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:	Tallaght University Hospital
Centre ID:	OSV-0001002
Address of healthcare service:	Tallaght Dublin 24 D24 NROA
Type of Inspection:	Announced
Date of Inspection:	10/03/2026 to 11/03/2026
Inspection ID:	NS_0193

About the healthcare service

Model of hospital and profile

Tallaght University Hospital (TUH) is a model 4* voluntary public acute hospital. It is situated in the HSE's Dublin and Midlands Health Region.† The hospital provides local, regional and national specialties, including dialysis services and is a designated trauma unit. Tallaght University Hospital provides access for patients to over 20 medical and surgical specialities, with comprehensive on-site laboratory and radiology support services. The hospital has a directorate structure. The directorates are medicine, perioperative, emergency medicine, radiology and pathology.

The following information outlines some additional data on the hospital.

Number of beds	472 inpatient beds onsite 48 offsite beds at Tymon North 125 day case beds

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare Version 2 2024* (National Standards) as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare.

To prepare for this inspection, the inspectors‡ reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publicly available information since last inspection.

* A Model 4 hospital is a tertiary hospital that provides tertiary care and, in certain locations, supra-regional care. These hospitals typically have a category 3 or speciality level 3(s) Intensive Care Unit onsite, a Medical Assessment Unit, an Emergency Department, including a Clinical Decision Unit on site.

† The Regional Health Area HSE Dublin and Midlands provides health and social care services to Dublin South City and West and Dublin South West, Kildare, West Wicklow, Laois, Offaly, Longford and Westmeath.

‡ 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.

During the inspection, inspectors:

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

About the inspection report

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

1. Capacity and capability of the service

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

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)
10/03/2026	*09:00 – 17:25*	Maeve McGarry	Bairbre Moynihan Eileen O'Toole Elaine Farrelly Jennifer Smyth Sorcha Burns
10/03/2026	*18:00 – 20:10*§		Eileen O'Toole Jennifer Smyth
11/03/2026	*08:30 – 16:00*	Maeve McGarry	Bairbre Moynihan Eileen O'Toole Elaine Farrelly Jennifer Smyth Sorcha Burns

§ At this time inspectors visited an offsite ward located at Tymon North, which is under the governance of Tallaght University Hospital

Information about this inspection

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

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

The inspection team visited five clinical areas:

- Emergency department
- Vartry Unit (renal unit)
- Tymon North Unit (offsite inpatient acute medical gerontology unit)
- Franks Ward (surgical ward)
- Ruttle Ward (medical ward).

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

Acknowledgements

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

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

During the inspection, inspectors spoke with 25 patients about their experience at Tallaght University Hospital. Overall, patients were complimentary about the care they received. In the emergency department patients said that the "care was great" and while it was noted that staff were busy, they commented also that "staff are doing their best" and that "staff are kind".

[**] 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.

Patients in the unit at Tymon North were complimentary about the facility and care received by staff, noting "staff are lovely" and that "food is good with plenty of choice". It was also conveyed that staff were attentive and responsive when assistance was needed.

Patients in the Vartry Renal Unit spoke positively about the care received, noting that the care "could not be better". Inspectors observed that the environment was pleasant and welcoming. Art classes were offered to patients and their artwork was on display.

Patients who spoke with inspectors were not aware of how to make a complaint if needed, but most indicated that would speak with a staff member if they had any concerns.

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 and use of resources.

Tallaght University Hospital was found to be compliant with national standard 5.2, substantially compliant with national standards 5.5 and 5.8, and partially complaint with national standard 6.1 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.

Tallaght University Hospital had clear corporate and clinical governance structures for assuring the delivery of high quality, safe and reliable healthcare. Organisational charts clearly outlined responsibilities, accountability and oversight arrangements for management structures and governance committees. The governance arrangements described to inspectors by staff and management were consistent with the hospital's organisational charts.

The chief executive officer (CEO) was the senior accountable officer with overall responsibility for the hospital and reported directly to the Tallaght University Hospital

(TUH) Board of Directors. The Board was overseen by a chairperson and was supported by six subcommittees, including the Quality, Safety and Risk Management Subcommittee. The Board members, the CEO and senior representatives of the Executive Management Team (EMT) attended Board meetings. The TUH Board had a strategic plan for 2025–2029, which set out key objectives and guided the development of hospital services.

Tallaght University Hospital provides services for the Health Service Executive (HSE) under a service-level agreement, and the hospital is situated within the HSE Dublin and Midlands health region. In line with the service-level agreement, the hospital's CEO had a working relationship with the regional executive officer via an integrated healthcare area (IHA) manager. Hospital management met monthly with the IHA manager to review performance indicators, focusing on key metrics for both scheduled and unscheduled care.

The chief executive officer (CEO) was supported by an Executive Management Team (EMT), which provided oversight and governance of service delivery at the hospital. Membership of the EMT included the deputy CEO, the chief operating officer (COO), the director of nursing and integrated care, and the director of quality, safety and risk management. Since the previous inspection, changes in the EMT had occurred, with the appointment of a new CEO and COO. The clinical directors of each of the five clinical directorates were also members of the EMT. A sample of meeting minutes submitted to HIQA indicated that the EMT was meeting every two weeks. At the time of the inspection, a corporate and clinical governance developmental review was ongoing, commissioned by the CEO. The project charter for this review indicated that it had been established to assess the maturity and effectiveness of the current governance arrangements in supporting the TUH Board's strategic objectives.

Nursing services were under the responsibility of the Director of Nursing and Integrated Care. The hospital had a directorate structure and since the HIQA inspection in 2024, now had five clinical directorates with the addition of the emergency medicine directorate. Staff in the emergency department outlined to inspectors that this represented an improvement and they felt greater represented under the new structure. The clinical directors of each of the directorates were members of the hospital's EMT. The hospital also had a Medical Board, which had a reporting relationship directly to the TUH Board and to the CEO.

The Quality, Safety and Risk Management (QSRM) Executive Governance Committee oversaw the operation of quality and patient safety at Tallaght University Hospital and functioned under terms of reference, which were in date. The committee reported to the QSRM Board Committee quarterly, to the hospital Board monthly and to the Executive Management Team monthly. A total of 19 subgroups reported to

the QSRM Executive Governance Committee in line with an annual work plan and schedule. Reports were in a template format, which included key performance indicators (KPIs), risks, and learning. Committees and subgroups which reported to the QSRM Executive Governance Committee included; the Infection Prevention & Control Governance Committee, the Drugs and Therapeutics Committee, the Medication Safety Committee, the Deteriorating Patient Group and the Sepsis Steering Committee.

The hospital had, and at the time of inspection was in the process of further expanding offsite bed capacity. In July 2025, HIQA carried out an inspection at offsite wards under the governance of Tallaght University Hospital (TUH) located at the community unit in Tymon North. This clinical area was revisited on this inspection and notable improvements were identified in governance arrangements and operational oversight. Inspectors noted improved integration with TUH committees and governance structures, enhanced on-site presence from nursing management and inclusion in quality walkarounds. While medications continued to be supplied from a community pharmacy to the unit at Tymon North, medication management practices were now aligned to TUH practices.

Overall, the hospital had integrated corporate and clinical governance arrangements in place to support the quality and safety of healthcare services provided. Inspectors noted that a locally commissioned corporate and clinical governance review was in progress at the time of inspection. Governance structures, operational oversight and integration of the unit at Tymon North had improved since the previous inspection.

