation on the States Claims Agency (Section 11 of the National Treasury Management Agency Act 2000 as amended).

- review the gap between arrangements in place and ability to share learning with staff, for example following the occurrence of incidents.

Judgment: Substantially Compliant

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

Inspectors found the workplace arrangement in place in the Unit was planned, organised and managed to ensure high quality, safe and reliable healthcare.

Approval of posts was overseen by the RHA SW. The DON had oversight for human resource management at a local level within the Unit. The following whole time equivalent (WTE)[‡‡‡] complement was in place: 1 WTE DON and 1 WTE CNM 2, both of whom covered the District Unit and the older persons unit. There were 7.84 WTE Registered General Nurses (RGNs), 6.67 WTE Healthcare Assistants (HCAs). There were 4.9 WTE support staff which included hygiene and catering services. There was a 1 WTE grade IV administration officer, a 0.45 WTE grade III clerical officer, a 0.6 WTE porter. Additional RGN hours accounted for 0.14 WTE to cover public holidays and weekend cover. There was a deficit of 2.2 WTE which included HCA and domestic staff and these replacement posts were approved for recruitment. At the time of the inspection this deficit was covered by staff within the Unit working additional hours. Nurse staffing was slightly over the approved WTE.

There were no Health and Social Care Professionals (HSCPs) directly employed by the Unit. Recruitment of HSCPs was at a regional level and outside of the remit of the Unit. Inspectors were informed that physiotherapy hours were reduced to five hours a week from 10 hours. Access to a speech and language therapist (SLT) or dietitian was through paper referral. At the time of inspection there was no occupational therapist (OT) available to the Unit. Access to HSCPs was having a significant impact on the service, was rated as a high rated risk on the Unit's risk register and had been escalated to regional level. The DON had implemented control measures to mitigate risk by reviewing all transfer requests to ensure the Unit could meet the patients' care needs. However the profile of the admissions required input from speech and language and at the time of the inspection this resource was limited. Inspectors were informed that the DON utilised an OT reablement programme, patients who met a specific criteria and provided consent

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

were referred to the community OT. Under this programme, six weeks of OT were provided to the patient and detail on outcomes was provided to the DON.

Two RGNs and two HCAs were on duty Monday to Sunday, there was one RGN and one HCA on night duty. The DON and CNM 2 worked Monday to Friday. Inspectors were informed by management that nursing, HCA and support staffing was sufficient to meet the requirements at the Unit and a significant body of work had been completed to determine staffing requirements. A business case had been submitted in 2024 for an additional CNM 2 post but no update was available at the time of inspection. However inspectors would recommend a review of staffing levels particularly on night duty, taking into account the high care needs of patients and the number of falls related incidents reported to NIMS. On commencement of employment staff were provided with the HSE induction booklet and the Unit had individual induction booklets for both Nursing, and HCA - support staff. Staff were flexible to cover any gaps in duty rosters during periods of unplanned leave and rotated between the Unit and the co-located older person's service to mitigate disruption to service provision, ensuring appropriate levels of skill mix. The Unit facilitated the placement of student nurses who undertook a three-week placement and were assigned to an RGN at all times.

Compliance with mandatory and essential training for nursing staff was 100%. Training included standard based precautions (SBP) and transmission based precautions (TBP), hand hygiene, medication safety, outbreak management, basic life support and complaints management. HCAs and support staff training included SBP, TBP, hand hygiene, complaints management and compliance was 100%. Inspectors were informed that on commencing employment, staff were provided with a list of mandatory training requirements with a three-week timeline for completion. Management had oversight to ensure all staff were Garda vetted before commencing employment. Staff had completed children's first training, and the Unit's child safety statement was on display. Absenteeism was 2.8% which was below the HSE key performance indicator (KPI) of 4%. Back to work interviews were conducted following periods of unplanned leave and staff had access to the HSE employee assistance programme (EAP) and occupational health. Staff acknowledged that management were very supportive and an example of a de-briefing session was provided to inspectors.

Overall the inspectors were satisfied that the workplace arrangement in place in the Unit was planned, organised and managed to ensure high quality, safe and reliable healthcare. However, the regional service must support access to HSCPs for patients in the District Unit as it is outside of control of local management.

Judgment: 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. 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. Listowel Community Hospital District Unit was found to be compliant with five national standards (1.6, 1.7, 1.8, 2.7, 3.3) and substantially compliant with two national standards (2.8, 3.1) assessed. Key inspections findings informing judgments on 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.

Staff promoted a person centred approach to care and were observed by inspectors to be respectful, promoting the dignity, privacy and autonomy of patients.

The physical environment in the clinical area promoted the privacy, dignity and confidentiality of patients receiving care. Staff were observed knocking on the patient's room door prior to entering. Visiting was unrestricted for palliative care patients and a spacious room was available to accommodate patients requiring palliative care.

Patients were assisted with their individual needs and privacy curtains were available for use in the multi-occupancy rooms. Call bells were available if assistance was required and when activated there was an audible alarm with a digital read out of room location.

Inspectors observed the majority of patients were out of bed and dressed. Healthcare records and personal information was protected in the clinical area. Patients were provided with an admission booklet which outlined the Unit's vision and philosophy of care, the management structure, services and how to provide feedback providing detail on the HSE '*Your Service, Your Say*'. Information on independent advocacy services, confidential recipient and the Ombudsman was on display in the clinical area.

In summary inspectors were satisfied that patients' dignity, privacy and autonomy were protected and promoted in the Unit.

Judgment: Compliant

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

It was evident that a culture of kindness consideration and respect was actively promoted for people accessing and receiving care in the Unit.

This was confirmed by patients and relatives who spoke positively about their interactions with staff and was supported by evidence from feedback received in 2024. Each patient had a personal profile which identified individual care needs and inspectors observed staff actively listening and communicating with patients in a kind and sensitive manner. It was evident from the interior design of the Unit that significant consideration had been given to service user needs.

Inspectors observed the Unit's 'mission statement' and safeguarding policy on display. The National Healthcare Charter, citizens advice and 'rights based approach to health and social care services' was also on display. The Unit had a communications policy and open disclosure training was available for staff.

In summary inspectors were satisfied that service users were treated with kindness and respect in the Unit.

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 Unit had a complaints procedure in place and information on independent advocacy services, SAGE, '*Your service, your say*', and the Ombudsman were available.

The DON was the designated complaints officer and had oversight of all complaints to the hospital. The complaints officer ensured complaints were investigated within 30 working days from acknowledgement of the complaint. The complaints officer was also responsible for ensuring implementation of recommendations arising from any review. Staff were encouraged to resolve complaints locally. Inspectors observed in documentation that verbal complaints were tracked and a log was maintained by the complaints officer. Inspectors were informed, that if staff could not resolve the issue locally, the complaint was escalated to the complaints officer. Feedback was provided to staff at daily handovers and documented in a communications book. At the time of the inspection, all staff had completed complaints management training and inspectors

were provided with evidence of four verbal complaints from March to December 2024, all of which were closed.

Service user feedback was carried out intermittently during the year and inspectors observed a comment box at the main entrance. Patients were not provided with individual evaluation forms to complete on discharge but in speaking with management, this was an option they were planning to explore by linking with other sites within the RHA SW.

Inspectors were satisfied that there were systems and processes in place in the Unit to respond to complaints and concerns in a coordinated and timely manner

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.

At the time of inspection, inspectors observed the overall physical environment in the clinical area visited was well maintained and clean. The area was bright, spacious with wide corridors and was well ventilated. Inspectors were informed that significant upgrading had taken place in recent years, which was evident.

Wall-mounted alcohol hand gel dispensers were strategically located and readily available for patient and staff use. Signage promoting hand hygiene was clearly displayed. There were four single rooms to include two wheelchair accessible en-suite (one with a WC, and one with both WC and shower). There were two three-bedded rooms. There was one six-bedded room with a floor to ceiling divider separating the room into two. All rooms had televisions and call bells and there was appropriate spacing between beds. While hand hygiene sinks were available, not all sinks conformed to national standards. There were three wheelchair accessible bathrooms with WC and shower and four wheelchair accessible WCs to include one assigned for visitor use. Inspectors observed 'red' toilet seats in a number of the WCs, which shows the contrast with the floor and surrounding area and helps with depth perception for patients with cognitive impairment. Patient hoists were available, with re-usable slings which were laundered on-site.

External hygiene staff, rostered up to 40 hours per week from Monday to Sunday were responsible for environmental cleaning in conjunction with Unit staff. Oversight of environmental cleaning was from the CNM 2 or senior staff nurse, this included an increased cleaning scheduled during periods of outbreaks. Inspectors saw evidence of signed cleaning schedules to indicate cleaning had taken place. The Unit had a separate 'clean' and 'dirty' utility room and also a 'janitors' rooms for storage of cleaning equipment and supplies. Posters on display indicated colour coding system for cloths used when cleaning. Inspectors noted in the 'janitors' room, open cleaning solutions for equipment were not dated and this was brought to the attention of the management.

