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:	CareChoice Parnell Road Stepdown Facility
Centre ID:	OSV- 0008985
Address of healthcare service:	Parnell Road Drimnagh Dublin D12 PX80
Type of Inspection:	Announced
Date of Inspection:	25 and 26 March 2025
Inspection ID:	NS_0134

About the healthcare service

CareChoice Parnell Road is a private stepdown facility owned and operated by the CareChoice Group. A formal arrangement was in place with St James's Hospital for the provision of care and services as outlined below. The mission statement on display in the facility outlines that the aim is to deliver quality care in an environment where patients remain active, their dignity, independence and choices are respected while staying connected to their family and friends.

The facility provides the following care and services:

- rehabilitation following stroke, surgery or chronic illness allowing the patients to regain function and life skills.
- stepdown care for people awaiting long term care, home care packages, home adaptations and equipment
- convalescent care.

The following information outlines some additional data on the facility.

Number of beds	143 stepdown 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 announced inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare* as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors* reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publically available information. This was the first inspection of the facility undertaken by HIQA.

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 facility
- 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.

*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.

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 facility. 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-centered 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)
25 March 2025	11:30 – 17:30	Angela Moynihan	Geraldine Ryan Elaine Egan Laura Byrne
26 March 2025	08:45 – 16:30	Angela Moynihan	Geraldine Ryan Elaine Egan Laura Byrne

Information about this inspection

This announced 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 four clinical areas:

- Samuel Beckett unit
- O'Connell unit
- James Joyce unit
- Ha'penny unit.

The inspection team spoke with the following staff Representatives of the facility's Executive Management Team:

- Chief Executive Officer (CEO)
- Director of Nursing (DON)
- Director of Governance
- Director of Human Resource
- Director of Operations (DOO)
- Lead Representative from the attending General Practitioner service
- A representative for:
  - Infection Prevention and Control
  - Medication safety
  - Deteriorating patient
  - Bed Management and transitions of care
  - Nominated complaints officer.

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.

† 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.

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

On the first day of the announced inspection there were 137 patients admitted to the facility. Inspectors visited all four clinical areas (one accommodated 26 beds and three accommodated 39 beds) all with single rooms and private en-suite bathrooms.

Inspectors spoke with patients in each of the four units. Patients stated that "staff were extremely helpful" "were kind and very good" while another patient stated that "staff would do anything for you" and the food was "nice and hot". Other comments referenced the cleanliness of the facility and satisfaction with the bedroom facilities.

Staff actively engaged with patients in a respectful and kind manner and ensured patients' needs were promptly responded to. This observation was validated by the patients spoken with during the inspection. Staff were observed promoting and protecting patients privacy and dignity when delivering care and during interactions.

Inspectors observed effective communication approaches used by staff to support patients who may have difficulties with communication. 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. One patient said that they "use their call bell and the staff respond immediately". Another patient stated that they receive "enough physio" and staff "encourage you to be up and mobilising".

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes the standards related to workforce, use of resources.

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

The DON, DOO and the Group Director of Governance outlined the governance arrangements, reporting structures and responsibilities from the DON and DOO to the CEO of the group and upwards to the Board. Organisational charts setting out the facility's reporting structure detailing the direct reporting arrangements were provided. However, these required updating to reflect the reporting structures described to inspectors. While inspectors found formalised corporate and clinical governance arrangements in place with defined roles, accountability and responsibilities for assuring the quality and safety of healthcare service there was scope for improvement at facility level. For example, including and formalising the oversight of risk management, the deteriorating patient and medication safety practices in the governance framework.

The DON was responsible for managing and leading the delivery of patient care and the DOO was responsible for the operational running of the stepdown facility. Both the DON and the DOO reported directly to the CEO of the group and the CEO reported directly to the Group Board of Directors.

The DON was supported in their role by three assistant directors of nursing (ADONs). Nursing and support staff reported to the clinical nurse managers (CNMs) and upwards to the ADON and onwards to the DON. Health and social care health professionals, for example, medical social workers and physiotherapists reported to the DOO.

Two local general practitioners (GPs) were responsible for the medical care of patients admitted. On-call medical cover was provided by an out-of-hours medical service. A consultant geriatrician attended the facility as required to assist with complex discharge planning for admitted patients.

CareChoice Group Governance Quality and Safety committee

At group level there was a quarterly governance quality and safety committee meeting convened and chaired by a member of the board. As stated in the terms of reference (TOR) the committee aimed to ensure that quality of care was of a high standard and provided oversight and direction in regards to the company's quality of care and safety regime. Membership of the committee comprised the CEO, Director of Governance, Director of Human Resources and two directors of nursing from within the CareChoice Group. The TOR for this committee required review and updating at the time of inspection. Agenda and minutes reviewed by inspectors indicated that the committee was functioning as described and actions were

reviewed at each meeting however some actions were not time bound or assigned to committee members.

CareChoice Parnell Road governance arrangements

At a local level a quarterly clinical governance meeting was held with the DON, DOO, ADONs and practice development staff. A draft TOR to include the oversight of the four key areas of harm and risk management practices was provided. From review of the minutes and on discussion with staff the purpose of this committee was to ensure that appropriate and effective systems were in place to ensure the delivery of safe and effective care. It was apparent that a particular format for discussion of matters was followed. However, it was not evident in the agenda or minutes of the meeting that risk management, the deteriorating patient or transitions of care were discussed. While medication incidents was an agenda item at this meeting it was not clear if additional medication safety matters were discussed or overseen at this forum. This was discussed with the senior management on the days of inspection who had commenced reviewing the function and oversight of this meeting to include the four areas of harm and associated risk management.

A monthly governance meeting was held with a governance support officer and the senior nursing team. Minutes reviewed indicated that complaints, incidents, falls, medication errors, infection prevention and control (IPC) practices and audit activity were discussed and resulting actions were assigned, time bound and reviewed from meeting to meeting. There was no TOR available for this meeting at the time of inspection.

An infection prevention and control committee was in place and aimed to provide strategic leadership and direction on infection prevention and control activities as per the TOR. The committee met quarterly and was operationally accountable to the DON. Meeting minutes reviewed identified that actions were identified and reviewed from meeting to meeting; however, these were not always assigned to an identified person or time-bound.

A home operational walk by the senior management team (CEO, DON and DOO) was conducted monthly in the facility. There was no TOR set however inspectors viewed the minutes and agenda items for discussion during the walk about. Included in the agenda items was IPC, governance and management, staffing, health and safety and clinical and quality concerns. It was not clear if required actions were identified following this meeting.

Patient flow governance arrangements with the acute hospitals

Management stated that a formal arrangement was in place with St James's Hospital and CareChoice Parnell Road for the provision of beds and services. Every second

month the DON, DOO, and CEO attended an operational key performance indicator (KPI) review group meeting with senior management from St James's Hospital. No TOR or agenda were provided for these meetings. Upon reviewing the meeting minutes and from discussions with staff, it was clear that the purpose of these meetings was to review operational planning such as patients with complex discharge needs, KPIs, for example, patient incidents, medication errors, infection prevention and control practices, falls rates, complaints and patient satisfaction. It was clear from minutes reviewed that actions were reviewed from meeting to meeting however these were not time-bound or assigned to specific staff.

Additionally, fortnightly meetings were held with acute hospitals to discuss admissions and discharges at the facility. A weekly multidisciplinary admissions and discharge planning meeting was held in the facility to review and agree future patient admissions and discharges. All planned patient discharges required sign-off by multidisciplinary team members at this meeting. Recently, a principal social worker from St James's Hospital started attending the weekly meetings to assist with admission and discharge planning. At the time of inspection, there were no TOR, agenda, or minutes in place for this meeting.

While the facility did not have a medication safety committee, a deteriorating patient committee or a transitions of care committee, the management and oversight of these were in development at the time of inspection. This is discussed further under national standards 5.5 and 3.1.

Overall, governance arrangements with defined roles, accountability and responsibilities for healthcare services delivered to the facility however:

- formalising the governance and oversight of the deteriorating patient, medication safety, transitions of care and risk management practices is required.
- a number of meetings and committee functions required formalised terms of reference, agendas and/or meeting minutes. Additionally, time bound actions agreed from meetings were not assigned to a responsible person and monitored from meeting to meeting.

Judgment: Substantially Compliant

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

Effective management arrangements were in place to support the delivery of safe and reliable healthcare in the facility. Inspectors observed and were informed by staff that management continuously engaged with staff, provided additional staff when required and had a constant presence on the ground. Some patients informed inspectors that they were aware of the senior management team in the facility and had met them on admission and after. Senior management were observed addressing patients by name and discussing discharge plans with patients. Management had arrangements in place in relation to the four key areas of know harm:

Infection prevention and control (IPC)

The DON had overall oversight of the IPC program and chaired the IPC committee meetings. The GP described close links with St James's Hospital for microbiology and antimicrobial stewardship advice if required which was available Monday to Friday during office hours. This is discussed further under national standard 3.1.

Medication safety

Pharmacy supplies were provided by a local pharmacy, who delivered medicines to the facility seven days per week. The GP confirmed they reviewed patients' medicines on admission and patient-specific prescriptions were ordered from the local pharmacy via a digital ordering system. A community pharmacist was available by phone and email to address any medication related queries. Management reported that a pharmacist attended the facility twice a year to complete a medication safety audit and shared findings with staff. This is discussed further under national standard 3.1.

The deteriorating patient

Management stated that while the facility did not have a deteriorating patient committee, a recently developed policy to guide staff was provided to inspectors. The facility utilised the Irish National Early Warning System (INEWS) to support the recognition of and response to clinical deterioration in patients. A GP or locum out-of-hours service was available to attend if a patient required a clinical review. This is discussed further under national standard 3.1.

Transitions of care

Inspectors were informed that while the facility did not have a transitions of care committee, an ADON was responsible for the management of patient admissions and discharges. It was evident that bed management and patient flow featured in the multidisciplinary team (MDT) admission and discharge meetings held weekly. Additionally, meetings were held every two weeks with St James's Hospital where patient admissions and discharge planning were reviewed and agreed. This is discussed further under national standard 3.1.

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

Judgment: Compliant

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

The facility had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of services provided, however clinical risk management processes and oversight required strengthening. Meetings with staff and minutes of meetings reviewed reflected that performance data was reviewed at local meetings, operational and key performance indicator meetings (KPIs) meetings with St James's hospital and at Board level.

Monitoring service's performance

Information reviewed demonstrated that data in relation to patient flow was being tracked for example, the number of admissions, dependency levels, discharges, transfers to acute care, discharge destinations, total bed days, average length of stay and average bed occupancy were discussed at the operational and KPI meeting held with St James's Hospital. The facility also collected data on, for example, patient safety incidents, medication errors, falls, complaints, patient satisfaction, risks and monitoring of healthcare associated infections. It was evident from discussion with senior management that collated performance data was reviewed at facility meetings. This is discussed further under national standard 2.8.

Risk management

While the facility had some risk management systems and processes in place to identify, manage and minimise risk, structures to support the management and oversight of risk were unclear.

Risks in relation to health and safety practices were discussed at a health and safety meeting; however, clinical risk oversight and management was not in line with the facility's governance policy or risk management policy, for example:

- the process of escalating risks to the risk register was not in line with the facility's policy. Additionally, it was not clear how risks were escalated to the corporate risk register
- risks were not reviewed in line with the facility's risk management policy.

The process of risk identification, assessment and escalation was discussed with the management team on the days of inspection who committed to enhancing the governance and oversight of this process with a focus on the risks related to the four areas of known harm.

Audit activity

The DON had oversight of local audits. A schedule of audit developed for the year provided included audits, for example, on medication management, antimicrobial stewardship and IPC practices such as hand hygiene. There was evidence that findings from audits were addressed in the clinical area audited. The 2024 annual report for the facility summarised audit findings for the year in relation to, for example, privacy and dignity and patient satisfaction and outlined actions taken that addressed findings from the audits completed. Additionally, inspectors were provided with an audit summary related to patient incidents for falls and medication errors, all which detailed person-specific time-bound actions for improvements. It was evident from discussions with staff and on review of minutes of local meetings that audit findings were discussed and learning shared with the wider team. This is discussed in further detail in national standards 3.1 and 3.3.

Patient-safety incidents

The DON oversaw the reporting and management of patient-safety incidents and serious reporting events as outlined in the facility's risk management policy. Management stated that incidents were logged onto a digital electronic system and this was validated by inspectors who spoke with staff and observed this practice in the clinical areas. This is discussed further under national standard 3.3.

Patient satisfaction

Inspectors noted that patient feedback and complaints were a standing agenda item in the monthly local governance meetings with senior management. A local patient satisfaction survey was completed in 2024 and results were collated and findings were incorporated into a report completed by the DON. Findings were mostly positive and related quality improvement initiatives had either been implemented or

were in the process of being implemented at the time of inspection. Further discussion on this topic can be found under national standard 1.7.

Overall, there were systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services however:

- the process of escalating risks to the risk register was not in line with the facility's policy. Additionally, it was not clear how risks were escalated to the corporate risk register
- risks were not reviewed in line with the facility's risk management policy.

Judgment: Partially Compliant

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

The workforce arrangements in the facility were planned, organised and managed to ensure high-quality, safe and reliable healthcare.

Staffing levels

A Human Resource (HR) generalist was responsible for staff recruitment with oversight by the DON. Meeting minutes and interviews with senior management indicated that workforce was a regular agenda item at both local and Board level meetings. An induction programme over two weeks was provided to all new staff and this was confirmed by staff who had attended same. Inspectors were informed during interviews with management that agency usage was uncommon, which was confirmed by staff in the clinical areas. It was noted that an agency orientation process document was in place in the event of the requirement of agency staff.

At the time of inspection, the facility had an approved complement of one whole-time equivalent (WTE) [††]DON and DOO, three ADONs and 10 clinical nurse managers (CNMs). The units inspected had a full complement of nursing and care staff at the time of inspection and a supernumerary CNM was operationally responsible for the units at night. Inspectors reviewed the rosters for the week

[††] Whole-time equivalent - allows part-time staff working hours to be standardised against those working full-time. For example, the standardised figure is 1.0, which refers to staff working full-time while 0.5 refers to staff working half full-time hours.

preceding the inspection and no vacant shifts were noted and this was confirmed during meetings with staff.

The facility had an approved compliment of 4.0 WTE physiotherapists, 3.5 WTE occupational therapists, 2.5 WTE medical social workers, 8.0 WTE rehabilitation assistants and 2.0 WTE pre-assessment assessors. At the time of inspection, management reported a low vacancy rate across all staff categories, with five positions actively being recruited for: three CNM roles, an occupational therapist and a physiotherapist. There were no vacancies or staff deficits reported for staff nurses, healthcare assistants, cleaning and housekeeping staff during the inspection.

Pharmacy

Inspectors were informed that a pharmacist from the community pharmacy attended the facility twice per year to complete medication safety audits and additionally complete four monthly medication reviews for patients with the GP as required. Staff reported that they could contact the pharmacy via phone or email with queries or concerns. However, deficits were identified in areas such as the management and oversight of ward and emergency stock and pharmacy input and oversight of medication safety practices. This is discussed further under national standard 3.1.

On-call arrangements

The DON confirmed that a small number of senior management staff provided an on-call rota for the facility seven nights a week. While no impact to patient care was noted on the days of inspection, the sustainability of this arrangement was discussed with management who advised that they would review this arrangement to formalise and enhance the sustainability of the on-call rota. Medical cover was provided by a community GP service on-site, Monday, Wednesday and Friday to conduct formal rounds and review all patients with a focus on discharge planning. Additionally, inspectors met with the GP who advised they were available by phone for any queries or concerns and could come on site if required. An out-of-hours GP service was in place to attend the facility overnight and on weekends if the need arose.

Staff training

A meeting with the Director of Human Resource confirmed that staff training compliance was tracked and reported to the DON who had oversight of the training records. It was evident from management meetings at local and at Board level that compliance with staff training was a rolling agenda item for discussion. From records reviewed and discussions with staff it was clear staff were up to date with training appropriate to their scope of practice. Clinical staff were knowledgeable on, for example, how to use the early warning score system and the management of a deteriorating patient. Training records received indicated that:

- 100% of nurses, healthcare assistants, housekeeping, cleaning, health and social care professionals were up to date on training in standard and transmission-based precautions, donning and doffing, infection outbreak management and hand hygiene
- 100% of nurses were trained in medication safety and INEWS
- 96% of nurses were trained in basic life support.

The DON stated that staff from the facility had close links with St James's hospital training programs and recently members of the nursing team had attended intravenous medication training. This was confirmed by staff. Additionally, nursing staff were able to access the clinical skills training sessions convened in St James's hospital.

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

- current senior management on-call arrangements required review.

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.

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

It was evident that staff promoted a human rights approach to care in the clinical areas visited. Staff spoken with and the physical environment visited reflected that all management and staff were committed to promoting an approach to care and service delivery that understood and respected patients' privacy, dignity and autonomy.

All patient bedrooms were single occupancy with en-suite bathrooms, televisions and call bells. Patient hygiene preferences were accommodated with separate assisted bathrooms with a large modern bath for patient use on each unit. Inspectors observed staff knocking on patient room doors before entering and the interactions with patients were dignified and respectful. However, it was noted that patient names were placed on bedroom doors. This was addressed by management on the days of inspection.

Inspectors observed patients mobilising and receiving assistance from staff which prompted their independence. The clinical areas were bright and featured spacious corridors in all units. There was a day room and a garden on the ground floor that patients could use to socialise and each unit had a dining room where patients could attend if they wished. Inspectors spoke with patients who were satisfied with the food offering in the facility and enjoyed attending the dining room for meals while other patients that inspectors spoke with preferred to have meals in their rooms which was also accommodated.

A variety of information leaflets to keep patients informed on matters such as the complaints and feedback process, details of the SAGE advocacy services, falls prevention, healthcare associated infection prevention and a patient information book were accessible in each of the units.

Inspectors were informed that an annual privacy and dignity audit was completed in 2024 and results indicated 100% compliance in this area. Inspectors spoke with patients who reported that the care that they received protected their privacy and dignity.

Inspectors observed patients' personal information on computers and medical charts which were stored in a secure manner, and computers were locked when staff were not using them. The white boards at the nurses' station were designed to maintain the privacy of patient information. Closed Circuit Television (CCTV) was in use in the public areas of the facility only.

Overall the facility respected and protected patients' dignity, privacy and autonomy.

Judgment: Compliant

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

It was evident that a culture of kindness was actively promoted by staff and management. Staff were observed providing care with kindness, consideration and respect and responsive to patients' individual needs.

Inspectors observed that patient preferences were respected; for example, do not disturb signs placed on patients' bedroom doors. Many patients expressed how kind staff were.

The facility had arrangements in place for patients to access independent advocacy services. Posters and information leaflets were observed within the units visited on how to access advocacy services.

Senior management stated they welcomed feedback from people using the service. Inspectors observed that patients appeared comfortable discussing any issues or concerns with staff and the management team on the days of inspection. Additionally, inspectors spoke with the catering team who reported that patient feedback was actively sought to enhance the dining experience. For example, hot boxes were introduced in the facility following patient feedback on the food temperatures during meal service. On the days of inspection patients reported high levels of satisfaction with food temperatures and meals served. Inspectors observed menus displayed on digital screens with the addition of pictures to assist patients in their meal choices.

Inspectors were informed by management that the facility was affiliated with the Irish hospice foundation CARU[‡‡] program which provides support and continuous learning for staff in the delivery of palliative and end-of-life care for patients. Additionally, management described close links to Our Lady's Hospice Harold's Cross when additional specialist care was required for patients. Inspectors observed patient and family information leaflets on end-of-life care and services.

Judgment: Compliant

[‡‡] CARU is a continuous learning programme developed by the Irish Hospice Foundation (IHF) in partnership with the All Ireland Institute of Hospice and Palliative Care (AIIHPC) and the Health Services Executive (HSE). The programme aims to support and empower nursing homes and their staff in delivering person-centred palliative, end-of-life, and bereavement care. This initiative enhances the quality of life for residents, ensures a good death, and eases the bereavement process for their families

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 DOO was the designated complaints officer assigned with responsibility for managing complaints and for the implementation of recommendations arising from the review of complaints. There was a culture of local complaints resolution in the clinical areas visited and inspectors observed this practice while on inspection.

If a complaint could not be resolved at this level, a process was in place to escalate it to the DOO or the DON. Staff reported that complaints were resolved locally where possible and were aware of the complaints policy and how to support a patient in raising a concern or making a complaint. Staff verified that informal complaints were tracked, trended and learning was shared at staff meetings, handover and via a digital messaging application. Staff stated that they received complaints resolution training on induction and additional tool box talks were arranged.

An electronic complaints management system was in place and a local policy outlined the management of complaints. Inspectors noted that the complaints procedure was on display on the units inspected and on the CareChoice website. Information for independent advocacy services was available.

In 2024 the patient guide was updated. It was noted that the guide provided an overview of the facility and was given to each patient on admission and included details of the complaints procedure, advocacy services, Ombudsman and HIQA concerns contact details.

From a review of meeting minutes inspectors found complaints were discussed at the monthly governance meetings and quarterly clinical governance meetings. Additionally, complaints management was a standing item for discussion at the quarterly Quality and Safety Board committee meeting and the operational meetings held with St James's Hospital.

The DOO stated that that complaints were acknowledged within five days with the aim to resolve same within 20 or 30 days. Inspectors were informed of the low number of formal complaints received and managed since the opening of the facility in October 2023, during which, ten formal complaints had been received and closed to the satisfaction of the complainant.

One patient informed inspectors of an issue that they had raised and described the management and satisfactory resolution of the verbal complaint which validated that complaints were managed in line with local complaints management policy in the facility. Inspectors reviewed the documentation of the concern on the complaints management system.

Judgment: Compliant

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

On the days of inspection, four clinical areas were visited and inspectors observed that the overall physical environment was well maintained, clean and modern. All patient bedrooms were single occupancy with en-suite toilets and shower facilities.

A gymnasium and on-site hair dressing salon was accessible to all patients and a dining and day room were located on each unit. Patients had access to a large well maintained garden and putting green, with tables and chairs available for patients and visitors. The garden was accessed via the ground floor dining room. On the day of inspection, patients were observed sitting in the garden enjoying the outdoors with visitors.

Wall-mounted alcohol-based sanitiser dispensers were readily available for staff and visitors with hand hygiene signage clearly displayed at each point. Hand hygiene sinks conformed to the required specifications with the exception of sinks in the sluice rooms.

Infection prevention and control signage in relation to contact and transmission based precautions was noted in areas visited. Inspectors observed rooms in use for isolation purposes with appropriate signage and waste bins in place at the entrance of the room. Staff were knowledgeable on infection prevention and control practices and procedures to reduce the spread of infection. Personal protective equipment was available.

Environmental cleaning was carried out by designated housekeeping staff and equipment was cleaned by healthcare staff. Equipment was observed to be clean and there was a system in place to identify equipment that had been cleaned, for example, use of a tags and checklists.[§§]Terminal cleaning was completed each time a patient was discharged and this was validated by both cleaning and nursing staff.

Management stated that a cleaning supervisor had oversight of the cleaning schedules in the units visited. Clinical staff stated that they were satisfied with the level and standard of cleaning in their respective units. Daily cleaning checklists were

[§§] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

in place and signed by the house keeping staff and overseen by the CNMs. Cleaning schedules reviewed indicated that all required cleaning was completed as required. Environmental and patient equipment audits were carried out and these are discussed further under national standard 2.8. Hazardous material and waste was observed to be securely stored. There was appropriate segregation of clean and used linen. Supplies and equipment were stored appropriately in the units.

The facility provided a safe and secure environment for patients, with controlled visitor entry managed through a call bell camera system on the ground floor. Stairwells, medication and clinical rooms were all accessed with coded entry pads. Maintenance service was available and staff expressed satisfaction with the service.

Overall, inspectors found that the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care.

Judgment: Compliant

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

Inspectors found that the facility had systems in place to monitor, evaluate and respond to information from various sources such as KPI findings from audits, patient safety incidents and complaints. The management team were proactively and systematically monitoring, evaluating and responding to information to identify areas for improvement and provide assurances on the quality and safety of the service provided to patients.

An annual audit schedule was in place and included audits that related to, for example, medication safety and infection prevention and control (IPC). Inspectors were informed that findings were discussed at meetings and staff in the clinical areas outlined how findings from audits were shared and actions were implemented and closed out. The IPC link nurse stated they conducted audits on staff hand hygiene, environmental and equipment hygiene in each of the clinical areas and actions following the audits were noted to be time bound and assigned to specific staff. However overall compliance was not scored for all audits completed, for example the IPC weekly walkabout.

Monthly hand hygiene practice audits were reviewed between December 2024 and February 2025 with compliance levels between 86% and 100%. Electronic audits reviewed by inspectors identified agreed time-bound actions to a specific staff member for the chosen area.

Medication safety and storage audits were conducted internally by clinical staff and findings of these audits indicated compliance of between 89% and 91%. Actions following the audit were assigned and time-bound. The external pharmacy provider completed a twice yearly audit of medication safety practices; however, an overall compliance score was not calculated for this and an improvement plan was not implemented. Additionally, inspectors observed similar findings on the days of inspection to that identified in the audit, for example, non-compliances with regular and emergency stock management practices. Following the inspection the DON provided a quality improvement plan template that will be used going forward to track actions arising from audit findings in the facility.

An INEWS and clinical handover audit had recently commenced and inspectors noted that the overall compliance was not recorded for these audits and it was unclear if a quality improvement plan was initiated following the findings of the INEWS audit completed.

The facility reported monthly on the number of new cases of infections and any outbreaks reported to the public health team and this was noted to be discussed at the monthly governance meetings held. This is discussed further under national standard 3.1.

Reports reviewed included an annual report 2024 which captured incidents and detailed common causes of harm, for example, medication errors and falls. Additionally, inspectors were provided with annual trending and evaluation reports on medication errors, falls and incidents reported throughout 2024. A falls prevention working group was established to assist in identifying falls prevention strategies and this is further discussed under national standard 3.3.

The facility reported performance data and this included, the number of admissions, discharges and discharge destination, transfers to acute services, average length of stay, bed occupancy and dependency levels. It was evident that this data was discussed internally and additionally at the St James's operations meetings held with the senior management teams.

Overall, the facility was systematically monitoring and evaluating the service, however:

- quality improvement plans were not always developed and compliance scores were not always calculated for audits (medication safety, IPC, INEWS) conducted.

Judgment: Substantially Compliant

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

Risk Management

The systems in place to support the governance, management and oversight of risk are discussed under national standard 5.8. Inspectors were shown the facility's risk register and noted that the documented risks had controls and actions in place to manage or reduce the risk recorded. While all risks had an annual review date, it was unclear what the most recent update or action was. Additionally, the majority of these risks were health and safety related, for example, water safety, manual handling, maintenance, lone working, laundry and the use of ladders. Inspectors reviewed patient-specific risk assessments, completed by staff in the clinical areas, which formed part of each patient's individualised care plan. It was noted that these were up to date and reviewed regularly.

Infection Prevention and control (IPC)

Risks in relation to IPC were included in the risk register provided and included outbreak management and non-compliance with isolation for patients with dementia. Risks reviewed had controls in place to manage and reduce recorded risk; however, it was unclear where these risks were reviewed and updated. The facility had an IPC committee and this was chaired by the DON. They were supported in their role by the ADONs and two IPC link practitioners and champions in each of the units who provided guidance, training and reviewed practice and processes through the auditing schedule. It was clear that IPC committee meetings were held quarterly and actions identified however, these were not time bound or assigned to a specific person. Topics for discussion at this forum included, for example; IPC audits, IPC walk about findings, antimicrobial stewardship, multi-drug resistant organism (MDRO) register, PPE and cleaning schedules. Inspectors were advised that legionella risk assessments were completed routinely and documents reviewed identified that the most recent one was completed in June 2024.

A current and up-to-date MDRO register was in place on each unit and detailed facility and hospital-acquired infections. Staff and management advised that patients were not screened for MDROs routinely on admission as the patient's infection status was part of the pre admission information gathered prior to transfer. If a patient became symptomatic the facility completed screening for patients as required. In the event of an outbreak the DON described close links with the public heath team in the community who provided guidance and support and additionally implemented the vaccination program in the facility. An outbreak of influenza and respiratory syncytial virus occurred in January 2025 which was notified to the public health team. The outbreak was contained to one ward and an outbreak report was

completed in line with national guidance. To guide and inform staff an up-to-date infection prevention and control policy was in place. Additionally, inspectors observed up-to-date cleaning registers and checklists and use of a tagging system to identify clean equipment was in place. Staff had access to a washer disinfector on each unit. A weekly IPC walk about was completed by the IPC link nurses who stated that findings were communicated to staff with areas for improvements outlined. At the time of inspection two additional staff members were enrolled to complete the link practitioner IPC course the following month.

Transitions of care

Risk in relation to transitions of care was not noted on the risk register; however, it was evident from speaking with management and staff that systems were in place to reduce the risk of harm associated with the process of patient transfer and discharge. It was clear that personal details, medical history, current medications and infection status was recorded on the discharge and transfer forms. The facility had a recently developed admissions policy in February 2025, which outlined the referral and admission process for patients. Additionally, a transfer and discharge policy outlined the procedures for patients' discharge or transfer to other services. A suite of documents were available to ensure that required information was shared between services during transitions of care. Discharge plans also included for example, home support assessments by the MDT, contact or correspondence with the public health nurse and the patient's GP. It was noted that patient planned discharges were discussed at the weekly MDT meeting chaired by the DON and DOO. Additionally, meetings was held with the acute hospitals to discuss potential discharges and admissions to the facility every two weeks. Patient assessment was undertaken prior to admission by a pre admission assessor who attended the hospital. Patients' pre assessment documents were reviewed at the MDT meeting prior to accepting new patients. Additionally, patient dependency levels was monitored in the facility. The pre assessment document viewed included detailed documentation of any known infections, medical history and any specialised nursing care needs for each patient. Staff were knowledgeable about the admission and discharge processes in the facility and were able to advise that they had access to the policies outlined above for the safe transitions of care. Patient records reviewed by inspectors validated that appropriate information was shared during care transitions. While the ISBAR*** communication tool was not in use, the DON stated they were looking into developing this in electronic format in the future.

Medication Safety

Three medication safety risks were noted on the risk register. For example, unauthorised access to the medication room and accidental poisoning/toxic harmful effects, which had controls in place however the review process was unclear.

Medication reconciliation was routinely carried out by the GP and nursing staff. Prescriptions were received before or on the day of admission, ordered digitally, and delivered to the facility. A community pharmacist was available seven days a week for queries. Medications were reviewed and prescribed by the GP on admission. Inspectors noted that the dispensing system lacked two patient identifiers, thus raising potential for errors and some medicines did not have patient labels or opening dates. This was raised with management on the day of inspection. Medication trolleys were securely stored. The British National Formulary (BNF) was available for reference. Regular stock management was overseen by the CNM, but some items were noted to be overstocked, for example insulin and controlled drugs. Arrangements were in place for accessing medications out of hours via the local pharmacy. It was noted by inspectors that emergency stock level recording was inaccurate for the majority of medicines reviewed and this required a focus and ongoing oversight as a priority. A designated fridge for medicines was available, with daily temperature recordings completed. The facility had recently developed a list of high-risk and look-alike-sound-alike medicines and staff described risk reduction strategies implemented for these medicines. Nursing staff who were completing medication rounds were observed wearing a red apron which was an initiative to reduce the number of interruptions during medication administration.

The deteriorating patient

There was no risk on the risk register that related to the deteriorating patient. It was evident from speaking with management and staff that systems were in place to reduce the risk of harm associated with a clinical deterioration of a patient. The facility had introduced the Irish National Early Warning System (INEWS) to support the recognition, response and management of deteriorating patients. Additionally, the stop and watch assessment was in use. Staff were aware of the policy for managing deteriorating patients and were knowledgeable about the INEWS escalation and response protocol. Inspectors observed the management of a patient who required a transfer out of the facility due to a clinical deterioration and noted that the care delivery was timely and in line with the policy. Emergency equipment such as a resuscitation trolley was available in two of the four clinical areas and oxygen and suctioning equipment was available on all floors. Following the inspection the DON advised that they had introduced emergency equipment in the additional two floors to aid the timely access to emergency equipment as necessary.

Document management

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

The facility had an electronic document management system and staff were observed accessing a range of up-to-date policies and procedures, additionally these were available in folders on the units. Medication safety, transitions of care, IPC and the deteriorating patient policies, procedures protocols and guidelines (PPPGs) were all current and up to date. However, it was noted by inspectors that some policies and procedures required review and updating. For example, the risk management policy outlined the reporting requirements to the Chief Inspector of HIQA. This reporting obligation applies to designated centres for older persons and does not align with the services provided at this facility. This was raised with senior management who committed to addressing same.

It was evident that the facility had systems in place to identify and manage potential risk of harm associated with the four key areas of known harm. However the following areas for action were identified:

- medication dispensing system required two patient identifiers
- some medicines did not have patient labels and dates of opening, for example insulin and eye drops
- oversight of stock management of regular and emergency medicines required review
- policies procedures and guidelines required review and updating to reflect the current service provision and/or reporting requirements.

Judgment: Partially Compliant

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

There was a system in place in the facility to identify, manage, respond to and report patient-safety incidents, in line with national legislation and standards, policy and guidelines. Staff were knowledgeable on how to report an incident and were able to describe incidents they previously reported and the process for reporting them.

On review of the minutes of staff meetings, inspectors noted that patient-safety incidents were a standing item on the agenda. Staff confirmed that feedback on incidents was provided to them during meetings, huddles and via a digital messaging application. Incidents occurring in the facility were reported on an electronic system. Senior management reported that both they and a quality support officer had oversight of same. It was evident that incident reports were reviewed tracked, trended and reported to senior management monthly and six monthly. Reports reviewed had actions assigned to a responsible person and were reviewed meeting to meeting. The summary report for 2024 indicated that 379 patient safety incidents were reported with the most commonly reported incident being patient falls. Staff were aware of the most common patient-safety incidents occurring in the facility and detailed patient-specific falls prevention measures implemented. Management stated that a falls working group had been established and reported that the incidence of falls had reduced following this improvement initiative. For example, 28 falls were reported in March 2024 while 13 falls were recorded in January 2025. Of note, the facility effectively identified, managed, responded to patient-safety incidents however the completion of a root cause analysis (RCA) was not in line with the risk management policy. For example, inspectors were informed that an RCA had not been completed following a serious incident.

Overall, the facility effectively identified managed, responded to patient safety incidents:

- completion of a root cause analysis following a serious incident was not in line with the facility's risk management policy.

Judgment: Substantially Compliant

Conclusion

HIQA carried out an announced inspection of CareChoice Parnell Road 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 facility had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare. Integrated strong links between the facility, the Board and with St James's hospital were in place. However, the senior management team need to formalise the governance and oversight of the risk management practices at facility and Board level. Additionally a number of meetings and committee functions required formalised terms of reference, agendas and/or meeting minutes with documented agreed time bound action plans that are reviewed from meeting to meeting. There was evidence of effective management arrangements in place to support the delivery of safe and reliable healthcare. Senior management planned, organised and managed their workforce to achieve high quality, safe and reliable healthcare. However, it is imperative that the senior management on-call arrangement that is currently in place is reviewed and enhanced to ensure sustainability into the future.

Quality and Safety

Inspectors observed staff being kind and caring towards people using the service. People who spoke with inspectors were positive about their experience of receiving care in the facility and were complementary of the staff and management team. It was evident that a person-centred approach to care was promoted. The physical environment supported the delivery of high-quality, safe, reliable care to protect people using the service. Management systematically monitored, evaluated and improved the service; however, it was noted that audits did not have compliance scores calculated which makes it difficult to track improvements in a given area. Additionally, improvement plans needed to be developed following some audits completed.

It was evident that there were systems in place to identify and manage potential risk of harm; however, the oversight and review of clinical risk management required review. Medication safety practices relating to appropriate patient identification, storage and stock management of regular and emergency medicines require further review and oversight. All policies and procedures reviewed were up to date; however, these require review and updating to reflect the current service provided

and/or reporting requirements. Management effectively identified, managed, and responded to patient-safety incidents. However, the completion of a root cause analysis following a serious incident did not align with the existing risk management policy. Despite this, there was a clear proactive approach to incident management and prevention in the facility, demonstrated by the introduction of the falls review group.

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

Compliance Classifications

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

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

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

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

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Partially Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant

Compliance Plan for CareChoice Parnell Road.

Inspection ID: NS 0134.

Date of inspection: 25 and 26 of March 2025.

Compliance plan provider's response:

Standard	Judgment
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.	Partially Compliant

Outline how you are going to improve compliance with this national standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with national standards.

It was identified that the process of escalating risks to the risk register was not in line with the facility's policy. Additionally, it was not clear how risks were escalated to the corporate risk register.

In order to fulfil this requirement,

The risk register in the facility has been reviewed and the risks now include the four areas of harm i.e. Medication Safety, Infection prevention and Control, The deteriorating patient and Transitions of Care. The clinical and non-clinical risks are separately identified as discussed on the day of inspection.

The risk register that was previously in paper format is now accessible on the SharePoint site within the facility. All clinical and non-clinical risks are notified to both the DON/DOO who oversee the register.

To ensure risks are reviewed in line with the facility's risk management policy, all risks will be reviewed at the clinical governance meetings at a minimum quarterly.

Where any risk is required to be escalated to the CEO, this is discussed at the monthly Senior Management team meetings and added to the corporate risk register as relevant. The Corporate risk register is reviewed at the Board meeting annually or more frequently where required.

(b) where applicable, long-term plans requiring investment to come into compliance with the national standard

A group-level review is in progress to standardise the risk register, risk management and its oversight.

Timescale: Q3/Q4 2025

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. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with national standards.

(I) It was identified that minutes from the Infection prevention and control meetings while actions arising from the meetings were outlined, the person responsible and timeframes for each action was not identified.

In order to fulfil this requirement

All Infection prevention and control meetings will have an action plan which will be timebound and assigned to a responsible person.

A quality improvement template is now available and will be used where appropriate.

(II) It was identified that the medication management dispensing system lacked two patient identifiers, thus raised potential for errors.

Some medicines did not have patient labels or opening dates.

Certain items were overstocked e.g. Insulin and controlled drugs.

Emergency stock level recording was inaccurate for the majority of medicines and this required a focus and ongoing oversight as a priority.

In order to fulfil this requirement:

The gaps identified regarding the medication dispensing system was promptly brought to the attention of the pharmacy provider, and the patient's entire name and date of birth are now included, reducing the possibility of errors. The floor managers and nursing staff will monitor this.

To guarantee improved monitoring, a new monthly checklist has been commenced. This checklist covers medication labelling, opening of medications and expiry dates.

The current weekly checklist for nurses will be strengthened as a result. The CNM in charge of the floor will complete this new checklist and this will be supervised by the ADON.

Following a stock review, all extra inventory items were returned to the pharmacy. There is now a new monthly checklist in place. This checklist will ensure oversight of medication ordering/receiving process and medication storage. The ADON/CNM will oversee the completion of this checklist.

Weekly onsite meetings with pharmacy have commenced. Nurses and pharmacy technicians will verify the amounts of prescription drugs being ordered and administered. Emergency supplies are part of this verification system. A new SOP on emergency house stock was developed in collaboration with the chief pharmacist and the GP. This is now in use and covers biweekly stock inspections and dispensing procedures. Additionally, a new house stock inventory list has been implemented, to guarantee that the facility always has access to a sufficient stock of emergency drugs. The Chief Pharmacist has reviewed this process to determine the usage and stock quantity required and this is approved by the GP.

To keep track of medication usage and supply levels, a new medication dispensing list has been established. This is monitored by the ADON /CNM.

(III) Policies, procedures and guidelines required review and updating to reflect current service provision and /or reporting requirements.

In order to fulfil this requirement

The Risk Management policy is under review to include a clearly defined pathway on how to escalate risks to the corporate risk register.

(b) where applicable, long-term plans requiring investment to come into compliance with the national standard

A full review of all policies, procedures and guidelines will take place to reflect the current service provision and all reporting requirements.

Timescale: Q3/Q4 2025