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.

Overall, the hospital had effective management arrangements to support the delivery of safe, high quality and reliable healthcare services. Committee structures were in place to provide oversight of key areas, including infection prevention and control, medication safety, the deteriorating patient and safe transitions of care. As per findings of the previous inspection, the demand-capacity deficit continued with challenges in meeting demand for both unscheduled and scheduled care. However, inspectors found that arrangements were in place to manage patient-flow and escalation.

Management arrangements were supported by TUH Quality and Patient Safety Leadership walk arounds which involved onsite visits to clinical areas in the hospital

by the CEO and senior leadership team. The approach was structured and clinical areas were assessed against *National Standards for Safer Better Healthcare* themes. The walk arounds took place every two weeks and visits to clinical areas alternated between announced and unannounced and findings were documented with actions required and assigned to responsible persons.

The hospital's pharmacy service was overseen by the head of pharmacy, who reported to the chief operations officer and was part of the EMT. Medication safety was discussed at monthly quality and patient safety meetings. Clinical governance for medication safety at the hospital was provided through the Drugs and Therapeutics Committee, which was chaired by a medical consultant and reported to the QSRM Executive Governance Committee on an annual basis, most recently in March 2025. The terms of reference of the committee were developed in June 2023 and were due to be reviewed after three years. A medication safety managers' report was provided to the Drugs and Therapeutics Committee and discussed as part of the agenda which included incidents and near misses, and current medication safety initiatives and risks. The hospital's Antimicrobial Stewardship Committee was a subcommittee of the Drugs and Therapeutics Committee and presented reports to it.

The hospital also had a medication safety committee, which reported to both the Drugs and Therapeutics Committee and the QSRM Executive Governance Committee annually. The committee was chaired by the medication safety manager. There was a Medication Safety Strategy in place for 2026, which included strategic goals. Overall, there were effective oversight arrangements for management of medication safety at the hospital.

The hospital's infection prevention and control (IPC) team was multidisciplinary and included; consultant microbiologists, microbiology registrars, surveillance scientists, antimicrobial pharmacists, an IPC assistant director of nursing, IPC specialist nurses and administrative support. The Infection Prevention & Control Governance Committee (IPCGC) had oversight of the infection control programme. Meeting minutes indicated that the committee met quarterly, in line with terms of reference, and was chaired by the deputy CEO. The committee reported to the QSRM Executive Governance Committee annually. The committee was responsible for monitoring healthcare associated infections rates and other IPC key performance indicators. Rates of hospital-acquired infections were collated and reported as part of the monthly quality and safety performance metrics. An IPC programme was in place for 2026, which was a work programme aligned to a wider IPC strategy in place for 2024-2028. The IPCGC completed an annual report for 2025, which outlined training and audit activity, surveillance and IPC incidents. The IPCGC had a number of subcommittees including the Air and Water Committee, Surgical Site Infection

Steering Group and Decontamination Committee.

Since the last inspection of Tallaght University Hospital in 2024, an overarching Deteriorating Patient Group had been implemented which was chaired by a consultant anaesthesiologist. This group had oversight of the emergency response system and team, early warning systems, sepsis and the standardised communication tool, Identify, Situation, Background, Assessment and Recommendation (ISBAR)[***]. The national early warning systems in use at the hospital were; the Irish National Early Warning Score (INEWS), the Irish Maternity Early Warning System (IMEWS), and the Emergency Medicine Early Warning System (EMEWS) which had been implemented since the time of the previous inspection. There were clinical leads in place for each early warning system used at the hospital. A project had been initiated to evaluate a digital early warning system in one clinical area, but due to technical challenges associated with increasing the frequency of observations the digital system was not implemented. The terms of reference of the Deteriorating Patient Group provided to inspectors were not ratified and did not fully reflect the committee's reporting structure. The terms of reference indicated that the group reported to the Executive Management Team but there was evidence that the group reported to the QSRM Executive Governance Committee as part of the annual schedule.

The hospital had an Unscheduled Care Committee that was an operational meeting, chaired by the chief executive officer, but was not meeting monthly in line with its terms of reference. Unscheduled care was also monitored at the Executive Management Team meetings, which took place every two weeks. A Community Hospital Integration Forum (CHIF) took place every two weeks. Further meetings took place with external services providing offsite bed capacity.

Patient flow, hospital capacity, activity and fluctuations in service demand were monitored and managed through daily huddles and patient journey rounds, and monthly operational meetings. Under new hospital management there was an emphasis on using huddles throughout the day to support effective patient flow and to respond to increases in service demand. Multidisciplinary patient journey rounds took place in ward areas attended by representatives of the Executive Management Team evaluating length of stay and predicted discharge. In addition, there were four huddles per day to manage daily hospital activity commencing with a 7.30am huddle in the emergency department and a 9.30am senior executive huddle.

The hospital's occupancy rate in 2026 up to the time of inspection was 111%. There was an ongoing mismatch between demand and available hospital inpatient bed

[***] ISBAR =**I**dentify, **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation), a technique used to facilitate prompt and appropriate communication in relation to patient care and safety is used for clinical handover.

capacity, which affected the emergency department. In response to deficits in inpatient bed capacity, there was a range of offsite capacity being accessed and utilised. Some offsite capacity was operating under the hospital's governance such as two wards located at the unit at Tymon North and Ward C, which is located at St. Luke's Hospital in Rathgar. Tallaght University Hospital also had access to beds in facilities under the governance of external healthcare providers.

The hospital was in escalation at the time of the inspection, and there was an approved escalation plan to address demand for urgent and emergency care, which was part of the patient journey policy. The emergency department was operating above its planned capacity of 45 treatment bays with 80 patients registered, 16 of whom were accommodated on trolleys and there were 19 admitted patients awaiting an inpatient bed in the department. The acute medical unit, acute surgical assessment unit and the age related assessment unit were not functioning as intended on the days of inspection and were accommodating admitted patients. In addition, on the day of inspection, three surge trolleys were in use on the wards. The senior intervention following triage (SIFT) workflow which was designed to improve patient flow and had been resourced since the previous inspection, was not operational as the additional staff were redeployed within the emergency department to manage increasing presentations. There were 63,331 emergency department attendances in 2025, which represented a 5.5% increase on the previous year and a 15% increase in ED presentations between January 2025 and January 2026. Attendances by patients aged 75 years and older increased by 11% between 2024 and 2025. However, there was clear prioritisation to meet Patient Experience Times (PETs) targets, particularly the 24-hour PETs for patients aged 75 years and older, which had improved along with other unscheduled care metrics, despite increasing attendances. Data presented to the hospital Board highlighted the improvements in unscheduled care metrics but also noted deterioration in some scheduled care metrics for inpatient and day case waiting lists. Furthermore, inspectors reviewed minutes of the hospital's medical board which outlined concerns about the impact of unscheduled care on scheduled care, as services competed for resources. Key risks on the hospital's corporate risk register included both hospital overcrowding, and the cancellation of elective surgery and procedures due to prioritisation of unscheduled care, which reflected the complexity of competing priorities and associated challenges for effective management arrangements.

Overall, the hospital had effective management arrangements in place to support and promote the delivery of safe and reliable healthcare services, despite increasing emergency department presentations, challenges with hospital overcrowding and competing clinical demands. A number of initiatives designed to improve patient flow and patient experience were not operational on the day of inspection. The terms of reference for the Deteriorating Patient Group require updating and the Unscheduled

Care Committee was not meeting in line with its terms of reference.
Judgment: Substantially Compliant

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

The hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services. The quality, safety and reliability of healthcare services were monitored by the Quality, Safety and Risk Management (QSRM) directorate, which was under leadership of a hospital consultant. Performance data and metrics were reported from the chief executive officer (CEO) and the QSRM Executive Governance Committee to the TUH Board of Directors via *The Board Integrated Management Report* which provided updates on key areas within the organisation.

The CEO had oversight of the hospital's risk management processes and was responsible for the hospital's corporate risk register. There was evidence of good oversight of the corporate risk register which was kept up to date and updates of risks added and closed were communicated up to hospital Board level. Risks were escalated to the corporate risk register following discussion with the CEO and noting at the Executive Management Team.

The hospital had systems in place to identify and manage patient safety incidents through a local Serious Incident Management Team (SIMT) chaired by the Clinical Director of Quality Safety and Risk Management. The SIMT ensured that all serious reportable events and incidents were recorded on the National Incident Management System (NIMS) and managed in accordance with the HSE's Incident Management Framework. A sample of minutes reviewed indicated that the SIMT was meeting monthly, and as per the terms of reference, inspectors were informed that the SIMT would meet urgently in the event of a serious incident. A summary of SIMT activity and incidents was reported at monthly Board meetings. There was evidence of proactive identification, documentation and monitoring of patient-safety incidents with trending of incidents collated per clinical area. The offsite wards at the unit at Tymon North were included in the data but not all offsite wards were accounted for, which represents an opportunity for improvement.

The hospital had systematic monitoring arrangements in place for overseeing clinical audit activity. Inspectors observed a proactive approach to audit, with evidence provided of audit across the four areas of harm which were the focus of this inspection – infection prevention and control, medication safety, the deteriorating

patient and transitions of care. The hospital had a high-level overall annual audit plan in place with 13 topics and a schedule. There was an Audit Committee in place, which monitored audit activity across the services. Audit activity and the implementation of quality improvement plans arising from audit findings was the responsibility of the clinical directorates. There was evidence of proactive monitoring of medication safety practices through targeted audit activity which was a positive initiative and findings were clearly communicated. However, the audits focused on on-site wards and not all the offsite wards were included in all these audits.

Patient complaints and feedback was under the responsibility of nursing governance with oversight in place up to Board level. Relevant performance metrics were reported to the Board through a performance dashboard. Since the inspection at the unit in Tymon North, changes had been made to the triage of complaints with enhanced oversight of complaints received.

As outlined under national standard 5.5, the hospital had expanded offsite bed capacity, with some beds under the governance of Tallaght University Hospital and other beds under governance of external healthcare providers. Criteria for each service was set out but not formalised. A report submitted as part of monthly meetings with one external provider was seen to be comprehensive, and included incident rates and length of stay. However, the oversight arrangements was not consistent across external services.

Overall, the hospital had effective oversight and monitoring arrangements in place, supported by dashboards and performance metrics, which were reported to the Executive Management Team and the Hospital Board. Offsite wards under the governance of Tallaght University Hospital were not always included in audit activity and incident metrics. As offsite services providing bed capacity continued to expand, there was opportunity to enhance oversight arrangements through a consistent approach to their management and evaluation.

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.

Hospital management had systems in place to plan, organise, and manage the workforce. In January 2026, the total workforce at the hospital was 3719 whole-time equivalents (WTE). Workforce updates and human resources (HR) data were

communicated via directorate meetings with the chief executive officer and upward to the Hospital Board.

The absenteeism rate was 6.47% in January 2026 was which is above the HSE's target absenteeism rate of ≤4% and data seen by inspectors indicated that the rates of absenteeism had been trending upwards. HR management indicated that back-to-work interviews were conducted and that staff could self-refer to the employee assistance programme and an onsite occupational health service. Further strategies were in place to support staff such as resilience training provided to emergency department staff by a staff support psychologist. At the time of the inspection, there were no risks on corporate risk register in relation to recruitment or staffing levels.

Since the previous inspection in 2024, challenges in relation to pharmacy staffing levels had improved to a vacancy rate of less than 10%. All onsite inpatient areas were now supported by a clinical pharmacy service including Ormsby Ward, Lane Ward and at the time of inspection a service to the emergency department was being re-established. There was no clinical pharmacy service in place at the offsite wards at the unit at Tymon North and inspectors were informed that there was no service at the ward located in Ward C, also offsite. However, since the previous inspection, the unit at Tymon North now had onsite pharmacy and technician presence, which was an improvement in the allocation of resources.

The emergency department was operating with almost a full complement of staff on the day of the inspection. Vacancies included one clinical nurse manager 1 post and one healthcare assistant. The non-consultant hospital doctor complement for the emergency department was 32 and 7.8 WTE consultants. In addition, there were two registrar posts unfilled. There was now a lead clinical director, which was a change since the 2024 inspection. Nursing staffing in line with the *Framework for Safe Nurse Staffing and Skill Mix*[†††] had not been implemented in the emergency department and the approved staffing complement of 60 staff nurses was in place. While there had been an uplift in specialist posts, with a funded complement of 19 specialist nursing posts in place, inspectors were informed that there no increase in staff nurse numbers since 2016, despite 27% increase in attendances and increased patient acuity. A review carried out internally by nursing management estimated an increase of 28 WTE nursing staff was needed. Inspectors reviewed duty rosters and while overtime was offered, there were significant gaps identified with unfilled shifts due to sick leave and other leave, which was not covered. In the week preceding the inspection, there were gaps recorded in the roster each day for staff nurses, with six shifts remaining unfilled on one day. While the impact of these staffing shortfalls

††† ††† Framework for Safe Nurse Staffing and Skill Mix

were not observed on the day of inspection, inspectors were informed that staffing arrangements were challenging during periods of increased activity.

In other clinical areas visited, overall staffing levels were found to be adequate. Safer nursing staffing was in place in other clinical areas visited, with the exception of the unit in Tymon North. However, as per findings of the previous inspection at unit in Tymon North, some patients who required enhanced care observation (ECO) as a supportive intervention were not allocated the required resource as per hospital policy. For example, one healthcare assistant was observed caring for two patients who required one-to-one supervision. At the unit in Tymon North, there were 21.9 approved healthcare assistant posts and 19.4 posts actually filled. On Franks ward, while patients requiring enhanced care observation were cohorted, gaps in resourcing of ECO were also observed. Hospital management outlined challenges in resourcing ECO, attributed to increasing clinical need for enhanced care and a reliance on usage of agency healthcare assistants where resources above the complement were required.

The hospital had a system in place to manage mandatory and essential training, which was overseen at directorate level, and clinical directors collated monthly compliance reports. Records indicated varying levels of staff attendance at and uptake of mandatory and essential training across disciplines.

Overall, training records reviewed by inspectors indicated the following uptake levels mandatory and essential training:

- Standard and transmission based precautions: 75% of nurses, 72% of health and social care professionals, 68% of healthcare assistants, 100% housekeeping staff and 18% of doctors
- Hand hygiene: 91% of nurses, 90% of health and social care professionals, 89% healthcare assistants, 100% of housekeeping staff and 67% of doctors
- Medication safety: 83% of nurses and 9% of doctors
- Irish National Early Warning System (INEWS): 79% of nurses and 40% of doctors
- Basic life support: 64% of nurses and 38% of doctors
- ISBAR: 86% of nurses and 9% of doctors
- Sepsis 83% of nurses and 68% of doctors.

The hospital had a schedule in place of infection, prevention and control mandatory training and used modules delivered on HSELand. However, as indicated above, the recorded rates of compliance for doctors were poor across the mandatory training areas, particularly in relation to hand hygiene, standard and transmission based precautions, INEWS and basic life support. Compliance with hand hygiene was good

across all staff groups, with the exception of doctors. Records also demonstrated good rates of compliance among housekeeping staff.

On the ward areas visited, reasonable compliance with mandatory training by nurses and healthcare assistants was reported. However, compliance with mandatory training was lower in the emergency department, for example, records indicated; 39% of nurses had up-to-date standard and transmission based precautions training, 59% nurses had up-to-date hand hygiene training and 100% of nurses, where relevant, had completed training on the Manchester Triage System. Compliance rates were higher with Emergency Medicine Early Warning System (EMEWS) training, at 82% for nurses and 68% for doctors.

Overall, systems were in place to plan, organise, and manage the workforce. Staffing in place for nursing was in line with the assigned complement. There was improvement in vacancy rates within the pharmacy department since the previous inspection and a resultant improvement in the provision of clinical pharmacy services. Hospital management should consider the staff nurse complement relative to increasing activity levels in the emergency department to ensure adequate staffing levels are in place. As per findings of the previous inspection at the unit in Tymon North, enhanced care observation was not fully resourced in line with hospital policy in two of the clinical areas visited and this needs to be addressed. The oversight of mandatory and essential training requires focus, as records indicated low compliance rates particularly among doctors and in the emergency department.

Judgment: Partially Compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred.

Tallaght University Hospital was found to be compliant with national standard 1.7 and 1.8, substantially compliant with national standards 3.1 and 3.3 and partially compliant with national standards 1.6 and 2.7. 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.

Through observations and discussions with staff, it was evident that staff respected and promoted the dignity, privacy and autonomy of patients.

The infrastructure at the unit at Tymon North supported patient's dignity, privacy and autonomy as patients were accommodated in spacious single rooms, all of which were ensuite. Other clinical areas visited had patient family rooms for private conversations. However, the short stay trauma bay on Frank's ward was a mixed gender bay, which was used for patients before surgery only. The use of the bay for mixed genders was risk assessed.

At the time of inspection, three patients were accommodated on trolleys in ward areas of the hospital. Patients were also observed accommodated on trolleys, which were in close proximity to one another on corridors of the emergency department. Patients accommodated on trolleys did not have access to call bells. In the emergency department, staff were observed making efforts to maintain dignity by transferring patients to cubicles and using privacy screens for examinations. In addition, patients who arrived by ambulance were moved into a cubicle for triage and family rooms were available for use. The emergency department had a sensory room available for patients with sensory sensitivities. Hospital overcrowding presented challenges to maintaining patients' dignity and respect and was not consistent with a human rights-based approach to care supported and promoted by HIQA.

Healthcare records were appropriately stored in locked trolleys, and personal information was handled securely in the clinical areas visited supporting patient confidentiality. In the dialysis unit, closed circuit television (CCTV) was in operation as was indicated by signage, which stated it was not recorded. Hospital policy stated that clinical areas should not be captured by CCTV, however, inspectors observed that an isolation room in the dialysis unit was observable via CCTV. Inspectors discussed this issue with senior management and were informed that this monitoring was in place for patient safety and that the monitor was switched off for personal care, however, the practice was not in line with local policy.

Overall, staff promoted a person-centred approach to care. However, mixed gender bays were in use and hospital overcrowding did not support patient's dignity, privacy and autonomy. The use of CCTV observed in one clinical area was not used in line with local policy and should be reviewed in line with best practice and in accordance with relevant data protection requirements.

Judgment: Partially Compliant

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

The hospital promoted a culture of kindness, consideration and respect. Inspectors observed staff interacting with patients in a kind and sensitive manner.

Since the previous inspection of the unit in Tymon North, there was improvement in compliance with this national standard. Patients who spoke with inspectors indicated that staff answered requests for assistance promptly. Patients who spoke with inspectors indicated that they were offered showers daily and assistance with personal care. Patients were aware of their plan of care.

Some patients who spoke with inspectors reflected positive experiences with Frank's Ward while others felt there were delays in receiving assistance when requested.

In the emergency department, leaflets were available through emergency department patient information leaflets about medical conditions. Information was available on a screen in the emergency department waiting room which had subtitles in multiple languages. Patients were complimentary about kindness shown by staff but understood staff were busy and that they were "working flat out" "couldn't speak more highly of staff – they are so busy".

Overall, while there was evidence that management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital.

Judgment: Compliant

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

The hospital had systems and processes in place to respond to complaints and concerns. There was evidence of improvement in the management of complaints since the previous inspection carried out at the unit at Tymon North supported by onsite staff training on complaints management and improved triage to identify complaints for escalation.

The management of complaints and patient feedback was carried out by the Patient Advice and Liaison Service (PALS), which was the primary point of contact for patients, families and carers when engaging with the hospital. The PALS team operated within the nursing governance structure. The PALS manager was the designated complaints officer for the hospital and was responsible for managing

complaints. In their absence, the deputy PALS manager acted as the designated complaints officer.

Complaints received were triaged daily by the PALS team and escalated to the director of nursing and integrated care. Every two weeks a meeting took place between the PALS team and the director of nursing and integrated care to discuss and monitor complaints received. There was representation from the PALS team on hospital safety walkarounds, which took place every two weeks. In addition, a monthly meeting was held between the PALS team and the emergency department.

Complaints and compliments were reported to the QSRM Executive Governance Committee through monthly casebooks. Complaints were included as part of the integrated management report metrics which reported at the Hospital Board meetings. This reporting outlined the number of complaints received each month, year-to-date totals, percentage variation from previous periods, and the number of complaints completed. Furthermore, each Board meeting was opened with a reflection drawn from the casebook of patient feedback reflecting experiences from compliments and complaints. This was a positive initiative to capture patients and their experiences as part of wider strategic discussions.

Patients who spoke with inspectors were not aware of the complaints procedure but stated they would speak with a nurse if they had a complaint to make. The Tallaght University Hospital PALS information leaflets were available in hard copy beside comment boxes in the clinical areas visited. The PALs service was promoted on digital screens in the emergency department. Since the previous inspection at the unit in Tymon North, inspectors noted improvement in the visibility of feedback boxes. Formal complaints were submitted in hardcopy format on the PALS leaflet or via email to the PALS department. The locally developed PALS leaflet included information on external review of responses by the Office of the Ombudsman. However, information on independent advocacy services was displayed in some but not all of the clinical areas visited.

Complaints resolution training was provided at induction but was not part of mandatory staff training. The PALS team had carried out onsite complaints resolution training with staff at the unit at Tymon North since the previous inspection at that site.

Complaints were resolved at the point of care whenever possible. Complaints resolved at the point of care were not recorded on the wards inspected but were captured in the emergency department. In 2025, 727 verbal complaints were resolved directly within the emergency department. This work was supported by two whole-time equivalent complaints officers who were assigned to and worked as part of the wider emergency department team. These complaints officers helped to

improve patient feedback processes by managing a substantial volume of concerns and complaints.

At the time of the inspection, 83% of complaints were investigated and responses sent to the complainant within 30 working days, which was compliant with the HSE's target (75%). Inspectors reviewed the annual performance metrics report for 2025 produced by PALS, which indicated that 2060 complaints were received. There were 11% more complaints received in 2025 compared with 2024. Complaints were reported as the number of formal and informal complaints received each month and these were analysed and trended into themes such as access, communication and information and safe and effective care, diagnosis. Under the category safe and effective care, there was some trending of complaints identified in relation to discharge care and planning.

In response to the previous inspection findings at the unit at Tymon North, which identified issues in complaints management and patient feedback, the hospital conducted a face-to-face survey with a small sample of patients. This was carried out in addition to PALS processes and to gain deeper insight into the patient experience. A survey of 17 patients in the Transition/Discharge Lounge was carried out in December 2025 with an action plan put in place to improve the environment and patient experience, including increased cleaning hours on foot on feedback on cleanliness.

There was evidence that quality improvement initiatives were introduced based on patient feedback, for example, a pathway for serious hearing impairment and deafness in the emergency department and headphones to reduce noise levels in dialysis unit. The hospital had a patient advisory council, which had been in place for 15 years and was chaired by community representative and input was sought from relevant members of the patient advisory council for some quality initiatives.

Overall, service users' complaints and concerns were responded to promptly, openly and effectively. Feedback on the patient experience was integrated into governance processes and was considered from ward level up to the Hospital Board. Access independent advocacy services was not clearly displayed in all the clinical areas inspected.

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.

The physical environment of some of the clinical areas visited by the inspectors were recently constructed or refurbished and supported high-quality, safe and reliable care. However, there was variation in the physical infrastructure, and some ward areas visited were outdated and did not support infection control practices.

At the unit in Tymon North, the physical environment supported the delivery of high quality care. The ward area visited comprised of single rooms and two, two-bedded rooms. All rooms had ensuite toilet and shower facilities. The patient rooms were spacious, clean and well maintained. Patients who spoke with inspectors were also complimentary about levels of cleanliness in the ward.

Inspectors visited the Varty Unit, which was a purpose built facility opened in 2020 that provides dialysis services. While the overall infrastructure was satisfactory, flooring in one area was worn and damaged. Dialysis machines were observed to be stored on the corridor and inspectors were provided with a risk assessment to support this practice. The risk assessment was carried out with the infection prevention and control team and controls were in place for placement on the corridor once equipment was disinfected and externally cleaned. There was also evidence of insufficient storage, with linen stored at the end of beds kept on the corridor.

On Frank's ward, the infrastructure was in a state of disrepair, required upgrading and was not maintained to an acceptable level of cleanliness. Floors were in poor condition and did not facilitate effective cleaning, and several bathrooms and shower rooms had an unpleasant odour. There was widespread wear and tear such as scuffed and chipped wall paint. Inspectors noted inadequate storage, with equipment on corridors and boxes stored on floor in a storeroom. There was also evidence of wear and tear on Ruttle ward, particularly in some ensuite facilities with issues such as wall damage, shower call bells and shower fittings. There was also damage to the surface of the medication trolley in use.

There were challenges in relation to the physical environment in the emergency department, with insufficient space to ensure physical distancing for patients accommodated on trolleys, which was not in line with national guiding principles. There were insufficient toilet and shower facilities given the volumes of presentations and one shower. In addition, four chairs were available for respiratory assessment with screens erected between them but with limited spacing. There was one negative pressure room however, the door was broken. The emergency department had two family rooms, a sensory room, and two purpose-built

psychiatric assessment rooms designed with input from mental health services.

In ward areas visited, physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms. The Transition/Discharge Lounge comprised of ten chair spaces. There was no dedicated space for doctors to review patients and so an outpatient room was used if a patient required assessment. A bottle of disinfectant was out of date, there was a lack of privacy screens and limited space between chairs.

Challenges with the availability of rooms for patients requiring isolation continued, as per findings of the 2024 inspection, and this remained a risk on the corporate risk register. While almost all rooms in the unit in Tymon North were single rooms, there was a lack of single room capacity across the hospital. A prioritisation matrix was used to place patients based on risk. Doors to isolation rooms were found generally to be closed, with two exceptions and in these cases, there were risk assessments to support them remaining open.

In clinical areas visited, wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available for staff and visitors. Hand-hygiene signage was displayed in the clinical areas. While many hand-hygiene sinks in the hospital had been upgraded, many sinks in Frank's ward did not meet the required specifications.

Cleaners who spoke with inspectors were knowledgeable about cleaning processes. In general, management of waste, including hazardous was appropriate with some exceptions noted. Cleaning schedules were found to be up to date and were signed off by cleaning supervisors in the clinical ward areas visited. There was a system was in place to identify equipment which had been cleaned using green tags and this system was seen to be in use, although in some areas this system was not consistently applied. For example on Ruttle ward, some but not all equipment was seen to be tagged in the storage room.

Overall, while clinical areas were observed to be generally clean, some issues identified by inspectors require attention:

- infrastructural issues in Frank's and Ruttle wards required repair and refurbishment
- insufficient physical space between trolleys and toilet and shower facilities in the ED
- not all hand hygiene sinks conformed to the required standards
- the system used for indicating equipment was clean was inconsistently applied
- storage was inadequate in some clinical areas.

Judgment: Partially Compliant

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

Tallaght University Hospital had systems in place to monitor, evaluate and continuously improve the effectiveness of healthcare services, using key performance indicators, clinical metrics and audit activity. These metrics were collated and monitored by QSRM Executive Governance Committee and were communicated to the Hospital Board via the chief executive officer. An annual audit schedule was in place and included audits that related to medication safety, the environment, infection prevention and control (IPC), the deteriorating patient, sepsis and the use of ISBAR handover communication tool.

Key performance indicators relating to the prevention and control of healthcare-acquired infection were reported. Hand hygiene compliance was monitored and reported up to Board level. The hospital monitored monthly rates of new cases of multidrug-resistant organisms (MDROs), including Methicillin-resistant *Staphylococcus aureus* (MRSA) and Vancomycin-Resistant *Enterococci* (VRE). Variations in monthly rates were mapped against the corresponding period in the previous year. In 2025, the rate of new cases of hospital-associated *Clostridioides difficile* (C.difficile) ranged from 0 to 7.48 per month, which was above the HSE's target (less than 2 per 10,000 bed days) for nine months of the year. A spike in rates during the summer of 2025 was attributed to increased levels of community acquisition. Hospital-acquired *Staphylococcus aureus* blood stream infections ranged from 0 to 1.8 new cases per 10,000 bed days used per month, which exceeded target levels for four months of the year in 2025. The number of new Carbapenemase-producing *Enterobacterales* (CPE) cases in 2025 was monitored and the number of CPE screens carried out.

Hand hygiene audits were carried out monthly in the clinical areas visited, in line with the annual audit plan. The overall result for the hospital in February 2026 was 85% compliant, which was slightly below the HSE's 90% target. A hand hygiene improvement strategy was in place. In the emergency department, there was evidence of a hand hygiene improvement plan based on audit results, with multidisciplinary responsible persons and timelines assigned to actions. Similarly, in Ruttle ward there was evidence of an action plan developed as a result of hand hygiene audit findings in February 2026.

The hospital conducted annual environmental audits and in the haemodialysis unit, there was evidence of an action log on foot of these findings. Environmental hygiene audits were conducted using a checklist completed by clinical nurse managers. While these were not recorded on the central audit platform they included actions, named responsible persons and associated timelines.

There was evidence of action plans in place following receipt of medication safety alerts. As part of quality care metrics, nursing staff conducted medication safety and medication storage and custody audits. In August 2025, nurse practice development carried out audits of compliance with medication safety related policies; intravenous medication policy, medication management policy including medication storage, and oral medication administration policy. Audits were conducted across 17 clinical areas with ward-specific feedback collated outlining areas for improvement and recommendations. These audit results were presented narratively rather than numerically.

Targeted audits were carried out by the pharmacy team during 2025 as part of medication safety calendar campaigns. For example, an insulin audit was completed in April 2025 to coincide with insulin safety week. This involved a review of 158 patients, 17% of whom had diabetes and a memo was developed to communicate learnings as part of educational tool for staff.

In 2025, a number of targeted medication safety related audits carried out including audits of; oral anticoagulants, allergy status, and height and weight. These audits were carried out across ward areas in the hospital but not on offsite wards. There was evidence that the unit in Tymon North was included in some targeted medication safety audits such as a targeted national point prevalence survey. This audit involved a review of 47 adult inpatient charts and a poster was developed to communicate learning points.

There was evidence that the QSRM Executive Governance Committee monitored the effectiveness of healthcare provided and presentations to this committee included data on clinical outcomes and mortality. In addition, the resuscitation officer presented annual data to the QSRM executive committee focused on in-hospital cardiac arrest data.

Irish National Early Warning System (INEWS) documentation audits were completed twice per year and a sample of 20 charts were reviewed to assess INEWS escalation and response. The aim was 80% compliance and an example was observed from one of the clinical areas visited where the escalation and response result was 28.6% and a time-bound action plan was developed, with subsequent improvement to 96.4% compliance.

In the emergency department, there was evidence that sepsis audits were completed monthly as per the annual audit plan, with gaps in compliance identified and addressed through an action plan. There was also evidence that the Emergency Medicine Early Warning System (EMEWS) was audited and that an action log was maintained to track actions arising from non-compliances, which included documentation and escalation. However, audits were completed in July 2025,

December 2025 and February 2026, which was not in line with the annual plan, which stated they were carried out every three months.

Irish Maternity Early Warning System (IMEWS) had more recently been introduced and audits of compliance were carried out towards the end of 2025. There was evidence of audits being conducted to assess compliance with documentation requirements and escalation and response, and quality improvement plans were developed to address gaps in compliance.

Identify, Situation, Background, Assessment and Recommendation (ISBAR) handover was audited as part of quality care metrics carried out by nursing staff. In October 2025, nurse practice development department carried out an audit of nursing handover and included offsite wards.

Management had committed to undertaking a hospital-wide audit of discharge summaries following a patient-safety review; however, this audit had not been completed at the time of inspection.

Overall, the hospital was systematically monitoring and evaluating the service. There was an opportunity to improve the consistency of the approach to continuous monitoring, as not all ward areas were included in relevant audit activity.

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

Local risk registers were held at ward level and were observed in the clinical areas visited, and inspectors noted that risks had mitigating actions documented. The infection prevention and control team had a risk register, as did the pharmacy department. There was a tiered escalation process to escalate risks from local risk registers at ward level to directorate level to the corporate risk register.

On day one of the inspection, the hospital was in escalation with 80 patients registered in the emergency department. There were 19 admitted patients in the department and 16 patients were patients accommodated on trolleys. Patients in the emergency department were triaged and prioritised in line with the Manchester Triage System. The waiting times ranged from:

- Registration to triage times ranged from 3 minutes to 21 minutes, with an average of 9.5 minutes.
- Triage to medical assessment ranged from 21 minutes to 96 minutes, with an average of 53.1 minutes.

- The decision to admit to actual admission to an inpatient bed ranged from 46 minutes to 4 hours and 55 minutes and the average time was 2 hours and 35 minutes.

The average triage time on the day of inspections was 9.5 minutes, which was within the HSE target of 15 minutes. Management informed inspectors that work had been done to improve the average triage wait time which in 2025 was 25.2 minutes and 29.1 minutes in 2024.

Average patient experience times (PETs) from March 2024, March 2025 and the day of inspection compared with HSE Targets

	% of all patients admitted or discharged within:		% of patients aged 75 years or over admitted or discharged within:	
	6 hours	24 hours	9 hours	24 hours
HSE Target	**70%**	**97%**	**99%**	**99%**
Tallaght University Hospital (data from the day of inspection March 2026)	54%	100%	56%	100%
Tallaght University Hospital average data from March 2025	30%	89%	35%	95%
Tallaght University Hospital average data from March 2024	40%	94%	43%	96%

In the table above, data submitted by the hospital representing PET times on the day of inspection in March 2026 is compared with the average PET times for March 2025 and March 2024. The data indicates improved compliance with the PETs, although not all targets were being met. Further data on PET times for 2025 submitted by the hospital also indicated improvement with unscheduled care key performance indicators. While ED attendances in 2025 were 5.5% higher than the previous year, breaches of the 24 hour KPI were reduced by 30%, and there was a moderate improvement in nine-hour PET compliance.

The risks of violence and aggression towards staff in the emergency department was identified as a key risk on the local risk register. A project was undertaken to improve staff safety, which introduced measures to identify and flag patients who may exhibit such behaviours, while also supporting those patients to have a timelier transition through and improved patient experience in the emergency department.

On the day of inspection there were three patients accommodated on ward corridors. Inspectors observed these patients to be ambulatory without assistance. Inspectors were provided with criteria for suitability of patients accommodated on trolleys which

was not within an approved policy or guideline, and therefore it was unclear whether the criteria were formally applied in practice.

Patients admitted to the hospital were screened for multi-drug resistant organisms (MDROs) in line with national guidelines. Outpatients in the renal dialysis unit underwent screening every three months. In the clinical areas visited, each patient's MDRO status was documented and appropriate isolation signage was in place. Patient information leaflets about MDROs were observed in one of the clinical areas visited. Staff indicated there was on site access to the infection prevention and control team members and access to microbiologists 24/7 for advice when required. There were 48 outbreaks in 2025 and there was evidence that outbreaks were appropriately managed. Inspectors reviewed an example of an outbreak report and associated action plan from July 2025. Information from outbreaks were collated and themes and key learnings were identified.

Due to increased pharmacy resources, clinical pharmacy services were available in all on-site inpatient areas which was an improvement since the HIQA inspection in 2024. From the sample of records reviewed by inspectors in the inpatient clinical areas visited, there was evidence of medication reconciliation being carried out by pharmacy team. The haemodialysis service could access support from the pharmacy team over the phone however, there was no clinical pharmacy service provided. While inspectors were informed by senior management that medication reconciliation was completed by medical staff, this was not documented. Additionally, staff communicated to inspectors that the process in place meant that inpatients could have both an inpatient and an outpatient kardex in use concurrently, and this practice was not supported by policy.

There was evidence of risk-reduction strategies in place such as lists of high-risk medicines and sound-alike look-alike drug posters on display. There were examples observed of appropriate segregation, labelling and storage of high-risk medications. Medications information was available on a mobile application and via the intranet, and intravenous medication information was available in medication rooms. Smart intravenous pumps were in use in the hospital, which represented a further risk reduction strategy and while the hospital identified a risk relating to updating the clinical knowledge libraries, mitigating actions had been put in place. Inspectors were informed that the environmental temperature of medication fridges were monitored by pharmacy technicians but were not recorded. There was an algorithm in place to guide staff on actions to take if the fridge alarmed.

At the offsite clinical area in Tymon North, there was a notable improvement in medication storage and management since the previous inspection. While medicines continued to be supplied from a community pharmacy, the service was now supported by a pharmacist on site three days per week and a technician on site one

day per week. Inspectors acknowledged the work done to improve medication storage, which had been updated and rationalised, with high-risk medications appropriately segregated, and insulin was stored and labelled correctly in line with best practice. Safety alerts were displayed and medicines information was available to staff at the point of preparation. Issues previously identified in relation to monitoring of medication fridge temperatures were resolved and there was an appropriate system in place to monitor temperatures.

There was evidence that the hospital promoted quality antimicrobial prescribing through the Antimicrobial Stewardship (AMS) Committee, which was chaired by a consultant microbiologist. An example of the work carried out included hospital participation in a HSE targeted point prevalence survey evaluating route of administration, which involved a review of 302 inpatient charts. The AMS team produced a flyer to communicate findings and a quality improvement programme was in progress at the time of inspection following on from this audit and local hospital audits.

Improvements were identified since the last inspection in 2024 with the Irish National Early Warning Score (INEWS) and the Irish Maternity Early Warning System (IMEWS) now in place. While the Emergency Medicine Early Warning System (EMEWS) was now in use in the emergency department, it was not in use in the waiting areas and therefore had not been fully implemented. The inspectors were informed that an additional resource of 5.5 whole-time equivalent nurses were needed for full implementation. Inspectors reviewed a sample of patient records and noted that escalation of care was not carried out in line with the EMEWS policy. Sepsis forms and sepsis grab boxes were observed in the inpatient clinical areas visited. Inspectors noted that two resuscitation trolleys in the emergency department had not been checked in line with policy, and this was rectified at the time of inspection.

In ward areas visited, inspectors reviewed a sample of patient records and noted that escalation of care was carried out in line with policy, although there were some gaps in documentation. Hardcopy INEWS forms were in use and documentation of escalation was in the electronic system. The ISBAR communication tool was in use for escalation of care and version three of this tool was integrated into the hospital's electronic platform. Inspectors were informed that the critical outreach team supported clinical areas 24/7 in the case of deteriorating patients.

Since the previous inspection at the unit at Tymon North unplanned transfers due to patient deterioration were now being monitored, which was an improvement in the oversight in terms of monitoring the number of transitions of care. In the latter half of 2025, for example, 27 patients were transferred from the unit at Tymon North to the emergency department.

Inpatients had planned discharge dates and the Transitional/Discharge Lounge was used to support patient flow. Physical whiteboards in the ward areas and in the operational hub were used to manage patient flow. The status of hospital activity in terms of capacity and potential discharges was recorded at four time points during the day. Inspectors were informed that daily patient flow huddles commenced at 7.30am in emergency department, followed by three senior executive huddles at intervals during the day. There was daily assessment of patients for potential suitability for offsite beds. Offsite capacity had different services available to support patients, for example, some had physiotherapy and there was varying medical support available. Transfer arrangements between onsite and offsite beds was based on patient needs. Multidisciplinary patient journey rounds were also carried out which included a review of patient's length of stay, and predicted discharges.

At the time of inspection, the average length of stay for medical patients was 11.69 days (HSE target 7.0). The average length of stay for surgical patients was 6.99 days (HSE target less than or equal to 4.5 days). Hospital management reported 10 patients experiencing delayed transfers of care.

Policies, procedures, protocols and guidelines (PPPGs) were accessible to staff via a document management system. The system for approval of PPPGs had changed since the previous inspection and PPPGs were now approved at relevant committees and came to the Executive Management Team for noting. Inspectors reviewed a sample of PPPGs relating to the four known areas of harm – infection prevention and control, medication safety, the deteriorating patient and transitions of care and found them to be in general in date, with the exception of the Risk and Incident Management Policy and the Closed Circuit Television Policy.

Overall, the hospital had systems in place to protect service users from the risk of harm and progress was noted in some areas since recent inspections. There were improvements in clinical pharmacy service provision across the hospital and medication safety practices were improved in the unit at Tymon North since the previous inspection. Trending indicated progress in relation to PET times despite increasing presentations to the emergency department. However, the hospital was not compliant with all PETs. Early warning systems were now in place, though EMEWS was not yet fully implemented. Some areas for improvement included; potential use of two medication kardexes for inpatient haemodialysis patients, escalation of care was not consistently documented, resuscitation trolleys were not consistently checked in line with policy and the average length of stay was in excess of HSE targets.

Judgment: Substantially Compliant

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

The hospital had systems in place to identify report, manage and respond to patient-safety incidents, supported by a Risk and Incident Management Policy. The senior accountable officer (SAO) at the hospital was the chief executive officer.

The hospital's Serious Incident Management Team (SIMT) had oversight of patient-safety incidents and reviews carried out on foot of such incidents. The clinical directors for each directorate were members of the SIMT. An outline of SIMT activity was part of the integrated management report presented to the Hospital Board. Arrangements were in place, supported by policy, to report mandatory notifiable incidents in line with the Patient Safety (Notifiable Incident and Open Disclosure) Act 2023.

Key updates on patient-safety incidents were provided to the Executive Management Team on trending, completion of reviews and incidents of note. A monthly quality and safety performance metrics report detailed trend analysis of patient-safety incidents, benchmarked against a defined set of metrics and key performance indicators. The hospital determined and monitored the incident rate per 1,000 bed days used (BDU), which was 31.9 in January 2026.

Staff reported incidents via electronic point of entry to the National Incident Management System (NIMS) and the hospital was 99% compliant with the national target for incidents entered onto NIMS within 30 days of notification. In relation to the national target to complete comprehensive reviews of adverse incidents within 125 days, hospital management reported that it was challenging to meet this target and in January 2026 63% of reviews were closed out within this timeline. Management attributed delays in closing out reviews to vacancies in the QSRM team and delays when multidisciplinary input was required. Reviews of pressure ulcers were now carried out by nursing instead of QSRM team to improve timeliness, however, inspectors found that there were reviews relating to pressure ulcers outstanding from 2024.

Incidents reported per discipline were tracked and trended. Clinical staff who spoke with inspectors were familiar with the requirement to report clinical incidents, could describe the process and had access to the electronic point of entry reporting system. However, inspectors noted opportunity to strengthen learning from incidents at ward level, as some staff who spoke with inspectors were unaware of the outcomes and learnings from incidents which were reported from their clinical area.

There was evidence that incidents were included in the performance reviews undertaken by Tallaght University Hospital (TUH) for contracted offsite services. For clinical areas under the governance of TUH, the trending of falls, pressure ulcers and

medication-safety incidents were analysed per ward and clinical area. These analyses included the offsite wards at Tymon North, but other offsite wards were not included in all metrics, which represents an opportunity for improvement.

Medication-related patient-safety incidents were categorised according to the severity of outcome in line with the National Coordinating Council for Medication Error Reporting and Prevention (MERP) classification system. Medication incidents were monitored by Medication Safety Committee, were thematically analysed and calculated per 1,000 bed days used. Most medication incidents were reported by nursing and initiatives were ongoing to improve reporting across disciplines. There was evidence of actions taken in response to trending, for example risk reduction strategies were put in relation to potential risks identified around discharge prescriptions. There was a staff campaign as part of medication safety week on the why and how of medication error reporting which indicated that reporting was actively encouraged.

Incidents relating to infection, prevention and control were reported at meetings of the Infection, Prevention and Control Committee and as part of quality and safety performance metrics. The majority of incidents reported were related to patient placement issues due to a lack of isolation rooms. Hospital acquired line related *Staphylococcus aureus* bloodstream infection cases were reviewed by the Serious Incident Management Team following completion of a root cause analysis.

Overall, there were systems in place to identify, manage, respond to and report patient-safety incidents. While there was oversight of trending of incidents, reviews carried out on foot of patient-safety incidents were not always timely. The national target to complete comprehensive reviews of adverse incidents within 125 days was not being met and there were some reviews outstanding from 2024. There was opportunity to strengthen staff awareness of learnings from patient-safety incidents.

Judgment: Substantially Compliant

Conclusion

An announced inspection of Tallaght University Hospital was carried out to assess compliance with the *National Standards for Safer Better Healthcare*. Overall, the hospital was found to be compliant with three national standards (5.2, 1.7 and 1.8), substantially compliant with five national standards (5.5, 5.8, 2.8, 3.1 and 3.3) and partially compliant with three national standards (6.1, 1.6 and 2.7).

Capacity and capability

Corporate and clinical governance arrangements were in place and the hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe, reliable healthcare services. Since the previous inspection at the Tallaght University Hospital (TUH) in 2024, there were changes to the Executive Management Team with a sustained focus on the management of unscheduled care. Improvements were evident in relation to some emergency department patient experience times. However, as per previous findings, the demand-capacity deficit for inpatient beds continued, resulting in hospital and emergency department overcrowding and challenges in meeting demand for unscheduled and some scheduled care.

An unannounced inspection was carried out at an offsite ward located in Tymon North under TUH's governance in July 2025. On this inspection, there was evidence of improved oversight, governance and integration of the service, with enhanced on-site presence from nursing management and the Executive Management Team. Improvements were also observed in medication management practices and feedback from patients who spoke with inspectors was more positive.

Overall, workforce arrangements were in place at Tallaght University Hospital to ensure delivery of high-quality, safe and reliable healthcare. There were improvements in pharmacist resourcing which had resulted in improved provision of clinical pharmacy services. However, records demonstrating compliance with mandatory and essential training indicated low attendance among some staff groups and in certain clinical areas.

Quality and safety

The hospital had systems in place to evaluate and improve healthcare services using key performance indicators, clinical metrics, and audit activity. There were some opportunities identified to improve the inclusion of all ward areas, including those offsite, in relevant metrics.

While staff were observed to promote a person-centred approach to care, hospital overcrowding did not support patient's dignity, privacy and autonomy. There was

variation in the physical infrastructure, with some recently developed clinical areas in good condition, and other areas in need of refurbishment. The hospital had systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services, with some areas for improvement identified.

Staff were observed delivering care with kindness, consideration and respect. The hospital had systems and processes for managing complaints and concerns, which were effective, and there was improvement in these systems since the previous inspection.

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

Compliance Classifications

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

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

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	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	Partially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Partially 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	Partially Compliant

quality, safe, reliable care and protects the health and welfare of service users.	
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.	Substantially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant

Compliance Plan for: University Hospital Tallaght

Inspection ID: NS_0193

Date of inspection: 10 and 11 March 2026

Compliance plan provider's response:

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

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

1. ED staffing reviewed daily and redeployment occurs as required.

2. Since the inspection, 2.0 WTE RGNs have been re-allocated to the ED on a permanent basis

3. The Estimates for NSP 2026 for Phase 2 were submitted to Dublin Midlands REO by the RDoNM.

4. The DNM will oversee a review of the ED nursing complement against the safer nursing framework in line with increased activity within the ED.

5. Business case for agency conversion for 25 WTE HCAS approved in April 2026. Awaiting confirmation approval uplift by Region. Savings generated by this conversion will facilitate additional HCA hours to facilitate ECO.

6. A monthly report of compliance with mandatory training is generated by the HR Department and communicated to all EMT members. Clinical Directors for Medicine, Peri-operative, and ED to oversee the compliance of key mandatory training for doctors and promote attendance.

7. All EMT members including Clinical Directors to ensure that staff under their remit are compliant with mandatory training requirements

Timescale:

Q 3 2026

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

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

1. An independent review of the use of CCTV in one clinical area has been commissioned. As part of this review, the operational controls in place to oversee the appropriate management and use of CCTV in this area will be examined. The Hospital will ensure that recommendations arising from that review are implemented fully, so that the use of CCTV in the clinical area is appropriate in line with data protection requirements
2. The Director of Infrastructure will ensure that the CCTV Policy is updated in line with best practice and in accordance with data protection requirements. The revised policy will include non-recording CCTV in patient areas where remote monitoring of patient welfare is considered clinically necessary for patient safety purposes and will include the governance arrangements that are in place.

2. The Operations team and wider EMT will continue to improve patient flow through the implementation of:

i. Daily Patient Journey Rounds to improve Patient Flow throughout the hospital

ii. Daily ED MDT meetings at 07.30 hr

iii. Unscheduled Care Oversight Committee to meet monthly

iv. DTOC weekly meetings

v. Weekly LOS Meeting

vi 100% utilization of all available offsite capacity

vii 50% increase in footprint of TCU providing additional treatment capacity for 10 additional ambulatory patients

viii TUH Health Planning report has outlined a need to expand the ED - and this need will be reflected in our Development Control Plan - which will be finalised in Q4 2026.

ix TUH has been allocation an additional 192 single inpatient acute beds by the DoH. The first 96 beds is due for delivery in 2032.

Timescale:

Medium term actions Q3 2026	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant

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

The Director of Infrastructure will oversee the following:

1. Franks refurbishment and upgrade is included in the TUH Estate Refurbishment Programme. A QIP will be developed and agreed to address the immediate fabric upgraded required to get to a condition where it can be cleaned and utilised by patients by 30/05/2026.

2. Flooring contractor being appointed to address immediate repair required through the hospital. Franks will be prioritised as part of these works - subject to access.

3. TUH has a capital water safety project approved by HSE Capital - this includes the replacement of non-compliant wash hand basins (whb) - Franks Ward is included in this replacement programme. The timeline to replace all whb is 3 years

4. Ruttle ward refurbishment and upgrade is included in the TUH Estate Refurbishment Programme. A QIP will be developed and agreed to address the immediate fabric upgraded required to get to a condition where it can be cleaned and utilised by patients.

5. TUH Health Planning report has outlined a need to expand the ED - and this need will be reflected in our Development Control Plan - which will be finalised in Q4 2026.

6. TUH will prepare assessment and feasibility report providing additional toilets and shower facilities.

7. TUH has been allocated an additional 192 single inpatient acute beds by the DoH. The first 96 beds is due for delivery in 2032.

Timescale:

Medium term actions Q4 2026