While inspectors were informed that there was a tagging system in place to indicate if a piece of equipment had been cleaned, evidence of this was not seen. IPC informed inspectors that this practice was no longer in use and visual inspection of the equipment was a more reliable indicator of ensuring equipment was cleaned. Portable suction and oxygen compressors were used and an automated external defibrillator (AED) was available. Inspectors noted dust on some equipment in the clinical room and this was brought to the attention of management. Requests were forwarded to maintenance if equipment required repair and there was a timely response. Inspectors noted service history details on equipment. The porter carried out weekly tap flushing for taps not in use, and the DON received weekly compliance reports. While water testing for legionella was not conducted, inspectors were shown a legionella risk assessment for the Unit. There was a designated medication preparation area, with a controlled drugs press and medications, including insulin were stored securely. Entry to the clinical room was authorised access only. There was one dedicated 'locked' drugs fridge and inspectors saw evidence of documented daily temperature log checks.

There was appropriate segregation of linen and inspectors were informed that the hospital had an onsite laundry. Disposable curtains were in use, while dates were not recorded on a number of curtains, they were visibly clean and management confirmed the date they had been changed. There was appropriate segregation of clinical waste and inspectors observed posters in relation to disposal of healthcare waste, sharps and management of blood spillages. Sharps bins were partially closed, signed and dated. The inspectors noted that the Unit did not have security personnel but authorised access and security cameras were in place, pharmacy and emergency exits were alarmed.

In summary, inspectors were satisfied that the healthcare was provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.

Judgment: Compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.
The clinical development coordinator provided the Unit with an annual schedule of audits to be conducted. A range of audits were conducted on a monthly basis, through the use of an electronic audit tool. Audits were conducted by the CNM 2 or were designated to nursing staff and if the required standard was not met, a quality improvement plan (QIP) was developed. 'Ad hoc' audits could also be conducted and instructions were available on an algorithm chart available in the DON's office. Environmental audits were conducted on three occasions in 2024 and compliance ranged from 86% to 99%. Following the environmental audit in August, which showed compliance of 86%, there was no evidence of re-audit between September to December. Clinical waste audits ranged from 94% to 100%. There were three linen audits conducted in 2024 and compliance ranged from 94% to 100%. Three equipment cleaning audits were conducted in 2024 with compliance at 100%. Mandatory hand hygiene training records for staff were 100%. Audits in relation to medication safety showed compliance with usage and legibility of prescriptions ranged from 91% to 99%, while medication administration was 94% to 100%. The Unit submitted data for the monthly HSE Community Operations, monitoring of a HCAI – AMR and antimicrobial consumption minimum data set. Reports were published on a quarterly basis, were anonymised, but each provider had a unique code to interrogate their results. The aim was to provide an ongoing level of assurance to management in relation to quality and safety of services, the burden of HCAI and AMR and the effectiveness of IPC and antimicrobial stewardship measures. One quality improvement initiative included the introduction of patient identification bands in conjunction with existing photographic identification. Person identification was audited on a quarterly basis and compliance ranged from 83% to 100%. Following a reported incident to NIMS, an additional step was added to the absconsion policy, whereby a copy of the patients photograph would be provided to individuals searching for a patient for easy recognition of the individual. The most commonly reported incidents were falls, 33 of which were reported to NIMS in 2024 and a further six in 2025. While a QIP had not been developed, management outlined control measures to mitigate falls occurring such as individual assessment, provision of a 'low-low' electric bed, sensor mats and accommodation close to the nurse's station. Falls assessments were conducted for all patients, audits were conducted on eleven occasions in 2024 and compliance ranged from 93% to 100%. For bench marking purposes, a cross-site audit result comparison report was issued to the GM on a quarterly basis by clinical development.

While the Unit had systems and processes in place to monitor, analyse, evaluate and respond to information from a variety of sources in order to inform continuous improvement of services. Areas for focused improvement include:

- ensure audit schedules are conducted quarterly for example environment, linen and equipment
- timely re-audit if the compliance is below the national KPI for example environmental audit
- development of QIPs in response to trending incidents reported.

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 Unit had systems in place to protect service users from the risk of harm associated with the design and delivery of healthcare services.

There were two RGNs and two HCAs rostered on day duty from Monday to Sunday, and one RGN and one HCA on night duty in the Unit. A DON and a CNM 2 worked Monday to Friday covering Listowel Community Hospital. Patients admitted to the clinical area underwent a nursing assessment using standardised documentation to mitigate risk, prompts on the documentation included observing for signs of sepsis and delirium. Staff conducted daily handovers (8.15am and 8.30pm) which included a safety pause, to communicate issues related to patient care. There was an end-of-bed personal profile for all patients, and patients on restrictive practice were observed on a two hourly basis. On discharge, patients received a nursing discharge letter, a prescription and a letter for the patients GP. Copies were sent to the ADPHN, and kept on file within the Unit.

Patients transferred from acute services were accompanied by a three-day prescription and patients for respite and palliative care brought their medications on admission. Evidence of nurse-led medication reconciliation was documented in the admission assessment nursing care plan. Evidence of medication review by the Medical Officer and medication reconciliation by the Pharmacist was seen by inspectors. If changes to medication had been made, the Medical Officer wrote to the patient's GP. An Irish Medicines Formulary (IMF) was available to access medication information however this was held in the nurse's station as opposed to the point of drug preparation. Red aprons were available to wear during medication administration to mitigate interruption, however staff noted interruptions could occur.

Controlled drugs were checked by two nurses prior to administration and controlled drug stock levels were checked at each change of shift. The Unit had a medication management policy and the 'medicines complete' online medication information resource was available on the computer in the nurse's station. There were three medication incidents reported to NIMS in 2024-2025, one of which included a patient allergy. Inspectors were informed that the DON would be notified in the event of any Health Products Regulatory Authority (HPRA) alerts.

Same-name, high-risk and allergy labels were available for use within the Unit to mitigate medication errors. Inspectors found from review of 13 medication records that the stickers were not always in use, for example, one medication record seen, while correctly identifying patient allergies, an allergy label had not been used. While inspectors were informed that there were no high-risk medications prescribed at the time of inspection, one medication record indicated a patient was prescribed an oral anticoagulant. This was discussed with management.

In some instances where patients felt the wrist ID was uncomfortable, inspectors were informed that the ID was placed on the ankle, however it was noted that two patients did not have a wrist or ankle ID, in one case the patient ID was placed on the patients clothing. This was discussed with management who informed inspectors that to mitigate risk, patient photographs were on the medication record (MPAR).There was a sound-alike-look-alike drugs (SALADs) poster outside the nurse's office and there was a presentation on SALADs available in the nurse's station. Inspectors observed a high-risk medication poster by the clinical room, posters displaying the five moments of medication safety and a poster outlining an algorithm for the prescribing of psychotropic drugs. Inspectors were informed that the pharmacist had provided training to staff relating to the administration of buccal midazolam and a QIP relating to transdermal patches was discussed with inspectors.

Inspectors were informed that all patients had a ceiling-of-care assessment. In the event that a patient deteriorated, the medical officer was contacted to review the patient while on-site, and also took queries from staff in the Unit when not on site. An out-of-hours GP medical service was contacted should a patient deteriorate out-of-hours Monday to Sunday (6pm – 8am). The ISBAR[3] communication tool was used and the inspectors saw evidence of this in a patients' healthcare record. All unplanned transfers to acute services included a transfer letter and a copy of their medication record. Information leaflets on 'respiratory rate the most neglected vital sign' were available in the Unit.

The Unit had assigned an IPC link practitioner nurse, providing support for staff on a daily basis. The IPC link nurse had the opportunity to link with the regional IPC on approximately ten occasions throughout the year. The Unit had a COVID-19 contingency plan dated March 2025. Online IPC training sessions were available for staff however, at the time of inspection, staff noted time limitations posed a challenge to attendance.

Information and communication technology access to online IPC webinars was also posing a challenge for staff. The Unit had access to training and advice from an AMS pharmacist. IPC recommended conducting point-of-care risk assessments and patients with MDROs were assessed on a case by case basis if single room isolation was required to mitigate the risk of transmission. Dedicated personal protective equipment (PPE) trolleys were available for staff if a patient required isolation.

The Unit had a risk management PPPG which was due for review since February 2025. The risk register was reviewed on quarterly basis with updates sent to the GM. Risks that could not be managed locally were escalated to the RHA SW. Risks were also discussed at the older persons DON management meeting and the quarterly QPS meeting. The Units risk register indicated control measures in place and the residual risk was determined.

Thirty-three falls incidents were reported in the unit in 2024 and six in 2025. While there was no QIP developed, data had been collected by the DON to progress the development of a QIP. Inspectors were informed that incidents of falls were reported to the Medical Officer to ensure patient review and implement a treatment plan. Patients were assessed for falls and control measures such as room accommodation near the nurses station, non-slip socks, use of 'low-low' beds and use of senor mats was in place. Patients were assessed using the 'Dewing' wandering assessment tool and 'wandering' devices were available for use if appropriate. Regular falls audits were conducted, a falls log was maintained and results ranged from 93% to 100%.

Overall the inspectors was satisfied that the Unit had systems in place to protect service users from the risk of harm associated with the design and delivery of healthcare services however areas for focused improvement include:

- development of a QIP related to falls
- update training on medication safety to include SALADs and high-risk medications
- ensure the Unit is consistently using allergy and high-risk medication labels that are currently in place in the Unit on medication records where required
- ensure all patients have an ID band in place, in line with local policy.

Judgment: Substantially Compliant

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

The Unit 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.

In instances where incidents occurred, National incident management forms (NIRF) forms were completed manually and scanned to the central office, RHA SW for upload to NIMS. Incidents were classified by category and type. Data was issued monthly to the DON, who had oversight of all incidents. The HSE national key performance indicator (KPI), where incidents should be entered onto NIMS within 30 days of notification of the incident is 70%. There were 57 patient incidents reported to NIMS by the Unit in 2024 and compliance with the national KPI was 95%. The number of falls reported in 2024 were 33, to include five classified as moderate-category two and 28 classified as minor – negligible category 3. There were two medication incidents reported to NIMS, classified as minor – negligible category 3. There were a further three falls and one medication incident reported in 2025. Inspectors were informed that there was a reduction in the number of medication incidents from 2023, where 12 incidents had been reported and this was attributed to a number of actions, including updating of the medication record and medication reconciliation.

Feedback to staff was on an informal basis at the daily handovers and formally at local quarterly QPS meetings. There was also a communications book in the nurse's station. Inspectors were informed that the DON or CNM 2 attended the daily handovers to ensure all incidents or near misses were reported and to provide feedback on incidents. Staff who spoke with the inspector were knowledgeable about how to report and manage a patient safety incident. At the time of inspection there were no open safeguarding incidents, one safeguarding incident was reported in 2024. There was an online safeguarding reporting portal and all staff had completed safeguarding training. The Unit has a risk management PPPG and incidents were discussed at the 'older persons' quarterly DON meetings and the quarterly QPS meeting.

In summary the Unit 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.

Judgment: Compliant

Conclusion

HIQA conducted an announced inspection of Listowel Community Hospital District Unit to assess compliance with 11 national standards from the Nationals Standards for Safer Better Healthcare. The inspection focused on four key areas of harm – infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall the inspectors found evidence of compliance with seven national standards (5.5, 6.1, 1.6, 1.7, 1.8, 2.7, 3.3) and substantial compliance with four national standards (5.2, 5.8, 2.8, 3.1).

Capacity and Capability:

The Unit had clear lines of accountability and responsibility in relation to corporate and clinical governance. However terms of reference are required for all regional meetings. There were effective management arrangements in place to support the delivery of high quality, safe and reliable healthcare. In the absence of specific committees, the DON had oversight for IPC, the deteriorating patient, medication safety and transfers of care. Inspectors viewed contingency plans for COVID-19, and PPPGs were in date with the exception of risk management which was due for review. At the time of inspection there were 2.2 WTE staffing deficits identified to the inspectors by management and recruitment was approved. Access to HSCPs was having a significant impact and was rated as a high rated risk on the Units risk register. While local management was implementing control measures, support from the regional service is required. Patient safety incidents were reported and risks were discussed at regional DON and QPS meetings. Risks that could not be managed at a local level were escalated through the line management structure of the RHA SW. Areas for improvement included the development of QIPs in relation to reported incidents and review the process for sharing learnings from incidents with staff.

Quality and Safety:

It was evident to the inspectors that the hospital staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital. Patients and relatives spoke positively of care delivered in the Unit. The physical environment was bright and spacious and supported the delivery of high quality, safe care. While the Unit had safe systems in place to protect the patient from harm, focus on medication education with specific emphasis on SALADs and high-risk medication is an area for improvement. Inspectors found there was a system in place to identify, report and manage patient safety incidents. The Unit was meeting the national KPI of 70% whereby incidents were reported to NIMS within 30 days and there was a positive culture of reporting.

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.

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially 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	Compliant
Dimension: Quality and Safety	
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,	Compliant

safe, reliable care and protects the health and welfare of service users.	
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially Compliant
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.	Substantially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant