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:	Unannounced
Date of Inspection:	26/11/2025 and 27/11/2025
Inspection ID:	NS_0172

About the healthcare service

CareChoice Parnell Road is a private stepdown facility owned and operated by the CareChoice Group. A service level agreement was in place with St James's Hospital for the provision of care and services as outlined below. This agreement included caring for patients from St James's Hospital and Tallaght University Hospital.

The facility provides the following care and services:

- rehabilitation care
- stepdown care for people awaiting long term care, home care packages, home adaptations and equipment for homecare
- convalescent care.

The following information outlines some additional data on the facility.

Number of beds	143 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, information submitted by the provider, unsolicited information and other publicly available information since last inspection.

During the inspection, inspectors:

- spoke with people who used the healthcare service to ascertain their experiences of receiving care and treatment

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

- spoke with 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.

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-centred and safe. It also includes information about the environment where people receive care.

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
26/11/2025	*13:00 – 18:00*	Eileen O'Toole	Maeve McGarry Cathy Sexton Sorcha Burns
27/11/2025	*08:30 – 16:30*	Eileen O'Toole	Maeve McGarry Cathy Sexton Sorcha Burns

Information about this inspection

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

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

The inspection team visited two clinical areas:

- Samuel Beckett Ward
- James Joyce Ward.

During this inspection, the inspection team spoke with representatives from the CareChoice Group, the facility's Management Team, the Senior Nursing Leadership Team and Clinical Staff.

Acknowledgements

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

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

Inspectors spoke with a number of patients in the clinical areas visited. Patients were, in the main, complimentary about the care they received across the two clinical areas visited as part of this inspection.

Inspectors spoke with some patients on the ward who commented that the food was *"lovely"* and that their dietary needs were met. Inspectors also witnessed patients receiving timely assistance with their meal if required, both in their rooms and in the dining room. Spacious dining rooms were available for patient use and inspectors

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[†] 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.

witnessed both nurse and catering staff presence during mealtimes to provide assistance for patients as necessary.

Patients informed inspectors that they were *"happy with the care"* they received and reported that their call bells were answered promptly. Staff were described as *"proactive, accessible and caring".*

Although not all patients who spoke with inspectors were aware of the complaints process, they outlined that they would raise any issues they may have with the nursing teams on the wards.

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.

The service was found to be compliant with two national standards 5.2 and 6.1 and substantially compliant with two national standards 5.5 and 5.8 assessed under this dimension. Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

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

CareChoice Parnell Road provides care for patients that require rehabilitation care, stepdown care and convalescent care from St James's Hospital and Tallaght University Hospital. Within the agreements in place, St James's Hospital had access to 104 beds and Tallaght University Hospital had access to 39 beds.

The Director of Nursing (DON) and Director of Operations (DOO) were the accountable officers with overall responsibility and accountability for the governance of healthcare services provided at CareChoice Parnell Road. The DON and the DOO reported directly into the Chief Executive Officer (CEO) of the CareChoice Group who reported into the board of CareChoice Group, which had responsibility for governance and quality of care at the CareChoice Parnell Road facility.

Senior Management Operations meetings took place between CareChoice Group and CareChoice Parnell Road and were attended by the CEO, Group Director of Governance, DON and the DOO. These meetings had a standing agenda, which included occupancy, human resources, quality, patient transfers, complaints and risk register review. Minutes of the meetings (dated May, August and October 2025) reviewed by inspectors showed that meeting discussions included oversight of the governance and strategic direction at CareChoice Parnell Road but meetings were not held monthly as per terms of reference. The terms of reference did not have a date of development or a review date.

CareChoice Parnell Road met quarterly with senior management from St James's Hospital to provide data and information on four identified key performance indicators (KPIs): complaints, patient falls, pressure ulcers and medication incidents. From minutes reviewed by inspectors, there was evidence that information relating to activity and performance, clinical data, finance, hygiene and infection control and patient satisfaction was presented at this forum. As detailed in the terms of reference, this forum was to provide assurances around the services being provided as per service agreement and as per agreed KPIs.

Within CareChoice Parnell Road, the monthly Clinical Governance meeting was tasked with ensuring quality of care and had oversight of patient safety arrangements. This committee reported into the Governance Quality and Safety Committee at group level. Since the previous HIQA inspection in March 2025, the Clinical Governance meeting had undergone review and was now organised under the four key areas of known harm as identified by HIQA — infection prevention and control, medication safety, deteriorating patients and transitions of care. This committee also had oversight of the risk management processes including complaints, incidents and review of the risk register. Audit, KPIs and staff training were also a standing agenda item.

The governance team from the CareChoice group had oversight of KPIs, incidents, complaints and metrics of patient care such as pressure ulcers, falls and infections. The data was collated in a monthly site report which contained benchmarks, trending and actions taken. Inspectors were informed that this data was reviewed monthly and discussed at the group governance monthly meeting.

As per previous inspection findings, the DON was responsible for the organisation and management of nursing services and the DOO was responsible for the operational running of the stepdown facility. The DON was supported in their role by three assistant directors of nursing (ADONs) who had been tasked with areas of responsibility in relation to the four key areas of known harm. Two clinical nurse managers (CNMs) were on duty 24/7. Health and social care health professionals reported to the DOO. The DON, ADONs and DOO formed an on-call rota 24/7.

Inspectors were informed that the on-call rota included attending the facility at the weekend.

Medical cover remained unchanged since the previous inspection where 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 GP medical service. A consultant geriatrician attended the facility weekly to assist with complex discharge planning for admitted patients.

Compared with previous inspection findings, there was an improvement in compliance with this national standard. At the time of inspection, it was clear that there were governance arrangements with group oversight in place. Governance committees met and in the main, functioned in line with their agreed terms of reference. The Clinical Governance meeting had oversight of the stepdown facility's performance and there was a formalised upward reporting structure to the group, which was clearly identified in the organisational charts.

Judgment: Compliant

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

Inspectors found there were management arrangements in place to support the delivery of safe, high-quality healthcare services in relation to the three areas of known harm which were the focus of this inspection — medication safety, the deteriorating patient and transitions of care. As per previous inspection findings, the leadership team were observed to be available and visible in the clinical areas and interactions with both staff and patients were observed.

Pharmacy supplies were provided by a local pharmacy as found at the last inspection. Processes were in place for review and ordering of patient specific medicines prior to patient admission through the pre-assessment process. Medication audit results with associated quality improvement plans and medication incident trending were discussed at the monthly Clinical Governance meeting.

The national early warning system in use at the facility was the Irish National Early Warning Score (INEWS)[††]. Inspectors were informed that each patient was assessed

[††] Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned ICU admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.

on admission using the INEWS system and that INEWS was not used for assessment of observations again unless the patient scored above zero or in case of deterioration. A different observation chart was utilised to record patient observations at all other times. This is discussed further under national standard 3.1. The staff also described a stop and watch tool, which they utilised, which is an early warning communication tool if they notice something different in a person's daily care routine. Inspectors were informed that patients were not screened for sepsis and that if sepsis was suspected then the patient would be transferred out for a higher level of care.

Patients were pre-assessed for suitability for admission by a nurse manager from CareChoice Parnell Road, with input from a consultant geriatrician on the St James's Hospital campus. The stepdown facility had no inclusion or exclusion criteria but assessment was individualised and risk based. Patients who required a higher level of care or with suspected deterioration of their condition were transferred typically to the nearest acute hospital by emergency ambulance. This transfer could be activated by the nurse in charge, without medical input. The volume of such transfers were tracked monthly and were discussed at the monthly Clinical Governance meeting. From review of data received after inspection, there was a total of 253 patients that required transfer to hospital for a higher level of care in the first 11 months of 2025, which resulted in 386 hospital transfers, some patients being transferred multiple times. With an average of 35 transfers per month for a higher level of care, the service should continue to review their processes to ensure that transition of care episodes are minimised, whilst ensuring patient safety is maintained.

Inspectors were informed that the pre-admission assessment initiated the discharge planning process. There were a series of multidisciplinary meetings with referring hospitals and within the facility to support care and discharge planning. Nursing staff had access to medical advice from GP services 24/7. Inspectors saw evidence that the Identify, Situation, Background, Assessment, Recommendation (ISBAR) tool was utilised when the nursing staff were communicating with the GPs in relation to patient deterioration.

The pre-assessment process flagged any patient specific risks prior to admission which included the assessment if a higher level of observation was required as a supportive intervention. On day one of the inspection, all patients that were assessed as requiring a higher level of observation were observed as receiving that care. Staff who spoke with inspectors informed them that there was no issues securing the extra staff to perform the higher level of observation and this was also evident from staff rosters. Prior to admission patients' dependency levels were assessed into categories of independent, low, medium, high and maximum. Depending on the dependency levels and the nursing assessment performed on

admission each patient was placed on a schedule of comfort checks ranging from 15 minute checks to one hourly checks. The dependency levels of patients were reported on at the quarterly meeting held with St James's Hospital senior management.

It was evident to inspectors that there were management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services. However, the frequency and number of patient transfers for a higher level of care, whilst performed to keep patients safe should continue to be monitored closely to ensure processes are efficient and effective.

Judgment: Substantially Compliant

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

There were systematic monitoring arrangements in place at CareChoice Parnell Road to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services. Data was collected on a range of different clinical measurements related to the quality and safety of healthcare services such as bed occupancy rate, average length of stay, delayed transfers of care, patient-safety incidents and workforce. Data was reviewed at meetings with St James's Hospital, at CareChoice group level and within CareChoice Parnell Road.

Inspectors reviewed progress made with the compliance plan submitted by the facility following on from HIQA's previous inspection in March 2025. Management had progressed the goals within their compliance plan and there was evidence of risk management structures and processes in place to proactively identify, manage and minimise risk and arrangements to escalate risks to group level as required. The management of reported risks related to the focus of this inspection – medication safety, deteriorating patient and transitions of care are discussed further in national standard 3.1.

There were systems and processes in place to identify, report, manage and respond to patient-safety incidents and serious incidents which was underpinned by a policy. Serious incidents were trended and discussed at the CareChoice Parnell Road Clinical Governance meeting. The governance team at group level informed inspectors that they had oversight of each review process undertaken to ensure correctness. Inspectors saw evidence that a root cause analysis (RCA) was completed if a review

was undertaken which demonstrated lessons learned with arrangements for shared learnings, an action plan and recommendations.

There was an agreed annual plan for audit and evidence was provided of audit and monitoring in the areas of medication safety, the deteriorating patient and patient assessment and care planning. Audit activity was discussed at the Clinical Governance meeting and reported on at the KPI meeting with St James's Hospital. Examples of audit and monitoring activities were provided to inspectors which included quality improvement plans that were carried out following audit activity.

As discussed in national standard 5.5, patients who required a higher level of care were transferred to the nearest acute hospital by emergency ambulance. Trending of the reasons for transfer were categorised and reported on. Respiratory issues were the cause of the highest number of transfers. Transitions of care is a key risk area for patient harm and the service should continue to monitor and analyse transfers to a higher level of care to inform practice and improve the safety and quality of care.

Patient feedback and complaints were discussed at the Clinical Governance meeting, the Senior Management Operations meetings and the KPI meeting with St James's Hospital. All patients received a hard copy of a feedback survey on discharge. Feedback was collated with the 2024 results and in the main, were positive. CareChoice Parnell Road had an ongoing time bound action plan with identified responsible persons based on feedback received from patients.

Overall, there were systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. However, given the inherent risks associated with transitions of care, management should ensure that these risks are monitored, reviewed and minimised.

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.

Workforce arrangements at the facility were planned, organised and managed to ensure high-quality, safe and reliable healthcare. The group human resources (HR) team had overall responsibility for the key performance indicators (KPIs) related to workforce. The Group HR Director reported directly to the CEO of CareChoice Group

and there was one whole time equivalent (WTE)[‡‡] HR generalist based at CareChoice Parnell Road with administrative support. The HR generalist had a weekly forum with the group HR department to discuss any issues and report on data in relation to CareChoice Parnell Road.

At the time of inspection, inspectors were informed that the facility had a total of 99 WTE nurses in post with a vacancy rate of 4.9% (4.9 WTE) and three WTE nursing posts were currently going through the recruitment process. The healthcare assistant posts (HCA) were above complement with 55 WTE in post with a complement for 39.2 WTE. The planned nurse-to-patient ratios were 1:6 (maximum of 7) during day time and rising to 1:13 at night time. HCA-to-patient ratio of 1:12 during day time and between 1:17 and 1:18 at night time which were the staffing levels in place at the time of inspection. There was two CNMs on at all times for the facility. On review of the roster, there were no shortfalls identified over the previous four weeks. As discussed in national standard 5.5, patients who were assessed as requiring a higher level of observation as a supportive intervention received that care through an overtime process by the staff. Inspectors reviewed rosters for the weeks preceding the inspection and all requests were fulfilled. Inspectors were informed that there were no vacant positions in health and social care professionals.

The reported staff turnover rate for 2025 year to date was 18.5%, 11% in the staff nurse group and 22% in the healthcare assistant group. The absenteeism rate for 2025 year-to-date was 6% which is above the CareChoice group KPI of less than 5%. Inspectors were informed that back-to-work interviews were conducted by clinical nurse managers at ward level and absent management plans were put in place as necessary.

As per previous inspection findings, the DON had oversight of staff training compliance. Training records demonstrated good levels of staff attendance at, and uptake of mandatory and essential training. Compliance with staff training was a standing agenda at governance meetings at group and local level.

CareChoice Parnell Road planned, organised and managed their workforce to provide quality, safe and reliable healthcare.

Judgment: Compliant

Quality and Safety Dimension

[‡‡] Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.

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.

CareChoice Parnell Road was found to be compliant in two national standards (1.8 and 3.3), substantially compliant with two national standards (1.6 and 2.2) and partially compliant with one national standard (3.1). Key inspection findings leading to these judgments are described in the following sections.

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

Staff were aware of the requirement to respect and promote the dignity, privacy and autonomy of patients. Staff were observed to be caring, kind and responsive to patients' individual needs in the clinical areas inspected. The two clinical areas visited during the inspection had single rooms with en-suite bathroom facilities. Each of the two clinical areas also had an assisted bathroom. The physical environment in the wards supported the delivery of care that respected and promoted the patient's dignity and privacy.

As per findings of the previous inspection, patient names were placed on bedroom doors. Inspectors were informed that this had been considered since the time of the last inspection, and a decision was taken to keep the patient names on the doors as a safety measure for staff and for patient orientation. Inspectors were informed that consent from patients was sought to authorise use of names on display on doors at the time of admission and there had been no issues reported from patient feedback.

Patients were familiar with their surroundings, had access to call bells and were aware of how to seek assistance from staff. Patients who spoke with inspectors said that their call bell *"was answered very quickly",* were offered assistance with *"whatever I want"* and reported that they felt *"well looked after".* Inspectors noted some examples of individualised requests from patients that had been accommodated which promoted autonomy. One patient described how they thought that the staff did not spend much time with them and described the time that staff spent in their room as *"in and out very quickly".*

The physical environment was designed to promote the autonomy of people who used the service, with bright spacious communal areas. However, in one of the clinical areas visited, on arrival in the afternoon, inspectors observed all patients were in their rooms. Some patients commented on the lack of activities in place at the facility. Inspectors noted that the average length of stay for patients was 61

days. Whilst acknowledging that the focus of care is on rehabilitation and preparation for discharge, the service would benefit from considering optimal utilisation of communal spaces to promote social engagement, particularly for patients having a lengthy stay.

Healthcare records were appropriately stored and personal information was handled securely in the clinical areas visited. Closed circuit television (CCTV) was in use in the public areas of the facility only and monitored at reception.

The physical environment was designed to promote and protect the dignity, privacy and autonomy of people who use the service but further utilisation of communal spaces to promote autonomy could be considered.

Judgment: Substantially Compliant

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

There were effective processes in place at CareChoice Parnell Road to respond to feedback and complaints received from patients and or their families. The Director of Operations (DOO) was responsible for the management of complaints.

Complaints were resolved at the point-of-care where possible, and escalated to the CNM, ADON and or DON. Staff who spoke with inspectors reported that all complaints were logged, reported on and were documented in the monthly site report and were aware of the complaints process and procedure for escalation.

As per previous inspection findings, complaints were discussed locally at the Clinical Governance meetings, at group level at the senior management operations meeting and were reported on at the KPI meeting with St. James's Hospital. Learnings from complaints were shared at the morning huddles and at "Toolbox Talks".

The DOO reported that the facility was meeting their internal KPIs of acknowledging complaints within five days and closing out complaints within 30 days. Inspectors were informed that the facility received minimal complaints, a total of nine were received in the five months previous to the inspection, four verbal and five written. There were no trends noted and quality improvement projects, were in the main, associated with improvement of food and menus.

Inspectors observed information on how to make a complaint and how to access advocacy services on the clinical areas visited.

Patients were given an opportunity to feedback on their experience on discharge from the facility through a patient survey. In the first 11 months of 2025 the response rate was reported as 52%. The patient survey sought information in relation to overall experience, involvement in decisions and quality of care. The facility maintained an action plan to ensure that patient feedback items were followed up which identified staff responsible with timelines for completion.

There was no change in the compliance from previous inspection. Overall, there were effective processes in place to respond promptly and openly to complaints and concerns made by patients and or their families.

Judgment: Compliant

Standard 2.2: Care is planned and delivered to meet the individual service user's initial and ongoing assessed needs, while taking account of the needs of other service users.

Inspectors found that care was planned and delivered based on an individual's initial and ongoing assessed healthcare needs.

Assessment of patient needs began at the pre-admission assessment that was undertaken in the referring hospital by a nurse manager from CareChoice Parnell Road. On arrival to CareChoice Parnell Road, the admission process involved assessment of the patient, their risks and their care needs using clinical tools and focused assessments as determined in line with their prioritised needs. Based on this assessment, a care plan for each patient was then devised. Inspectors saw evidence that this assessment and care planning was undertaken in a timely manner and was underpinned by a CareChoice Group policy. The policy did not fully align with how patients were admitted to the facility and referenced designated centres.

Each patient was assessed on admission for their requirement for a higher level of observation as a supportive intervention. Prior to admission, through the pre-admission process, dependency levels were categorised as independent, low, medium, high and maximum. Depending on the dependency levels and the nursing assessment performed on admission each patient was placed on a schedule of comfort checks ranging from 15 minute checks to one hourly checks. If required, patients were also placed on regular schedules for repositioning and hygiene checks. Inspectors saw evidence that these supportive interventions were performed by both nursing and healthcare assistants, in line with patient assessments, and were documented in the patient record.

Each patient was screened for risks as part of their admission assessment. Risk assessments were carried out where risks were identified. Inspectors viewed risk assessments completed and saw evidence that care was individualised and patient care needs identified protecting both patient and staff. Re-assessment of patient risk was carried out at a minimum of every four months and more regularly if there was a change in the patient's condition.

There were examples of good practice in relation to care assessment and planning. There was evidence of appropriate commencement of care plans for patients. For example, inspectors saw evidence of a care plan for a patient identified as having a high risk of developing a pressure ulcer. The risk was determined by their assessment using a standardised tool, the Braden Scale. At the time of inspection, for most care plans reviewed by inspectors the actions determined in the care plans were being carried out. However, one patient determined as having a high risk of falls (using the Scott Fall Risk Assessment Tool) did not have their call bell within easy reach and was not using the mobility aid that was identified in the care plan. Inspectors also noted that the visual communication tool used for risk of falls i.e. colour coded leaves on doors, were not always in line with patient's care plans. This was brought to the attention of the staff at the time of inspection.

Nursing progress notes were used to monitor and document the patient's condition. Inspectors were informed that the ADONs had responsibility to ensure that the care plans were updated following the regular multidisciplinary meetings held with the referring hospitals and with the consultant geriatrician.

Inspectors saw evidence that relevant referrals were made to health and social care professional (HSCP) staff and to the GP for review. For example, a patient was risk assessed as having nutritional needs using the Malnutrition Universal Screening Tool (MUST). Inspectors saw evidence of a dietician review, weekly weights, documentation of dietary intake and communication to the kitchen in relation to the patient's dietary requirements.

Inspectors were informed that patients and families were included in the care planning process and some patients that spoke with inspectors confirmed that they had been included in the planning process and were aware of their plan of care. Cognitive assessment is performed on admission using the Mini-Mental State Examination which then informed the staff if a patient required family involvement in care planning and or consent.

On the occasions that restrictive practice, such as use of bed rails was necessary to keep a patient safe, inspectors saw evidence that a risk assessment tool was completed. The care plan then detailed actions necessary to mitigate against the

risks identified. Consent was sought when bed rails were necessary and signed by the patient or family member, the CNM and the GP.

Inspectors saw evidence that each patient had an individualised personal emergency evacuation plan developed and recorded as part of the care plan.

Inspectors were provided with evidence of audits undertaken in relation to care planning and patient's needs. Call bell audits were carried out quarterly with good compliance levels. On review of call bell audits, it was unclear as to what the goal was for response times and what constituted a "prompt" answer to a call bell which is an opportunity for improvement. Assessment and care planning audits were carried out monthly which demonstrated detailed assessment of care planning, assessment and review with good compliance levels. Non-compliances had actions assigned to individual staff members with associated timeframes. Touch care spot checks were also carried out which was a checklist of whether actions in relation to comfort checks and care activities had been carried out. Overall these checklists demonstrated good compliance but it was unclear who the actions were assigned to or if actions were completed where non-compliances were found.

Review of training records received demonstrated 100% training compliance for nursing staff with assessment, care planning and delivery of care training which was delivered at time of start of employment.

While there was some opportunity to improve the use of visual clues and the consistency of keeping care plans up-to-date, overall, there was evidence that care was planned and delivered to meet the individual service user's initial and ongoing assessed needs.

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

Overall, while CareChoice Parnell Road had systems and processes in place to identify, evaluate and manage immediate and potential risks to people using the service, these systems were not fully effective.

All risks from the facility were recorded on a single risk register. The DON had oversight of the risks within the facility and was responsible for maintaining, reviewing and updating the risk register. Inspectors saw evidence that the risk register was reviewed and kept updated. Risks were reviewed at the monthly Clinical Governance meeting. Since the previous inspection, as discussed in national standard 5.5, management had progressed the goals within their compliance plan

and there was evidence of risk management structures and processes in place. There was evidence that risks were discussed at the Senior Management Operations meetings at group level however, the escalation mechanism was not identified within the newly developed risk management policy. Staff who spoke with inspectors were not aware of the risks that were on the risk register.

Medicines were supplied by a community pharmacy. Risks recorded in relation to medication safety detailed a change in the community pharmacy provider with detailed control measures. A community pharmacist was available seven days per week for queries via telephone. The Irish Medicines Formulary was available for staff in one of the clinical areas visited but staff who spoke with inspectors informed them that, in the main, the patient information leaflet/package leaflet was their source of information for medicine information. There was a process for receiving patient specific medicines information from the referring hospital and subsequent medication reconciliation[§§] by nursing staff and the GP which was underpinned by a policy.

At the previous inspection, it was noted that the medicines dispensing system lacked two patient identifiers. At the time of this inspection, there was a variation in how medicines were identified for specific patient use. Patient specific regular medicines that were suitable for storage in a type of packaging that organised pills into individual, sealed compartments had three patient identifiers. Patient specific pro re nata (PRN) medicines and regular medicines not suitable for sealed compartments had a patient name on the medicine box only and were stored in a plastic box with two patient identifiers on the box. The facility would benefit from a review of their processes to ensure consistency in the identification process for all medicines.

Staff at CareChoice Parnell Road did not administer any intravenous medicines. The facility had a list of high-alert medications and inspectors observed the use of risk reduction strategies to support the safe use of opioids. Improvement was required in relation to risk reduction strategies for insulin as inspectors observed patient specific insulin had a patient label on the patient box only and not on the vial of insulin as is best practice. High-alert medicines were not stored separately to other medicines.

As part of their compliance plan, management had put a monthly checklist in place to oversee the ordering, receiving and storage of medicines. There were no issues identified in relation to overstocking of medicines at the time of this inspection.

The possibility of a patient deteriorating clinically was identified as a risk on the risk register. There was a newly developed local policy on the management of the

[§§] §§ Medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.

deteriorating patient which included INEWS and the national escalation and response policy. As discussed under national standard 5.5, patients were assessed on admission using INEWS, but not subsequently unless the score at admission was above zero or in case of deterioration.

A sample of healthcare records reviewed by inspectors demonstrated that increased frequency of observations was not undertaken, as per the local policy when a patient deteriorated. This finding was also validated by audit activity undertaken by the service. The actions stated in the policy did not reflect the onsite arrangements for medical personnel and did not reflect the two separate observation charts utilised. Going forward, the service would benefit from a review of their processes to recognise, respond and manage the deteriorating patient reflecting their resources.

In addition to using INEWS, the facility had developed an escalation and response pathway which included the use of stop and watch, INEWS, initial management and the escalation pathway to ADON, DON and/or GP. Inspectors were informed that patients are not screened for sepsis and that if sepsis was suspected then the patient would be transferred out for a higher level of care. The ISBAR communication tool was used for the escalation of the care of the deteriorating patient, if there was communication with the GP. As discussed in national standard 5.5, staff who spoke with inspectors reported that any suspicion of deterioration or a requirement for a higher level of care resulted in a transfer out by emergency ambulance.

The provision of transitional care was identified as a risk by management. All patients were pre-assessed prior to admission and the average length of stay was 61 days. There were processes in place for liaison with the referring hospital regarding admissions and discharge planning. At the time of inspection, there was one patient with a delayed transfer of care. The occupancy rate was 96.5% in 2025 year-to-date.

Patients' infectious status was determined prior to admission and there was no further screening undertaken at the facility unless the patient became symptomatic. At the time of inspection, it was observed that some patients had contact precautions signage on their doors and some of these doors were open and patients were not in their rooms. As per local policy, patients with a history of multidrug resistant organisms who were not symptomatic were not required to remain in their rooms. Patients who were symptomatic were isolated with doors closed or had a risk assessment performed if door closure was deemed unsafe. The facility had not differentiated the actions on the door signage for these two groups of patients which they managed differently. This was brought to the attention of management at the time of inspection for action.

Staff had access to a range of up-to-date policies, procedures, protocols and guidelines through the electronic document management system and there were hard copies stored on the clinical areas that were inspected. The governance team at group level had the responsibility to develop and update the policies. The policies reviewed did not always reflect what was happening in the clinical area and so did not support decision making, for example, the use of two separate observation charts. Policies did not always reflect what resources the facility had, for example, the onsite arrangements for medical personnel. The policy on risk management did not identify the risk escalation mechanism to the Senior Management Operations meetings at group level. As per findings of the previous inspection, policies should reflect the current service provision and support best practices.

In summary while there were systems and processes were in place to identify, evaluate and manage immediate and potential risks to people using the service further action was required based on the following findings:

- in the case of a deteriorating patient, increased frequency of observations was not undertaken, as per local policy and this policy requires review to reflect onsite resources
- there was a lack of consistency in the use of patient identifiers on all medicines
- high-alert medicines were not stored separately to other medicines
- lack of identification of different actions undertaken for cohorts of patients on the infection prevention and control signage on patient doors
- policies, procedures, protocols and guidelines should guide practice in the clinical area, support decision making, reflect resources available at the facility and support best practice.

Judgment: Partially Compliant

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

The facility had systems and structures in place to identify, report, manage and respond to patient safety incidents with oversight by the DON. Incidents were discussed at the Clinical Governance meetings and were reported on at the KPI meeting with St. James's Hospital.

There were systems were in place for the tracking and trending of patient-safety incidents. The number of incidents reported from the beginning of 2025 to the time of inspection were 411 patient safety incidents. The incidents were trended into falls, wounds, elopement, responsive behaviour and safeguarding. Inspectors

reviewed analysis of trending of incidents. For example, the analysis for fall incidents included: if witnessed or unwitnessed, by time of day, location and where on the unit the fall occurred. The analysis also included actions, responsible person and timeframe for completion which is an example of good practice.

Incidents were categorised into incidents and serious incidents. Serious incidents included an incident that had the potential for harm. A root cause analysis (RCA) was carried out when any serious incident occurs. Inspectors reviewed a sample of RCAs completed by the senior nursing team and the reports included findings, recommendations, and actions implemented and arrangements for sharing and learning. All RCAs were reviewed by the group's governance team and discussed at the Clinical Governance meeting at the facility.

Staff who spoke with inspectors were able to describe how a patient-safety incident was reported and were aware of the most frequently occurring incidents in the facility.

Medication safety incidents were categorised into the type of error: administration, dispensing, documentation, storage, monitoring, ordering and prescribing. There were a total of 99 medication safety incidents reported from the beginning of 2025 to the time of inspection. Medication safety incidents were discussed at the Clinical Governance meeting and were reported at the KPI meeting with St. James's Hospital.

The facility effectively identified, managed, responded to and reported on patient-safety incidents. There was evidence that information from patient-safety incidents was shared with relevant governing committees and staff at the facility to share learning and promote improvement.

Judgment: Compliant

Conclusion

Capacity and Capability

There were governance arrangements at CareChoice Parnell Road facility with group oversight in place. The Clinical Governance meeting had oversight of the stepdown facility's performance and there was a formalised upward reporting structure to the group. There were management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services. There

were systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. However, the frequency and number of patient transfers for a higher level of care, whilst performed to keep patients safe should continue to be monitored closely to ensure processes are efficient and effective.

CareChoice Parnell Road planned, organised and managed their workforce to provide quality, safe and reliable healthcare. Review of training records received demonstrated good levels of training compliance.

Quality and Safety

There was evidence that management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the facility however, consideration could be given to further promoting autonomy particularly for longer-stay patients.

There were systems and processes in place to identify, evaluate and manage immediate and potential risks to people using the service but further actions was required. The processes in place with regards the use of INEWS and a second observation chart would benefit from a review. In the case of a deteriorating patient, increased frequency of observations was not undertaken. The processes in place with regards the use of INEWS and a second observation chart would benefit from a review. The escalation and response protocol requires review to reflect onsite arrangements for medical personnel. Medicines did not have consistent identifiers and the storage of high-alert medicines needs attention.

All policies, procedures, protocols and guidelines should be reflective of local clinical practice, support decision making, reflect resources available at the facility and support best practice.

Inspectors saw evidence that care was planned and delivered to meet the individual service user's initial and ongoing assessed needs. Management should ensure that all actions detailed in the care plan are carried out, that visual clues are correct and that care plans are kept updated to reflect a change in a patient's condition.

There were effective processes in place to respond promptly and openly to complaints and concerns made by patients and or their families. Management effectively identified, managed, responded to and reported on patient-safety incidents.

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

Compliance Classifications
An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the 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	Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	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	Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.2: Care is planned and delivered to meet the individual service user's initial and ongoing assessed needs, while taking account of the needs of other service users.	Substantially Compliant

Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan for CareChoice Parnell Road.

Inspection ID: NS_0172

Date of inspection: 26 and 27 November 2025

Compliance plan provider's response:

Standard	Judgment
3.1	Partially Compliant

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

It was identified that

1. In the case of a deteriorating patient, increased frequency of observations was not undertaken, as per local policy and this policy requires review to reflect onsite resources.

In order to fulfil this requirement

The policy on the Management of the deteriorating patients has been reviewed to ensure it aligns the current onsite resources, staffing levels, and clinical supports available.

The practice of the use of two separate observation charts has been discontinued in the facility and only the iNews observation chart is now in use to ensure consistency and support safe clinical monitoring. Clear guidance will continue to be provided to staff regarding observation frequency, escalation pathways, and documentation requirements for deteriorating patients.

At present, two NCHDs are onsite Monday to Friday to provide enhanced clinical support to the GP service.

Staff education and training will be reinforced to ensure that all clinical staff are aware of the updated policy and the importance of escalating care when required.

Compliance with the revised policy will be monitored through regular audits, clinical supervision, and governance oversight.

2. There was a lack of consistency in the use of patient identifiers on all medicines

In order to fulfil this requirement

The facility has reviewed its practices to address the use of patient identifiers on PRN medicines and medicines not suitable for sealed compartments. When supplied by pharmacy, these medicines display one patient identifier (patient name) only. These medicines were and continue to be only administered following verification against the Kardex/MAR and the patient’s identification band, providing a second and third identifier at the point of administration.

The Facility will ensure that individual insulin pens will have a printed label applied, to include name, DOB and opening date. The Pharmacy will continue to label the insulin box for the specific patient.

The facility will continue to provide targeted education and training to all clinical staff on correct patient identification procedures, including the safe administration of medicines.

The facility will continue to ensure Nurses' carry out their mandatory annual HSEland Medication Management training that educates on correct patient identification and safe administration of medicines.

The facility will continue with scheduled medication safety audits and completion of checklists to ensure compliance with patient identification processes.

3. High-alert medicines were not stored separately to other medicines

In order to fulfil this requirement

The facility acknowledges the importance of safe storage of High-Tech medicines and follows professional guidance to minimise the risk of medication error and to support safe medicines management.

The facility will implement dedicated insulin only shelves in each refrigerator on every floor. Insulin products will display 2 patient identifiers on the box packaging

and nurses will apply a printed label with name, DOB and open date to the insulin pens.

4. lack of identification of different actions undertaken for cohorts of patients on the infection prevention and control signage on patient doors

In order to fulfil this requirement

The facility has reviewed its current infection prevention and control (IPC) signage to ensure it clearly distinguishes between different patient cohorts and the specific precautions required for each.

The facility has updated the policy and standardised IPC signage to clearly indicate required actions (e.g., contact precautions, droplet precautions, use of personal protective equipment).

The facility will continue to provide education and training to all staff on the correct use, interpretation, and updating of IPC signage in line with the HSE/Resist guidelines.

The facility continues to implement a regular audit process to monitor compliance with Infection Prevention and control practices and identify any gaps.

The facility continues to include findings from audits in governance meetings to inform ongoing improvements in infection prevention and control practices.

5. Policies, procedures, protocols and guidelines should guide practice in the clinical area, support decision making, reflect resources available at the facility and support best practice.

In order to fulfil this requirement

Transfer data will continue to be reviewed monthly at the Clinical Governance meeting with a reinforced emphasis on reason for transfer out, any delays, INews score etc.

The facility will use learning from transfer reviews to support decision making and best practice.

The facility will continue to monitor the effectiveness of implemented actions through ongoing performance monitoring and audit.

The policy and escalation and response protocol have been reviewed to reflect current monitoring practices and ensure clarity in the management of deteriorating patients and regarding medical personnel to accurately reflect onsite arrangements and escalation pathways. The Risk management policy has been amended to clearly define the process for escalating risks to Senior Management. The facility will continue to educate staff on revised policies to ensure safe, informed decision-making. The facility will ensure ongoing monitoring and auditing to ensure policies remain current and reflect clinical practice.
Timescale: Q1 2026