Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	St Theresa's Hospital
Address of healthcare service:	Clogheen Co Tipperary E21 Y447
Type of inspection:	Announced
Date(s) of inspection:	11 and 12 December 2024
Healthcare Service ID:	OSV-0007831
Fieldwork ID:	NS_0107

About the healthcare service

Model of hospital and profile

St Theresa's District Hospital is a 18-bed, statutory hospital, that is owned and managed by the Health Service Executive (HSE) under the governance of, Dublin and South East, Regional Health Authority Community Health Organisation (CHO) 5.*

St Theresa's District Hospital provides the following care and services to adults over 18 years:

- short stay services for patients who have completed the acute phase of their illness and who now require additional community support in order to assist them in their discharge home
- community admissions for palliative care
- community admissions for respite care.

The following information outlines some additional data on the hospital.

Number of beds	18

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

* Community Health Organisation area 5 consists of South Tipperary, Carlow, Kilkenny, Waterford and Wexford

†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.

previous inspection findings, 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 in the hospital to ascertain their experiences of care and treatment received
- 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 in the hospital, 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.

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.

[‡]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.

A full list of the 11 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 – 18.20	Mary Flavin	Lead
		Mary Redmond	Support
12 December 2024	09.00 – 15.30	Rosie O Neill	Support

Information about this inspection

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

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

The inspection team visited the clinical areas within the hospital, which consisted of a number of multi-occupancy and single rooms. During this inspection, the inspection team spoke with the following staff at the hospital:

- Director of Nursing (DON)
- Clinical Nurse Manager 2 (CNM2)
- Manager of Older Persons' Services, Carlow, Kilkenny and South Tipperary Community Nursing Units, CHO 5

[§] 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.

- General Manager of Older Persons' Services, Community Nursing Units and Integrated Care Programme for Older People (ICPOP), HSE South East Community
- A General Practitioner (GP) – medical officer for the hospital
- Quality Patient Safety (QPS) advisor and support person for Carlow, Kilkenny and South Tipperary Community
- Staff working in the clinical areas visited.

Inspectors also spoke with a number of staff from different professions and disciplines, and people receiving care in the clinical areas visited.

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

St Theresa's Hospital was an 18-bedded unit. On the first day of inspection there were 12 patients present in the hospital. The clinical areas visited by inspectors included three double-bedded rooms, one four-bedded multi-occupancy room, each with en-suite bathroom facilities. There were five single rooms, two of which were hospice suites specifically designed for palliative care patients and these suites included a patient kitchenette area, a pull-out sofa bed and chairs designed for comfort to accommodate family members. A day room was available for patients, along with an oratory, and several small enclosed outdoor areas designed for patient use. Inspectors observed that the clinical areas inspected were clean and free from clutter. Inspectors observed staff actively engaging with patients in a respectful and kind way, taking time to talk and listen to them. Staff were observed promoting and protecting patients' privacy and dignity when delivering care. Inspectors observed staff addressing patients by name and speaking to them in a kind and courteous manner. When performing specific treatments, staff were observed explaining the procedure to patients and asking if it was a convenient time to proceed.

Patients who spoke with inspectors told them about their experience of care received in the hospital. When describing staff one patient told inspectors "the staff could not do more for you", with another describing staff as "everyone does everything they can for you". One patient who spoke with inspectors commented on the cleanliness of the facility and noted that they had plenty of space. Inspectors observed staff in the clinical areas visited responding promptly to patients requiring assistance. All patients who spoke to

inspectors told them that staff would assist them when they needed it. One patient said that "I have my call bell at night and if I need to use it I know they will be here". Another patient said that "I get physio whenever I ask for it".

When asked about making a complaint, patients told inspectors that they had no complaints. One patient told inspectors that "everything was fabulous" and another saying "everything is really good here". All patients expressed satisfaction with the food provided, describing it as "lovely" and "fabulous".

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, use of resources.

St Theresa's Hospital Co Tipperary was found to be compliant with three national standards (5.2, 5.5 and 5.8) and substantially compliant with one national standards (6.1) assessed. Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

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

Inspectors found that St Theresa's hospital had formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of healthcare services. Organisational charts setting out the hospital's reporting structures were submitted to HIQA, as part of the pre-onsite documentation, data and information request. These charts detailed the direct reporting arrangements for hospital management and the governance and oversight committees. The reporting and accountability relationship to Older Persons Services, HSE South East Community Healthcare Region was also clearly outlined on the organisational charts.

The director of nursing (DON) was the person with overall responsibility for the day-to-day management of the hospital. The DON reported upwards to the manager of Older Persons Services, Carlow, Kilkenny and South Tipperary Community Nursing Units, CHO 5. In turn, the manager for older persons reported upwards to the general manager for Community Nursing Units and ICPOP, CHO 5. On day one of the inspection, the DON, the manager for Older Persons and the general manager for Community Care met with

inspectors. During this meeting, they outlined the governance arrangements within the service, detailing the reporting structures and responsibilities from the general manager for community care who reported up to the Head of Services for Older Persons and onwards to the Integrated Healthcare Area (IHA) manager who reported up to the Regional Executive Officer (REO) for HSE Dublin and South East Regional Health Area. The governance arrangements described during the meeting were consistent with the organisational charts provided to the inspectors. The organisational structure, as described during the meeting, was observed by inspectors displayed on the wall along the corridor.

The hospital had an admission and discharge policy in place, which was revised in October 2024. This policy outlines the admission process for the various types of care provided at the hospital and details the discharge process for patients transitioning to different destinations, such as returning home or moving to a nursing home for long-term care. Additionally, the policy specifies the exclusion criteria for admission to St Theresa's hospital, ensuring clear guidelines for patient eligibility and care pathways. Medical cover at the hospital was provided by a designated GP, who served as the medical officer for the hospital. The GP was allocated 15 hours per week, Monday to Friday to work within the hospital. In circumstances where a doctor was required out-of-hours, the CareDoc[§§] service was contacted.

A Director of Nursing Governance Group for Community Nursing Units, Older Persons, South East Community Healthcare (SECH) held meetings quarterly, in accordance with their terms of reference (TOR) which were in draft format and not signed at the time of inspection. Following a review of minutes of meetings, inspectors confirmed that this meeting had taken place in quarter two and quarter three of 2024. These meetings were attended by the DON in St Theresa's hospital, the manager of Older Persons' Services, Carlow, Kilkenny and South Tipperary Community Nursing Units (CNU) and the general manager of Older Persons' Services, CNU and ICPOP, HSE South East Community. It was chaired by the Head of Services Older Persons SECH. The minutes reviewed followed a structured format and documented discussions in relation to risks, delayed transfers of care, patient-safety incidents and recruitment.

A Quality and Safety Committee (QSC) for Residential and Rehabilitation Services South Tipperary held meetings six times a year according to the TOR which were due for review in 2023. The DON of St Theresa's hospital attended this multidisciplinary meeting which was chaired by the manager of Older Persons' Services, Carlow, Kilkenny and South Tipperary CNUs. The minutes provided to inspectors were for meetings held in December 2023 and May 2024. These minutes followed a structured format and showed that discussions took place in relation to infection prevention and control (IPC), clinical incidents, the risk register, audits, policies, quality initiatives, staff training and updates from regional QPS meetings. The chair of this committee was responsible for liaising with

[§§] CareDoc is a general practitioner out of hour's service part funded by the Health Service Executive.

the regional Older Persons Services Quality and Safety Executive Committee (QSEC) on a quarterly basis. Inspectors were informed during inspection that a sub-group of the QSC had been set up to oversee the governance and development of policies, procedures, protocols and guidelines (PPPGs) across the Older Persons Services SECH. Minutes reviewed by inspectors confirmed this.

Local medication management meetings were held quarterly at the hospital in line with their TOR and were chaired by the DON, there was no Drugs and Therapeutics Committee (DTC) in place at the hospital at the time of inspection. Inspectors were informed during an interview with the general manager of OPS that a regional community DTC has been established six months earlier. At the time of inspection, TOR and membership of this regional committee were still under review or being finalised.

Local IPC meetings were held quarterly at the hospital in line with their TOR and were chaired by the DON. SECH IPC Link Practitioner meetings were held monthly and attended by the hospital's designated IPC link practitioner nurse. Upon reviewing the minutes of the local management IPC and staff meetings, inspectors observed that information from these meetings was made available and communicated back to the hospital's management and staff. Inspectors were informed during the interview with the IPC link nurse that they attend a Practitioner Appreciation Day twice a year. These events provided opportunities for the sharing of information and education among practitioners. Inspectors also observed IPC to be a standing item on the QSC agenda.

At the time of inspection a standard operating procedure (SOP) for the deteriorating patient, revised in June 2024 was in place. Inspectors observed evidence in minutes of the local management meetings that the deteriorating patient was discussed. Additionally, the hospital had two SOPs in place for the transition of patients. One SOP outlined the process for transitioning patients from the acute hospital to St Theresa's hospital, while the second SOP detailed the transition of patients from St Theresa's hospital back to acute services. Both SOPs were revised in September 2024. Inspectors also observed evidence in the minutes of management meetings that these transitions of care were regularly discussed. Additionally, inspectors noted that both transitions of care and the deteriorating patient were topics of discussion in the minutes of the DON Governance Group meetings.

Judgment: Compliant

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

Inspectors found that management arrangements were in place in St Theresa's hospital to support the delivery of safe and reliable healthcare. Structured management meetings,

chaired by the DON were held in the hospital every second month, in line with their TOR. These meetings were action-based, with responsibilities assigned to specific individuals however, inspectors noted that the actions were not always time-bound. On review of the minutes, inspectors observed that the four areas of known harm were a standing item on the agenda for these management meetings.

The hospital did not have an on site pharmacy service. The pharmacy service available to the hospital was supported by a local pharmacy, who delivered medications to the hospital six days a week. The GP reviewed patients' medication weekly and patient specific prescriptions were ordered from the local pharmacy. The community pharmacist was available by phone and email to address any medication related queries when required. Access to a senior antimicrobial pharmacist from the CHO 5 area was available by email or phone Monday to Friday for education or advice when required.

At the time of inspection there was one IPC link nurse in place at the hospital. Their role included updating management and staff on the monthly IPC Link Practitioner meetings. This was communicated at the local IPC management meetings. Minutes of meetings reviewed by inspectors confirmed this. The link nurse was also responsible for conducting staff training and carrying out audits within the hospital. The IPC clinical nurse specialist (CNS) for SECH provided oversight of the audits conducted in the hospital. Inspectors were informed during interview that the IPC CNS visited the hospital three to four times a year to conduct audits and provide additional staff training.

The Irish National Early Warning System (INEWS)[***] record was used at the hospital to support the recognition of and response to clinical deterioration in patients. The process for managing a deteriorating patient was outlined in the Deteriorating Patient SOP. An escalation protocol was in place for patients whose condition did not stabilise or continued to deteriorate. The Identity, Situation, Background, Assessment and Recommendation (ISBAR)[†††] communication tool was used during the escalation process to inform the on duty GP Monday to Friday or CareDoc during out-of-hours about the patient's condition. Inspectors observed a generic risk assessment for recognising and responding to a deteriorating patient during inspection. This assessment outlined control measures and additional actions required to mitigate the risk. Actions were assigned to a designated person and were time bound.

The process for ensuring safe transitions of care was outlined in the Transition of Care SOPs. Daily communication occurred between the DON of St Theresa's hospital and the discharge planners from Tipperary University Hospital to identify appropriate admissions

[***] Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned ICU admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.

[†††] Identify, Situation, Background, Assessment, Recommendation (ISBAR) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

to St Theresa's Hospital following assessment. Additionally, structured multidisciplinary rounds were held twice a week, during which discharge plans and expected discharge dates were discussed to facilitate coordinated and safe patient transitions. A generic risk assessment had been completed to ensure the safe transition of patients, outlining measures to manage potential risks during the process.

Overall, St Theresa's hospital has 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.

Inspectors found that there were systematic monitoring arrangements in place in St Theresa's hospital for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Data in relation to patient flow was being tracked daily through a bed register system. Inspectors reviewed 2024 data from a live bed register system including, admissions, discharges, discharge destinations, total bed days, average length of stay and average bed occupancy. This was provided by the general manager of OPS, Community Nursing Units and ICPOP, HSE South East Community during an interview. The hospital also collected data on patient-safety incidents, complaints and compliments, risks and monitoring of healthcare associated infections, antimicrobial resistance and antimicrobial consumption as part of a minimum data set.

The hospital risk register, last updated in November 2024 was reviewed quarterly by the hospital DON, the manager of OPS, Carlow, Kilkenny and South Tipperary CNUs, CHO 5 and the QPS advisor for Carlow, Kilkenny and South Tipperary Community. Inspectors observed evidence of risk controls in place. Risks that could not be managed locally were escalated for potential inclusion in the CHO5 corporate risk register. At the time of inspection, there were no risks on the hospital register relating to the four areas of harm. However, inspectors observed a risk on the register concerning workforce and recruitment. This will be discussed further under national standard 6.1.

The DON had oversight of local audits in the hospital. The CNM 2 conducted hand hygiene, medication safety and nursing documentation audits. Environmental and equipment hygiene audits was carried out bi-annually using an online tool for data collection. This will be discussed further under national standard 2.8. The IPC CNS for SEHC provided oversight of these audits through the online audit too. Audit results were an agenda item at the QPC and local management meetings. Inspectors reviewed minutes showing that audit findings were discussed at local staff meetings and quality

improvement plans were implemented based on results. Inspectors were informed by the manager of OPS, Carlow, Kilkenny and South Tipperary CNUs, CHO 5 at the time of inspection that, an Older Person's Steering Group had been established through QSEC in November 2024. This group included representatives from all care divisions across CHO 5 region. The purpose of this group was to analyse audits completed in 2023 and make recommendations on the frequency of audits for 2025. They identified five key audits to focus on for 2025 including IPC.

The DON oversaw the reporting and management of serious reportable events (SRE) and patient safety incidents at the hospital. These incidents were reported to the National Incident Management System (NIMS).[‡‡‡] The QPS advisor for Carlow, Kilkenny and South Tipperary Community, had oversight of all reported incidents. SREs were escalated regionally to the QSEC and senior incident management team (SIMT) for review and management of the incident. The reporting of SREs and patient safety incidents were an item on the QSC and the DON Governance Group for CNUs, OPS, SECH meetings. The last reported SRE for St Theresa's hospital occurred in 2022 and was managed in accordance with the HSE's Incident Management Framework 2022, as confirmed by documentation reviewed by inspectors.

A local patient satisfaction survey was conducted for 2023 at St Theresa's hospital. The findings were incorporated into a report completed by the DON on Quality and Safety of Care of patients in St Theresa's hospital for 2023 and the Quality Improvement Plan for 2024. Inspectors observed that patient feedback, compliments and complaints were a standing item on the agenda for management meetings at the hospital. A review of meeting minutes showed that these topics were also discussed during local staff meetings.

Judgment: Compliant

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

The workforce arrangements in St Theresa's hospital were planned, organised and managed to ensure high-quality, safe and reliable healthcare.

Medical cover was provided by a GP who was contracted to work 15 hours a week at the hospital. They attended the hospital every Monday and Tuesday morning to conduct formal rounds and review all patients with a focus on discharge planning. The GP also attended the hospital every evening from Monday to Friday to address issues or admit new patients.

‡‡‡ The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

Additionally, the GP was available by phone outside these times for queries or concerns and could come on site if needed.

At the time of inspection, the hospital had an approved complement of one whole-time equivalent (WTE)[§§§] each for the DON, CNM 2 and CNM 1, all of which were filled. The hospital had an approved complement of 7.8 WTE staff nurses. At the time of inspection, 1.2 WTE of these positions were permanently vacant and were being covered by agency staff.

Nursing staff were supported by an approved complement of 10.3 WTE healthcare assistants (HCA). At the time of inspection 7.5 WTE positions were filled, with 2.8 WTE permanent vacancies which were covered by agency staff. Additionally, the hospital had an approved complement of 1.5 WTE for multitask attendants (MTA) positions, of which 0.7 WTE was permanently vacant. On the day of inspection, inspectors observed that staffing numbers at the hospital were in line with agreed levels.

Inspectors were informed and documentation confirmed, that the hospital had an approved 1 WTE physiotherapist position and 1.4 WTE kitchen staff positions, both of which were filled at the time of inspection. The hospital had approval for 1.2 WTE cleaning staff positions that covered 8am to 2pm seven days a week however, inspectors were informed that there was a permanent vacancy of 0.74 WTE which was being covered by agency staff. This was discussed with senior managers at the time of inspection and inspectors were informed that the hospital was in the process of outsourcing cleaning services, which was undergoing a tender process at the time.

Approval for vacant posts were submitted by the DON and went through the manager of QPS, Carlow, Kilkenny and South Tipperary CNUs, CHO 5 and upward to the general manager of OPS, CNUs and ICPOP, HSE South East Community for approval and sign off. Approval to fill vacant posts with agency staff was submitted weekly by the DON using an agency template. Inspectors were informed that approval had been granted to run a staff nurse recruitment campaign for the CHO 5 region in January 2025. The hospital's risk register documented the risk associated with vacant posts and the reliance on agency staff to fill these positions.

Training records provided to inspectors for St Theresa's hospital demonstrated that overall, there was good compliance with training, for example:

- 100% of nurses, healthcare assistants, housekeeping and health and social care professionals (HSCP) were trained in standard based precautions, transmission based precautions and donning and doffing PPE
- 100% of nurses, healthcare assistants, housekeeping and HSCP were trained in hand hygiene practices, above the HSE's target of 90%

[§§§] 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.

- 100% of nurses were trained in medication safety, INEWS and open disclosure
- 92% of nurses were trained in basic life support.

Inspectors were told that an induction program, set out over a two week period, was in place for new and agency staff. Inspectors observed documentation of this during inspection.

A human resource representative for St Theresa's hospital tracked and reported on staff absenteeism rates. Documentation provided to inspectors showed the absenteeism rate for the hospital to be 6.65%, which is above the national KPI target of 4%. To reduce the absenteeism rate, the hospital had back to work interviews in place and provided access to occupational health support for staff.

Overall, the hospital had workforce arrangements in place to support and promote the delivery of quality, safe and reliable healthcare. However:

- there were risks associated with vacant posts and the reliance on agency staff to fill these positions
- staff absenteeism rates were above the national KPI.

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.

St Theresa's Hospital Co Tipperary was found to be compliant with six national standards (1.6, 1.7, 1.8, 2.8, 3.1 and 3.3) and substantially compliant with one national standard (2.7) assessed. Key inspection 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.

Overall, inspectors observed that the dignity, privacy and autonomy of those using the service were respected and promoted.

The physical environment promoted privacy, dignity and confidentially of patients receiving care. For example, patients located in multi-occupancy rooms had access to bathroom and

shower facilities. The spacing between beds provided a more comfortable environment for patients to carry out personal care activities. Inspectors observed staff using privacy curtains when providing assistance and personal care to patients. There were five single rooms with en-suite facilities, two of which were designated for those requiring palliative care, including those at end of life. These rooms featured a kitchenette and a designated seating area for families and patients to use. Inspectors observed staff knocking on patient room doors before entering. There was a day room where patients could socialise, sit and eat together. The day room contained a variety of information leaflets to keep patients informed such as 'SAGE', '*Your Service Your Say'*[****] and 'Age Friendly Ireland'. As discussed under national standard 5.8, a patient satisfaction survey was conducted in 2023. This revealed that 99% of patients felt their privacy and dignity were protected.

Inspectors observed patients' mobilising around the clinical areas which featured bright and spacious corridors, receiving assistance from staff while promoting their independence. For patients unable to get out of bed, call bells were provided at their bedside. Inspectors observed patients' healthcare records and patients' personal information were stored securely.

Judgment: Compliant

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

There was evidence that staff promoted a culture of kindness, consideration and respect for patients receiving care in the clinical area visited. Inspectors observed staff actively listening and effectively communicating with patients in a kind and sensitive manner, taking into account their individual expressed needs and preferences. For instance, during a medication round, inspectors noted that patients' preferences were respected; for example, a patient declined a medication providing a rationale for their decision. Similarly, during evening supper, patients were asked for their meal choices and their preferences were accommodated. Kind and respectful interactions between staff and patients were also observed. The hospital's philosophy of care was displayed on a wall in the clinical area.

The hospital welcomed feedback from people using the service. Inspectors noted that patients appeared comfortable discussing any issues or concerns with staff. Vulnerable patients requiring palliative or end of life care were accommodated in a hospice suite. At

[****] 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 time of inspection 93% of staff had completed a two-day palliative care course. Inspectors observed St Theresa's vision statement displayed on the wall in the day room.

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.

There was evidence that service users' complaints and concerns were responded to promptly, openly and effectively in the hospital. The DON was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from review of complaints.

The hospital had a complaints management system and used a local policy in line with the HSE's complaints management policy '*Your Service Your Say'.* An algorithm outlining the complaint process was observed displayed on a corridor wall in the clinical area. There were '*Your Service Your Say*' leaflets on display in the day room. A suggestion box for feedback was located on the wall in the main lobby area. Information leaflets on independent advocacy services for patients were available in the day room.

The hospital used a local resolution approach for managing complaints, with the DON or CNM 2 handling them locally. If a complaint could not be resolved at this level, a process was in place to escalate it to the manager of OPS, CNUs and ICPOP, HSE South East Community. Staff who spoke with inspectors stated that complaints were resolved locally. For example, a complaint was made by a patient regarding an incident involving staff communication. A member of hospital management addressed the issue by speaking with the patient's spouse, clarifying the situation and resolving the concern locally. From a review of the minutes inspectors found complaints were discussed at the local management and staff nurse meetings in the hospital. A local log of complaints was maintained in a folder in the DON office. This was shown to inspectors at the time of inspection. Formal complaints were processed through the 'Y*our Service Your Say*' system. Any complaints related to St Theresa's hospital were forwarded to the DON for review. During an interview, inspectors were informed that these complaints were acknowledged within five days. Additionally, patient consent was obtained to review medical notes, ensuring that the complaint could be thoroughly addressed. At the time of inspection no formal complaints had been received by the service for 2024.

Patient satisfaction questionnaires were provided to all patients during their hospital stay. A yearly report was generated by the DON which was shared with staff. Inspectors reviewed this report for 2023 at the time of inspection. Patients who spoke with inspectors at the time of inspection did not have any complaints.

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.

On the day of inspection, inspectors visited the clinical area of the hospital and observed that the overall physical environment was well maintained and clean.

Inspectors observed wall-mounted alcohol-based hand sanitiser dispensers were readily available for staff and visitors with hand hygiene signage [World Health Organization (WHO) 5 moments of hand hygiene] clearly displayed throughout the clinical areas visited. While some hand hygiene sinks met the required specifications,[††††] sinks observed by inspectors in some areas did not meet these requirements for example, in rooms one, two, three, four, five and seven.

Inspectors observed sufficient physical distancing between beds in multi-occupancy rooms and adequate storage for patients' personal belongings, including separate wardrobes for each patient. One patient who spoke with inspectors said "it's very clean and airy, with plenty of space". The hospital had five single rooms, each equipped with en-suite toilet and shower. Infection prevention and control signage in relation to transmission based precautions was observed in the clinical area and a supply of personal protective equipment was available outside rooms. On the day of inspection, inspectors observed one room in use for isolation purposes. Appropriate isolation signage was in place at the entrance of the room.

Environmental and terminal cleaning was originally carried out by a designated cleaner. Inspectors were informed that, due to a permanent deficit of cleaning staff within the hospital, this role was being filled by long term agency staff at the time of inspection. This was discussed further under national standard 6.1. The CNM 2 and DON had oversight of the cleaning schedule in the clinical area and told inspectors that they were satisfied with the level of cleaning staff in place to keep the clinical area clean and safe. All areas observed were clean and well maintained.

Cleaning of equipment was assigned to staff in the hospital. There was a system in place to identify equipment that had been cleaned through the use of a tagging system. Daily cleaning checklists were in place and signed by the CNM 2 or DON. Cleaning schedules from August to December 2024 were provided to inspectors at the time of inspection. Environmental and patient equipment audits were carried out and these are discussed

[††††] Clinical hand wash basins should conform to HBN 00-10 part C Sanitary Assemblies or equivalent standards. *National Clinical Effectiveness Committee. Infection Prevention and Control (IPC) National Clinical Guideline No. 30*. May 2023. Available on line from: gov - Infection Prevention and Control (IPC) (www.gov.ie)

further under national standard 2.8. Hazardous material and waste was observed to be safely and securely stored. There was appropriate segregation of clean and used linen. Used linen was stored appropriately. Supplies and equipment were stored adequately and appropriately.

The hospital provided a safe and secure environment for patients, with controlled visitor entry managed through a call bell camera system.

Overall, inspectors found that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care, with action required in relation to the following:

- where hand wash sinks were non compliant with the required specifications.

Judgment: Substantially compliant

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

Inspectors found that the hospital had systems in place to monitor, evaluate and respond to information from various sources, such as KPIs, findings from audits, patient safety incidents and complaints. These systems help continuously improve healthcare systems.

The IPC link nurse conducted audits on hand hygiene, environmental hygiene, and equipment hygiene. Inspectors observed follow up actions and feedback from these audits documented in the minutes of meetings.

Hand hygiene practice audits reviewed by inspectors for January, June and October 2025 were compliant with the HSE target of 90%. Environmental and equipment hygiene audits was carried out six monthly using the online data collection tool. Audits reviewed by inspectors for July 2024 demonstrated an overall compliance rate of 93%. The hospital reported monthly on the rate of new cases of *Clostridioides difficile* infection, the number of residents colonised or infected with *Carbapenemase-Producing Enterobacterales* (CPE) and the number of outbreaks of infection. A comprehensive CHO 5 level report detailing findings from data returned in Quarter three was made available to the hospital via the CHO IPC/AMS team.

Medication safety and storage of medications audits conducted in January, June and October of 2024 indicated overall compliance of 92% to 99% for the hospital. Audit results were discussed and actions were identified during medication management meetings, with feedback provided to staff during clinical handovers and local staff meetings.

The INEWS chart was used in the clinical area, and the escalation process followed national guidelines for early warning systems and sepsis management for adults. While it was not audited, minutes of management meetings in the hospital dated June 2024 provided evidence that the EWS chart had been audited through a documentation audit. This audit demonstrated good observation practices and effective communication regarding changes in patients' condition.

Patient flow data was tracked daily using a bed register system. Inspectors reviewed data from January to October 2024, which indicated an average LOS of 18 days. Discharge paperwork is audited on the nursing documentation audit. Documentation audit in November 2024 showed 87.3% compliance. A review of a sample of discharges identified communication gaps in discharge documentation. Inspectors were informed that action plans were developed by the CNM, which included developing a one page communication document to ensure all relevant information to facilitate a safe patient discharge was captured. Once finalised, the CNM planned to deliver short information sessions using scenarios as examples to familiarise staff with the new document. Evidence of this plan was confirmed in meeting minutes reviewed by inspectors.

Overall, there were processes in place at the hospital to systematically monitor, evaluate, and continuously improve the service.

Judgment: 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 protect patients from risk of harm associated with the design and delivery of healthcare services.

Risk assessments were conducted at ward level, and appropriate controls were implemented to mitigate risks to patients. The DON was responsible for implementing these controls and overseeing their effectiveness. Inspectors were informed that any risks that could not be managed locally were escalated to the manager for OPS for further review and action. As discussed under national standard 5.8, a hospital risk register was in place and reviewed by the hospital DON, the manager of OPS, Carlow, Kilkenny and South Tipperary CNUs, CHO 5 and the QPS advisor for Carlow, Kilkenny and South Tipperary Community quarterly. At the time of inspection there were no risks recorded on the risk register which related to the four areas of harm. However, a workforce and recruitment risk was noted and documented on the hospital register. This risk had been escalated to the manager of OPS, Carlow, Kilkenny and South Tipperary CNUs, CHO 5 where it was actively being monitored. The risk register included detailed action updates and due dates for addressing identified risks. For example, one action

was to secure external agency staff to address workforce deficits within specified timeframes.

Patient referrals to the hospital were managed through a pre-nursing admission form, which included documentation of any known infections. Patients identified as having an active infection on this pre assessment document were not accepted into the hospital. For patients who developed symptoms while in hospital, appropriate screening was conducted, and they were managed in accordance with the HSE community IPC guidelines. Inspectors observed an IPC folder which was available for all staff to refer to. As discussed under national standard 2.8 the hospital reported monthly on the rate of new cases of *Clostridioides difficile* infection, the number of residents colonised or infected with *Carbapenemase-Producing Enterobacterales* (CPE) and the number of outbreaks of infection. Reports reviewed by inspectors from April to September 2024 reported no new cases of *Clostridioides difficile* or CPE; however, two outbreaks for COVID-19 were reported. The last COVID-19 outbreak in the hospital occurred in September 2024. An outbreak report was completed and submitted to inspectors, identifying the source of the outbreak. The report also documented that patients affected by COVID-19 were isolated to prevent further spread. Minutes from the hospital's IPC management meetings reviewed by inspectors outlined the actions taken to manage the outbreak, along with additional measures planned to ensure ongoing management; for example, ensure cleaning and support staff are aware of the cleaning schedules and what to use during an outbreak. Inspectors noted the presence of an outbreak folder accessible to staff. This folder served as a reference resource, providing guidance for managing outbreaks effectively.

As discussed earlier under national standard 5.5, the pharmacy service available to the hospital was supported by a community pharmacist who was available six days a week to address any medication related queries. Patient medication was reviewed on admission to the hospital by the GP and transcribed into the hospital medication kardex. Inspectors were informed that medication reconciliation[‡‡‡‡] was conducted by nursing staff during the night shift, comparing the acute prescription with the hospital kardex to ensure accuracy in transcribing. Additionally, the hospital GP reviewed each patient's medication kardex weekly following admission. Minutes from medication management meetings, reviewed by inspectors, confirmed that these practices were being followed. Inspectors observed that the medication trolley was locked and securely stored. Medications within the trolley were organised into individual boxes containing patient specific medications. An up-to-date British National Formulary (BNF) and the National Institute for Medication Safety (NIMS) guidelines were available on the trolley for reference regarding administration of medications. Patient specific medications were ordered weekly. The CNM 2 maintained oversight of regular stock. Inspectors reviewed checklists in the clinical area that demonstrated effective stock management practices.

‡‡‡‡ Medication reconciliation is the formal process of establishing and documenting a consistent, definitive list of medicines across transitions of care and then rectifying any discrepancies

Inspectors observed that the temperature for the medication fridge was checked daily and was within the recommended temperature parameters. Inspectors were informed that staff implemented risk-reduction strategies with high-risk medications; for example, insulin pens were labelled as one person, one pen and stored with the patient's name on them. Prescribing guidelines, antimicrobial guidelines and medicines information were available and accessible to staff to access.

As referenced under national standard 5.5 and 2.8, the INEWS chart was implemented in the hospital to support the recognition, response and management of a deteriorating patients. Staff who spoke with inspectors were aware of the SOP for managing deteriorating patients and were knowledgeable about the INEWS escalation and response protocol. Inspectors observed ISBAR stickers placed beside each phone at the nurses' station. This served as a communication tool to support staff when escalating patient care. Emergency equipment such as a resuscitation trolley, suction machine and oxygen were available and accessible in the clinical area.

The hospital had an updated admission and discharge policy, revised in October 2024, which covered the referral and admission processes for patients seeking convalescence, respite, palliative, and end-of-life care. The policy also included procedures for patients being discharged or transferred to other services; for example, home or a long term care facility. Each process was supported by a set of documents available at the hospital, such as pre-assessment, admission, referral, transfer and discharge forms ensuring the effective sharing of important information between staff during transitions and transfers of care. Staff who spoke with inspectors were knowledgeable about these processes. In addition, as outlined in national standard 5.5, the staff had access to SOPs for the safe transitioning of patients.

Staff had access to a range of up-to-date infection prevention control, medication safety, transitions of care and the deteriorating patient policies, procedures, protocols and guidelines (PPPGs).

Overall, the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of harm.

Judgment: Compliant

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

There was a system in place in the hospital to identify, manage, respond to and report patient-safety incidents, in line with national legislation and standards, policy and guidelines.

Patient-safety incidents occurring in the hospital were reported using the National Incident Report Form (NIRF). This form was sent to the QPS advisor for Carlow, Kilkenny and South Tipperary Community, for input on to the NIMS. Hospital management and the QPS advisor had oversight of all reported patient-safety incidents at the hospital. All incidents were tracked and trended by the QPS advisor and a summary report from the NIMS was provided to the DON on a six monthly and yearly basis. Monthly and three monthly reports were provided to the DON by the head of OPS. The summary report for January to June 2024 indicated that 16 patient-safety incidents were reported in the hospital, compared to 14 incidents reported during the same period in 2023. The most commonly reported patient-safety incidents were falls. There were no patient-safety incidents relating to the four areas of harm. The percentage of incidents reported onto NIMS within 30 days of notification of the incident from January to June 2024 was 89% which is above the national target of 70%.

Staff who spoke to inspectors were knowledgeable about what and how to report and manage a patient-safety incident. Staff were aware of the most common patient-safety incidents occurring in the hospital. On reviewing the minutes of staff meetings, inspectors observed that patient-safety incidents were a standing item on the agenda. Feedback on incident reports was provided to staff and discussed during these meetings.

Overall, the hospital had a system in place to identify, report, respond to and manage patient-safety incidents.

Judgment: Compliant

Conclusion

An announced inspection of St Theresa's Hospital Co Tipperary was carried to assess compliance with 11 national standards from the *National Standards for Safer Better Health*. Overall, the inspectors found good levels compliance with the national standards assessed.

Capacity and Capability

There were formalised corporate and clinical governance arrangements in place, to ensure the delivery of high quality, safe and reliable care provided to patients in St Theresa's hospital. The hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services. There were systematic monitoring arrangements in place in the hospital for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The hospital planned, organised and managed their workforce to achieve high quality, safe and reliable healthcare. However, there were risks associated with vacant posts and the

reliance on agency staff to fill these positions, and staff absenteeism rates were above the national KPI.

Quality and Safety

St Theresa's hospital promoted a person-centred approach to care. Inspectors observed staff being kind and caring towards people using the service. Hospital management and staff were aware of the need to respect and promoted the dignity, privacy and autonomy of people receiving care in the hospital. People who spoke with inspectors were positive about their experience of receiving care in the hospital and were very complimentary of staff. The hospital were aware of the need to support and protect more vulnerable patients. The physical environment mostly supported the delivery of high-quality, safe, reliable care to protect people using the service; however, a number of hand hygiene sinks did not meet the required specifications. The hospital was monitoring and evaluating healthcare services provided at the unit to improve care. There were systems in place to identify and manage potential risk of harm associated with the four areas of harm. The hospital 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.

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	Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
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.	Substantially compliant

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	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.	Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant