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

Name of healthcare service provider:	Rehabilitation Unit, St Patrick's Hospital Campus
Centre ID:	OSV-0007857
Address of healthcare service:	Cahir Road Aswell's-Lot Cashel Co. Tipperary E25VO24
Type of Inspection:	Announced
Date of Inspection:	12/11/2025 and 13/11/2025
Inspection ID:	NS_0171

About the healthcare service

Model of hospital and profile

The Rehabilitation Unit, St Patrick's Hospital Campus, Cashel is a statutory hospital, owned and managed by the Health Service Executive (HSE) under the governance of Dublin and South East Regional Health Area. Prior to the Regional Health Area structure, the Unit was under the governance of HSE Community Health Organisation 5.

The Rehabilitation Unit, St Patrick's Hospital Campus, provides the following services:

- rehabilitation

The following information outlines some additional data on the Unit.

Number of beds	21 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 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 Unit
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors during the inspection
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during the inspection and information received after the inspection.

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector	Support Inspector
12/11/2025	*13:00 - 17:45*	Bairbre Moynihan	Laura Byrne
13/11/2025	*08:45 – 13:45*	Bairbre Moynihan	Laura Byrne

Information about this inspection

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

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

The inspection team visited:

- the Rehabilitation Unit

During this inspection, the inspection team spoke with representatives of the Unit's Senior Management Team, 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 greeted and chatted to a number of patients during the inspection and in more detail with seven of the 18 admitted patients. Patients were positive about the staff and the care that they received in the Rehabilitation Unit, St Patrick's Hospital Campus. Patients stated that staff were "excellent", "unreal" and the physiotherapist was "the best physiotherapist I ever got". They described how staff responded to call bells in a timely manner and were able to articulate to inspectors their plan of care. Patients knew who to speak to if they wished to raise an issue and stated they would speak with staff if they had a concern or complaint.

[†] 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.

On the tour of the unit, inspectors were shown a courtyard and were informed that funding had been secured for flowers, plants and seating for patients which would be completed after the winter months.

Inspectors observed that some patients were placed in mixed gender bays. On discussion, patients did not raise any concerns about this arrangement. This will be discussed in further detail under national standard 1.6.

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.

The Rehabilitation Unit, St Patrick's Hospital Campus was compliant with one national standard (5.8), substantially compliant with one national standard (5.5) and partially compliant with two national standards (5.2 and 6.1).

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

Overall, while management described the governance arrangements for assuring the delivery of high quality, safe and reliable healthcare, the three governance meetings which provided oversight for the Unit were not meeting in line with the terms of reference (TOR) and therefore not providing the necessary oversight.

Management described the lines of accountability and responsibility. An organisational diagram was provided which aligned to what inspectors were told. The director of nursing (DON) was responsible for the operational management of the Rehabilitation Unit and two older persons residential services and reported to the older persons service (OPS) manager, who reported to the general manager for OPS, and upwards to the integrated health area (IHA) manager for Carlow Kilkenny and South Tipperary, and the regional executive officer (REO) in the Regional Health Area (RHA) of Dublin and South East region.

A committee organisational chart provided to inspectors indicated that the Unit had committees in place, for example; Infection Prevention and Control Committee (IPCC), Clinical Nurse Manager (CNM) meetings and 3PG group (Policies,

Procedures, Protocols group). The organisational chart detailed that a Quality and Patient Safety (QPS) committee was in place and reported to the Regional Audit Group Committee and the Regional Quality and Safety Executive Committee (QSEC), however, it is not clear from a review of the organisational chart if the committees (IPCC, 3PG group and CNM) reported to the QPS committee. In addition, the chart did not include the Cashel Residential Older Persons service (CROPs) Senior Management Governance meeting which was the overarching governance meeting where senior management from the Rehabilitation Unit reported to.

Older Persons Services (OPS) Quality and Safety Executive Committee

The TOR for this committee were in date but had not been updated in line with the new RHA changes. The TOR indicated that the committee met monthly however, the last three meeting minutes and agendas were requested and these indicated that the last meeting was in 2024. Inspectors were informed that one meeting took place in October 2025 but no minutes or agenda were provided to confirm this. Both the Cashel Residential Older Persons service (CROPs) Senior Management Governance meeting and the Residential and Rehabilitation Services South Tipperary Quality and Safety Committee indicated that they reported to the regional QSEC. This meant that there was no formal pathway in place for the escalation of quality and patient safety issues from the Rehabilitation Unit and for sharing of learning in the region. This will be discussed further below.

Cashel Residential Older Persons service (CROPs) Senior Management Governance meeting

This committee included senior management from all three services under the remit of the DON. Chaired by the manager for older person's services Carlow, Kilkenny and South Tipperary, the committee met quarterly and reported to the general manager for OPS and the regional QSEC. The ADON from the Rehabilitation Unit attended this meeting and provided an update on for example, risks and issues relating to the unit under the agenda item of clinical matters. Inspectors were informed that none of the four key areas of focus for this inspection were agenda items at the meeting, but were discussed by exception as issues arose. At the feedback meeting senior management provided assurances that this was effective. It was evident from a review of meeting minutes that issues and concerns relating to the deteriorating patient, transitions of care and medication safety were discussed at the meeting in October 2025.

Residential and Rehabilitation Services South Tipperary Quality and Safety Committee

Chaired by the OPS manager, the TOR outlined that the committee met six times a year, however, the TOR did not indicate who approved, and developed them, were

not reviewed since 2023 and the ADON for the unit was not included as a member of the committee. Furthermore, the TOR stated that the committee reported to the South East Community Healthcare (SECH) Chief Officer and the Senior Management team (SMT) – QPS committee. Since the reconfiguration of the RHA the Chief Officer post was no longer in existence. Meeting minutes received indicated that the committee was not meeting in line with the TOR. Two meetings were held to date in 2025, in March and June. Notwithstanding this, the two meetings were well attended with representatives from the Rehabilitation Unit, quality and patient safety advisor, clinical nurse specialist and a link nurse from infection prevention and control (IPC) and health and social care professionals, for example, speech and language therapist (SLT). Agenda items included input from IPC, risk register, update on clinical incidents, audits, policies and training.

Overall, while the Unit had governance arrangements in place these were not fully functioning for senior management to be assured of the delivery of high quality, safe and reliable healthcare:

Specifically:

- the Residential and Rehabilitation Services South Tipperary Quality and Safety Committee and the CROPs Senior Management Governance committee were not meeting line with the TOR
- the OPS Quality and Safety Executive Committee which provided the regional oversight for the two committees above had met once in 2025 and no evidence of this meeting taking place was provided to inspectors
- the organisational committee diagram was not aligned to what inspectors were told on the days of inspection.

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.

The DON had identified an assistant director of nursing (ADON) to oversee the day-to-day management of the Rehabilitation Unit. The ADON was supported in the role by a clinical nurse manager (CNM) 1 and 2. A list was available outlining who was in charge during the day Monday to Sunday and an out of hour's mobile number for contacting an on-call senior member of the management team. This was viewed by inspectors.

A CNM meeting was held every second month, chaired by the DON and included all ADONs and CNMs from both the residential and Rehabilitation Unit. Agenda items relevant to this inspection included IPC, quality and health and safety, compliments and complaints, training and education and auditing. It was evident from a review of meeting minutes that the committee was meeting in line with the terms of reference with the exception of one occasion and information in relation to the above agenda items was discussed at the meetings. There was no evidence that issues in relation to the deteriorating patient or transitions of care were discussed at the meeting.

The DON had identified an infection control link practitioner for the Rehabilitation Unit who had completed the relevant training for this role, attended the regional link nurse practitioner meetings and the CROPs infection prevention and control (IPC) link nurse working group. Inspectors were informed that the IPC link nurse was allocated eight hours a fortnight to the role. The role included for example, hand hygiene training, standard and transmission based precautions and audits. The IPC link nurse practitioner was supported by an IPC clinical nurse specialist (CNS) from the community who was available by phone for advice. Inspectors were informed and documentation was provided to evidence that IPC CNSs and a microbiologist were onsite on the week prior to inspection. This will be discussed later in the report.

Pharmacy supplies to the Unit were provided by a community pharmacy. Inspectors were informed that staff could get advice from the pharmacy when required, however, no onsite input and oversight was available from a pharmacist. Unit management had not identified this as a risk. This will be discussed under national standard 3.1.

The Irish National Early Warning Score (INEWS) was introduced in the Unit in 2022. Inspectors were informed that if a patient triggered a high score, the medical officer or an ambulance was contacted. Outside of working hours an out-of-hours general practitioner (GP) service was contacted. Inspectors were informed that the Identify, Situation, Background, Assessment, Recommendation (ISBAR) communication tool[††] was used when escalating a patient who was unwell to the medical officer or out of hours GP. However, the use of the tool was not embedded in the Unit. This will be further discussed under national standard 3.1.

The clinical nurse managers were responsible for the safe transitions of patients at admission, discharge and transfer. 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. The Unit had a waiting list and beds were allocated in order of

[††] Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

the waiting list. Inspectors were informed that patients were admitted from Tipperary University Hospital (Tipp UH), St Luke's General Hospital (SLGH), University Hospital Waterford (UHW) or other hospitals for patients in the geographical catchment of the Unit. The Unit had an up-to-date admission policy in place with defined admission criteria.

Overall, effective management arrangements were in place to support and promote the delivery of high quality, safe and reliable healthcare services. However,

- the deteriorating patient and transitions of care were not agenda items nor was there evidence of discussion of them at CNM meetings.

Judgment: Substantially Compliant

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

The Unit had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

An up-to-date risk register was in place which was reviewed quarterly at a risk register review meeting. Examples of risks on the risk register relating to the four areas of focus for this inspection included limited IPC isolation facilities and a lack of a dietitian for the Rehabilitation Unit. The lack of access to an onsite clinical pharmacist was not identified as a risk and this will be further discussed under national standard 3.1.

Incidents were logged on the National Incident Management System (NIMS).[‡‡] A serious incident management team was convened when required and evidence was provided of this.

An audit schedule was in place for 2025. IPC audits were completed on an information technology (IT) system and included, for example, audits of the dirty utility, cleaner's room and a mattress and pillow audit. Actions were assigned to a person who was alerted to the action via the IT system. A yearly audit of the INEWS was completed. However, while a score of 82% for 2024 and 96% in 2025 was achieved, repeated findings were identified. For example, staff were not adhering to

[‡‡] 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.

the recommended timeframes for repeating observations in line with the INEWS chart. Six monthly medications management audits were completed with good results. In addition, the community antimicrobial pharmacist had completed an antimicrobial prescription audit in May 2025.

Unit management were collating data on the number of patients admitted per year, the source of admission, the length of stay and the discharge location. Trending of this information identified an increase in the number of patients under 65 years who were admitted to the unit. Unit management were trending the number of patients who were readmitted back to an acute hospital, source of readmission, reason for transfer and the number of patients who triggered a high INEWS resulting in transfer.

Overall, the Unit had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of 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.

The Rehabilitation Unit had effective workforce arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare with the exception of access to a dietitian and an onsite pharmacist. In addition, Unit management had identified the requirement for a second occupational therapist. This was on the risk register and senior management were aware of it.

On the days of inspection the Unit had no staffing deficits. An ADON, CNM 2 and 1 was allocated to the Unit and it was approved for 14.5 whole-time equivalent (WTE) staff nurses with 11.5 WTE in post. Inspectors were informed and documentation confirmed the recruitment of two additional staff nurses was ongoing at the time of inspection. In the interim agency staff were used. This was confirmed in the agency roster reviewed and from speaking to staff. 12.5 WTE healthcare assistants (HCAs) were approved with 9.2 WTE in post. Documentation confirmed that two WTE posts were being converted from agency to permanent posts at the time of inspection.

Clinical governance for the unit was provided by a consultant physician from Tipp UH who attended onsite once weekly. During this time a ward round was conducted and family meetings if required. In addition, a locum medical officer (MO) was available

for the Rehabilitation Unit and the residential unit Monday to Friday during working hours. Inspectors were informed that the MO was onsite daily.

As discussed earlier in the report the Unit did not have access to a clinical pharmacist onsite. Inspectors identified an impact of this through the multiple findings in relation to medication safety as outlined under national standard 3.1.

3.2 WTE physiotherapist, 1 WTE occupational therapist (OT), 1 WTE speech and language therapist (SLT) and 0.5 WTE social worker were allocated to the unit. However, the Unit did not have access to a dietitian. This was on the risk register and in order to mitigate the risk inspectors were informed that patients requiring enteral feeding were not admitted to the Unit and patients were admitted from an acute hospital with supplements already prescribed. If staff had concerns they escalated them to the MO. Documentation reviewed indicated that a second OT was required. This was on the risk register, controls were in place and additional actions included a comparative study of OT staffing in rehabilitation units in the DSE region. No impact of this deficit was identified to or by inspectors on the days of inspection.

The ADON and CNM 2 had oversight of staff training in the Unit. A schedule of training and the required frequency was on display in the CNM office. In addition, the CNM maintained a training matrix with red, amber and green (RAG) coding to alert the CNM when training is due. Staff training was an agenda item at the Residential and Rehabilitation Services South Tipperary Quality and Safety Committee and the CNM meeting. Good training compliance was identified in standard and transmission based precautions, hand hygiene, medication safety and complaints management. 60% of HCAs had up-to-date training in basic life support. Inspectors were informed and documentation confirmed that these would be completed by the end of November 2025.

The unit had workforce arrangements in place to support and promote the delivery of quality, safe and reliable healthcare, however,

- there was no onsite oversight from a clinical pharmacist
- patients did not have access to a dietitian
- deficits were observed in BLS training compliance for HCAs.

Judgment: Partially 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.

The Rehabilitation Unit, St Patrick's Hospital Campus was substantially compliant with three national standards (1.6, 1.8 and 3.3) and partially compliant with two national standards (2.7 and 3.1).

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

Inspectors observed that staff working in the Unit were committed and dedicated to promoting a person-centred approach to care. Staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients.

The Rehabilitation Unit contained five, four bedded multi-occupancy rooms and one single room. Privacy curtains were in place around each bed space however, due to the design and layout of the unit with only one single room, inspectors observed that patients were accommodated in mixed gender wards. Inspectors were informed that this was required to facilitate patient flow from the acute hospitals. No patients identified a concern with this arrangement however, management had not identified this as impacting on patient's dignity and privacy and as a risk and assessed it. This was completed while inspectors were onsite and will be further discussed under national standard 3.1.

Inspectors observed a bright open plan sitting area where patients could come to relax, meet other patients, family members or watch television. In addition, a quiet room was available where patients could have some time to themselves if they so wished. Staff had access to a meeting room where patient and family meetings could take place in private.

A whiteboard with patient information was located in the nurses' station and only staff had access to this area. Patients and members of the public were unable to view this information from the corridor.

During the inspection patients were observed sitting at their bedsides in their clothes, with call bells in reach.

Overall, while staff endeavoured to respect and promote the dignity, privacy and autonomy of patients,

- mixed gender multi-occupancy rooms impacted on this.

Judgment: Substantially Compliant

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

The Unit had systems in place to respond effectively to complaints, however, information on accessing advocacy services was not on display.

The ADON was the designated complaints officer assigned with the responsibility for managing complaints. Complaints and compliments were an agenda item at the CROPs CNM meeting and there was evidence of discussion of complaints at the CROPs Senior Management Governance meeting.

The Unit used the HSE's complaints management policy '*Your Service Your Say*.' [§§] There was a culture of local complaints resolution. Information on how to make a complaint was on display in the reception area and at the nurses' station. Leaflets were available on the corridor. Staff described how they aimed to resolve a complaint at the first point of contact. Verbal complaints were maintained in a complaints log which was viewed by inspectors. A small number of written complaints were received. Inspectors were informed that complaints were closed out immediately and therefore they were not monitoring against the HSE KPI of 75% of complaints closed within 30 working days.

Trending of complaints was provided for 2024 and year to date in 2025. 17 verbal complaints were received in 2025. 12 of these related to lack of access to a consultant. At the time of the inspection this was resolved with a consultant attending onsite once a week and whom inspectors met onsite on day 2 of inspection.

Inspectors were informed that patients had access to independent advocacy services. However, no leaflets or posters were on display to indicate that this service was available.

[§§] 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.

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

- information on access to advocacy services was not on display.

Judgment: Substantially 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 identified that the physical environment did not always fully support the delivery of high-quality, safe and reliable care that protects the health and welfare of service users.

Meeting minutes reviewed of the CROPs Senior Management Governance meeting indicated that Unit management were concerned about anti-social behaviour on the grounds of the campus and that this was escalated to senior management within the region. Inspectors were informed by the DON, manager for OPS and the general manager for OPS that on the day prior to inspection that 24 hour security of the campus was approved to commence from 19 November 2025.

The Rehabilitation Unit was a 21 bedded unit, consisting of five, four bedded rooms and one single en-suite room. Three multi-occupancy rooms contained toilet and showers with the other two rooms accessing these on the corridor. As discussed under national standard 1.6, staff were challenged by the lack of isolation rooms resulting in mixed gender bays. In addition, patients with the same multi-drug resistant organism (MDRO) or respiratory infection were cohorted. The lack of isolation facilities was on the Unit's risk register. On the days of inspection two bays were closed due to cohorting of patients with MDROs resulting in a reduction in bed capacity of three beds. Senior management described to inspectors the daily management of the 21 beds to ensure patient flow from the acute hospitals and the appropriate placement of patients to prevent onward transmission. This was supported by a prioritisation flow chart of patients requiring transmission based precautions. Infection prevention and control signage in relation to contact precautions was observed. Personal protective equipment (PPE) was readily available outside the isolation room and cohorted rooms.

The IPC team from the region consisting of a consultant microbiologist, IPC ADON, two IPC CNSs attended onsite on the week prior to inspection to review the facilities. Meeting minutes reviewed evidenced that discussion had taken place on the short,

medium and long term options for addressing the lack of isolation facilities. Actions included a review by estates of the unit. None of the actions were time bound.

Clinical hand-wash sinks observed throughout conformed to requirements[***]. Wall-mounted alcohol-based hand sanitiser dispensers were readily available for staff and visitors.

Clinical areas were clean with few exceptions. The CNM had oversight of cleaning who informed inspectors that cleaning checklists were reviewed weekly. Cleaners were onsite five days a week from 0830-1630hrs. Outside of these hours cleaning was completed by healthcare assistants. Inspectors were informed that equipment cleaning was the responsibility of all staff. A tagging system was used to identify equipment that was clean. This was observed on equipment on the days of inspection. No deficits in the cleaning of equipment were observed on inspection.

There was appropriate waste management processes observed. Clean and used linen was appropriately segregated and stored appropriately in the unit.

Overall, Unit management were challenged by the lack of isolation facilities resulting in the cohorting of patients with transmissible infections, a reduction in available bed capacity and mixed gender bays. While a review of the facilities was completed by the IHA IPC team, this resulted in actions which were not time bound.

Judgment: Partially Compliant

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

The Unit had systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services however, deficits in medication safety and the deteriorating patient were identified.

As discussed under national standard 5.8, risks were recorded on the Unit's risk register. As discussed earlier in the report the lack of access to an onsite clinical pharmacist was not identified as a risk. Inspectors requested a risk assessment of the mixed gender bays while onsite. This was provided indicating a residual risk rating of 10 with controls in place. The risk assessment identified additional controls which included for example, a dynamic daily assessment regarding patient

[******] Clinical hand wash basins should conform to Health Building Note 00-10 Part C: Sanitary Assemblies. United Kingdom: Department of Health. 2013 or equivalent standards. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf.

placement by the nurse in charge and ensuring that staff have access to up-to-date individual care plans which are comprehensive.

Inspectors were informed that patients were not routinely screened for multi-drug resistant organisms (MDROs) or respiratory illnesses on admission to the Unit, however, patients with MDROs were identified pre transfer from the acute hospital and following discussion with the IPCT were isolated and or cohorted as required. At the time of the inspection, the Unit had a COVID-19 outbreak which was due for closure on 14 November 2025 and following consultation with the IPCT the Unit had recommenced admitting patients. Outbreak reports were completed following outbreaks and evidence of these was provided to inspectors. Aspects of the outbreak that were handled well and those that could have been managed better were detailed in the reports.

The Unit had engaged with a community pharmacy to provide medications onsite daily with the exception of Sunday. Out-of-hours staff stated they could access medications from the residential unit or Tipperary University Hospital if required. Staff reported that they could contact the pharmacy for medication advice, however, no clinical pharmacy service was available and no pharmacist attended on-site. This deficit was identified in a medication management audit and escalated to Unit management but had not been risk assessed.

The in-patient prescription record with a title of "HSE Southern Area" did not support some medication safety practices. For example, inspectors were informed that medication reconciliation[†††] was taking place on admission, however, from a review of records there was no documentary evidence of this, nor did the prescription record support this practice. There was no pharmacist input into or support with medication reconciliation. Furthermore, the medication management policy did not identify who was responsible for completing medication reconciliation and identify where it should be documented. In addition, inspectors were informed that on occasion registered nurses administered medications from the hospital's discharge prescription if it was not prescribed on the prescription record. This was recorded on the back of the prescription record, however, this practice was not documented in the medication management policy.

Staff had access to commercial drug prescribing guides dated 2024 at point of care. No access to online prescribing information resources was available. Inspectors observed a sound-alike-look-alike (SALAD) medicines poster on display from the Irish Medication Safety Network dated 2024.

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

The Unit had implemented the Irish National Early Warning Score (INEWS) in 2022. Staff were knowledgeable on the escalation process. Inspectors reviewed a sample of INEWS patient records and observed that the score was correctly calculated and observations completed at the required frequency. However, the South East Community Healthcare (SECH) INEWS chart in use did not indicate the frequency of observations if the score was 0 or following admission to the unit. This was discussed with senior management at the end of the inspection. Furthermore the INEWS 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. Furthermore, the standard operating procedure (SOP) in place was not ratified and did not reference the INEWS observation chart in relation to the deteriorating patient.

The Identify, Situation, Background, Assessment, Recommendation/Read back/Risk (ISBAR3) tool was not fully embedded. For example, posters and stickers indicated that it was in use but in practice inspectors were informed that it was not routinely used. Furthermore, the use of the ISBAR sticker to communicate a deteriorating patient was not implemented in the Unit. Documentary evidence was provided that the introduction of ISBAR3 and the associated training are a quality initiative for 2026. Notwithstanding this, a quality and safety management report was completed at each handover outlining if there were any incidents during the shift, patients with an infection or if any patient required a review or were transferred to an acute hospital during the shift. Samples of these completed on the days of inspection were provided to inspectors.

Emergency equipment was readily available if required such as a basic life support trolley and an Automated External Defibrillator (AED) which were checked nightly. Oxygen points were at each bedside and suction at alternate bed spaces. One portable oxygen cylinder was available if required for an emergency situation.

The Unit 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. Inspectors overheard a verbal handover being provided from the acute hospital to nursing staff prior to transfer to the Rehabilitation Unit. This was documented on a template and included the patient's INEWS score, medications, diet, and IPC status. The patient's healthcare record transferred with the patient from Tipp UH. As discussed earlier in the report the consultant physician attended onsite weekly and did a ward round which was attended by the public health nurse on alternate weeks, social worker who inspectors met on inspection, occupational therapist and physiotherapist. On that day, if required, patient and family meetings were convened to prepare patients for discharge. In addition, the predicted date of

discharge was reviewed on each patient and the manager for OPS was informed if there was any delays in discharges.

A policy procedure protocol guideline (3PGs) committee was set up for district and rehabilitation units in Carlow, Kilkenny and South Tipperary to provide a standardised approach to the development of 3PGs. Meetings were held quarterly and they reported to the regional QSEC. The Unit was using national guidance for infection prevention and control and complaints. All policy procedure protocol guidelines (PPPGs) provided to inspectors were up to date with the exception of the deteriorating patient SOP, as discussed earlier in this standard.

In summary, while the Unit had systems in place to identify and manage potential risk of harm associated with areas of known harm — infection prevention and control, medication safety, transitions of care and the deteriorating patient. The following areas for action were identified:

- the risks associated with the lack of access to a clinical pharmacist were not identified and risk assessed
- there was no documented evidence that medication reconciliation was taking place and the medication management policy did not identify who was responsible for completing it
- the medication management policy did not support the practice of the administration of medications directly from a prescription when not prescribed on the medication record
- staff had minimal access to up-to-date medicines information at the point of care
- the INEWS observation chart was not in line with national guidelines and did not guide staff on the frequency of observations when there was a score of 0
- the deteriorating patient SOP was not ratified and no reference to the INEWS was included in the SOP
- the ISBAR3 tool was not embedded in the Unit.

Judgment: Partially Compliant

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

The Unit had systems in place to identify, report, manage and respond to patient-safety incidents, however, while trending of incidents was taking place there was no evidence that this was shared and discussed with staff. The Unit used national PPPGs to support the incident management process.

Incidents were reported using a National Incident Reporting Form (NIRF) form and entered on to NIMS. 100% of incidents between January and June 2025 were uploaded onto NIMS within 30 days achieving the HSE key performance indicator (KPI) of greater that 70%.

Reported incidents were tracked and trended by the Quality and Patient Safety advisor for Kilkenny, Carlow and South Tipperary. Inspectors were informed by staff members that incidents were discussed at morning handover and the learning shared. It was evident from a review of meeting minutes that incidents were discussed at the CNM meeting. However, while staff were able to discuss individual incidents they were unaware of emerging trends. This is a missed opportunity to identify areas for improvement. Furthermore, there was no evidence from meeting minutes reviewed that emerging trends were routinely discussed.

Overall, the Unit effectively identified, managed, responded to patient safety incidents relevant to the size and scope of the unit. The following was identified:

- trending of information was taking place, however, staff were unaware of trending of incidents.

Judgment: Substantially Compliant

Conclusion

An announced inspection of Rehabilitation Unit, St Patrick's Hospital Campus was carried out to assess compliance with *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 and safe transitions of care.

Overall, the Unit was found to be compliant in one national standard (5.8), substantially compliant in four national standards (5.5, 1.6, 1.8 and 3.3) and partially compliant in four national standards (5.2, 6.1, 2.7, 3.1).

Capacity and capability

Overall, while management were able to describe the governance arrangements for assuring the delivery of high quality, safe and reliable healthcare in place the three governance meetings which provided oversight for the Unit were not meeting in line

with the terms of reference (TOR) and therefore not providing the necessary oversight.

The management arrangements supported the operational functioning of the Rehabilitation Unit and promoted the delivery of safe, high-quality healthcare. However, there was no evidence of discussion of the deteriorating patient or transitions of care at the CNM meetings. Monitoring arrangements in place in the Unit enabled the identification of opportunities to continually improve the quality, safety and reliability of healthcare services and were systematic. The workforce arrangements in the Unit were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare. However, there was no onsite clinical pharmacist presence and patients did not have access to a dietitian.

Quality and Safety

It was evident through observation and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients. However, inspectors observed mixed gender bays. While no patient identified a concern with this arrangement, management had not identified this as a risk and risk assessed it.

The Unit had systems and processes in place to respond openly and effectively to complaints and concerns raised by people using the service and while inspectors were informed that patients had access to advocacy services there was no visual or written information available on this service. The physical environment did not always fully support the delivery of high-quality, safe and reliable care that protects the health and welfare of service users. Management were challenged by the lack of isolation facilities resulting in the cohorting of patients with transmissible infections, a reduction in available bed capacity and mixed gender bays.

Unit management protected service users from the risk of harm associated with the design and delivery of healthcare services in the four areas of focus of the inspection, however, deficits were identified in medication safety and the deteriorating patient. These are discussed in more detail under national standard 3.1. Systems were in place to identify, manage, respond to and report patient-safety incidents.

HIQA will, through the compliance plan submitted by Unit management as part of this monitoring activity, continue to monitor the progress in implementing actions to address compliance with areas identified under national standards 5.2, 6.1, 2.7 and 3.1.

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	Partially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially 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 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially Compliant
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.	Partially 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.	Substantially Compliant

Compliance Plan for Rehabilitation Unit, St Patrick's Hospital Campus, Cashel

Inspection ID: NS_0171

Date of inspection: 12 and 13 November 2025

Standard	Judgment
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.	Partially Compliant
Outline how you are going to improve compliance with this national standard	
Timescale: Both terms of reference of the Residential and Rehabilitation Services South Tipperary Quality and Safety Committee and the CROPs Senior Management Governance committee are to be reviewed in regards to frequency of meetings Due for completion: 31st March 2026 Discussion to be held at the OPS Quality and Safety Executive Committee which provides the regional oversight for the two committees above in regards to frequency of meetings and generation of minutes in a timely manner. Completed 28/01/26 The organisational committee diagram to be reviewed and updated. Completed 29/01/26	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.	Partially Compliant
Outline how you are going to improve compliance with this national standard	

Timescale:

1. Review of medication management policy to include additional sections on i) medication reconciliation defining who is responsible for completing it and ii) to support the practice of the administration of medications directly from a prescription when not prescribed on the medication record. - Completed
2. A review of the current Terms and Conditions of the pharmacy providers contract, to include an undertaking to allocate resources for regular on site presence for the purpose of medication reconciliation and management. The current provider has committed to implementing a service commencement on Tuesday 17th February and to provide an onsite visit every second Tuesday morning from thereon - Completion date 17/02/2026

3. The current pharmacy contract for the provision of services to CNUs in South Tipperary is under review. The new contract will include a stipulation for the provision of regular onsite presence for the purpose of medication reconciliation and management. - Ongoing with a projected completion date of April 2026.

3. The current pharmacy provider has committed to commencing a regular on site visit for the purposes of medication reconciliation and management – Immediate

Business case submitted in 2022, to be re-submitted & to be discussed again at governance meeting regarding patients not having access to a dietitian. Approval to be sought for agency cover as an interim measure. Remains ongoing risk on risk register.
Due for completion: 31st March 2026

HCA staff to be prioritised to complete BLS training
Due for completion: 18th February 2026

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

Outline how you are going to improve compliance with this national standard

Timescale:

Estates completed site survey regarding creation of additional isolation rooms on 22/01/26. Awaiting report and associated costings of potential alterations.
Due for completion: 30th June 2026

Prioritisation to accommodate single gender bays to be emphasised when planning admissions, daily review undertaken by ward management in accordance with risk assessment. Underway since 14/11/25	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services	Partially Compliant
Outline how you are going to improve compliance with this national standard	
Timescale: A full Risk Assessment has been conducted and completed in respect of the "lack of onsite pharmacy" and has been included in the response. The risk assessment is active and has been escalated to the OPS Manager and will be reviewed at the next scheduled risk register review meeting. Review of medication management policy to include additional sections on i) medication reconciliation defining who is responsible for completing it and ii) to support the practice of the administration of medications directly from a prescription when not prescribed on the medication record Due for completion: 28th February 2026 Review of current drug charts to include addition of medication reconciliation section Due for completion: 31st May 2026 Online medicines information database sourced and added to ward desktops. Completed: 16th December 2025 Review of INEWS observation charts to update them in accordance with national guidelines and additional section to guide staff on the frequency of observations when there was a score of 0 Due for completion: 31st May 2026 The deteriorating patient SOP to be amended to reference INEWS and ratified at 3PG committee Due for completion 30th April 2026 Completion of quality improvement on embedding the ISBAR3 tool in the rehab Due for completion 30th September 2026	