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:	Carlow District Hospital
Centre ID:	OSV-0007832
Address of healthcare service:	Athy Road Carlow Co Carlow R93Y2V0
Type of Inspection:	Unannounced
Date of Inspection:	26/08/2025 and 27/08/2025
Inspection ID:	NS_0159

About the healthcare service

Model of hospital and profile

Carlow District Hospital is a statutory hospital which is owned and managed by the Health Service Executive (HSE). It is a member of and is managed by the Dublin and South East Regional Health Area (RHA).Services provided by the hospital include:

- respite services for older persons (7 beds)
- transitional care services (6 beds)
- palliative care services (4 beds)

The following information outlines some additional data on the hospital.

Number of beds	17 beds

How we inspect

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

During the inspection, inspectors:

*Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare.

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

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
26/08/2025	*12:50 – 17:45*	Laura Byrne	Elaine Egan Kay Carlos
27/08/2025	*08:45 – 15:40*	Laura Byrne	Elaine Egan Kay Carlos

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.[**]

During this inspection, the inspection team spoke with representatives of the hospital's management, Quality and Risk, and clinical staff.

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

Inspectors spoke with patients, who were positive about their care in the hospital and commented that it "couldn't be better". Patients were complimentary about the staff and inspectors observed staff engaging with patients in a kind, caring, respectful and pleasant manner and responding promptly to patients' needs. Positive feedback was received about the food choices on offer. Call-bells were observed within patients' reach and patients commented that staff responded in a timely manner when called and that staff were very helpful.

Inspectors observed that the hospital environment was clean and bright. A multi-faith oratory, communal dining room and sitting room were available for use by patients and their families. Thank you cards and notes were displayed on a notice board. A kitchen area was available for families of patients who were receiving end-

[†] 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.

of-life care which was equipped with recliner armchairs and tea and coffee facilities. An interior garden space was well maintained and had garden furniture for use by patients and their families.

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 standard related to workforce.

Carlow District Hospital was compliant in two national standards (5.8 and 5.5), substantially compliant in one national standard (6.1) and partially compliant in one national standard (5.2).

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

Overall while inspectors identified that the hospital had formalised arrangements in place with defined roles, accountability and responsibilities, deficiencies were identified in the governance, oversight and reporting arrangements. Senior management stated that the current arrangements were effective; however, the oversight mechanism of the four key areas of harm were not functioning effectively. For example, the local Carlow District Hospital Governance Group had not met for a period of ten months and there was no oversight at this meeting of transitions of care, the deteriorating patient or medication safety.

The hospital was now under the governance of the HSE Dublin and South East Regional Health Authority (RHA). These governance arrangements were embedding at the time of inspection. Management described the lines of accountability and responsibility and these reflected what was outlined in the organisational charts provided. However, the organisational charts did not fully reflect the committee reporting and oversight arrangements described to inspectors during inspection. For example, the Carlow District Hospital Governance group was not outlined on the organisational chart nor was the reporting relationship for the infection prevention and control committee.

The clinical nurse manager 2 (CNM2) was responsible for the operational management of the hospital and reported to the manager for older persons' services, Carlow, Kilkenny and South Tipperary. They reported to the general manager for older persons who in turn reported to the head of service for older persons, accountable to integrated health area (IHA) manager for Carlow, Kilkenny and South Tipperary and upwards to the regional executive officer (REO) for the Dublin and South East RHA.

There was no director of nursing (DON) in post at the time of inspection. Inspectors found there was a significant reliance on the CNM2 and CNM1 to provide operational and strategic oversight. There was an impact on some quality and safety functions for example, a project aimed at the introduction of quality care metrics to the hospital was on hold until the DON position was filled. Management described efforts to recruit for the position, however this vacancy remained since the previous inspection in August 2023. Although interim arrangements had been implemented, these were no longer in place. Inspectors were informed that a DON had been recently recruited and would commence in post in November 2025. A workforce plan was provided which outlined the key duties that would be handed over to the incoming DON in November 2025 and the planned reversion of the CNM2 and CNM1 duties to their substantive posts.

The general manager for older persons informed inspectors that they attended an older persons' performance meeting, chaired by the IHA manager and represented Carlow District Hospital. However, minutes or terms of reference (TOR) were requested for this meeting and not provided and therefore inspectors were unable to ascertain what items relating to the hospital were discussed at this forum.

Carlow District Hospital Governance Group

Attended by the CNMs and chaired by the manager for older persons' services, the Carlow District Hospital Governance Group meeting had been held in September 2024 and July 2025, representing a gap of ten months. This group had oversight of items such as workforce, complaints, and infection prevention and control (IPC). Inspectors were informed that governance of the four key areas of harm that were the focus of this inspection, were discussed at this meeting. However, with the exception of IPC, no evidence was provided they were standing agenda items nor was there evidence of discussion. A review of meeting minutes showed that actions arising were identified but not consistently assigned to a responsible person or time bound. No TOR were provided for this committee and this group was not reflected on the organisational chart, however, inspectors were informed that issues arising could be escalated via the chairperson. Overall this group was not meeting regularly

or functioning effectively to assure hospital management that a quality and safe service was being provided to patients.

Quality and Safety Committee

A local Carlow District and Castlecomer Hospitals' quality and patient safety committee, chaired by the manager for older persons' services and attended by the CNM2 and CNM1, had commenced since the last inspection in August 2023 as part of the compliance plan. This committee had oversight of complaints, risk, serious incident management team activity, quality initiatives and incident reporting. However, this committee was not functioning at the time of inspection as no meeting had taken place since November 2024. Inspectors were informed of a planned meeting in August 2025 and minutes of this were provided after the inspection. This nine month gap was not in line with the TOR which outlined quarterly meetings. This committee was accountable to the Older Persons' South East Community Hospital Quality and Safety Executive Committee (SECH QSEC) however this committee had ceased meeting since December 2024 as discussed below. Overall, it was identified that this committee was not functioning in line with its TOR.

Management stated that the last meeting of the SECH QSEC was in December 2024 with a view to moving to a new quality and safety executive committee for the IHA of Carlow, Kilkenny and South Tipperary. However, the TOR for this new committee were in draft form and meetings had not commenced at the time of the inspection. Management informed inspectors that they were managing the quality and patient safety functions locally during this gap in meetings however, the local committee was not functioning as discussed above and therefore no formal escalation pathway was in place for reporting quality and patient safety performance, and issues arising to the regional structures.

Directors of Nursing Governance Group

An older persons' south east community hospitals directors of nursing governance group met three times annually as per the TOR. Chaired by the head of service older persons, it was attended by the manager for older persons' services, the quality and patient safety (QPS) advisor, and directors of nursing (DONs) from within the south east region, including the CNM2 who represented Carlow District Hospital. Items discussed included for example, incident reports, clinical matters, policies and educational updates. A review of sample minutes indicated that a set agenda was followed and actions were identified however these were not time bound.

Deteriorating Patient Committee Castlecomer District Hospital and Carlow District Hospital

Since the last inspection in 2023 a local deteriorating patient committee (DPC) had commenced jointly with Castlecomer District Hospital. Minutes reviewed for the most recent three meetings showed that Carlow District Hospital was represented by the CNM1 and CNM2. The frequency of meetings was outlined as four times per year and minutes showed that it had met twice so far in 2025. Inspectors were informed that this committee reported to the general manager for older persons however, no reporting relationship was defined in the TOR and this committee was not outlined on the organisational diagram provided. Inspectors were informed that any issues highlighted were brought to the Carlow District Hospital governance meeting however, a review of the minutes of this meeting did not show that updates were provided from this committee. Items discussed at this meeting included early warning system practices and a review of recent deteriorating patient cases. Meeting minutes reviewed contained assigned time-bound actions. However, the records for the most recent three meetings were requested and only one agenda was provided. It was evident from a review of this that the meeting did not follow the set agenda. For example, audit results were listed as an agenda item and minutes did not reflect that they were discussed.

Drugs and Therapeutics Committee

During the inspection in August 2023, inspectors were informed of the formation of a new regional drugs and therapeutics committee but this committee had not progressed and was not in place at the time of this inspection. Medication practices in Carlow District Hospital were overseen by the Sacred Heart Hospital's drugs and therapeutics committee. Chaired by the Carlow District Hospital general practitioner (GP), this meeting was attended by the CNM2 or CNM1 for Carlow District Hospital and the antimicrobial stewardship (AMS) community pharmacist. Items discussed included AMS, audit results, training, and medication safety incidents. A sample of minutes reviewed indicated that the committee was meeting quarterly as per the TOR. The function of this committee outlined in the TOR were in relation to medication and therapeutics for Sacred Heart Hospital however, no reference was made to Carlow District Hospital.

Transitional Care Committee (TCC) Carlow District Hospital, Castlecomer District Hospital, St. Columba's Hospital and St Luke's General Hospital

A joint Transitional Care Committee was established to facilitate effective coordination and communication between St. Luke's General Hospital (SLGH) and district hospitals within the Carlow and Kilkenny regions. Carlow District Hospital was represented by the CNM2 or CNM1 and there was evidence that issues in relation to Carlow District Hospital were discussed at meetings. TOR indicated that meetings

were held quarterly however there was a six month gap in meetings between January 2025 and July 2025.

Infection Prevention and Control Committee (IPCC) Carlow District Hospital and Castlecomer District Hospital

In the compliance plan from the inspection in August 2023, hospital management committed to forming a joint infection prevention and control committee with Castlecomer District Hospital. On this inspection, inspectors identified that this had been established. Meetings were co-chaired by the IPC link [††] nurses from both hospitals and minutes showed that the group had met once in 2025. However, the TOR outlined a meeting schedule that was four times a year. This committee discussed audit findings, updates from IPC clinical nurse specialists (CNSs) and educational updates. Reporting from this committee was to the CNM2 in Carlow District Hospital who was in attendance at one meeting for which records were provided for November 2024. A review of these showed that while minutes for one meeting were action-oriented and time bound, another record showed that actions identified were not assigned to a responsible person or time bound and attendance at the meeting was not documented.

In summary, while the hospital had defined accountability arrangements for the management team, deficiencies were identified in the functioning of the local oversight and reporting arrangements of the Carlow District Hospital governance committee and the local QPS committee. This impacted on the effectiveness of the oversight for the four key areas of focus of the inspection.

Specifically;

- the DON position was vacant and this was a finding on the previous inspection in August 2023
- there had been a gap of ten months between meetings of the Carlow District Hospital governance group and frequency of meetings of Carlow District and Castlecomer Hospitals' Quality and Safety Committee and IPCC were not in line with the TOR
- transitions of care, the deteriorating patient and medication safety were not routinely discussed at meetings of the Carlow District Hospital Governance Group
- there was no clear line of reporting from the hospital to the regional structures

[††] Infection prevention and control link nurse is a link between the clinical areas and the infection control team. A key part of their role is to help increase awareness of infection control issues in their ward.

- reporting relationships for a number of committees were not outlined in the TOR or on the organisational diagram, for example the Carlow District Hospital Governance group and the DPC.

Judgment: Partially Compliant

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

Carlow District Hospital had effective management arrangements in place to support the delivery of safe and reliable healthcare in relation to the four areas of focus of this inspection; infection prevention and control, medication safety, the deteriorating patient and transitions of care.

Nursing and support staff, with the exception of catering staff, in the hospital reported to the CNM2. Out-of-hours responsibility for the service was covered on a rota basis between the CNM2 and the CNM1. Inspectors were informed that the frequency of the on-call arrangements had been escalated regionally and there was evidence that it was discussed at the Directors of Nursing Governance Group in December 2024 and May 2025. Management provided assurances that arrangements in place were effective at the time of inspection and inspectors were informed that management were also available if an issue needed escalation out of hours, however a sample clinical governance rota provided did not reflect this arrangement.

A quality and patient safety (QPS) advisor for older persons worked with and supported the CNM2 in Carlow District Hospital on matters relating to risk management and quality improvement opportunities including those related to the four areas of harm. This will be discussed further in national standard 2.8. Inspectors were provided with a schedule of activity for the year that included audits, training and risk register reviews.

Staff meetings were held for nurses and healthcare assistants. Topics relating to the four key areas of harm were discussed for example, IPC, transitions of care and staffing. Inspectors were told that these meetings took place quarterly however, minutes provided showed that meetings were held in July 2024, December 2024 and July 2025.

During core working hours, medical care was provided by a GP from a local practice who visited the hospital each day. Outside core working hours, medical care was provided by a GP out-of-hours service.

The specialist IPC team for community were available to staff at the hospital and provided IPC guidance and on-site support, for example hand hygiene training and new IPC initiatives. The hospital had an IPC link nurse who attended meetings of the South East Community Healthcare (SECH) IPC link practitioner group. This meeting was held monthly and discussed items such as national and regional updates, training opportunities and infection prevalence.

The pharmacy service at SLGH provided a satellite pharmacy service to Carlow District Hospital. Operational oversight and governance of the satellite pharmacy, such as medication stock, storage, supply, delivery and recalls were the responsibility of the pharmacy department at SLGH. Stock could be ordered daily. Urgent out-of-hours stock could be requested via the Sacred Heart Hospital which shared the same campus.

Referrals and admissions were managed operationally by the CNM2 or CNM1. A daily bed census was taken and available beds were updated on a regional bed register which was used by acute hospital discharge teams in the area. Inspectors were informed that patients were admitted from the community, SLGH, University Hospital Waterford or other hospitals for patients in the geographical catchment of the hospital. Carlow District Hospital had defined admission criteria for transitional, palliative and respite patients.

In summary, Carlow District Hospital had management arrangements in place to support the delivery of safe and reliable healthcare in relation to the four areas of focus.

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.

Hospital management had systematic monitoring arrangements in place for identifying opportunities to continually improve the quality, safety and reliability of services provided.

Monitoring Performance

Arrangements were in place to monitor the hospital's performance. The hospital collected data on a range of different measurements related to the quality and safety of healthcare services, for example, hospital activity, outbreaks, antimicrobial prescribing rates, patient-safety incidents, patient satisfaction, complaints, and training. Monthly monitoring of healthcare-associated infections (HCAI) and antimicrobial consumption were completed and reported by the AMS pharmacist. While a quality and patient safety report was compiled and presented at the local QPS committee, this committee had not met since November 2024.

Risk Management

Formalised risk management structures and processes were in place to proactively manage and minimise risks at the hospital. Nurse management outlined that they could escalate a risk to the hospital's risk register. Risks that could not be managed could be escalated to risk register of the manager for older person's services and upwards to the head of service risk register. Inspectors were informed that no risks had been escalated to this level. Inspectors were informed that the risk register was reviewed quarterly by senior management and a sample of risks reviewed by inspectors had been reviewed in June 2025. Risks in relation to IPC and workforce were recorded on the risk register. These are further discussed under national standard 3.1.

Incident Management

Management stated that incidents were logged on the National Incident Management System (NIMS)[‡‡] in line with the HSE's Incident Management Framework. The CNM2 had oversight of all incident notifications. A serious incident management team was convened when required. Inspectors were informed and evidence reviewed showed that no serious reportable events (SREs) occurred in 2024 or January to June 2025. Evidence was provided that incidents were tracked and trended and this was shared at the local QPS committee meeting. This is further discussed under national standard 3.3.

Audit

The hospital had identified an enhanced senior nurse as audit lead who was responsible for the completion of audits in the hospital and in Castlecomer District Hospital, for example care planning and medication management. The IPC link nurse had responsibility for IPC audits. The CNM2 had oversight of the results and was responsible for the implementation of action plans. An older persons' services audit

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

steering group was in place. The hospital was represented on this group by the QPS advisor and this committee discussed audit plans and tools. It was evident through a review of documentation that audits were taking place in relation to IPC, the deteriorating patient and medication safety and results of these are discussed further under national standard 2.8.

In summary, there was evidence that the hospital had systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

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.

Inspectors found Carlow District Hospital had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare.

The hospital was funded for 11 whole-time equivalent (WTE) nursing positions. This included nine staff nurses, one CNM1 and one CNM2. At the time of inspection there was no staff nurse vacancies, however as discussed under national standard 5.2, the director of nursing post was vacant. Two full time healthcare assistants (HCA's) were employed at the hospital. In addition the hospital had put in place additional agency staffing of two HCAs and one staff nurse which had been identified as a requirement from a safe staffing review. Inspectors were informed that a submission had been made to convert these long term agency posts to permanent posts. There was evidence that staffing was kept under review and discussed at meetings of the Carlow District Hospital governance group. A risk in relation to staffing cost containment measures and recruitment was recorded on the risk register.

One nurse was a trained IPC link practitioner who was assigned six hours protected time per week to fulfil this role. However, inspectors were told that staffing issues had impacted on the ability to release staff to fulfil their IPC link practitioner responsibilities. This was also a finding on the previous inspection. Inspectors were informed that an additional staff member had been identified to complete the link practitioner training commencing September 2025.

Inspectors were informed of timely access to physiotherapy services from the co-located primary care centre. Occupational therapy services were provided on a

referral basis via community staffing. There was limited access to speech and language therapy (SLT) and management informed inspectors that patients requiring SLT input were not accepted to the hospital.

Inspectors were told that one 0.5 WTE basic grade pharmacist, from the pharmacy department at SLGH was allocated to provide pharmacy services to Carlow District Hospital and other community nursing units in the region. The pharmacist visited one half day per week.

Inspectors were informed and records confirmed that staff were receiving training relative to their role in the hospital. Staff training records were maintained locally by clerical staff. A list of mandatory training courses and their required frequency was available for staff which included topics such as basic life support (BLS), hand hygiene and outbreak management. Some areas of training had good compliance, for example, attendance at training for nurses in personal protective equipment (PPE) was 100% and hand hygiene was 92%. Compliance with INEWS training was 100% for both nursing and HCA staff and compliance with safe medication training for nursing staff was also 100%. However, training compliance for nurses in standard and transmission-based precautions and basic life support (BLS) was 85%, outbreak management was 77% and sepsis training for nurses was 69%. Management informed inspectors that while no key performance indicator (KPI) was in place for mandatory training, they were aiming for 100% compliance across all areas.

Overall, the following was identified:

- mandatory training compliance was low in some areas. For example, sepsis training compliance for nurses was 69% and outbreak management was 77%.

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.

Carlow District Hospital was compliant in five national standards (1.6, 1.7, 1.8, 2.7 and 3.3), substantially compliant in one national standard (2.8) and partially compliant in one national standard (3.1).

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

It was evident through observation and discussions with staff members that patients' dignity, privacy and autonomy was respected and promoted. Staff were observed communicating with and providing care to patients in a manner that respected their privacy and dignity. Inspectors spoke to a number of patients who did not highlight any concerns regarding privacy.

Privacy curtains were in place and patient's privacy was observed to be promoted and supported during the inspection. There was an en-suite toilet and shower in each room. Doors to patient rooms had glass panels that could be turned opaque to protect patient privacy. Patients' personal information was stored appropriately and in a secure manner. For example, patient's names were covered on the whiteboard at the nurses' station.

There was evidence of the service taking into account patients' individual needs and preferences. For example, inspectors observed staff engaging with patients on their meal preferences and offering multiple choices and there was a specific care needs assessment in place for palliative care patients. Booklets with information about supporting autonomy were on display. Patients were observed wearing their own clothes and sitting out of bed.

Overall, there was evidence that hospital management and staff were aware of the need to respect promote and protect the dignity, privacy and autonomy of patients.

Judgment: Compliant

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

The service promoted a culture of kindness, consideration and respect. Inspectors observed a calm and quiet environment. Patients told inspectors that staff were responsive when they needed assistance. Inspectors observed that staff responded to call bells in a timely manner and this was validated by patients in their feedback to inspectors. Staff were provided assistance to and interacted with patients and their families in a kind, respectful and caring manner. Inspectors observed that families were offered refreshments alongside patients.

Patients were provided with an information pack, developed from a quality improvement plan (QIP) in 2024, which contained information about the service and a patient satisfaction survey. There was evidence that QIPs were developed in response to survey findings, for example a QIP was completed in April 2025 to introduce staff name badges and this practice was observed on the days of inspection.

A project to introduce a specialised bed known as a "cuddle bed" had been introduced in one of the palliative care rooms and this was aimed at enhancing the comfort of patients and their families. Palliative care rooms were also equipped with small fridges for patient use, televisions and air conditioning units. Inspectors were informed that a hairdresser came on site once per week and that services such as chiropody were available on request.

The hospital had arrangements in place to facilitate access for patients to independent advocacy services where required. Posters displayed provided information on how to access advocacy services. Safeguarding information was on display along with the pictures of the designated safeguarding officers. Overall, staff and management of the hospital promoted a culture of kindness, consideration and respect.

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 hospital had identified the CNM2 as the designated complaints officer and this information was on display for patients in the hospital. Inspectors found there were systems and processes in place in the hospital to respond to complaints and concerns received from patients and their families.

Formal complaints received by hospital management were managed in line with the HSE's complaints management policy 'Your Service Your Say'[§§]. Staff in the hospital maintained a written record of all complaints received and any actions or associated outcomes. Posters and leaflets on 'Your Service Your Say' were observed in the hospital. An admission pack for new patients also contained information on how to raise a complaint. None of the patients who spoke with inspectors had a complaint, but they said they would speak to staff if they had a concern or complaint about the care received. Inspectors were informed that feedback and learning from complaints was shared at ward meetings, clinical handover and safety pauses. There was evidence of the service responding to patient's complaints and feedback, for example a project to install Wi-Fi internet access in the palliative care rooms had been completed in February 2025.

Complaints were discussed at the Carlow District and Castlecomer hospital's local QPS committee and the Carlow District Hospital Governance Committee. Inspectors were informed that complaints were escalated to the general manager, head of service if required.

Inspectors were informed that complaints at the hospital were not trended, however data reviewed by inspectors indicated that the overall number of formal complaints received by the hospital was low. The service was tracking compliance with complaint KPI's and in 2025 they reported that 100% had been responded to within 30 days. However, inspectors were informed that the service was not always able to close complaints within this timeframe and this was attributed to changes in management personnel over the preceding year.

Overall, there was evidence that the hospital had systems and processes in place to respond effectively to complaints and concerns raised by people using the service.

[§§] 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

Judgment: Compliant

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

Inspectors observed that the physical environment in the areas visited supported the delivery of high-quality, safe, reliable care. On the day of inspection, inspectors observed that the hospital was clean and well maintained. The infrastructure was built to modern specifications and patient areas were bright and spacious. The hospital layout consisted of six single rooms, one three-bedded multi-occupancy room and two four-bedded multi-occupancy rooms. All rooms had en-suite bathroom facilities. Adequate space of over one metre was observed to be maintained between beds in multi-occupancy rooms. None of the nine patients admitted at the time of inspection required transmission-based precautions. Personal protective equipment was available if required.

Hand-hygiene sinks in the clinical area did not meet the required specifications[***]. This was a finding on the previous inspection and was recorded on the hospital's risk register. Inspectors were informed that funding had been secured and a plan was in place for upgrade but that the work had not commenced. Staff had access to wall-mounted alcohol based hand sanitiser dispensers throughout the ward areas. Hand-hygiene information was included on the back of staff identification badges and displayed in the wards.

Routine environmental cleaning was completed by cleaning staff from 8am to 6pm. A colour-coded system was in place for cleaning cloths and cleaning staff were knowledgeable about the cleaning processes in place. A south east community cleaning guideline was provided to inspectors however, it was noted that the colour coding for cleaning materials outlined in this document did not align with the practice observed during the inspection and no local hospital document was available to guide staff. This was raised with management and staff on the day of the inspection. Cleaning schedules were up to date and there was evidence of regular oversight of these by the CNMs. Inspectors were informed that terminal cleaning was completed when a patient was discharged. A schedule was in place for the changing of curtains in the wards. However, records evidenced that five curtains

[***] National Clinical Guidance No. 30-Infection Prevention and Control (IPC). Available online from https://www.gov.ie/en/publication/a057e-infection-prevention-and-control-ipc/#national-clinical-guideline-no-30-infection-prevention-and-control-ipc-full-report-volume-1.

had not been changed within the three month frequency outlined in the hospital guideline.

Inspectors observed that equipment was clean in the clinical areas visited. HCA's were assigned with responsibility for the cleaning of the equipment. A system was in place to identify equipment which had been cleaned, for example, the use of tags and checklists and these were kept up to date. Evidence of a daily equipment cleaning checklist was maintained in the wards and this was maintained by a HCA with oversight by the clinical nurse manager. Staff reported they had adequate access to maintenance services who were responsive to requests. Stock and equipment were stored appropriately and the environment was free of clutter. Inspectors' observed that sharps waste material was correctly stored and there was appropriate segregation and storage of linen and waste.

In summary, the physical environment supported the delivery of high-quality, safe, reliable care.

Judgment: Compliant

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

Inspectors found that there were systems in place at the hospital to monitor, evaluate and continuously improve the healthcare services and care provided. The hospital were completing a range of audits based on an annual audit schedule.

The IPC link nurse carried out audits for example, hand hygiene facilities, laundry and equipment. Overall IPC compliance for 2025 was reported as 82%. Some audits had high compliance rates, for example patient equipment had achieved 100% compliance in 2025. However, some audits showed areas of repeated non-compliance in the same domain. For example, a mattress and pillow audit which showed compliance of 63% for 2025 showed the same three non-compliances on audits in both March and June 2025. Actions plans or QIP's were requested but not provided in response to IPC audit findings therefore inspectors were unable to ascertain if actions were implemented appropriately.

Monthly antimicrobial stewardship audits were carried out and this was benchmarked against other HSE regions along with data on outbreaks and incidences of HCAI. Environmental audits were not taking place but inspectors were informed that the environment was monitored via twice annually quality and safety walkarounds and that issues arising from this were communicated to the CNM2 for

action. The ward environment was clean and well maintained on the day in inspection.

Inspectors were informed that medication safety prescribing audits were carried out by the clinical pharmacist. Records reviewed for January 2025 showed that while a total score for this audit was not calculated, 90% of records were reported as having high accuracy and only one issue was clearly identified in relation to generic medication prescribing. The most recent three audits were requested, however no previous or subsequent audits were provided and therefore inspectors were unable to verify if items were actioned between audit cycles. Medication management audits were taking place twice annually and there was evidence that the service was responding to audit findings, for example a time-bound action plan was put in place after a December 2024 medication management audit showed compliance of 93% and the result improved to 96% on the repeat audit in May 2025.

Annual audits of the modified early warning score (MEWS) were taking place. There was evidence that improvements had been made in this area with the March 2025 overall audit compliance at 92%, an improvement from the previous audit result of 85% in 2024. Staff outlined how improvements had been made through education and the development of an SOP. A time-bound action plan was developed in response to the 2025 audit and healthcare records reviewed by inspectors showed that MEWS usage aligned with the SOP.

Although tracking of bed occupancy and admission was taking place, no audits were taking place on transitions of care or the use of the Identify, Situation, Background and Response (ISBAR) tool.

Noticeboards in the ward displayed details on audit results and this was observed to display up-to-date information. Learning from audits were discussed at staff meetings.

Overall, the hospital were systematically monitoring and evaluating the service, however;

- no transitions of care or ISBAR audits were taking place
- action plans were not always provided for audits where non-compliances were identified and some audits showed repeated non-compliance in the same domain.

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

While the hospital had some systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services, staff did not have access to clear or up-to-date information to guide practice and some policies had not been reviewed in line with their planned review dates.

As discussed under national standard 5.8, risks were recorded on the hospital's risk register. Examples of risks relating to the focus of this inspection included risks relating to IPC and workforce, for example, the risk of harm due to acquiring a healthcare associated infection. Items on the risk register had documented controls.

The hospital had implemented a modified version of the Irish National Early Warning Score (INEWS) known as the MEWS. Inspectors reviewed a sample of MEWS patient records and observed that the score was correctly calculated and observations completed at the required frequency. However, inspectors were informed that observations were carried out once per 24 hours for all patients with a score of 0 and this practice was not reflected in the local MEWS standard operating procedure (SOP) which did not contain a documented observation frequency for patients with a score of 0. This meant that staff did not have clear guidance on observation frequency for these patients. Furthermore the MEWS assessment was not aligned with the National Clinical Guideline (NCG) No.1, INEWS version 2. For example, it had a section for the documentation of modified parameters and there was no section for documenting repeat observation frequency and healthcare worker or family concern.

The local protocol in the event of a cardiac arrest was to commence cardiopulmonary resuscitation and phone an ambulance. Information on the emergency call response system and the out-of-hours GP service was on display. Oxygen and suction equipment was available at bed spaces or access to portable suction machines available. Automated external defibrillators were available for use in the hospital and regular checks of emergency equipment were carried out.

The service was not routinely testing patients on admission for infection, but management outlined that they completed screening assessments on admission and any known infections were routinely documented in the nursing assessment. Inspectors were informed that testing was taking place if a patient showed symptoms of a respiratory infection and that patients would be isolated in single rooms if possible. Inspectors were informed that the while the hospital was following the HSE community infection prevention and control manual, these pre-dated the most recent NCG that was published in 2023. For example, the stated required

frequency of curtain changing in the hospital was every 3 months and not biannually as in the updated guidance.

Outbreak reports were completed following an infection outbreak and an example of this outlined lessons learned. Management stated that microbiology advice was available from SLGH if required and staff had access to an antimicrobial pharmacist from the community for advice as needed.

Medications were kept securely in a locked medication room with keypad access. Controlled medications were appropriately stored and there was evidence that a count of these was completed on each shift. A sample of these were reviewed and were correct. A fridge for storage of medications was available and daily temperature checks were carried out. Staff had access to a list of high-risk medications and a list of sound-alike look-alike medications (SALADs), however, the high-risk medication list was not displayed in the medication room. Staff had access to medication information in hardcopy at the point of administration however, medication formularies observed in the medication room were out of date. This was communicated to hospital management during the inspection. This was also a finding on the previous inspection and had not been addressed. Inspectors were told that staff could access online prescribing information but staff were not aware of any specific resource available.

Medication reconciliation was carried out on the day of admission by the medical officer. The medication prescription record in use did not contain a specific section for recording medicines reconciliation, however, inspectors were shown a new version that was due to be implemented in the coming weeks. During their weekly visit, the clinical pharmacist reviewed medications for new patients and completed medication reconciliation on requested patients. Requests for the pharmacist were communicated by the nursing staff on duty each week.

Staff were supported in the admissions process by the use of a checklist. Predicted dates of discharge were recorded on admission. Inspectors were told that a multi-disciplinary team meeting was held weekly which discussed new patients and plans of care and was attended by nursing and therapy staff. A daily safety huddle was in place where updates were provided on any admissions, discharges and any changes in patients MEWS score. As committed to in the compliance plan, the ISBAR tool had been introduced since the previous inspection, and was in use for shift handover at the hospital and inspectors observed this practice. Inspectors were informed that the ISBAR sticker was available for use for a deteriorating patient requiring transfer out. A transfer letter was used for discharge referrals to public health nurses and this included for example, the IPC status, MEWS score and medication prescription. Inspectors were informed that the hospital had access to a mobile x-ray service for

any patient who required x-rays and access to laboratory services in University Hospital Waterford.

The hospital had a number of policies, procedures, protocols and guidelines (PPPGs) in place to guide staff in relation to the four known areas of harm, infection prevention and control, the deteriorating patient, medication safety and transitions of care. PPPG's were developed by a local policies, procedures and guidelines governance group for Carlow, Kilkenny and South Tipperary older person's services. The CNM1 and CNM2 were in attendance at meetings. Inspectors were informed that any new policies were approved by the local QPS committee. Inspectors reviewed a number of policies and SOPs and observed that some of these had not been reviewed in line with their planned review dates. For example, although it was indicated in the compliance plan from the inspection in August 2023 that a review of this policy was being undertaken, the medication management and administration policy was out of date with a review date of 2024. The resident transfer protocol and complaints SOP had planned review dates in 2023. An overarching policy for admission to community nursing units in the region, had been implemented. However, this policy did not fully align with admission practices at the hospital. Inspectors were informed that the hospital did not require approval from a consultant in palliative care for palliative admissions however this was the requirement outlined in the policy. Staff had access to hard copies of policies in the hospital. Although management informed inspectors that staff could also access policies via an online portal, staff that spoke with inspectors were not aware of this practice.

In summary, while the hospital had some systems in place to identify and manage potential risk of harm associated with areas of focus - infection prevention and control, medication safety, transitions of care and the deteriorating patient, the following was identified:

- some policies and SOPs were not up to date and staff were not aware of how to locate them on the online system
- hard copy medication information was out of date and this was also a finding on the previous inspection
- the local MEWS SOP did not outline observation frequency for patients with a score of 0
- the MEWS was not in line with national guidance.

Judgment: Partially Compliant

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

There were effective systems and processes in place in the hospital to proactively identify and manage patient-safety incidents. All patient-safety incidents were notified to the QPS advisor, using the National Incident Report Form (NIRF) via a designated email. Staff had access to an incident reporting standard operating procedure and guidance which was up to date.

Incidents were tracked and trended by the QPS advisor and an analysis trend report was generated every six months which categorised incidents and their outcomes and compared year on year data. Management were aware of the incident trends for the hospital. The compliance with the HSE KPI of recording incidents on the NIMS system within 30 days was tracked and this was reported as 100% for January to June 2025 and 99% for 2024.

The CNM2 had responsibility for the implementation of action plans arising from any incidents. Incidents were discussed at staff meetings. There was evidence that QIPs were developed in response to incidents, for example a new admission booklet had been developed and was recently commenced. Overall, inspectors found there was a system in place at Carlow District Hospital to identify, report, manage and respond to patient-safety incidents.

Judgment: Compliant

Conclusion

HIQA carried out an unannounced inspection of Carlow District Hospital to assess compliance with the *National Standards for Safer Better Healthcare.*

This inspection focused on four areas of known harm; infection prevention and control, medication safety, the deteriorating patient and transitions of care.

Capacity and Capability

The hospital had defined accountability and reporting arrangements for the senior management team, however the DON position remained vacant. Deficiencies were identified in the functioning, oversight and reporting arrangements of the governance committees and this impacted on the oversight and escalation pathways for the four key areas of focus of the inspection. The hospital had effective management arrangements in place to support the delivery of safe and reliable

healthcare in relation to the four areas of focus of this inspection. Senior management organised and managed their workforce, however some mandatory training areas had low levels of compliance. The hospital had effective monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Quality and Safety

Inspectors observed staff interacting in a kind and caring manner towards patients. Patients who spoke with inspectors were positive about their experience of receiving care in the hospital and were complimentary of the staff. It was evident that a person-centred approach to care was promoted. Through observation and discussions with staff members it was evident that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients.

Management monitored and evaluated the service, however inspectors noted that some of the areas of focus of the inspection had no audits taking place. Systems were in place to identify and manage potential risk of harm however, staff did not have access to up-to-date medicines information. Policies and procedures were available, however some of these reviewed by inspectors had not been updated in line with their planned review dates. Complaints management processes were in place. Management identified, managed, and responded to patient-safety incidents and there was evidence that QIPs were developed in response to incidents.

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 on-site 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	Partially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially Compliant
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	Compliant

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

Compliance Plan for Carlow District Hospital

Inspection ID: NS_0159

Date of inspection: 26 and 27 August 2025 .

Compliance plan provider's response:

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

1. The post of Director of Nursing has been filled as of 3rd November 2025.

2. In January / February 2025 a number of key management posts became vacant through various absences, resulting in a deficiency in management structures. Regrettably, this resulted in a gap in respect of governance and as such meetings did not take place in line with TORs. A review of the Terms of reference and membership for the following committees has been undertaken and where currently actionable, have been amended.

- Carlow District Hospital Governance Group (reviewed and ratified 11.12.2025)

- Health & Safety Carlow & Castlecomer Hospital (reviewed and ratified 11.12.2025)

- Carlow & Castlecomer QPS Committee (reviewed and ratified 11.12.2025)

- Transitional Care Committee (reviewed and for ratification at next meeting)

- Deteriorating Patient Committee (reviewed and for ratification at next meeting 24.02.26)

- Directors of Nursing Governance (request submitted in respect of actions to be time bound) date tbc

- Drugs and Therapeutic Committee (TORs reviewed to include Carlow District Hospital and for ratification at the next scheduled meeting 20/01/2026)

- 3PGs Policies, Procedures, Protocols & Guidelines (reviewed locally and for discussion and ratification under AOB at next scheduled meeting 15/01/2026)

- IPC (The TORs need to be reviewed to include a reporting relationship, this is proposed to be discussed at next convened meeting 04/02/2026)

3. The deteriorating patient medication safety & transitions of care have been placed as an agenda item at the governance meetings and will be included as a standing agenda item. A meeting convened on 11/12/2025 and both items addressed as standing agenda items.

Hospital management are now included and are part of the membership of the regional QSEC committee and the Director of Nursing represents Carlow District Hospital at this forum. .

4. A review of the onward reporting relationship and subsequent associated action plans for each committee meeting has been reviewed in conjunction with the TOR review. Where identified the onward reporting has been agreed locally and to be requested as an agenda items at such meetings. A full review of the organisational committee / reporting diagram has been requested from our OPS business manager to reflect the changes in the reporting structure.

Timescale: Immediate and Ongoing - closure by end of March 2026 Q1

Standard	Judgment
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant

A full review of all policies & SOPs is underway to bring all up to date, all staff at Carlow District Hospital now have access to the HCI online portal and hard copies of policies made available to all staff to view and acknowledge.

Online platform for medication formulary is available to all nursing staff and staff have been provided with the appropriate links. Out of date hard copy medication information has been removed and not currently available from the pharmacy provider currently. Staff are now required to use the online format.

MEWS "0" score - The current SOP has been update to reflect actions required for a MEWS score of 0 and patient and family or HCA concern in line with national iNEWS policy, this has been disseminated to all staff.
Timescale: Policy review & SOP - End of February 2026 Medical Information is now available via link MEWS "0" score - completed