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 Patrick's Hospital
Centre ID:	OSV-0007856
Address of healthcare service:	Summerhill, Carrick-on-Shannon, Co. Leitrim
Type of Inspection:	Announced
Date of Inspection:	01/04/2025 and 02/04/2025
Inspection ID:	NS_0138

About the healthcare service

Model of hospital and profile

St Patrick's Hospital is a model one* rehabilitation and community inpatient healthcare service owned and managed by the Health Service Executive (HSE). At the time of inspection, it was part of HSE Community Healthcare Organisation 1† (CHO 1) and was in the process of transitioning to the new HSE regional health structures under the governance of Integrated Healthcare Area (IHA), Sligo, Leitrim, West Cavan and South Donegal within the HSE West and North West Regional Health Area (RHA). The transition was expected to be completed by the end of quarter two 2025.

Services provided by the hospital include:

- convalescence care
- respite care
- palliative care
- rehabilitation

The following information outlines some additional data on the hospital.

Number of beds	Eight inpatient beds

How we inspect

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

* The National Acute Medicine Programme's model of hospitals describes four levels of hospitals. Model-1 hospitals are community and or district hospitals and do not provide surgery, emergency care, acute medicine (other than for a select group of low risk patients) or critical care.
† CHO 1 serves the populations of Cavan, Donegal, Leitrim, Monaghan, and Sligo, delivering a range of community health services.

HIQA's role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publically available information since last inspection.

During the inspection, inspectors:

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

About the inspection report

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

1. Capacity and capability of the service

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

[‡]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.

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)
01/04/2025	*13:20 – 17:00*	Éilish Browne	Robert McConkey
02/04/2025	*08:40 – 15:50*	Éilish Browne	Robert McConkey

Information about this inspection

St Patrick's Hospital comprised a short stay unit, located on the top floor of a designated centre for older persons. The hospital had the capacity to accommodate up to 16 beds, however, at the time of this inspection, only eight beds were operational. Inspectors were informed that the initial bed closures were attributed to fire safety works. Once all work was complete, the continued closure of beds related to insufficient staffing. Inspectors were informed by management that there were plans to re-open the closed beds in the hospital, and a formal plan had been submitted to HR requesting the necessary staffing to support the reopening of the additional beds.

Management informed inspectors that construction had commenced on a 90-bed community hospital in Carrick-on-Shannon, with 20 of these beds designated for short-stay patients.

This inspection focused on eleven 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 one clinical area:

- Rivermead Short Stay Unit (RSSU)

During this inspection, the inspection team spoke with representatives of the hospital's Executive Management Team, Quality and Risk, Human Resources and Clinical Staff.

The general practitioner (GP) from the practice that provides medical officer cover to the hospital was also invited to speak with the inspectors but respectfully declined.

[§] 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 improves 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.

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

Acknowledgements

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

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

During the inspection, inspectors had the opportunity to speak with a number of patients about their experience of care in the hospital. Overall, patients expressed satisfaction with the care they received and were complimentary of the staff in the clinical area. Patients stated that ”the staff were very good”, ”care couldn’t be better” and that staff were ”doing a remarkable job”. A collection of thank you cards was displayed in a collage outside the nurses' station, expressing appreciation for the care provided and acknowledging the nurses' commitment to their work.

Patients were also complimentary of the food provided in the hospital stating that ”the food was first class” and ”there was choice everyday”.

Inspectors observed staff actively engaging with patients in a respectful and kind manner. Staff were observed supporting and assisting patients and responding promptly to patients’ individual needs, this was validated by patients who told inspectors ”the staff are very good and provide service very quickly”. Staff also ensured that patient's privacy and dignity was protected during care by drawing curtains when attending to their personal needs.

Patients had access to a shared communal area in which they could choose to watch television, enjoy their meals or spend time with visitors.

A comprehensive suite of information leaflets was readily available to patients during their hospital stay. The leaflets were displayed in a wall-mounted unit located outside the nurses’ office. The leaflets covered a broad range of topics including how to access patient advocacy services, how to make a complaint, medication safety and healthy eating for older persons. In addition to this, the results from the recent patient satisfaction survey were also on display.

When patients spoken with were asked if they would know how to make a complaint if required, they stated they ”couldn’t fault anything” but they ”would talk to staff” or ”talk to the DON who had made herself known to me”. A suggestion box was located outside the nurses’ office allowing patients to leave any comments they desired regarding their stay in the hospital. In addition, inspectors were told that feedback was encouraged to ensure improved care in the hospital, this was evident as patients were asked to complete a feedback form at the end of their hospital stay.

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.

St Patrick's Hospital was found to be substantially compliant with national standard (NS) 5.2 and NS 6.1, and compliant with NS 5.5 and NS 5.8.

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

Inspectors were provided with organisational charts which set out the hospital reporting structures, detailing the direct reporting arrangements for hospital management and the governance and oversight committees. The reporting and accountability relationship to CHO1 was also clearly outlined on the organisational charts.

The DON was responsible for the operational management of St Patrick's Hospital and the onsite designated centre for older persons. The DON reported to the service manager, OPS CHO1, Sligo and Leitrim who reported to the general manager (GM) for OPS CHO1, and upwards to the head of service for older people and to the IHA manager, HSE Sligo, Leitrim, West Cavan and South Donegal who reported up to the regional executive officer (REO) for HSE West and North West. Nursing and support staff within the hospital reported to the clinical nurse manager (CNM) II and upwards to the ADON and then to the DON. The DON was responsible for the oversight and management of all staff members in the hospital.

Management at the hospital informed inspectors that the medical officer role provided clinical oversight at St Patrick's Hospital. One whole-time equivalent (WTE)[§§] medical officer role was filled by GPs from a local GP practice. The medical officer visited the hospital each morning from Monday-Friday and was available by phone during the hours of 9am to 5pm. There was an out-of-hours medical service available by the regional doctor on-call scheme, Nowdoc.

The DON reported that they received good support from the service manager, OPS CHO1, Sligo and Leitrim through consistent communications.

[§§] 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.

Inspectors were told about community-wide committees involved in the governance of St Patrick's Hospital as follows:

Community Healthcare Cavan, Donegal, Leitrim, Monaghan, Sligo (CH CDLMS) Older Persons Quality and Safety Review Committee

The CH CDLMS Older Persons Quality and Safety Review Committee was a multidisciplinary team with the purpose of ensuring quality and safety structures, processes and standards throughout older persons services (OPS) in CHO1. Membership included head of service for older persons as chair, GM for older persons' services, a service manager representing each of the respective areas within CHO1, quality and risk manager, health and safety manager, consumer services manager, safeguarding manager, infection control representative and administrative support. The committee also had the capacity to invite people with expertise from a variety of sources both internal and external, in order to inform its deliberations, address specific topics and enhance the decision-making process.

Inspectors were provided with the third version of the terms of reference (TOR) which was approved in December 2023. The TOR stated that the document was to undergo an annual review, however, it had not been updated accordingly. According to the TOR, meetings were to be held four times per annum and the committee was noted to be meeting in line with this.

Inspectors reviewed the agenda and minutes of the last three meetings of the committee held in May, August and November 2024. Review of the provided minutes indicated that each service manager provided an update for their respective areas on the following: safety incidents, safeguarding, infection prevention and control, complaints, compliments, mandatory training and HIQA inspections.

Additionally, during the committee meetings, updates were provided on health and safety, consumer services, contract management, and safeguarding across the OPS in CHO1. The quality and patient safety advisor for OPS or their representative also provided an update on quality and patient safety across all services including the number and type of incidents and training sessions available to staff. Meetings were observed to be well attended. The service manager, OPS CHO1, Sligo and Leitrim represented St Patrick's Hospital and was in attendance at all three meetings. The DON confirmed that the minutes of the meetings were circulated following each meeting.

Sligo and Leitrim CHO1 Services for Older Persons Quality and Safety Committee

According to the TOR dated May 2024, the committee was a senior management team with the aim 'to develop, deliver, champion, implement and evaluate a comprehensive quality and safety programme with associated structures, policies and processes which are the vehicle for promoting a culture of quality improvement across Sligo and Leitrim older persons services'. Membership included the service manager, OPS CHO1, Sligo and Leitrim as chairperson, quality and patient safety lead, nurse development co-ordinator and DON from each of the OP services in the Sligo and Leitrim CHO1 area. Health and safety representatives were listed as being in attendance 'as required'.

Inspectors found that the committee had been adhering to its TOR with regard to the frequency of meetings occurring every four weeks. Inspectors were provided with the minutes from the last three meetings held in December 2024, January 2025 and February 2025. Meetings were observed to be well attended with the DON from St Patrick's Hospital in attendance at two of the meetings and the ADON from St Patrick's Hospital in attendance at one meeting.

Minutes reviewed showed incidents, safeguarding, complaints, compliments, infection prevention and control, bed management, transitions of care, restrictive practices, HIQA inspections and tissue viability as items discussed at the forum. Incidents for each service were also discussed, however, inspectors noted that it was sometimes unclear whether incidents in relation to St Patrick's Hospital referred to the rehabilitation and community inpatient healthcare service or to the onsite designated centre for older persons. The minutes reviewed indicated that the meetings followed a structured format and were action-oriented, however inspectors noted that they would benefit from having clearly defined responsible persons for the completion of actions.

CHO 1 Infection Prevention and Control, Antimicrobial Stewardship and Health Care Associated Infection Committee

Inspectors were provided with version four of the *Guideline on Terms of Reference for Community Healthcare Organisation (CHO) Infection Prevention and Control (IPC) and Antimicrobial Stewardship (AMS) Committees* dated January 2023 with a review date of January 2025. It stated that the purpose of the CHO infection prevention and control and antimicrobial stewardship committee was to 'support in the development of infection prevention and control and antimicrobial stewardship services and structures in the community and to prioritise the use of these resources in line with national strategic objectives for health care associated infection'.

This document stated that committee meetings were to be held every three months and a review of meeting minutes confirmed adherence to this, as minutes from the meetings held in September 2024, December 2024 and March 2025 were available for inspectors to review. A review of the minutes indicated that the committees membership included head of service for quality, safety and service improvement HSE CH CDLMS, consultant microbiologist, consultant public health medicine, epidemiologist, ADON infection prevention and control team lead HSE CH CDLMS, clinical nurse specialist infection prevention and control, ADON public health, GM Primary Care, project manager estates department, head of service for health and wellbeing and regional DON for disability services. Minutes reviewed showed that the meetings followed an agenda, actions were assigned to a responsible person and were time bound. Minutes reviewed showed that agenda items included updates from public health medicine, estates, infection prevention and control, antimicrobial pharmacist, microbiology and quality and patient safety.

Medication Safety

Inspectors were informed there was no formal medication safety committee in place to provide oversight of medication management within St Patrick's Hospital. The practice development co-ordinator OPS Sligo and Leitrim had recently brought this to the attention of the project business manager for quality, safety and service improvement for community services CDLMS, who advised that the hospital had access to the community services CDLMS drugs and therapeutics advisory group. This group was not operational in nature but instead acted in an advisory capacity. The oversight of medication incidents in OPS fell under the remit of the OPS Serious Incident Management Team which was chaired by the head of service for older people. The hospital's lead representative for medication safety was a community pharmacist (Chief II). They visited the hospital to provide oversight and support of medication management at intervals of seven to 10 days. An antimicrobial pharmacist based in Sligo University Hospital (SUH) was available to staff in St Patrick's Hospital to provide guidance and support on antimicrobial stewardship, and staff could also access a microbiologist in SUH if required. Staff accessed microbiology results via the hospital's computer system.

Deteriorating Patient

Inspectors were informed by management that all admissions to St Patrick's Hospital had been medically discharged from acute services. Both management and staff in the clinical area visited were knowledgeable of processes in place in the hospital in relation to the early detection of a deteriorating patient. This will be discussed further under NS 5.5.

Transitions of Care

Matters in relation to transitions of care were managed by management at both hospital and CHO1 level. The hospital had an up–to-date admissions, transfers and discharge policy in place, which supported the safe transition of care for both internal and external transfers. The DON was the admitting officer for St Patrick's Hospital and was responsible for ensuring the efficient and effective use of all hospital beds in line with external patient flow processes within the acute and community services. The DON was supported in their role by the community discharge liaison officer OPS. Inspectors were informed that management in St Patrick's Hospital participated in a weekly bed occupancy tele-call between other short-term care facilities across Sligo and Leitrim, the OPS service manager and community discharge liaison officer to ensure appropriate usage of beds and facilitate discharge planning. A daily bed occupancy report was also submitted via the Bed Register app to the service manager to review all vacant beds across the services. Inspectors noted that these matters were discussed at each of the Sligo and Leitrim CHO1 Services for Older Persons Quality and Safety Committee as reflected in the minutes reviewed.

Serious Incident Management Team (SIMT) Older Person Services, CH CDLMS

A terms of reference for the Serious Incident Management Team, Older Person Services, CH CDLMS was provided, however, it had not been reviewed on an annual basis as outlined in the document itself. This issue was brought to the attention of management, after which, an updated terms of reference was submitted to HIQA post inspection, stating that it had been revised as of December 2024. The multidisciplinary team met on a monthly basis to ensure high standards in the review of adverse events that met the criteria of a category one incident (clinical and non-clinical incidents rated as major or extreme) or a serious reportable event (SRE).

Membership comprised head of service, older person services as chair and GM, older person services as vice chair, along with representatives from a range of other disciplines including an advanced nurse practitioner in tissue viability, clinical coordinator - falls and bone health, clinical nurse specialist in infection prevention and control, quality and patient safety advisor, and the quality and patient safety coordinator. A health and safety officer and social worker were in attendance as required. The chair of the SIMT was accountable to the chief officer.

Inspectors were provided with the agenda, which outlined the standing agenda items, indicating that the following were discussed at each meeting, new incidents across CH CDLMS, incidents for review or update, comprehensive or concise reviews submitted for review, claims and recommendation application status update. Inspectors were informed that recommendations resulting from incident outcomes discussed at SIMT were uploaded to a designated recommendation application. Management also stated that the implementation progress of these recommendations was actively monitored, with a responsible person assigned to each and specific timelines for completion. Inspectors were informed that there were no category one incidents or SREs reported by the hospital in 2024. A review of the hospitals 'Incident Management and Quality and Patient Safety Annual Report 2024' also confirmed this.

Overall, St Patrick's Hospital had formalised governance arrangements in place for assuring the delivery of high quality, safe and reliable healthcare, however, the following areas for improvement were identified:

- not all terms of reference were updated in accordance with the requirements as outlined within the terms of reference
- the clarity of committee minutes could be strengthened by explicitly differentiating the rehabilitation and community inpatient healthcare service from the onsite designated centre for older persons
- committee minutes would benefit from having an identified responsible person for completion of actions, this was noted in some but not in all minutes.

Judgment: Substantially Compliant

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

At the time of inspection, effective management arrangements were in place to support the delivery of safe and reliable healthcare in St Patrick's Hospital. Inspectors observed and were informed by staff that management continuously engaged with staff in the clinical area. The hospital had management arrangements in place in relation to the four areas of known harm.

Infection Prevention and Control (IPC)

The hospital had an infection prevention and control link practitioner with protected hours to conduct audits and to provide guidance and training to staff on infection prevention and control. The infection prevention and control ADON OPS CHO 1 described the close links with the hospital's infection prevention and control link practitioner. Inspectors were informed that the infection prevention and control link nurse attended six weekly meetings with the IPC team from CHO1. This forum provided the link practitioners with a platform for support, guidance, discussion and opportunities for shared learning across services. This was validated by hospital management and management in the clinical area.

Management and nursing staff on the ward confirmed that they received good support in infection prevention control from both the infection prevention and control team in CHO 1 and from public health. They could also access a community-based microbiologist and were able to seek additional guidance or consultation from the acute hospital if required.

Both staff and the medical officers had access to laboratory reports either through the hospital's computer system or by directly contacting the laboratory in the acute hospital by telephone.

Medication safety

The hospital pharmacy service was led by a community pharmacist (Chief II) who attended the hospital at intervals of seven to 10 days. The pharmacist was responsible for conducting medication reconciliation on all patients admitted to St Patrick's Hospital. They also provided oversight and input into the medication safety audits and delivered educational sessions to nursing staff focused on medication safety. They were supported in their role by a pharmacy technician, responsible for stock control, who visited the hospital twice weekly to manage medication supplies and inventory. Pharmacy supplies to the hospital were provided by SUH with weekly deliveries, while additional medications could be requested outside of scheduled delivery times if required.

Deteriorating patient

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

- referral forms were reviewed prior to admission to assess patient suitability
- if the patient was deemed suitable, a verbal handover was conducted with the nurse from the discharging unit prior to admission
- baseline observations were established on admission

- observations were monitored twice daily and compared to baseline to identify any deviations
- if any deviations noted, a review by the medical officer or out-of-hours doctor would take place
- clinical judgment was exercised by nurses to arrange the transfer of patients to acute care, initiating a 999 call as necessary
- patients transferred via ambulance to the acute hospital.

Transitions of care

The DON maintained oversight of all patient transitions of care. Effective processes were implemented to manage transitions of care both into and out of the hospital. All admissions were planned in advance and came from the following sources:

- SUH and other hospitals for convalescence, rehabilitation and palliative care
- general practitioners, public health nurses and other members of the community based primary community and continuing care team (PCCC) for assessment, palliative and respite care
- North West Hospice, for ongoing palliative and long term residential level one care
- private and voluntary nursing homes for assessment and rehabilitation.

Inspectors were informed that referrals from the acute hospital were received several days prior to admission. A request form, for primary community and continuing care supports and services assessment, was completed for patients transferred from the acute facility. This document was discussed with the patient in the acute facility and their consent to the request for service was obtained. The form outlined the reason for the patient's admission as well as the patient's current status including medical, cognitive and activity of daily functions. If the patient was deemed suitable for admission, the staff in St Patrick's Hospital obtained a verbal hand-over from the nurse in the discharging unit to ensure that the patient's needs could be met prior to admission. This included their medical needs, physical needs, vaccination status, infection prevention and control status and equipment needs.

In the case of patients being admitted for respite care, the referring source was required to complete the 'common summary assessment report form' to ensure the comprehensive transfer of all relevant social and clinical information. For respite admissions, a discharge date was established in collaboration with the family prior to admission.

In summary, HIQA was satisfied that the hospital had established local management arrangements to effectively manage, support, and oversee the delivery of high-quality, safe, and reliable healthcare services in the four known areas of harm, medication safety, infection prevention and control, the deteriorating patient and transitions of care.

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 St Patrick's Hospital had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of services provided. Inspectors viewed minutes of meetings which reflected that performance data was reviewed at meetings both internal to the hospital and at CHO1 level.

Monitoring service performance

The hospital collected data on a range of measurements related to the quality and safety of healthcare services. The DON was responsible for collecting data on the number of admissions, discharges, transfers out, delayed transfers and average lengths of stay. In addition, the hospital also collected data in relation to patient-safety incidents, complaints and compliments, risks and monitoring of healthcare associated infections. A review of meeting minutes demonstrated that collated performance data was discussed at meetings of the relevant committees as outlined under NS 5.2.

Risk management

The hospital had risk management structures and processes in place to proactively identify, manage and minimise risks in the clinical area. The hospital had a risk register with identified existing controls for each risk. Risks were reviewed annually in the absence of additional controls, and if additional controls were to be implemented, they were reviewed every two months by the DON. Risks were escalated to the service manager, OPS, CHO1, Sligo and Leitrim as required. The hospital's risk register relating to the four key areas of known harm was reviewed by inspectors. It included risk description, date risk entered, risk likelihood, risk impact, risk rating, existing controls, risk owner and review date.

Audit activity

The DON had oversight of local audits in the hospital. The hospital had a schedule of audit activity identified for the year. The schedule included audits, for example, on medication management, infection prevention and control, nursing care plans and the admission and discharge process. Information from monitoring was used to improve the quality of services, with evidence of implementation of quality improvement plans related to findings from some audits reviewed by inspectors.

Management of serious reportable events and patient-safety incidents

St Patrick's Hospital proactively identified, documented and monitored patient safety incidents. Management and staff informed inspectors that incidents were logged on the National Incident Management System[***] (NIMS), in line with the HSE's *Incident Management Framework*. Minutes reviewed by inspectors indicated that incident management was discussed at both local and CHO 1 level.

The Serious Incident Management Team for Older Persons Services for Community Healthcare Cavan, Donegal, Leitrim, Monaghan and Sligo had oversight of the management of all adverse events that met the criteria for SREs and serious incidents. Membership of this committee was multidisciplinary and included the head of service for older persons' and the general manager for older persons' services. Committee meetings were held on a monthly basis. Inspectors were informed that the recommendations that arose from the outcomes of the SIMT meetings were systematically tracked and monitored using a dedicated recommendation application. Progress updates were subsequently fed back to the head of service for OPS CH CDLMS. The DON and the quality and patient safety advisor OPS CHO 1 confirmed that no SREs had occurred in the hospital in the previous 12 months. Patient-safety incidents are discussed further under NS 3.3.

[***] 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.

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

Judgment: Compliant

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

Staffing Levels and Recruitment

St Patrick's Hospital had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare. All staff in the hospital reported to the DON who in turn reported to the service manager, OPS, CHO1, Sligo and Leitrim.

Inspectors were informed by management that there were plans to re-open the closed beds in the hospital, with the aim of returning to full operational capacity of 16 beds before the end of 2025. The DON confirmed that a formal plan had been submitted to HR requesting the necessary staffing to support the reopening of the additional beds.

The DON was the person with overall responsibility for the day-to-day management of the hospital. They were supported in their role by a 1 whole-time equivalent (WTE) ADON and 0.79 WTE CNM II. On the day of inspection, there was 1 WTE CNM I position which was vacant. Inspectors were informed that recruitment had taken place and an offer had been made to the successful candidate.

Management stated that the hospital's approved complement of 7 WTE nursing staff was supported by 5.82 WTE healthcare assistants (HCAs) and 1.4 WTE cleaning and housekeeping staff. At the time of inspection there was no staff nurse vacancies or cleaning and housekeeping staff vacancies. There was a vacancy of 0.5 WTE HCA, however, this was contingent upon the hospital functioning at full capacity. Management in the clinical area reported that there were no issues with HCA cover on the ward. In addition, the hospital had an approved complement of 0.6 WTE physiotherapy, 0.2 WTE dietician, 0.2 WTE speech and language therapy, 1 WTE occupational therapy (OT), 0.6 WTE OT assistant and 0.2 WTE social worker. All posts were filled at the time of inspection.

One WTE medical officer role was filled by GPs from a local GP practice. A medical officer provided cover for the hospital (from Monday to Friday from 9am to 5pm) attending the

hospital each morning and as required. There were also appropriate arrangements in place for out-of-hours times.

Absence levels were monitored on an ongoing basis and the absence rate for 2025 was 12.1%, which is above the HSE target of 4%. Inspectors were informed by the Acting HR Manager CHO 1, Sligo and Leitrim that HR and the staff wellbeing officer planned to visit the hospital in quarter two with the objective of addressing staff absenteeism rates. They intended to meet with staff on long-term sick leave to discuss the necessary measures for facilitating their return to work. The date for this had not yet been confirmed at the time of inspection.

Management informed inspectors that regular agency staff, redeployment from the onsite designated centre for older persons, and existing staff were effectively utilised to address staffing shortages across various disciplines. This was corroborated by a review of staff rosters for the month preceding the inspection, which indicated that all shifts had been adequately covered for each discipline. No agency staff were needed to cover nursing shifts in the previous month, while six HCA shifts were covered by agency staff.

Inspectors were informed that a community pharmacist (Chief II) attended the unit at intervals of seven to 10 days. Staff reported that they could contact the pharmacist at any time via phone or email and received good support. There was no provision for pharmacy coverage during periods of absence or leave. This risk was documented on the hospital risk register, identifying the potential for medication errors and harm to patients. As part of the risk register, the controls in place included management contacting the SUH Chief Pharmacist to request provision of annual leave or absence cover for the pharmacist service. There was no update on this action at the time of inspection, however, the community pharmacist (Chief II) informed inspectors that during periods of leave, the pharmacy department in SUH was accessible to staff in the hospital via telephone, should support or guidance be required. The hospital was also supported by a pharmacy technician who attended the hospital twice weekly.

Staff training

The DON had oversight of staff training, there were systems in place to monitor and record staff attendance at mandatory and essential training. It was evident from staff training records reviewed, and from speaking with staff, that they were up-to-date with training appropriate to their scope of practice. Good compliance rates were identified as 100% of staff had completed standard based precautions, transmission based precautions, infection outbreak management, hand hygiene, basic life support and complaints management. All nurses had attended medication safety training. In addition, hospital staff had begun completing human rights training with 80% of health and social care professionals (HSCP) having completed it, 75% of nurses and 25% of HCAs. Staff

had also completed open disclosure training with 100% of nurses, 87.5% of HCAs and 75% of HSCPs having completed the training.

Employee Supports

Counselling services were available to staff to access directly through the HSE Employee Assistance Programme (EAP). Posters regarding EAP resources and access procedures were observed in the clinical area. Staff also had access to occupational health services, either through management referral or self-referral.

Overall, while inspectors found that hospital management had effective arrangements in place to plan, organise and manage their staffing levels to support the provision of high-quality, safe healthcare, the lack of coverage for the clinical pharmacy service during staff leave was identified as a potential risk. A high level of compliance was observed in staff completion of training, however, there was potential for improvement in attendance in certain training sessions, as outlined above. The rate of absence was higher than the national average and inspectors were informed that hospital management, in line with HR support, were progressing with a plan to address long term absences. Inspectors noted that agency staff were being employed to cover shifts in the interim period.

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 Patrick's Hospital was found to be substantially compliant with NS 1.6 and 2.7 and compliant with NS 1.7, 1.8, 2.8, 3.1 and 3.3

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

Inspectors observed that staff working in the hospital were committed and dedicated to promoting a person-centred approach to care. Staff were committed to ensuring that patients' dignity and privacy was not only protected but also promoted in the clinical area. For example, staff were observed utilising privacy curtains when providing assistance and personal care to patients.

The clinical area could accommodate up to 16 beds but at the time of inspection only eight beds were operational. The clinical area was divided into two units. Each unit comprised two four-bedded bays. Inspectors were told by hospital management that the number of beds in use in each unit was adjusted according to the needs and number of admitted patients. Patients had access to two toilets and two showers located within each unit. Male and female patients were accommodated in separate units and no gender mix was observed on the day of inspection.

There were no single rooms or en-suite facilities available, this had been identified on the hospital risk register as a limitation in upholding patient privacy and dignity in end-of-life care situations. Inspectors were told by management that every effort was made to accommodate patients in receipt of end-of-life care, in a four bedded bay separate from other patients to ensure privacy and dignity. This arrangement was only feasible as the unit was operating below full capacity.

Patients' personal information in the clinical area visited was observed to be protected and stored appropriately. Patients' healthcare records were securely stored behind a key-code-protected door in the nurses' office. Patients' names were observed to be displayed above their beds, however, all patients were satisfied with this practice and provided informed consent for it during the admission process. Inspectors noted that patients' photographs were taken on admission to the hospital for care and social purposes, for example for inclusion on the medication record. Patients also formally consented to this practice upon admission.

Staff consistently demonstrated kindness, compassion and respect in all interactions with patients observed by inspectors. Patients who spoke with inspectors were very complimentary of the staff, as described at the beginning of this report.

Overall, while staff endeavoured to promote the dignity, privacy and autonomy of patients, they were challenged by an environment where these could not always be maintained, for example, no single rooms were available in the event of end-of-life care situations. Efforts to ensure privacy and dignity for end-of-life care patients in a separate four-bedded bay were feasible only due to the unit's current low capacity, which may be affected by plans to increase bed capacity by year-end.

Judgment: Substantially Compliant

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

A culture of kindness, consideration and respect was evident in the hospital. Inspectors observed many kind interactions between staff and patients. Staff were observed being friendly and attentive towards patients and assisting them with their needs.

Patients' views, values and preferences were actively sought and taken into account by staff. This was also observed through different food options at meal times. Patients praised the variety and quality of the food, with one commenting, "the food is good, better than a hotel" and another stating there was "plenty of choice". Inspectors also reviewed the variety of meal options available to patients on the weekly menu. Patients had access to a communal area with a dining table and chairs, in which they could choose to have their meals if they so wished. The hospital implemented a practice of protected meal times to enable patients to eat without interruptions.

The hospital had provisions to facilitate patient access to independent advocacy services when needed, information leaflets detailing these services were displayed at patients' bedsides and were included in the patients' admission packs.

Each patient's wardrobe also included a lockable cupboard, providing secure space for the safe storage of personal belongings and valuables.

The hospital welcomed feedback from people using the service and it was evident that patients were comfortable raising issues or concerns with staff. Patient feedback was obtained through various methods, including patient satisfaction surveys, feedback forms provided at discharge, and the use of the suggestion box.

Overall, it was clear that hospital management and staff fostered a culture of kindness, consideration, and respect for people accessing and receiving care at the hospital.

Judgment: Compliant

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

Inspectors found there were systems and processes in place in St Patrick's Hospital to respond to complaints and concerns received from patients and their families in a timely and efficient way.

The DON was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from reviews of complaints within the hospital. The DON reported that they received good support in their role from the CHO 1 consumer services department. The hospital had its own local complaints policy which was aligned with the HSE's *Your Service Your Say*[†††]' to manage comments, compliments and complaints. The policy also incorporated the national patient advocacy service which provides support and guidance to any patient that may wish to make a complaint.

Staff at the hospital focused on resolving complaints locally. If the issue could not be resolved locally, it would be escalated to the DON and subsequently to the service manager, OPS, CHO1, Sligo and Leitrim. Staff who spoke with inspectors were knowledgeable about the complaints process. Feedback and learning from complaints was shared at ward meetings, clinical handover and at safety pauses. Minutes of staff meetings that were viewed by inspectors, showed that patient experience, complaints and compliments were a standing item on the agenda. Minutes of the Sligo and Leitrim CHO1 services for older persons quality and safety committee showed that complaints were discussed on a monthly basis. The service manager, OPS, CHO1, Sligo and Leitrim also provided updates on the number and type of complaints received in St Patrick's Hospital at the quarterly CHO 1 OPS quality and safety review committee meetings.

Staff participated in training sessions focused on complaints management. At the time of inspection, 100% of nursing staff, 100% of HCAs, 100% of housekeeping and cleaning staff and 100% of HSCPs had attended this training.

Inspectors observed posters displayed in the clinical area detailing how to make a complaint including contact information for the HSE's *Your Service Your Say* and information in relation to accessing advocacy services. A suggestion box was also located outside the nurses' office. Inspectors reviewed the information pack provided to patients on admission, it included information on HSE's *Your Service Your Say,* SAGE advocacy services[‡‡‡] and also details of the Office of the Confidential Recipient[§§§].

[†††] 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.

[‡‡‡] Sage Advocacy acts on behalf of older people who need support in fulfilling their wish to remain living in their own homes and communities.

[§§§] The Office of the Confidential Recipient is a national free service that acts as an independent advocate for vulnerable adults with disabilities and older persons receiving various health services. Although appointed by the HSE, the Confidential Recipient operates independently to provide a confidential service for reporting concerns or making complaints.

A patient satisfaction survey had recently been completed in March 2025. The survey results were predominantly positive, reflecting a high level of satisfaction with the care and support provided among patients. Areas were identified for improvement and these were incorporated into a comprehensive quality improvement plan developed by the DON.

Patients who spoke with inspectors did not have any complaints and told inspectors that they would speak to staff if they had any concerns.

The DON was responsible for maintaining a log of all written and verbal complaints. The DON also formally tracked and analysed complaint trends annually. In 2024, the hospital had received a total of 10 complaints. Ninety percent of the complaints were resolved within 30 days. Inspectors reviewed a number of quality improvement plans developed by the DON in response to complaints received. These included the necessary actions to be undertaken, accompanied by the designation of a responsible person and a specified resolution date.

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.

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, which was divided into two units each containing two four-bedded bays and could accommodate up to 16 beds. During the inspection, eight beds were operational, with seven of them occupied. Inspectors were informed that there were no neutral or negative pressure rooms in the hospital.

Strategically placed wall-mounted alcohol-based hand sanitiser dispensers and prominently displayed hand hygiene signage were observed throughout the clinical area. Inspectors noted that all hand hygiene sinks conformed to requirements.[****]

[****] 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)

Inspectors observed sufficient physical distancing between beds in multi-occupancy bays and adequate storage for patients' personal belongings, including separate wardrobes for each patient. Inspectors observed that overall, the physical environment was free from clutter, clean and well maintained, with a few exceptions. There was evidence of minor wear and tear observed, as a few areas required repainting due to observed chipped paintwork.

The absence of single room facilities in the hospital, identified on the hospital risk register, posed a risk to patients by constraining infection prevention and control in the event that isolation was required. Inspectors were informed by management that potential patients who required isolation would not be accepted as an admission to the hospital. Inspectors reviewed the hospital's admissions, transfers, and discharges policy and noted that this was not listed as exclusion criteria for admission. This was brought to the attention of the executive management team. An updated policy was subsequently shared with inspectors following the inspection. The new policy included reference to patients with active infections being excluded from admission, due to the lack of single rooms.

Inspectors were informed that in the event a patient required isolation during their hospital stay, they would be accommodated in a four-bedded bay, separate from other patients. Patients could also be cohorted in these four-bedded bays if necessary. This arrangement was only feasible as the unit was operating below full capacity. Appropriate infection prevention and control signage was available in the clinical area to alert healthcare workers of the need to apply transmission-based precautions if required.

Patients had to access the adjoining bay in order to use the toilet and shower facilities. This layout, which resulted in a thoroughfare effect, has the potential to challenge infection prevention controls.

Environmental cleaning was performed by housekeeping staff, with HCAs assuming this responsibility during out-of-hours periods. Equipment cleaning was carried out by HCAs and nurses in the clinical area. On the day of inspection, equipment was observed to be clean and there was a system in place to identify equipment that had been cleaned, for example, use of tags and checklists. Inspectors observed that checklists and lists of cleaning duties were maintained, all of which were complete with no gaps. Inspectors were informed that management had oversight of the cleaning and cleaning schedules in the ward visited, who stated they were satisfied with the level and standard of cleaning. Inspectors were informed that the hospital had access to onsite maintenance services and had no issues assessing the service.

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

The hospital provided a safe and secure environment for patients, the entry door was key coded and visitor entry was managed through a call bell system.

In summary, there was evidence that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care, however, the infrastructure posed challenges as identified on the hospital risk register due to the lack of single rooms for isolation. Additionally, the open bays in both units continued to serve as thoroughfares for accessing other patients and areas, including toilets, shower and the communal sitting area.

Management were taking all reasonable actions to prevent the admission of patients requiring isolation and there were provisions in place to accommodate existing patients who required isolation after they were admitted, in a separate four-bedded bay, however, the feasibility of implementing this measure was largely contingent upon the reduced bed occupancy levels at the time of inspection.

Judgment: Substantially Compliant

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

Hospital management were systematically monitoring, evaluating and responding to information in order to identify opportunities for improvement and provide assurance within the regional health area on the effectiveness of healthcare services delivered at St Patrick's Hospital. There was an audit plan for 2025 for the hospital which demonstrated tracking of hospital audits including medication audits, health and safety audits, infection prevention and control audits and nursing care plan audits.

Hospital management monitored and regularly reviewed performance indicators in relation to infection prevention and control. Environmental and equipment audits were conducted on a monthly basis using a computerised system. Inspectors reviewed a range of environmental audits completed from January to March 2025. Overall, compliance levels were high. For each audit where non-compliances were identified, the DON ensured the implementation of a detailed, time-bound action plan, with designated responsible individuals. Inspectors reviewed the quality improvement plans which clearly indicated that the DON consistently monitored and ensured the progression of actions.

Hand hygiene audits were also completed monthly, these audits were not assigned an overall score. Instead, each staff member was evaluated on a pass or fail basis. Compliance was observed to be high in the audits viewed by inspectors and quality improvement plans were implemented for any staff member who did not achieve full compliance.

The hospital collected data on healthcare-associated infection surveillance monthly. In 2024, this data was combined with data collected from the onsite designated centre for older persons and a report was returned to the CHO 1 infection prevention and control and anti-microbial surveillance committee. Management confirmed that they plan to provide data specific to their unit separate to the designated centre beginning in April 2025.

Inspectors reviewed the unit's data collection form for the 'Monthly HCAI, AMR and Antimicrobial Consumption monitoring in HSE Older Person's Residential Care Facilities' for each of the four quarters in 2024 and for quarter one in 2025. In accordance with the reporting requirements, the hospital provided reports on incidents of:

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

The reports indicated no cases of CPE or *clostridioides difficile* during these periods, and no outbreaks were reported.

There was evidence of monitoring and evaluating medication safety practices at the hospital. Medication chart audits were conducted on a monthly basis by either the CNM II or a senior nurse. When non-compliance was identified in these audits, an action plan with specific timeframes and a designated responsible person was developed to address the issues. For example, the February 2025 audit achieved a 76% compliance score. After implementing the action plan and conducting a re-audit in March, the compliance score increased to 87%. The lead for pharmacy in the hospital who was a community pharmacist (Chief II) also conducted a medication reconciliation audit for 2024. The primary finding from the audit indicated that medication reconciliation by a pharmacist had been completed within two weeks of admission for 80% of patients. A comprehensive quality improvement plan had been developed, incorporating specific recommendations, actions, designated responsible person and a target completion date, with the aim of further increasing this percentage.

Audits were completed in relation to the admission process and discharge planning monthly. The three audits reviewed for January, February, and March 2025 demonstrated high levels of compliance. Each audit achieved an overall score of 100% for all three months, reflecting the consistent adherence to standards and protocols during this period. Although there were no audits being completed in relation to the deteriorating patient, staff who spoke to inspectors demonstrated a clear understanding of the procedures for managing and escalating care for patients whose condition deteriorated and required transfer to an acute care facility.

Overall, the hospital was systematically monitoring and evaluating the service and utilising information gathered to inform quality improvement efforts.

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 service users from the risk of harm associated with the design and delivery of healthcare services. Risks in relation to the service were recorded on a risk register, risks were reviewed annually in the absence of additional controls, and if additional controls were to be implemented, they were reviewed every two months by the DON. Inspectors were informed that any risks unable to be managed locally were escalated to the service manager, OPS, CHO 1, Sligo and Leitrim. Inspectors reviewed the last three meeting minutes for the Sligo and Leitrim CHO 1 services for older persons' quality and safety committee, dated December 2024, January 2025 and February 2025. Inspectors found that risk registers were a standing agenda item at each meeting. Each service provided updates to the meeting on any newly identified risks on their risk registers.

Inspectors reviewed the hospital's risk register and noted that risks reviewed had owners assigned, and controls and actions in place to manage and reduce recorded risks.

Infection prevention and control

Inspectors were informed that all admissions to St Patrick's Hospital were planned in advance. Patient referrals to the hospital were reviewed by either the DON or ADON before acceptance, with the referral form documenting any known infections. As discussed under NS 2.7, patients with active infection alerts were not admitted to the hospital due to the unavailability of single isolation rooms. This risk was recorded on the risk register, and the hospital had controls in place to minimise the associated risk. For example, in the event that a patient developed or was suspected of having an infection during their hospital stay, they were accommodated in a separate four-bedded bay, isolated from other patients for infection control purposes.

Patients admitted to the hospital were not routinely tested for multi-drug resistant organisms (MDRO) or transmissible infections. A screening process was implemented which involved the collection of patients infection status from the discharging unit prior to admission. Inspectors reviewed the nursing verbal handover template, it included a dedicated section on infection prevention and control. This section documented relevant information such as recent healthcare-associated infections (HCAIs) and the presence of MDROs, and the patient's vaccination status. In addition, management and staff in the clinical area confirmed that information was also collected on admission using a HCAI and MDRO surveillance form, which captured information on recent HCAI and MDRO occurrences within the past three months, as well as those occurring prior to three months. The form also documented the patient's vaccination status. A review of patients' healthcare records by inspectors confirmed that this practice was being implemented. Inspectors were informed that the hospital had no outbreaks in the previous 12 months. Both management and staff within the clinical area that spoke with inspectors demonstrated a comprehensive understanding of the processes to be followed in the event of an outbreak. Inspectors observed that adequate supplies of personal protective equipment were available to staff if required.

The hospital had an infection prevention and control link practitioner with protected time who provided advice and guidance to staff relating to infection prevention and control matters. The hospital also had access to the CHO 1 infection prevention and control, antimicrobial stewardship and health care associated infection committee which provided ongoing support and expert guidance. In addition, the committee facilitated discussion and promoted shared learning across services to enhance practice and improve service delivery.

Medication safety

The community pharmacist (Chief II) visited the hospital to provide oversight and support of medication management at intervals of seven to 10 days. In addition, a pharmacy technician also attended the hospital twice weekly to carry out stock control of medications. Inspectors were informed that formalised medication reconciliation was routinely carried out for all patients admitted to St Patrick's Hospital. For patients admitted from an acute facility, nursing staff conducted the initial medication reconciliation on admission against three sources, including the list of medications on verbal handover, discharge letter and the prescription from the discharging doctor from the acute facility. The community pharmacist (Chief II) who was based in SUH then undertook a more detailed medication reconciliation, which included an examination of the patient's hospital records during their stay in the acute care setting. This review comprehensively tracked the patient's progression from admission to the acute care unit through to their subsequent admission to St Patrick's Hospital. Staff who spoke with inspectors were knowledgeable and confirmed that these processes were being followed. A sample of medication prescribing and administration records was reviewed by inspectors, which provided evidence of medication reconciliation being completed.

The hospital had identified a risk related to the non-provision of annual leave or absence cover for the community pharmacist (Chief II) service on the risk register. Controls were in place to mitigate this risk as discussed under NS 6.1.

An up-to-date British National Formulary (BNF) was available to staff for reference regarding administration of medications. The hospital had a list of high-risk medications in the form of APINCH[††††] and sound-alike, look-alike drugs (SALADS). Staff who spoke with inspectors described the use of risk reduction strategies to support safe use of medications in relation to high risk medications for example, insulin and opioids. Inspectors observed that the temperature for the medication fridge was checked daily and was within the recommended temperature parameters. Medications were also observed to be stored in a secure manner.

Deteriorating Patient

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

Management and staff were aware of the process to follow for the management and escalation of patients who deteriorated and required transfer to an acute care facility. On admission, patients' baseline vital signs were established using the hospital's standard vital observation chart. Twice daily vital signs were completed on each patient, and any changes or signs of deterioration were promptly acted upon with a review by the medical officer, or by the doctor on-call service, outside core hours and at weekends. In the event of a patient's sudden deterioration or medical emergency, this was managed through transfer to the acute hospital by ambulance. Management informed the inspectors that they were awaiting confirmation of a date from the CHO 1 Centre of Nursing and Midwifery Education (CNME) regarding simulation training for staff on responding to a deteriorating patient

Transitions of care

The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services and support safe discharge planning.

It was evident to inspectors, from review of a sample of patient healthcare records, that patient's personal details, medical history, current medications and infection status were recorded on the discharge and transfer forms. The unit had transfer and discharge templates to facilitate and strengthen safe transitions of care.

When patients were referred to St Patrick's Hospital from the acute facility, the referring ward was required to submit a 'request for primary community and continuing care supports and services assessment form'. For patient referrals for respite care, the community discharge liaison officer OPS CHO 1, Sligo and Leitrim or public health nurse completed the 'common summary assessment report form'. The use of these referral forms ensured the comprehensive transfer of all relevant details regarding the patient's care prior to, management making a decision regarding admission. Inspectors also reviewed the nursing verbal handover template, which was utilised for transfer of patient care from the acute hospital and the rehabilitation and community inpatient hospital, which aligned to the Identify, Situation, Background, Assessment and Recommendation (ISBAR) format. Management told inspectors that they were assured that the implementation of this template ensured the comprehensive transfer of all relevant patient information.

Policies, procedures, protocols and guidelines (PPPGs)

The hospital did not have an electronic document management system for policies, procedures, protocols and guidelines (PPPGs). Instead, a collection of hard copy PPPGs were available to guide and inform staff. Inspectors reviewed a comprehensive range of policies designed to support staff in their roles.

The hospital, utilised the national HSE community infection, prevention and control manual to guide their staff on standard and transmission based precautions and equipment decontamination. Policies in relation to transitions of care for example, the admission, discharge and transfer policy and the hospitals medication policy on the ordering, receipt, prescribing, and administration of medications were found to be up-to-date.

Inspectors found that hospital management utilised the *HSE Enterprise Risk Management Policy and Procedures 2023* to help manage risk.

Overall, the service providers protected service users from the risk of harm associated with the design and delivery of healthcare services relevant to the size and scope of the services provided in the hospital.

Judgment: Compliant

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

St Patrick's Hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. Clinical incidents were reported by staff on a paper-based system using the 'national incident report form' (NIRF) and escalated to the CNM II. They were also referred to the ADON or DON for review. Administrative staff who were based in the hospital were responsible for inputting the incidents on the National Incident Management System (NIMS). Category one incidents and serious reportable events (SREs) were escalated to the SIMT, and a multidisciplinary team met monthly to ensure these incidents were reviewed in line with the *HSE Incident Management Framework* (IMF) 2020.

The last three meeting minutes for the Sligo and Leitrim CHO 1 services for older persons quality and safety committee, dated December 2024, January 2025 and February 2025, were made available to inspectors for review. The minutes reviewed, indicated that SREs and incidents relating to falls, medication errors, infection prevention control, skin tears and safeguarding were discussed at each meeting. Inspectors also reviewed the last three quarterly minutes of CH CDLMS older persons quality & safety review committee dated May 2024, August 2024, and November 2024 which demonstrated that incidents were also systematically reviewed and discussed at this forum. A quarterly quality and patient safety update was also presented by the quality and patient safety advisor for OPS or their representative. The service manager for OPS, CHO 1, Sligo and Leitrim was a member of both committees and facilitated the dissemination of shared learning and updates to management in St Patrick's Hospital.

The DON tracked and trended patient-safety incidents for the hospital. Inspectors reviewed the hospitals 'Incident Management and Quality and Patient Safety Annual Report 2024' which indicated that a total of 36 incidents were reported to NIMS in 2024 with 97% reported within 30 days which is above the national target of 70%. There were no category one incidents or SREs reported by the hospital in 2024. Of the 36 incidents reported, 29 pertained specifically to service users. The most commonly reported patient-safety incidents related to slips, trips, and falls (62%), followed by incidents relating to ergonomics (14%), 10% related to care management, 7% were classified as non-mechanical, 4% related to a virus while the remaining 3% of incidents were related to mechanical components.

Inspectors spoke with staff in the clinical area who demonstrated a clear understanding of the incident management process, and were able to describe incidents that they had previously reported and the process for reporting them. Management and staff both reported that learning from incident management was disseminated during staff handovers, safety huddles and ward meetings. This was substantiated through a review of the six-weekly staff meeting minutes by inspectors which confirmed that incident management and incident reporting timeframes were standing agenda items.

Overall, inspectors found that that the hospital had a comprehensive system in place for identifying, reporting, managing, and responding to patient-safety incidents and ensuring that learnings were disseminated among staff.

Judgment: Compliant

Conclusion

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

Capacity and Capability

Inspectors observed that, while 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 Patrick's Hospital, there were areas identified for potential improvement. For example, some committee minutes required clearer differentiation between services, terms of reference were in need of updating in some cases, and there was a need to identify responsible persons for required actions.

There were effective management arrangements in place to support and promote the delivery of high quality, safe and reliable healthcare services relevant to the size and scope of the hospital. The hospital planned, organised and managed their workforce to achieve high quality, safe and reliable healthcare, however, the lack of cover for the clinical pharmacy service during staff leave was identified as a potential risk on the hospital risk register.

Quality and Safety

Staff and management in the hospital made every effort to ensure their patients dignity, privacy and autonomy was respected and promoted, however, this was challenging due to the lack single rooms available in the event of end-of-life care situations. Management and staff fostered a culture of kindness, consideration, and respect. Patients stated that "the staff were very good" and "care couldn't be better". The hospital maintained effective systems and processes to address complaints and concerns from patients.

The physical environment broadly supported the delivery of high-quality, safe, reliable care to protect people using the service, however, the infrastructure posed challenges as identified on the hospital risk register due to the lack of single rooms for isolation purposes. The hospital systematically monitored and evaluated its healthcare services to ensure they were suitable for its size and scope. Inspectors found that the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of harm. In addition, there were systems in place to identify, manage, respond to and report patient-safety incidents, in line with national legislation and standards, policy and guidelines.

Overall, inspectors found that St Patrick's rehabilitation and community in-patient hospital was compliant or substantially compliant in all 11 of the national standards it was assessed against during this inspection.

Appendix 1 – Compliance classification and full list of standards considered under each dimension and theme and compliance judgment findings

Compliance Classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the national standards is identified, a compliance plan was issued by HIQA to the service provider. In the compliance plan, management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the progress in implementing the action(s) set out in any compliance plan submitted.

HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.

	Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.	

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

communication and support provided throughout this process.	
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	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.	Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant