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:	Leopardstown Park Hospital Rehabilitation Service
Centre ID:	OSV-0008790
Address of healthcare service:	Foxrock Dublin 18 D18 XH70
Type of Inspection:	Announced
Date of Inspection:	15/04/2025 and 16/04/2025
Inspection ID:	NS_0139

About the healthcare service

Leopardstown Park Hospital Rehabilitation Service is a voluntary public rehabilitation hospital. Healthcare services on behalf of the Health Service Executive (HSE) are provided in the hospital through a service level agreement under Section 38 of the Health Act 2004. It is managed on behalf of the Health Service Executive (HSE) by the Regional Health Area HSE Dublin and South-East[1] through a service level agreement. Leopardstown Park Hospital Rehabilitation Service has 7 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.

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

[1] The Regional Health Area HSE Dublin and South East provides health and social care services to South-East Dublin, Carlow, Kilkenny, South Tipperary, Waterford, Wexford and most areas of Wicklow.
[†] 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.

- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during the inspection and information received after the inspection.

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
15/04/2025	13:00 – 17:15	Laura Byrne	Bairbre Moynihan Elaine Egan
16/04/2025	08:45 – 15:30	Laura Byrne	Bairbre Moynihan

			Elaine Egan

Information about this inspection

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

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

The inspection team visited the Rehabilitation Unit and during this inspection, the inspection team spoke with representatives of the hospital's Senior Management Team, Quality and Risk, Human Resources 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

During the inspection inspectors spoke with patients in the Rehabilitation Unit. Patients stated they were happy with the care they received and were complimentary about the staff. Inspectors observed staff interacting with patients in a kind and friendly manner. Patients reported that staff are "all lovely" and that staff were "very visible" on the ward if they require assistance. Inspectors were told by patients that "staff really listen". Patients stated they would speak with staff on the unit if they had a concern or complaint and that they could use a complaint form which was available on the unit. Patients stated that they felt comfortable in the unit.

[‡] 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.

The unit had seven beds and at the time of inspection three patients were admitted. A communal dining room with a television was located at the end of the ward where patients could socialise. Patients were admitted for a period of rehabilitation after an admission to an acute hospital and described having access to physiotherapy services.

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. Leopardstown Park Hospital Rehabilitation Service was substantially compliant with two standards (5.8 and 6.1) and partially compliant with two standards (5.2 and 5.5).

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

Overall while inspectors identified that the unit had formalised governance arrangements in place with defined roles, accountability and responsibilities for healthcare services delivered, deficiencies were identified in the oversight and reporting arrangements. Senior management stated that the current arrangements were effective; however, it was not clear to inspectors that the necessary oversight mechanisms for the four key areas of harm were effectively implemented. For example, local governance and oversight committees were not reporting in line with their terms of reference (TOR) and no governance and oversight arrangements were in place for the deteriorating patient and transitions of care.

The interim chief executive officer (CEO) was the overall accountable person for the hospital and reported to the hospital board and was also the board secretary. The board had several sub-committees, for example, Audit and Risk, and Integrated Quality and Safety.

Organisational charts setting out the hospital reporting structures detailed the direct reporting arrangements for hospital management. An organisational chart of the reporting relationships of hospital committees was requested but not received.

A number of senior management posts were filled on an interim basis, for example, the CEO, director of nursing (DON) and assistant director of nursing (ADON). Although no impact of this interim arrangement was identified on the days of inspection, the ongoing vacancy of these leadership roles is not sustainable.

Nursing and support staff within the unit reported to the clinical nurse manager 2 (CNM2) and upwards to the ADON and DON. Medical cover for the service was provided by an onsite medical officer who reported to the CEO.

A number of governance and oversight committees were in place. These are described below.

Senior Management Team (SMT)

The Senior Management team met every six weeks and membership included the CEO, deputy chief executive, DON, human resources manager and medical officer. The CEO chaired the meeting and was responsible for communications between the committee and the board. A review of meeting minutes provided showed that an agenda was followed and actions identified and assigned to a responsible person but these were not time-bound. A review of meeting minutes indicated that some items were discussed at both the Integrated Quality and Safety Committee (IQS) and the SMT meeting. However, the reporting relationship between the IQS and the SMT was not formalised in their terms of reference (TOR) or on any organisational chart. Notwithstanding this, the CEO, DON and medical officer were members of and attended both meetings.

Integrated Management Reporting (IMR)

The service had a regular performance meeting with the HSE Regional Health Authority Dublin and South East known as the Integrated Management Reporting (IMR) Meeting. In attendance at these meetings were the CEO, head of finance and representatives from older person services in the HSE. There was a set agenda and items discussed included budget, human resources, absenteeism, activity, quality and risk, incidents, complaints and safeguarding. Minutes provided indicate this group was meeting every 8-12 weeks. It was clear from the minutes that issues identified at the senior management team meeting were escalated and discussed at this forum.

Integrated Quality and Safety Committee (IQS)

The Integrated Quality and Safety Committee was a sub-committee of the board. The TOR stated that it had an independent board nominated chair and membership included the CEO, medical officer, DON, quality and patient safety (QPS) manager, an external risk advisor and a health and social care professional (HSCP) nominee. The chair position was vacant, however minutes showed that an acting chairperson,

who was a board member, was in place for meetings. A number of sub-committees reported to this committee for example Falls, Health and Safety, Medication Safety and Therapeutics, and Infection Prevention and Control (IPC). However updates from these committees were not standing agenda items. There was evidence that an IPC report was discussed at one meeting in October 2024. The TOR provided were out of date since 2023. Standing agenda items of this meeting included for example, internal and external reports, metrics and audit. Minutes of meetings reviewed showed that this group was meeting quarterly, as per their TOR. Actions were identified but not always assigned to a responsible person or time-bound. The TOR stated that a composite report was provided to the board following each meeting and annual reports provided yearly. When these reports were requested, hospital management provided the minutes of the IQS meetings as evidence of composite reports. No annual report was provided on request but inspectors were informed that the board compiles an annual report, which contains a section on quality and patient safety. This is not in line with their TOR.

Medication Safety and Therapeutics Committee (MSTC)

The Medication Safety and Therapeutics Committee was a sub-committee of the IQS committee. It was chaired by the pharmacy executive manager. Membership included the QPS Manager, DON, ADON, nurse prescribers and medical officer. Agenda items included antimicrobial stewardship, quality improvement plans and medication incidents. The TOR provided, which were unsigned and not dated, outlined that meetings take place every two months. Inspectors were informed of a deficit in the pharmacy whole time equivalents (WTE) for a number of months in 2024, which impacted on the function of this committee. The committee met in May 2024 with the next meeting taking place in April 2025. Meeting minutes were action-oriented with a named responsible person but not time-bound. Overall, it was identified that this committee was not functioning in line with its TOR.

Infection Prevention and Control Committee (IPCC)

The Infection Prevention and Control Committee was a sub-committee of the Integrated Quality and Safety Committee. It was chaired by the DON and attended by the CEO, ADON and IPC link practitioner nurses. [‡‡] Agenda items discussed included infection outbreaks, personal protective equipment and audits. Minutes showed that while meetings were held in line with the stated frequency of six weekly intervals, attendance did not align with the membership outlined in the TOR. Additionally, actions were identified in meeting minutes but had no responsible person assigned and were not time-bound.

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

Inspectors were informed that the DON updated the senior management team (SMT) and minutes of IPCC meetings were shared with SMT. The TOR, signed December 2024, stated that quarterly reporting from this committee would be provided to the SMT. Inspectors observed that reports or minutes from the IPCC were not a standing agenda item on the SMT meeting agenda nor was IPC discussed at any of the SMT meeting minutes provided.

Inspectors were informed that the 2024 IPCC annual report to the CEO and IQS committee was in progress as outlined under the 2024 TOR. A report was requested but not provided for 2023 and management stated that one was not compiled as the TOR were signed off in late 2024. The previous TOR from 2021 describe reporting requirements, for example that they "produce reports to the IQS committee as per designated schedule or request" and that "an annual report of work undertaken would be submitted and presented". However, inspectors requested these reports and they were not provided. An extract from the Annual Report for 2023 was provided which showed a summary from the IPC team. Minutes of the IQS committee meetings showed that IPC report update was an agenda item at one meeting in October 2024. Overall this committee was not functioning in line with its TOR.

Transitions of care and the deteriorating patient were not a standing item at any of the hospital governance committee meetings. Issues in relation to early warning systems (EWS) audits and training were discussed intermittently at the IQS. Inspectors were informed that issues in relation to deteriorating patients were discussed with the DON/ADON on an individual basis and that transitions of care were discussed at the weekly Interdisciplinary Team (IDT) meeting; however, inspectors noted this was an operational meeting. Overall, there was no governance and oversight of transitions of care and the deteriorating patient.

The Rehabilitation Unit had some formalised governance arrangements in place for assuring the delivery of high quality, safe and reliable healthcare: However:

- there was no governance and oversight arrangements for the deteriorating patient and transitions of care
- the reporting relationship between the IQS and the SMT was not formalised in their terms of reference or on any organisational chart
- local governance and oversight committees were not reporting in line with their TOR and no organisational structure chart outlining committee reporting relationships was available
- the membership, attendance and reporting relationships of the Infection Prevention and Control Committee were not in line with the TOR
- the frequency of meetings of the Medication Safety and Therapeutics Committee was not in line with the TOR

- a number of governance committee meeting minutes reviewed showed that while the majority of meetings followed a set agenda and identified a responsible person for actions, many of the identified actions were not time-bound. For example, the IQS and SMT meeting minutes.

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.

Senior management arrangements in the Rehabilitation Unit to support the delivery of safe and reliable healthcare in the hospital were not sustainable or could potentially impact on the effectiveness of management oversight.

Inspectors were informed that a CNM1 or enhanced staff nurse was on duty each night from 19:00 to 08:00. Out-of-hours responsibility for the service was covered on a rota basis between the DON and ADON. Both reported they could delegate this role to another nurse, for example during planned leave. However inspectors noted that this roster was covered by two people for the majority of the time. One person cover in the event of leave and the one in two on-call arrangement was not sustainable.

Deputising arrangements were in place for senior management in the event of unexpected leave and these were documented as part of a risk assessment.

One CNM2 had the responsibility for the Rehabilitation Unit, a unit in the designated centre for older persons and undertook the patient pre-admission assessments in acute hospitals. This could impact on the ability of the CNM to have effective oversight and management of the Rehabilitation Unit on a daily basis.

Inspectors were informed and rosters confirmed that nursing staffing allocation was shared between the Rehabilitation Unit and another unit in the designated centre. The rosters showed that at night there was one staff nurse allocated across both units which were separated by a corridor. This could impact on the safety of patients particularly in the event of a sudden patient deterioration. Hospital management informed inspectors that staff were supported by the nurse in charge at night. A risk assessment of the staffing of the Rehabilitation Unit at night was requested after the inspection and it was provided. Existing controls were documented, however, no additional controls were identified and no inherent, residual or target risk-rating was

included. As a result, senior management were unaware of the level of risk associated with this arrangement.

Management reported that they were managing sudden increases in demand by planning admissions to the unit, for example by not having multiple admissions in one day. Management stated that there had been no issues with adapting to these changes in demand and reported that consistent review of this arrangement was underway to identify any issues. Inspectors were informed that one nurse could be allocated fully to the Rehabilitation Unit if it had its full complement of seven patients.

Inspectors were informed that a "circle" meeting was held every Monday which was an operational meeting for the whole hospital. Minutes were provided to inspectors for three weekly meetings in March and April 2025. In attendance were the DON, ADON, medical officer, resident services manager, CNMs, and health and social care professional (HSCP) staff. The CEO and chief financial officer (CFO) were in attendance at one of these meetings. Issues discussed at this forum included clinical care initiatives, mandatory training, recruitment updates catering and nutrition, updates on maintenance works and student placements. No time-bound actions were identified on the meeting minutes provided.

Infection, prevention and control (IPC)

A CNM3 with specialist expertise and training in infection prevention and control and was responsible for IPC activity in the hospital. A CNM1 and CNM2 with specialised IPC training were both allocated to the IPC team for half of their role, 0.5 WTE each. The team provided guidance and training on matters concerning infection prevention and control and completed audits. The CNM3 and CNM2 were both IPC link practitioners. These roles covered the Rehabilitation Unit and the designated centre.

Medication safety

The hospital pharmacy service was led by the chief pharmacist. Pharmacy supplies to the unit were provided by an on-site pharmacy. If a medicine was not available onsite there was an arrangement to contact local pharmacies or the pharmacy in St Vincent's University Hospital. The nurse in charge at night had access to the pharmacy as needed for out-of-hours requests.

The deteriorating patient

The unit had implemented the Irish National Early Warning System (INEWS). The quality and patient safety manager was the identified lead responsible for its implementation. The unit had adapted the tool for local use and a protocol was in place to support this practice. This will be discussed under standard 3.1.

Two medical officers, 1.5 whole time equivalent (WTEs), were responsible for the medical care of patients between 9am and 5pm, Monday to Friday. The medical officers had responsibility for the entire hospital including the Rehabilitation Unit. Out-of-hours cover was provided by a general practitioner (GP) on-call service.

Transitions of care

The ward CNM was responsible for patient discharge/transfer and operationally accountable to the DON. The CNM attended the Interdisciplinary (IDT) weekly meeting in the Rehabilitation Unit which was in place for multidisciplinary discussion of care needs and discharge planning. Relevant HSCP staff, nursing staff and the medical officer attended this meeting. A sample rehabilitation IDT form was reviewed and indicated that patients' expected dates of discharge and planned discharge destinations were discussed weekly.

Inspectors were informed that patients were admitted for up to six weeks for rehabilitation care from St. Vincent's University Hospital, St. Michael's Hospital, Dun Laoghaire and St. Vincent's Private Hospital. In addition, on occasion patients were admitted from a unit in the designated centre in Leopardstown Park Hospital for a period of rehabilitation.

The hospital's policy on resident admission, transfer and discharge outlined the admission of rehabilitation patients to the unit. However, the terminology reflected that of a designated centre for older persons (a long-term care setting) and not a short-term rehabilitation service for patients.

Overall, while there were management arrangements in place, in relation to staffing the following was identified:

- the one in two on-call arrangement for senior nursing management out of hours was not sustainable
- the Rehabilitation Unit CNM had the responsibility for the Rehabilitation Unit, a unit in the designated centre for older persons and undertook the patient pre-admission assessments in acute hospitals
- during night duty one staff nurse was shared between the Rehabilitation Unit and another unit in the designated centre for older persons. This risk had not been identified by management and was not adequately assessed or managed when identified to the service by inspectors.

Judgment: Partially Compliant

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

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

Monitoring performance

The hospital collected data on a range of measurements related to the quality and safety of healthcare services, for example, bed occupancy rate, average length of stay, rehabilitation outcomes, complaints, safeguarding and patient-safety incidents. It was evident that data in relation to quality metrics were reviewed at the IQS meeting and that service quality indicators and performance data were a standing agenda item at the Integrated Management Reporting (IMR) meeting with the HSE. Antimicrobial prescribing rates were reviewed at the Medication Safety and Therapeutics meeting in April 2025 and it was noted that monthly point prevalence data was collected by the QPS manager.

Risk management

The hospital had some systems in place to identify and manage risks in relation to three of the four key areas of focus. The hospital aligned to the HSE Enterprise Risk Management Policy 2023 and had an up-to-date local risk management policy. A corporate and local Rehabilitation Unit risk register were in place. Risks on the board corporate risk register were viewed by inspectors and risks in relation to workforce, medication errors and IPC were recorded and risk controls were documented. However, some of these risks had not been updated in line with their planned review dates. Inspectors were informed that the corporate risk register was reviewed at the Audit and Risk committee (ARC) two to three times per year. There was evidence of an agenda item of "Risk Summary Report (Corporate Risk Register)" and "Detailed Risk Reports" discussed at one meeting of the ARC in March 2025, but this was not included as an agenda item in January 2025 or November 2024.

Risks relating to IPC, lack of isolation rooms and transitions of care were recorded on the Rehabilitation Unit local risk register. A number of risks on the local risk register were not up to date and some were duplicated and this was attributed by management to a system changeover. Identification and management of risks on the unit are further discussed under standard 3.1.

Audit activity

The IQS committee had oversight of audit activity and audit reports. Examples of audits relating to the four areas of harm for this inspection included Early Warning Scores (EWS) and hand hygiene. These are discussed under national standard 2.8. The QPS manager was responsible for compiling EWS audit reports and the DON was responsible for implementing identified changes. An IPC audit plan provided by the IPC committee for 2025 listed two monthly audits and included topics such as hand hygiene, environment and management of patient equipment, spillages, waste and sharp management, environment (general and or patient areas) and laundry management.

Patient-safety incidents

Management stated that incidents were logged on the National Incident Management System (NIMS)[§§] in line with the HSE's Incident Management Framework. A serious incident management team (SIMT) was convened when required and inspectors were informed that no incident in the Rehabilitation Unit met the criteria for the convening of a SIMT in a number of years. Evidence was provided that incidents were tracked and trended. Incident trends were reported at the monthly Integrated Management Reporting meeting. Learning from incidents was communicated via a "sharing of lessons learned" notice and a sample of this was provided to inspectors. The CNM in the ward was aware of these notices but inspectors did not see evidence of these notices in the clinical area.

The hospital had systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. Notwithstanding this, the following was identified:

- a number of risks on the corporate and local rehabilitation unit risk registers had not been updated in line with their planned review dates.

Judgment: Substantially Compliant

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

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

Senior management organised and managed their workforce however, absenteeism was above the targets set by the HSE and a number of mandatory training areas had low levels of compliance.

Workforce allocation and absenteeism were discussed at the regular IMR meeting with the HSE and at the SMT.

On the day of the inspection the human resources manager position was vacant. However, inspectors were informed that the position had recently been filled and was awaiting commencement. In the interim, the CEO and CFO were sharing this role.

The unit no longer had the services of a consultant geriatrician, a service that had previously been in place. This was a risk recorded on the hospital's risk register. Staff informed inspectors that this impacted on the continuity of care from the acute hospitals to the rehabilitation unit.

One staff nurse was rostered on the day shift in the unit and one staff nurse was allocated to the unit and a unit in the designated centre at night. One healthcare assistant (HCA) was rostered on each shift for the Rehabilitation Unit. The impact of this arrangement was discussed under standard 5.5.

Two WTE pharmacists were employed at the hospital, one of which was the pharmacy executive manager. One of these posts was filled on a locum pharmacist basis and inspectors were informed that hospital management were in the process of recruiting for this position.

Three CNMs were involved in the IPC service with a combined 1.05 WTEs approximately allocated to their IPC role.

There was no specific allocated workforce for the Rehabilitation Unit but rather staffing allocation was from the workforce for the entire hospital campus including the designated centre for older persons. A workforce allocation report was provided to inspectors however, a breakdown for the Rehabilitation Unit was requested and not provided. Senior management said they were not aware of any deficits in staffing in the Rehabilitation Unit. Inspectors were informed by senior management that specific staff were assigned to the shifts in the Rehabilitation Unit, for example staff with specialist training in rehabilitation, and this was confirmed with staff present on day one of the inspection. Management in the unit reported that they were satisfied with their current staffing allocation.

A rehabilitation staff gap analysis was provided by management that compared the Rehabilitation Unit staffing to the recommended staffing in the *Post-Acute Inpatient Rehabilitation Service Provision: A National Overview of HSE Funded Services Report 2024.* Senior management identified that additional staffing was required in speech

and language therapy, dietetics, consultant staff and nursing. There was evidence that discussions were held with the HSE at the IMR meeting with regard to new posts. However, it is unclear from meeting minutes if posts specific to the Rehabilitation Unit were under consideration in response to this gap analysis. Health and social care professionals staffing was provided from the general hospital campus allocation and no specific WTE allocation identified for the Rehabilitation Unit.

The key performance indicator for HSE absenteeism is a target rate of below 4%. Management informed inspectors of issues impacting on the absenteeism rate. The rate was 5.94% July 2024, 5.89% October 2024 and 8.1% December 2024 for staffing across the Rehabilitation Unit and the designated centre units. The hospital reported that they were managing this by redeploying staff, deferring work and allocating additional agency shifts. Sick leave was monitored and inspectors were informed that back to work interviews were held with returning staff. An occupational health service and an employee assistance programme were available for staff.

Staff Training

Mandatory training for staff included fire safety, manual handling, medicines management, safeguarding, open disclosure and IPC training modules. Staff training records were provided by senior management in relation to staff in the Rehabilitation Unit. Compliance rates of over 87% for nursing were noted for training in standard and transmission based precautions, personal protective equipment, outbreak management and hand hygiene. INEWS training compliance for nursing was reported as 100%, however compliance for nursing in medication safety training was 75%. Training compliance in clinical handover for nurses was 87.5%. Attendance by healthcare assistants (HCA's) was over 90% for training in standard precautions, hand hygiene, basic life support and complaints management. However, attendance by healthcare assistants at training in outbreak management was 70%, and personal protective equipment (PPE) and transmission-based precautions were 80%. Improvements were required in attendance by HSCP staff from the hospital for training in PPE (35.7%) and in standard and transmission-based precautions (50%). Basic life support (BLS) training compliance was 100% for nurses and HCA's from the Rehabilitation Unit and 100% of doctors were trained.

Face to face training in relation to hand hygiene and INEWS was available. An induction programme and buddy system was in place for new staff.

Overall, the following issues were identified:

- mandatory training compliance was low in a number of areas. For example, medication safety training compliance for nursing was 75% and PPE training for HSCP's was 35.7%

- the absenteeism rate was above the HSE target of 4%.

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. Leopardstown Park Hospital Rehabilitation service was compliant in two standards (1.7 and 1.8), substantially compliant in two standards (1.6 and 3.3), partially compliant in two standards (2.7 and 2.8) and not compliant in one standard (3.1) in this dimension.

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

Overall, inspectors identified that service users' dignity, privacy and autonomy were respected and promoted in the unit. Staff endeavoured to do this, for example, through the use of privacy curtains. However, staff were challenged by the unit layout which did not fully support privacy and dignity.

The unit layout was a thoroughfare and patients had to mobilise through the unit to access toilets, showers and the dining area. In addition, staff had to mobilise through the thoroughfare to access the dirty utility and nursing office. This is further discussed under standard 2.7. This did not promote an environment which fully promoted patients dignity and privacy. No impact on patient privacy was identified during the inspection. Patients were accommodated in separate areas of the unit and four beds were vacant. If the unit had its full complement of seven patients, it could be challenging to maintain privacy due to the layout. One patient described a lack of privacy but reported they had been offered accommodation in the single room as an alternative. Ward management reported that there was a library area that could be used for private discussions with patients. One single room was available for patients and used when needed for example for end-of-life care. Patients' personal information was stored in a secure manner.

A leaflet informing patients about their stay, their rehabilitation care, visiting hours and unit facilities was provided to patients. The practice of providing these leaflets to patients as part of the admissions checklist was supported by a local standard operating procedure.

A variety of information leaflets to keep patients informed on matters such as the details of the patient advocacy services and falls prevention were accessible in the ward. There was a clear ethos and purpose of rehabilitation in the ward and this was reflected in the discharge home rate from the unit of 78% in 2024 and 100% for 2025 (January to April). Inspectors observed patients' individual exercise programmes and access to rehabilitation equipment. There was evidence of the service assessing individual's desires, wishes and rehabilitation goals as part of the pre-assessment process.

While on the day of inspection patients' dignity, privacy and autonomy was respected:

- the ward layout was a thoroughfare which did not fully promote privacy and dignity for all patients.

Judgment: Substantially Compliant

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

Overall, it was evident that a culture of kindness was actively promoted by all staff. Inspectors observed staff providing care with kindness, consideration and respect and that staff were responsive to the individual needs of patients. It was evident that staff knew patients and their families on the unit.

Inspectors spoke with patients who described staff as "lovely" and that "they really listen". Patients commented that although they had a call-bell they did not feel they had to use it, as staff were visible on the ward.

A suggestion box was located at the reception area of the hospital and in the unit area. The Rehabilitation Unit had a philosophy of care which was displayed in the unit along with information about "Your Voice Matters" and "Raising concerns and complaints. A step-by-step guide". Photographs of members of the management team were on display at the reception area of the hospital which also identified the designated complaints manager.

Overall, it was evident that the service was promoting a culture of kindness, consideration and respect through the design and delivery of the service.

Judgment: Compliant

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

The hospital had a designated complaints officer assigned with responsibility for managing complaints. There was a culture of local complaints resolution in the ward.

A complaints committee was chaired by the resident services manager who was the designated complaints officer. This committee met quarterly and was attended by the CEO. Rehabilitation specific complaints were an agenda item along with learning and quality improvements, and the complaints policy. Actions arising from this meeting were identified but not assigned to a responsible person or time-bound.

The hospital had a complaints management system for the recording of complaints and a local complaints policy which was in line with the HSE's complaints management policy 'Your Service Your Say'. Staff recorded verbal complaints on the hospital's electronic patient record system. Inspectors were informed that stage two formal complaints were escalated to the complaints officer and stage three complaints were escalated to the CEO. Online training in complaints management was mandatory training for all staff and compliance was 100% for nursing and 90% for HCA's. Training was also offered via workshops with the complaints officer. The complaints officer told inspectors they had run a workshop with staff in the unit to ensure all complaints were being captured.

A quarterly complaints and compliments report was provided to the CEO, IQS and SMT. Updates on complaints received were captured in minutes of the monthly IMR meeting. No formal complaints were received in relation to the Rehabilitation Unit since 2021.

Information on how to make a complaint was on display in the ward. Patients were aware of how to make a complaint and reported that they could speak with staff or use the complaint form available on the ward. The unit had arrangements in place to facilitate access to independent advocacy services where required. Posters displayed at reception and on hospital corridors provided information on how to access advocacy services.

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.

Judgment: Compliant

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

Inspectors identified good local ownership and oversight in relation to infection prevention and control. While it was evident that hospital management had endeavoured to maintain the unit, the design and layout posed challenges and this did not facilitate effective infection prevention and control practices. For example;

- the unit contained one four-bedded bay, one two-bedded bay and a single room. The bays were effectively an open-plan area divided by a partition wall
- a corridor was used to access each of these bays and this was a thoroughfare. At one end of the unit was the dining room and nurses' office and the dirty utility was located at the other end
- two bathrooms and one shower were available. The single room did not have en-suite facilities.

Notwithstanding this, on the days of inspection, inspectors noted that the unit's physical environment was clean, bright and well maintained.

Due to the lack of single rooms inspectors were informed that prior to admission staff completed an infection prevention and control risk assessment on patients for multi-drug resistant organisms (MDROs) and patients with an infection risk were not admitted to the unit. This practice was supported by the local policy and the rehabilitation referral criteria. However, local guidelines were not aligned with national guidelines and best practice which advise that patients should not be declined admission or have their admission delayed on the basis of colonisation status.

No patients requiring transmission-based precautions were admitted on the day of inspection. Inspectors were informed that patients admitted to the ward who became symptomatic or tested positive for an infection could be transferred back to the referring hospital, if no isolation room was available. Prioritisation of patients requiring transmission based precautions for placement in the single room was supported by the hospitals local Infection Prevention and Control Policy.

Patients' lockers, wardrobes and the corridors were free of clutter. Appropriate storage of equipment and sharps was observed. Linen and waste were appropriately segregated and stored.

No clinical hand-wash sink was available in the nursing office or the dirty utility room. Two hand-wash sinks were available in the unit: in the communal day area and in the four-bedded bay. These did not conform to requirements.[***] The sinks were clean. Wall-mounted alcohol based hand sanitiser dispensers were available throughout the ward. Hand hygiene instruction signage was on display. Appropriate personal protective equipment was available for staff.

Environmental and equipment cleaning was carried out by cleaning staff on the day shift and by nursing and health care assistants overnight. Cleaning records were kept for the daily environmental cleaning and these were up to date. A weekly deep cleaning schedule was in place for cleaning individual ward areas and this was up to date. Equipment appeared clean and there was a system in place to identify equipment that had been cleaned, for example, use of tags and checklists. A colour-coded system was in place for cleaning cloths and mop heads. A macerator was available for body fluid disposal. Ward management reported they had access to maintenance services as required.

The Rehabilitation Unit was clean on the days of inspection. However, hospital management were challenged by the design and layout of the environment. The following was identified:

- multi-occupancy areas were used as a thoroughfare to reach other patients and areas, such as dining room and the nurse's office
- the design of clinical hand wash sinks did not conform to requirements
- there was a lack of single rooms to accommodate patients with an infection prevention and control risk and the local policy of not accepting admissions based on infection prevention and control risk assessment was not in line with national guidance.

[***] Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf

Judgment: Partially Compliant

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

Hospital management were monitoring, evaluating and responding to information from multiple sources to inform improvement and provide assurances to the HSE on the quality and safety of the service provided to patients. However, some areas of focus had no audits carried out and some findings from audits were not improved between audits.

An IPC audit plan was provided which outlined two monthly audits. IPC link practitioners were responsible for carrying out the audits. Target areas, for example hand hygiene and spillages, identified for audit were allocated one audit each per year as per the audit plan. Three recent audits for each area of focus in IPC were requested with one audit report provided for each area. Inspectors were therefore unable to verify if findings from previous audits had been addressed and the audit cycle was being completed.

One hand hygiene audit was provided for March 2025 which showed 91.43% compliance in the Rehabilitation Unit. The target compliance rate was 90%. An action plan with associated time-bound actions and assigned persons was also documented.

An IPC environment audit for the Rehabilitation Unit was provided from March 2025 which showed that none of the four areas audited reached the target compliance of 85%. For example, the bath and or washroom scored 60% and the dirty utility scored 73%. A time-bound action plan with assigned person responsible was also documented along with this audit. Inspectors did not note any items of worn or torn furniture on inspection which had been noted in the audit. Other items for example, a lack of a separate sink for cleaning equipment in the dirty utility, were noted by inspectors. The action plan for this audit included a plan to re-audit this area in April 2025.

An IPC patient equipment audit for the unit was provided from March 2025 which had a compliance rate of 78% which was below the service's target of 85%. This audit had an associated time-bound action plan with identified responsible persons. Items identified on this audit, for example unclean dressing trolleys were found to be clean on the day of inspection.

A sharps audit was completed in March 2024 on four units including the Rehabilitation Unit. Issues identified were staff knowledge on sharps injury (50%), sharps bins assembly (50%) and use of the temporary closing mechanism on sharps bins (50%). An action plan was documented with a target completion date of April 2024. However, given the poor results there was no evidence that this was re-audited within the year. Therefore hospital management could not be assured about the sharps management practices in place in the unit.

There were no audits taking place on medicines reconciliation.[†††] While hospital management stated that medicines reconciliation was occurring, there was no documented evidence that it was taking place. This was in line with inspector's findings on the day of inspection. No medication safety audits were taking place but inspectors observed evidence of tracking and trending medication incidents which is discussed further in standard 3.3.

Antimicrobial prescribing rates were reviewed at the Medication Safety and Therapeutics Committee meeting in April 2025 and it was noted that monthly point prevalence data was collected by the QPS manager. Data reviewed indicated the hospital was using the HALT [‡‡‡] 2016 benchmark of 9.8% and were within this target.

The service had conducted an EWS audit in March 2025 which showed 100% compliance for all areas except for calculation of the EWS on the nightshift. Target overall compliance for this audit was 90%. An action plan, including discussions with nursing staff, agency staff and regular EWS calculation practice sessions, with assigned persons responsible was provided with a plan for re-audit in June 2025. However, included in the audit report was a graph detailing previous audits from 2024 which showed similar results of non-compliance in the same domain. For example, the calculation of the EWS on the nightshift was 50% in September 2024, 10% in December 2024 and 50% in March 2025. Previous audit reports were requested but not provided and so no action plans were provided with regard to previous non-compliances. No audits had been carried out in relation to the Identify, Situation, Background, Assessment and Recommendation (ISBAR)[§§§] communication tool.

[†††] Medication reconciliation: involves using a systematic process to obtain an accurate and complete list of all medications taken prior to admission.
‡‡‡ European-wide Point Prevalence Survey, of 'Healthcare Associated Infection and Antimicrobial Use in Long-Term Care Facilities' (known as the HALT study) May 2016
[§§§] The ISBAR clinical communication tool is a structured framework which outlines the information to be transferred when communicating information verbally and in writing between healthcare professionals.

No audits in relation to transitions of care had been carried out. Bed occupancy, admission and discharge trends were being tracked. An overview report on admission and discharge profile for 2024 to 2025 was provided. This showed bed occupancy of 63.5% in 2024 and 90% in 2025 from January to March 2025.

Overall, while monitoring and evaluation of the service was being completed,

- the most recent three audits for each area of focus in IPC were requested but one audit report was provided for each. Therefore inspectors were unable to verify if regular audits were taking place, if findings had been actioned from previous audits or if re-audits were carried out where poor results were identified
- audits of the EWS highlighted non compliances that had not been addressed between audits, specifically in relation to calculation of the EWS on the night shift
- no repeat audit was carried out in relation to management of sharps despite poor results in March 2024
- no audits were being carried out on transitions of care, medication safety or medicines reconciliation.

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

While the hospital had some systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services, these were not always found to be effective at reducing the risk of harm to patients.

As discussed under national standard 5.8, the hospital had a corporate and local risk register in place. Examples of risks included on the corporate risk register relating to the focus of this inspection included the "risk of medication error on transfer of care from an external agency to Leopardstown Park Hospital". Controls for this risk included that all prescriptions would be reviewed by pharmacy, however this did not align to the practice observed on the ward and this risk had not been reviewed since 2023. A risk was identified in relation to transitions of care and documented as "risk of failure of external agencies to inform Leopardstown Park Hospital of the full clinical picture on transferring a patient". Controls included in-person assessment for new admissions and the transfer of healthcare records with the patients from St Vincent's University Hospital (SVUH) which aligned to practices described during the inspection. Not all risks identified on inspection in relation to the unit, for example; the staffing of the unit at night and the thoroughfare layout of the unit with regard to the risk of transmission of infection or the impact on patient privacy, were identified and risk assessed. Risk assessments from the Rehabilitation Unit were reviewed by inspectors in relation to the four areas of focus of the inspection and workforce arrangements. These risks had existing control measures identified and a risk owner but no additional actions or due dates were recorded and in some instances the risk rating had not been identified. For example, a risk recorded in relation to medication errors was not risk-rated.

Infection Prevention and Control

As discussed under standard 2.7, patients with a multi drug resistant organisms (MDRO) were not admitted to the unit. This was based on a risk assessment on the pre-admission assessment form. No screenings for MDROs were carried out in the Rehabilitation Unit. Inspectors were informed that there had been no infection outbreaks in the Rehabilitation Unit in the previous 12 months. Management stated that microbiology advice was available via SVUH if required. Management stated that there was an antimicrobial stewardship pharmacist available in the community for advice if need and that a local antimicrobial stewardship register was maintained.

Medication Safety

A clinical pharmacy service [****]was provided to the whole hospital. Inspectors were informed that medicines reconciliation was completed by medical and nursing staff on admission and discharge, however on review of healthcare records inspectors noted that no documentation of this practice was in place. Medicines reconciliation was not referenced in the hospital's local Medication Management Policy Document. Unit staff reported that discrepancies noted during medicines reconciliation were recorded as incidents. This is discussed further under national standard 3.3.

[****] A clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.

Inspectors were informed that pharmacists aimed to review each patient twice in their six-week stay, however only one of the three charts reviewed showed evidence of a clinical pharmacy review.

Staff had access to up-to-date online medicines information. The unit had a list of sound-alike look-alike medications (SALADs) and high risk medications list. This was supported by the local policy which was up to date.

The medication trolley was stored in the nurses' office which was both a clinical and administrative room however, there was no door to this office and while the trolley storage area was locked, the trolley was not locked in position when not in use. High risk medicines were appropriately stored in a locked press. On review of the controlled drugs register inspectors noted that checks were recorded with AM and PM rather than the specific time using the 24 hour clock. This was brought to the ward management's attention. Inspectors observed staff engaged in appropriate medication safety practices when administering high-risk medications on the unit, for example by completing an independent second check. There was no medication fridge on the unit but staff had access to a fridge in another unit in the hospital when required. This fridge was located in a unit in the designated centre for older persons and would require staff to leave the unit to access it. This could cause a potential challenge, especially at night when only one staff nurse was allocated across two units or in an emergency situation.

Deteriorating Patient

The unit used the INEWS version 2 system to facilitate staff in recognising and responding to an acutely deteriorating patient and this was supported by a locally adapted INEWS protocol. Ward management in the Rehabilitation Unit were knowledgeable about the use of the INEWS, however inspectors noted that staff were not following their local INEWS protocol in relation to frequency of observations. Observations were carried out on a 12 hourly basis on all patients when the protocol for score 0-2 stated a 6-hourly basis. This was raised with senior management on the day of inspection. The local protocol also included ISBAR as a method for supporting communication in relation to a deteriorating patients. Staff confirmed that this was in use and the tool was displayed near the phone.

The local protocol in the event of a cardiac arrest was to commence cardiopulmonary resuscitation and phone an ambulance. Contact numbers and hours for the on-site medical officer were on display, however no emergency phone numbers were displayed near the phone. This was communicated to the ward manager on day one of the inspection. Four automated external defibrillators were available for use in the hospital. Emergency equipment for the Rehabilitation Unit was located in a number of locations within the unit. This could present challenges

in accessing equipment in the event of a cardiac arrest. While staff indicated that no incidents had occurred as a result of this, no simulation of a cardiac arrest in the unit had taken place to identify areas for improvement.

Transfers of Care

A standard template was used for pre-admission assessment and included demographic data, current care needs, medical summary, medication allergies and social history and this was uploaded to the hospital's electronic record system. An admission checklist was completed and all patients were reviewed by the medical officer on admission. An arrangement was in place with SVUH where the healthcare record of the patient accompanied them for three working days following transfer. This was documented in a local policy. A standard discharge template was also in use, along with a discharge checklist for staff. A checklist of documents to accompany this was used which included the medication administration record, medication list and infection status. Discharge planning was discussed at the weekly IDT meeting and information was provided to the referring hospital regarding planned length of stay, which was limited to six weeks maximum and extended only in exceptional cases. A phlebotomist was available onsite to reduce the need for patients to attend the acute hospitals for blood tests and the hospital had access to a mobile x-ray service for any patient who required x-rays. The hospital had developed links with St Vincent's University Hospital Emergency Department In The Home (EDITH) team who could also review appropriate patients, with a view to admission avoidance to the acute hospital where suitable.

Access to policies procedures and guidelines was via an online system which tracked when a staff member had signed to say they had read, understood and implemented each policy. Staff had access to a suite of local policies in relation to equipment decontamination, infection prevention and control, medication management, risk management, complaints and incident management which were all up to date. Staff had no access to a policy on the deteriorating patient to support the local INEWS protocol.

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

- not all risks identified during the inspection had been identified on the risk register, for example the layout of the unit as a thoroughfare and the staffing of the unit at night
- the local INEWS protocol was not being followed for patients with a score of 0-2

- inspectors were informed that medicines reconciliation was completed by medical and nursing staff on admission and discharge, however there was no documentary evidence of this when inspectors reviewed patient records
- medicines reconciliation was not referenced in the hospitals local policy
- the medication trolley was stored in the nurses' office which had no door and it was not secured in place and no fridge was available for medication storage
- entries on the controlled drug register were recorded with AM and PM rather than the specific time using the 24 hour clock
- no emergency phone numbers were displayed near the phone and emergency equipment was located in different places across the unit
- staff had no access to a policy to support management of deteriorating patients
- risk assessments completed in the Rehabilitation Unit had existing control measures identified and a risk owner but no additional actions or due dates were inputted. Some of these risks did not have a recorded risk-rating.

Judgment: Not Compliant

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

The hospital had a local Safety Incident Management policy approved in January 2025 that was informed by the HSE Safety Incident Management policy. However, this HSE policy has been replaced by the Incident Management Framework 2018 and updated in 2020 and therefore the unit policy was not up to date with the latest guidelines. Incidents were recorded using a National Incident Report Form (NIRF) and forwarded to Quality and Patient Safety department for review and logged on the National Incident Management System (NIMS).

Sixty four per cent of incidents were entered onto NIMS within 30 days of occurrence between March 2024 and March 2025, this did not meet the HSE target of 70%. Reports and meeting minutes reviewed by inspectors evidenced that patient-safety incidents were tracked and trended. A report was generated for and discussed at the monthly IMR meeting with the HSE. This report detailed monthly person-related harm incidents and outlined trends in relation to hazards identified from the NIMS reports.

A Rehabilitation Unit Incidents Report 2024 was provided to inspectors. This report was completed by the QPS manager and provided a breakdown of 18 incidents reported. For example, seven of the 18 incidents were in relation to medications. Medication occurrences were categorised according to NCCMERP[††††]. All seven of the medication occurrences were in category A to C which are categories of errors that do not result in patient harm. Of these, 57% were prescribing errors, 29% administration and 14% medication reconciliation. Staff on the unit stated that discrepancies identified during medicines reconciliation were captured via the incident management process however, this 14% equates to only one medication error associated with medicines reconciliation in a one year period. This did not align with information provided to inspectors. An action plan was provided which was time-bound and had assigned responsible persons and this included staff education on the incident reporting process and was due for completion by June 2025.

A medication safety occurrence report was discussed at the April 2025 meeting of the MST Committee. This report outlined a reporting rate of 0.93 per 1000 occupied bed days which is below the HSE target and the service had been below target in 2023 and 2022 also. The action discussed was to signpost staff to a Medication Occurrence Reporting Tool Box Talk. This was not assigned to a responsible person and a planned completion date was not identified. This report was for the entire hospital campus, and it was unclear if any of these incidences or actions were specific to the Rehabilitation Unit. A medication occurrence pathway displayed in the unit, dated March 2025 outlined the steps staff should take in the event of a medication error.

Overall, while the hospital identified, managed and responded to patient safety incidents relevant to the size and scope of the unit.

- the service was not meeting the HSE target for entering incidents onto NIMS
- low reporting rate of medication reconciliation errors was not in line with the practice that inspectors were informed was taking place.

Judgment: Substantially Compliant

[††††] The National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP)

Conclusion

HIQA carried out an announced inspection of Leopardstown Park Hospital Rehabilitation Service to assess compliance with national standards from the National Standards for Safer Better Healthcare. This inspection focused on four areas of known harm; infection prevention and control, medication safety, deteriorating patient and transitions of care.

Capacity and Capability

The unit had defined accountability and reporting arrangements for the senior management team. Notwithstanding this, deficiencies were identified in the oversight and reporting arrangements of the governance committees and this impacted on the oversight mechanisms for the four key areas of focus of the inspection. Additionally a number of meetings and committee functions required formalised up-to-date TOR and meeting minutes with documented assigned time-bound action plans reviewed from meeting to meeting. While the unit had a number of management arrangements in place it did not have effective senior management arrangements to support the delivery of high-quality, safe and reliable healthcare. Some arrangements were not sustainable or could impact on the effectiveness of management oversight.

Senior management organised and managed their workforce, however absenteeism was above the targets set by the HSE and a number of mandatory training areas had low levels of compliance. The unit had monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services but areas for improvement were identified in regard to the management of identified risks.

Quality and Safety

Inspectors observed staff interacting in a kind and caring manner towards people using the service. People who spoke with inspectors were positive about their experience of receiving care in the unit and were complimentary of the staff. It was evident that a person-centred rehabilitation approach to care was promoted. 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. Management were challenged by the layout and infrastructure of the unit.

Management monitored and evaluated the service, however inspectors noted that some of the areas of focus of the inspection had no audits taking place. Additionally, some areas of non-compliance had not been addressed between audits.

It was evident that there were systems in place to identify and manage potential risk of harm, however some areas of risk had not been identified or those that were identified had not been evaluated fully. Policies and procedures reviewed by inspectors were up to date and staff were knowledgeable of how to access them and their content. However, practice was not in line with local protocol in relation to the early warning score. Complaints management structures were in place. Not all necessary structured arrangements were in place on the unit to manage potential risk of harm to patients from the four areas of focus of the inspection. Management identified, managed, and responded to patient-safety incidents however, the hospital was not meeting HSE targets for incident reporting.

Following inspection, HIQA were notified by senior hospital management that Leopardstown Park Hospital Rehabilitation Service closed on 23 July 2025. As a result of this no compliance plan was required.

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.	Partially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	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 communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	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.	Not Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant