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:	Connolly Hospital Blanchardstown
Centre ID:	OSV-001018
Address of healthcare service:	Mill Road Abbotstown Dublin 15 D15 X40D
Type of Inspection:	Unannounced
Date of Inspection:	22/10/2025 and 23/10/2025
Inspection ID:	NS_0170

About the healthcare service

Model of hospital and profile

Connolly Hospital Blanchardstown (Connolly Hospital) is a model three* HSE hospital. The hospital is in the HSE Dublin and North East health region. The hospital serves a catchment area of West Dublin, North Kildare, and South County Meath. Services provided by the hospital include:

- medical services
- surgery services
- intensive and coronary care
- diagnostic services and outpatient care
- 24/7 emergency care

The following information outlines some additional data on the hospital.

Number of beds	374 inpatient beds 55 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 three hospital is a hospital that admits undifferentiated acute medical patients, provides 24/7 acute surgery, acute medicine, and critical care.

†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. A check on whether the service is a good quality and caring one 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)
22/10/2025	09:00 – 17:00	Aedeen Burns	Lorenza Cafolla Emma Cooke Rosarie Lynch
23/10/2025	09:00 – 13:45	Aedeen Burns	Lorenza Cafolla Emma Cooke

Information about this inspection

This was a targeted unannounced inspection prompted by information notified to the Health Information and Quality Authority. The inspection focused on seven national standards from five of the eight themes[‡] of the *National Standards for Safer Better Healthcare*. The inspection focused in particular, on three key areas of known harm, these being:

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

The inspection team visited the following clinical areas:

- Emergency Department
- Sycamore Ward
- Cedarwood Ward
- Rowan Ward

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

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like

[‡] 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.

to thank people using the service who spoke with inspectors about their experience of receiving care and treatment in the hospital.

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

Most patients who spoke with inspectors spoke highly of the care they received and of the staff delivering the care. They reported that call bells were answered promptly. Patients who spoke with inspectors reported that they were satisfied with the food provided and that snacks were available throughout the day or night if requested.

Some patients who spoke with inspectors during the inspection identified areas for improvement in the management of their care. Where this was the case, this was brought to the attention of clinical and management staff on the day of inspection. Care plans are further addressed under national standard 2.2.

Rowan Ward was located in the main hospital building. Sycamore and Cedarwood wards were located on the campus but not attached to the main hospital building. Inspectors observed care being delivered in a warm, calm environment. Sycamore Ward was a 27-bedded sub-acute unit, Cedarwood Ward was an 18-bedded medical short stay unit and Rowan Ward was an 17-bedded acute medicine of the elderly unit and accommodated a 10-bedded acute stroke unit.

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes the standard related to workforce. On this inspection, the standards examined in this dimension were 5.5 and 6.1. The hospital was found to be compliant with standard 5.5 and partially compliant with standard 6.1.

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

The hospital had effective management arrangements in place to support the delivery of high quality, safe and reliable healthcare services. These structures ensured a clear focus on achieving quality and safety outcomes for service users in the three key areas of known harm: medication safety, recognition and response to the deteriorating patient, and transitions of care, which were the focus of this inspection.

Management and governance structures in the hospital were unchanged since the last inspection in October 2024 and the hospital had completed the transition to new regional health area structures within the HSE. There had been a considerable change in personnel at Executive Management Team (EMT) level since the last inspection, and a new general manager and clinical director had been appointed in the months preceding the inspection. Connolly Hospital operates a directorate structure that provides clear clinical and managerial accountability for service delivery and performance. A clinical director, supported by an assistant director of nursing (ADON) and administrative leads, with devolved responsibility for monitoring activity, managing resources and driving performance improvement, leads each directorate. Each directorate reported regularly to the Executive Management Team. An operational assistant director of nursing (ADON) was on duty and contactable via bleep at all times. Working in collaboration with the Executive Management Team, bed management team and directorate ADONs, the operational ADON coordinated patient flow and nurse staffing across the hospital.

Hospital activity and patient journey coordination, including from the emergency department through to discharge, were monitored through daily patient flow meetings. These meetings aimed to identify and progress actions to support timely patient flow and safe transitions of care. During the inspection, these processes were functioning effectively. Despite a year on year increase in emergency department attendances, performance data showed that the hospital consistently operated with very low or zero trolley numbers. Daily escalation processes and effective use of capacity ensured that admitted patients did not regularly remain in the Emergency Department for extended periods. At the time of inspection, four patients were identified as experiencing delayed transfers of care from the hospital. Hospital management reported that these delays were attributed to patients awaiting specialist rehabilitation beds or home-care packages. The hospital had an escalation policy for periods when activity exceeded capacity; however, the escalation policy was not required to be enacted on the days of inspection. The

hospital had arrangements in place for transferring patients to model four[‡‡] hospitals when they required a level of care that could not be provided in Connolly Hospital. The use of ISBAR [§§] (Identify, Situation, Background, Assessment, and Recommendation) communication tool was widely adopted and in use throughout the hospital to support transitions of care.

The clinical director led the deteriorating patient improvement programme in the hospital and chaired the Deteriorating Patient Committee, which provided oversight and advice about the safety, effectiveness and ongoing improvement of the recognition and response for all early warning systems, Cardio pulmonary resuscitation (CPR) and sepsis management processes implemented in Connolly Hospital. From a review of minutes of this committee, it was evident that effective governance and management arrangements were in place. This committee was meeting in line with its terms of reference. All early warning systems relevant to the hospital had been enacted as per National Clinical Guidelines.[***] Relevant early warning systems such as the Irish Maternity Early Warning System (IMEWS) and the Irish National Early Warning Systems (INEWS) and Emergency Early Warning System EMEWS were used on the appropriate cohorts and policies regarding their use were in place.

The hospital had a well-defined governance structure for medication safety, which comprised two committees, the Drugs and Therapeutics Committee and the Medication Safety Committee. Both committees met in line with their terms of reference. The Medication Safety Committee provided update reports to both the Quality and Safety Executive and the Drugs and Therapeutics Committee. The chairperson of the Drugs and Therapeutics Committee, who was also a member of the Quality and Safety Executive, reported to the Quality and Safety Executive. The Drugs and Therapeutics Committee also fulfilled the oversight function for antimicrobial stewardship (AMS) in the hospital. The committees were performing their functions appropriately, with evidence of active oversight and follow-through on required actions.

The pharmacy service was led by a pharmacy executive manager. The hospital had an agreed medication safety programme for 2024 to 2029. This strategy focused on core priorities of detection of error, reporting, education and support of staff, reducing risk, and the use of technology to enhance safety. This strategy informed the development and prioritisation of the medication-safety programme. Evidence of progression in these priority areas was seen through practices observed in clinical areas and reflected in the minutes of the Drugs and Therapeutics Committee and the Medication Safety Committee.

Staff in the clinical areas who spoke with inspectors described clear reporting structures with defined lines of responsibility, which supported an effective response to changes in activity or patient acuity.

Overall, inspectors found that the hospital's management arrangements relevant to the areas of harm that were the focus of this inspection: medication safety, recognition and response to the deteriorating patient, and transitions of care were functioning effectively to support the delivery of safe, high-quality and reliable healthcare services. These arrangements ensured clear accountability and oversight, enabling timely decision-making and coordinated responses to changes in patient activity and acuity.

Judgment: Compliant

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

Workforce planning and management in the hospital was the responsibility of the human resource manager. The human resource manager reported to both the general manager of the hospital and the regional director of people. Approval to fill posts in the hospital, including replacement positions, was made at Integrated Healthcare Area (IHA) level.

In September 2025, the hospital reported a target whole-time equivalent (WTE) workforce of 1,680.47 with an overall staffing shortfall of 35.76 WTE vacancies. Nursing deficits represented 25% of these vacancies with 17% in management and administration, 25% in general support and 33% classified as "patient and client care". The hospital reported no vacancies in consultant or non-consultant hospital doctor (NCHD) posts. Workforce was a standing agenda item in Integrated Health Area (IHA) monthly performance meetings and evidence was seen that workforce deficits were escalated to the IHA.

[‡‡] A model four hospital is a tertiary hospital that provides tertiary care and, in certain locations, supra-regional care. The hospital has a category 3 or speciality level 3(s) Intensive Care Unit onsite, a Medical Assessment Unit, which is open on a continuous basis (24 hours, every day of the year) and an emergency department.
[§§] The ISBAR (Identify, Situation, Background, Assessment, and Recommendation) framework, endorsed by the World Health Organisation, provides a standardised approach to communication which can be used in any situation it is promoted by the HSE as part of National Clinical Guideline No.1 INEWS and Communication (Clinical Handover) in Acute and Children's Hospital Services National Clinical Guideline No. 11.
[***] The National Early Warning System (NEWS) National Clinical Guideline (NCG) 1 applies to adult (≥ 16 years) non-pregnant patients in acute settings. NCG 4 (IMEWS) applies to women with a confirmed clinical pregnancy and for up to 42 days in the postnatal period, irrespective of age or reason for presentation. NCG 18 EMEWS applies to adults patients (16 years and older) attending an ED in Ireland who meet the inclusion criteria from triage to discharge or decision to admit.

The hospital reported that the framework for safe staffing[†††] for nursing had been implemented in the emergency department and wards in the hospital. On the wards visited, there were no nursing vacancies. In evidence submitted to HIQA by hospital management the total nursing deficit was 23 WTE with the emergency department having a deficit of 13.4 WTE registered nurses. A deficit in nurse staffing in the emergency department was also a finding in the HIQA inspection in 2024. Inspectors were informed that vacant shifts were generally covered through staff working overtime or the use of agency nurses. The approved complement for registered nurses in the emergency department was 14 staff nurses per shift. On the day of inspection, 12 registered nurses were on duty, including one nurse who was redeployed from a ward, two agency nurses, and one emergency department nurse working an overtime shift. The clinical nurse manager (CNM) advised inspectors that activity levels on the day of inspection meant the deficit was manageable at that time. In Rowan Ward, staffing of the dedicated stroke beds was facilitated through the use of three regular WTE agency nurses on the ward. Inspectors were informed of imminent plans to fill these posts with permanent staff in the months following inspection. Hospital management should continue to regularly review the use of agency staff as a reliance on agency staff and overtime to maintain rosters is not sustainable in the long term.

Figures submitted to HIQA by hospital management indicated no vacancies in the current WTE allocation of 22.36 pharmacists (including management grades). Notwithstanding this, senior managers reported that two additional pharmacist posts were submitted for approval at IHA level. Inspectors were informed that the current allocation represented a reduced allocation following the HSE Pay and Numbers Strategy in 2023. This was affecting the provision of a clinical pharmacy service to all patients in the hospital. While inspectors were informed that pharmacy staffing levels was on the local risk register in pharmacy, evidence of this risk being escalated to the corporate risk register was not seen in the section of the corporate risk register provided to HIQA. This will be discussed further under national standard 3.1.

There was evidence that workforce and staffing performance reports were regularly reviewed at Executive Management Team and IHA performance meetings. The hospital's absenteeism rate was reported at 5.46% in August 2025, with an overall rate for 2024 of 5.13% which is above the HSE target of less than or equal to 4.0%. Managers described active monitoring of absenteeism, with staff supported through

[†††] Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland and Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland.

back-to-work interviews and access to services such as the employee assistance programme (EAP) and occupational health services.

Mandatory training compliance was monitored and reported to EMT. For nurses, compliance with training was high for early warning systems for deteriorating adult and maternity patients (INEWS and IMEWS) at 99%, sepsis at 98%, and clinical handover at 100%. Doctor's compliance with INEWS training was 79% non-consultant hospital doctors (NCHDs) and 94% for consultants. Compliance with IMEWS training was reported as being 17% for NCHDs and 2% for consultants. Basic life support (BLS) training compliance was low across all staff groups: nurses 45%, healthcare assistants 32%, NCHDs 47%, consultants 13%, and health and social care professionals 27%. This was a similar finding to the inspection in 2024 and while inspectors saw some evidence of management oversight, the level of compliance observed remained low for this essential skill. Hospital management reported that recording of BLS training figures was dependent on staff uploading certificates and that work was ongoing to validate data and encourage timely uploading of documentation. Hospital management also reported that the cardio pulmonary resuscitation (CPR) officer post, previously vacant, had recently been filled (0.5 WTE), and that there was a focused programme planned to increase training compliance. Inspectors were told that a Mandatory Training Committee had been re-established with plans to target areas of low compliance. Compliance with training in medication safety (65% for nurses and no records submitted for doctors) also required improvement. There was evidence that education sessions were provided by the medication safety pharmacist at induction for new staff and regularly throughout the year, however, recording of attendance at this training did not facilitate tracking of the percentage of relevant staff trained.

An induction programme was available to all new staff in the hospital and a specific programme was repeated for new intakes of NCHDs on rotation. Evidence was provided to HIQA that education related to the three areas of harm that formed part of this inspection were included in the induction education programme for new staff.

Overall, inspectors found that while measures were in place to support workforce planning and training, significant challenges remained, and further improvement is required to ensure sustainable staffing and full compliance with essential training requirements. Areas requiring improvement included:

- nursing vacancies in the emergency department had the potential to impact on patient safety
- pharmacy workforce was not delivering comprehensive clinical pharmacy
- compliance with mandatory training in early warning scores by some staff groups was poor
- recording of attendance at medication safety training did not facilitate oversight of the percentage of relevant staff trained

- compliance with basic life support training was low across staff groups which could pose a risk to patient safety, particularly in emergencies where timely and effective resuscitation is critical
- absenteeism rates were above the HSE target of less than or equal to 4.0%.

Judgment: Partially Compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred. The hospital was found to be compliant with standard 1.6 and substantially compliant with standards 3.3 and 3.5. The hospital was found to be partially compliant with standards 2.2 and 3.1.

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

In the emergency department, when visited by inspectors, there was no overcrowding. Patients awaiting medical review were accommodated in single cubicles or designated waiting areas. An area with armchairs was used for patients who needed to be under the supervision of a nurse but who did not require a cubicle. These patients told inspectors that they had been taken to a private area for examination or confidential conversations. Staff reported that this area was actively managed by a registered nurse with oversight by the clinical nurse manager (CNM) to ensure its suitability for the patients accommodated there. As with the last inspection in the hospital, the emergency department had a room with special equipment and lighting, which offered a suitable environment for neurodiverse patients or patients for whom the emergency department might cause sensory overload.

Dementia-friendly signage was noted on the wards to support autonomy for patients who might find it difficult to orientate themselves in the hospital environment and there was a garden available for use by patients and their families. Patients were accommodated in a mix of single and multi-occupancy rooms. Multi-occupancy rooms accommodated a maximum of four patients. Privacy curtains were used in multi-occupancy spaces to help maintain dignity and confidentiality. Staff reported that family rooms (available on some wards) or offices were used for sensitive

conversations and family meetings. The hospital was a hospice-friendly hospital[‡‡‡] and had an end-of-life care coordinator. Staff reported that patients receiving care at the end of life were prioritised for single rooms.

Patients who spoke with inspectors on the days of inspection reported being involved with or kept informed of their plan of care (care plans are discussed further under standard 2.2).

Inspectors observed that patient records were not always stored in a manner that respects patients' privacy and confidentiality. For example, some patient charts were stored on open shelves near the nurses' station on Rowan Ward. Inspectors brought this to the attention of the clinical nurse manager (CNM) and hospital management on the day of inspection.

The hospital had reconvened its Patient Partnership Committee. The purpose of which was to ensure that patients and families have a say in how health services are planned, delivered, and improved. Records submitted to HIQA provided evidence of patient and senior management representation on the committee and consideration of patient input.

Judgment: Compliant

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

While systems were in place to ensure care was planned and delivered to meet the initial and ongoing needs of people who use the service, inspectors found that there were gaps in the ongoing assessment and updating of care plans.

Inspectors reviewed care planning as it related to care on the wards visited on inspection. Care plans are fundamental clinical records that support continuity of care, evaluation, communication between professionals and during transitions across care settings.

Inspectors reviewed a sample of care plans in the clinical areas inspected. Standardised risk assessments were in place for key aspects of care, including skin integrity, nutrition, oral hygiene and falls risk. In a small sample of patient charts reviewed by inspectors during the inspection, care plans for patients (for example,

[‡‡‡] The Hospice Friendly Hospitals Programme, an initiative of the Irish Hospice Foundation delivered in partnership with the Health Service Executive. The programme aims to ensure that compassionate end-of-life, palliative and bereavement care is embedded in everyday hospital practice. This approach is underpinned by national quality standards and is supported through education, environmental improvements and structured leadership networks within hospitals.

for some patients with communication difficulties or pain) did not consistently reflect their assessed needs. In the sample reviewed by inspectors, pain assessments had not been consistently conducted following the administration of medication for the purpose of managing pain, which had the potential to result in ineffective pain relief for patients. Inspectors identified that feedback from patients regarding the effectiveness of pain management was not consistently incorporated into care planning. Inspectors noted that care plans were not always updated to reflect changes in patients' reported symptoms or needs. This finding was raised with clinical staff and hospital management on the day of inspection, who confirmed that processes for reviewing and updating care plans in response to patient feedback would be examined.

On Rowan Ward, patient risk assessment tools had been completed in the sample of healthcare records reviewed by inspectors. However, despite daily review, the care plans reviewed were not always adequately individualised to reflect the assessed condition and needs of each patient, such as their communication needs.

In the sample of healthcare records reviewed by inspectors on Sycamore Ward, nursing assessments had not been consistently completed, and in the case of oral hygiene, care plans were not consistently put in place when indicated. Individualisation of care plans to reflect the assessed condition and needs of each patient was not evident for all patients in the sample of records reviewed. While there was a policy in place to support the safe and ethical use of bedrails, the bedrail assessment tool in use in the hospital had not been completed on all patients who may have required bedrails on Sycamore Ward.

On Cedarwood Ward, a review of a sample of healthcare records found that nutritional assessments had not been completed on all patients and care plans were not always reflective of the assessed condition and needs of the patients. Documentation reviewed showed gaps in how medical conditions and their impact on the activities of daily living were incorporated into care planning.

These findings were consistent with data submitted by the hospital to the HSE in July 2025 where the overall hospital score for nursing assessment of nutrition and hydration was 74% with a top score of 83% in the preceding three months. Accurate assessment and documentation of the patients' nutrition and hydration status and risks is essential to providing safe patient care and onward referral to appropriate health and social care professionals. Not individualising care based on nursing assessment can lead to care that does not fully address the ongoing needs of patients.

The hospital used the HSE Quality Care Metrics for Nursing and Midwifery in Acute Services (2018)[§§§] to measure nursing-sensitive quality indicators. The clinical areas

visited on inspection scored between 43% and 82% for metrics related to discharge planning, and between 79% and 85% for the parameter that measures the level to which the care plan reflects the patient's current condition. The overall score for the hospital for this parameter was 72.5%.

A document submitted following the inspection covering the period from 31 July to 31 October 2025 showed that quality improvement plans (QIPs) had been put in place for Rowan and Sycamore wards for some elements of the nursing quality care-metric audits where compliance with the target was not achieved. While, based on the audit results, an action plan should have been developed for Cedarwood Ward, there was no evidence that any QIP for this area had been developed. Where QIPs were documented, actions were not always targeted or specific to the metric in question.

Overall hospital compliance for metrics related to the following nursing-sensitive quality indicators for July to September 2025 were as follows:

- care plan development and evaluation 61% - 73%
- pain assessment and management 58% - 68%
- delirium prevention and management 52% - 62%
- continence management 46% - 76%
- pressure ulcer prevention and management 84- 94%.

Responsibility for the development, implementation and review of nursing documentation had been delegated to the Nurse Practice Development Department, which also oversaw audit processes to monitor compliance and drive continuous improvement. Hospital management informed inspectors of a planned initiative led by the director of nursing and the Nurse Practice Development Unit to improve care and documentation in relation to key nursing-sensitive quality indicators, including nutrition and hydration, delirium, medication management and pressure ulcer prevention. Measures introduced included appointing link nurses, increasing oversight by assistant directors of nursing at monthly meetings, and enhanced oversight by the director of nursing through planned monthly meetings with clinical nurse managers where nursing quality metrics are a standing agenda item. Additional educational sessions were also planned to support improvements in care and documentation in these targeted areas. This was a new initiative with the first data collection planned in November 2025 following the inspection.

Inspectors were informed by hospital management and clinical staff, that a quality improvement initiative to improve continence care and promote the maintenance of

§§§ Quality Care-Metrics are a measure of the quality of nursing and midwifery clinical care processes aligned to evidenced based standards and agreed through national consensus in healthcare settings in Ireland.

continence in patients admitted to the hospital had been undertaken in the months preceding the inspection. However, this was not reflected in the care and care plans of a small number of patients who spoke with inspectors during the course of the inspection.

Patients who spoke with inspectors reported being involved in or kept informed regarding their plan of care.

Overall, inspectors found that while systems were in place to support care planning and documentation, these were not consistently implemented across all wards. Further improvement is required to ensure nursing care is appropriately assessed, individually planned, delivered, and evaluated to meet the initial and ongoing needs of patients.

- patient assessment tools were not consistently completed following an identified need (e.g nutrition and hydration, bed rails)
- care plans reviewed were not always adequately individualised to reflect the assessed condition and needs of each patient, such as their communication needs
- care plans were not consistently reviewed and updated to reflect patients initial and ongoing assessed needs
- quality improvement plans with defined actions were not developed for all metrics that fell below the target level of compliance to address concerns specific to that area.

Judgment: Partially Compliant

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

The hospital had systems and processes in place to identify, assess and manage both immediate and potential risks to people using the service. The hospital's Executive Management Team maintained a corporate risk register and held responsibility for reviewing and managing risks that could affect the quality and safety of healthcare services. Risks were further escalated and discussed at IHA meetings if required.

Local risk registers were maintained in the clinical areas inspected. While this is a positive development, inspectors noted that not all risks captured in these registers accurately reflected the risks present on the day of inspection. For example, the requirement for the provision of enhanced care for patients on Cedarwood Ward was not recorded. Inspectors discussed this with hospital management and were

informed that training was ongoing with clinical staff at the time of inspection and that development of local risk registers is a work in progress.

Medication Safety

The risk of medication errors as it pertained to Connolly Hospital was recognised by hospital management and recorded on the risk register. With controls in place to mitigate the risk, the hospital still rated this risk high. There was evidence that these risks were reviewed regularly and controls described in the risk register and described to inspectors during interviews with medication safety leads were seen action in the clinical areas visited.

Despite recruitment within the pharmacy department since the last inspection in 2024, a clinical pharmacy service was not provided to all wards in the hospital. In data submitted to HIQA for an audit performed in Q1 2024, it was recorded that 34% of eligible patients received medicine reconciliation[****] by a clinical pharmacist on admission, 38% of eligible inpatients received a medication record review by a clinical pharmacist, and 13% of eligible patients had received a clinical review by a clinical pharmacist in same period. Data from 2025 was not collected; this was reported to be due to staffing constraints. As previously mentioned, pharmacy staffing was not included in the corporate risk register. Staffing in the pharmacy department is discussed further under standard 6.1.

The hospital maintained a list of high-risk medications aligned with the acronym 'APINCH.'[††††] Inspectors observed the implementation of risk-reduction strategies to promote the safe use of anticoagulants, insulin, opioids, and potassium in the clinical areas inspected. A list of commonly used sound-alike, look-alike drugs (SALADs) was also in place. Up-to-date prescribing guidelines, including antimicrobial guidance and other medication-related alerts, were readily accessible to staff at the point of preparation. These resources were available through a desktop and smartphone application, which management advised inspectors was the sole authorised source of medicines information within the hospital. In response to medication errors, policies and procedures for medication administration were updated. Staff received education on these changes to reduce the likelihood of recurrence. This is further discussed under standard 3.3.

[****] Medication reconciliation is defined as the standardised process of obtaining the most accurate and complete medication list possible and comparing it with current medication orders to identify and resolve discrepancies at transitions of care. World Health Organization.

[††††] Medications represented by the acronym 'A PINCH' include anti-infective agents, anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants.

Audits were completed, related to medication safety and medication custody and storage, as part of the nursing and midwifery quality care metrics. Scores ranged from 90% - 92% in monthly compliance audits, from July to September 2025.

The Deteriorating Patient

The hospital identified the lack of beds for patients requiring escalated levels of care, such as intensive care unit (ICU) or high dependency unit (HDU) care, as a risk related to the deteriorating patient. This was rated as high by the hospital on the corporate risk register with controls in place. The hospital was not meeting national key performance indicators for timely admission to ICU in Q1 2025 (HSE target is that admission to ICU should happen within one hour of the need being identified). Inspectors were informed that an additional 5 ICU beds were planned to come on stream in 2027. In the interim, inspectors were informed that there was a plan to open a four-bedded HDU within the hospital. This was currently under discussion at IHA level. In the interim, the Critical Care Outreach Team (CCOT) continued to form part the hospital's mitigation response to a lack of HDU and ICU beds. In 2024, the CCOT team recorded more than 1,000 episodes where the team assessed, reviewed or provided clinical intervention to a patient. In the same period this team attended 21 patients who required ICU level care outside of ICU. However, the CCOT was not available on a 24/7 basis and were only on duty 8am to 8pm Monday to Friday and every second weekend.

The CCOT had expanded since the inspection of 2024, but 24/7 cover was not possible with the current WTE allocation. Hospital management reported that it was their intention to expand this team further to provide more comprehensive cover.

Inspectors saw evidence of quality improvement initiatives, including ward walk-arounds, tracheostomy rounds, and improved access to emergency equipment initiated by the team, all of which formed part of the service's mitigation of the risk to the deteriorating patient.

Another control put in place to mitigate risks related to the deteriorating patient was the appointment of a second medical registrar on night duty to support the response to the deteriorating patient.

The hospital had implemented national early warning systems for relevant patient cohorts to support the recognition, escalation and management of deteriorating patients. These included the Irish National Early Warning System (INEWS), the Irish Maternity Early Warning System (IMEWS), and the Emergency Medicine Warning Score (EMEWS). The 'Sepsis 6' care bundle and the ISBAR ‡‡‡‡ (Identify, Situation,

‡‡‡‡ The ISBAR (Identify, Situation, Background, Assessment, Recommendation) framework, endorsed by the World Health Organisation, provides a standardised approach to communication which can be

Background, Assessment, and Recommendation) communication tool were also used to support timely escalation of care. Policies and procedures were in place to underpin these systems, and staff demonstrated knowledge of escalation pathways and response protocols. Monitoring of compliance with INEWS was done through the patient monitoring and surveillance element of the nursing and midwifery quality care metrics. Scores ranged from 80-91.2% in monthly compliance audits. This represented an improvement on 2024 figures. INEWS audits showed 100% compliance with most audit elements; however, improvements were required in activating and completing sepsis screening tools and in documenting modified response protocols. For non-compliant elements, an action plan and plan to re-audit had been developed. Monthly sepsis audits in the emergency department reported 98 – 100% compliance across all elements from July to September 2025.

Inspectors were informed that the team responsible for responding to cardiac arrests held a huddle before each shift to review situational awareness regarding high-risk patients and access to ICU beds and to clarify roles, and ensure readiness for potential emergencies. Staff reported that safety huddles took place daily and followed a standardised safety huddle script to highlight patient-safety concerns or immediate care needs. Emergency equipment was available and accessible on the wards and checks of emergency equipment were being performed at the prescribed frequency.

Admission criteria and transfer protocols were in place for one of the clinical areas inspected, Cedarwood Ward, which was not attached to the main hospital building but located within the hospital grounds. This assured inspectors that risks associated with patient deterioration in, and subsequent transfer from, this outlying ward to the main hospital had been mitigated. However, similar criteria had not been established for all outlying wards. Staff informed inspectors that emergency response teams would attend all wards regardless of location if contacted and that agreed systems were in place to transfer patients back to the main hospital in an emergency, including direct admission to the resuscitation area in the emergency department.

Transitions of Care

Risks on the corporate risk register linked to transitions of care related to handover (both internally and externally) and to discharge letters. There was evidence that these risks and the controls in place were being actively managed and monitored.

used in any situation it is promoted by the HSE as part of National Clinical Guideline No.1 INEWS and Communication (Clinical Handover) in Acute and Children's Hospital Services National Clinical Guideline No. 11.

Inspectors observed that the ISBAR tool continued to be used during transitions of care from the emergency department and throughout the hospital. Inspectors were informed that Patient Journey Ward Rounds, seen on the last inspection, had continued. These utilised an adapted ISBAR format and were used to support safe transitions of care between teams through oversight by senior clinicians, including the assistant director of nursing and the clinical director.

Inspectors also noted that safety huddles and clinical handovers followed the ISBAR structure. Standardised documentation had been developed to record essential information at points of transfer.

Hospital management conducted monthly audits of the quality of discharge letters against HIQA's *National Standard for Patient Discharge Summary Information*. Audit results demonstrated consistent compliance above the HSE KPI of 90% for July and August 2025. However, delays in issuing discharge letters had been identified on the last inspection and challenges persisted in issuing discharge letters in a timely manner. The hospital reported that, year to date September 2025, only 47% to 66% of discharge letters were issued within one week of patient discharge. Staff told inspectors that patients discharged to another facility, or those requiring immediate engagement with their general practitioner, were provided with a discharge letter at the point of discharge. Hospital management identified this as an area of focus and inspectors noted that it was being monitored at Executive Management Team and IHA meetings, however, no improvement was noted since the previous inspection. Inspectors were informed of plans to change the IT platform used for the administrative tasks associated with these letters, which was expected to have a positive impact on this metric.

Overall, inspectors found that while the hospital had systems in place to manage risks and support safe care, improvements were required in key areas. While initiatives such as safety huddles, early warning systems, and risk-reduction strategies related to high-risk medications were in place, further action is needed to address gaps and ensure consistent compliance with national standards for example:

- a clinical pharmacy service was not provided to a significant proportion of patients in the hospital
- there was an identified lack of HDU and ICU beds leading to delayed admissions to higher levels care when required
- CCOT availability outside core hours remained limited
- discharge letters were not being issued to all patients in a timely manner.

Judgment: Partially Compliant

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

The hospital had systems in place to ensure that patient-safety incidents were identified, reported and managed in line with local and national policy and legislation, including the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023. The hospital used the Health Service Executive (HSE) Incident Management Framework (2020) to guide and support the management of patient-safety incidents and Serious Reportable Events (SREs).

Patient-safety incidents were recorded on the National Incident Management System (NIMS). Hospital management produced monthly reports for the Integrated Health Area (IHA) of Dublin and North East performance meetings detailing the number of clinical incidents per 1,000 bed days used (BDU). All incidents were classified by hazard type, severity and clinical specialty.

The Local Incident Management Team (LIMT) had appropriate membership and was functioning in accordance with its terms of reference, which were aligned to the requirements of the HSE Incident Management Framework. While the LIMT met both regularly and in response to specific incidents, the necessity for regular meetings was not reflected in the terms of reference. The LIMT supported effective oversight, review and learning from incidents, and monitored the implementation of associated recommendations. The hospital's Quality and Safety Executive Committee, which reported to the Executive Management Team, also monitored progress on recommendations from reviews commissioned following patient-safety incidents; the implementation of which was devolved to directorate level. Incidents were also reported at monthly performance meetings at IHA level.

Staff who spoke with HIQA inspectors were knowledgeable about the process for reporting patient-safety incidents and were aware of the most commonly reported incidents within their areas of responsibility.

Medication related patient-safety incidents were tracked and trended and further categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. A KPI of greater than or equal to three reported medication safety incidents per 1000 bed days used (BDU) was used in the hospital (as per the HSE service plan 2025) as one metric for medication safety. The hospitals' monthly rate up until September 2025 was between 4.2 and 7.4 per 1,000 BDU. This may reflect strong reporting practices rather than increased medication-related harm; however, the hospital needs to continue review the types and causes of these incidents to ensure that this is the case and to identify any trends and underlying risks requiring action.

Inspectors discussed medication errors that had been notified to HIQA, and the actions taken to prevent their recurrence, with hospital management. Reviews into medication safety incidents since the previous inspection were either completed or ongoing at the time of inspection. Through these discussions and evidence submitted to HIQA, inspectors were assured that reviews had been initiated appropriately in line with relevant guidelines. Of the reviews that were completed, there was evidence that recommendations and a time-bound action plan to reduce the likelihood of a similar error occurring was implemented and completed. For medication safety incident reviews that were ongoing at the time of inspection, immediate actions and quality improvement initiatives including staff education had been implemented. Inspectors discussed the composition of teams appointed by the Local Incident Management Team for review of serious medication incidents with hospital management and were informed that pharmacists were now always included in this type of review.

Inspectors discussed incidents relating to the deteriorating patient and transitions of care that had been brought to their attention. Management outlined the actions taken to address these events and prevent a recurrence. Incident reviews were either completed or ongoing at the time of the inspection. The evidence provided showed that reviews had been initiated in line with relevant guidelines. For those reviews that had been completed, inspectors saw evidence that the resulting recommendations and time-bound actions had been implemented to reduce the risk of similar incidents happening again. Evidence was seen of policy development to mitigate risks identified through patient safety incidents that related to the deteriorating patient, transitions of care and medication safety.

Shared learning following patient-safety incidents was facilitated through formal teaching sessions and the dissemination of learning bulletins, such as ”Medication Minutes” and the quality and safety newsletter where anonymised incidents and recommendations from reviews were shared with staff. Multidisciplinary meetings and staff huddles also supported this process. Responsibility for disseminating information was devolved through the directorate structure.

Overall, inspectors found that the hospital had effective systems in place to identify, report, and manage patient-safety incidents in line with national policy and legislation. Incidents were monitored, reviewed, and escalated appropriately, and shared learning was facilitated through multiple channels. There was evidence that were a review was in progress, initial quality improvement measures had been implemented, and inspectors were assured that governance arrangements supported continuous improvement in patient safety. Further focus is required regarding the analysis of medication related incidents to ensure that this reflects strong reporting practices rather than underlying safety risks.

Judgment: Substantially Compliant

Standard 3.5: Service providers fully and openly inform and support service users as soon as possible after an adverse event affecting them has occurred, or becomes known, and continue to provide information and support as needed.

From evidence reviewed by inspectors before, during and after inspection it was apparent that the hospital had structures and processes in place to ensure that the service openly informed and supported patients after an adverse event affecting them had been identified.

Open disclosure was promoted and staff who spoke with inspectors were aware of their obligations in this regard. Open disclosure was supported through the presence of appropriate policies, procedures and guidelines that aligned to the HSE Open Disclosure Policy 2025 and the HSE Incident Management Framework 2020. It was evident that staff in the hospital continued to engage with families involved throughout the review process.

The Quality and Safety Executive Committee had oversight of the implementation and monitoring of the open disclosure policy in the service. A designated person at a senior management grade was appointed as the person with responsibility for open disclosure in the hospital. At the time of inspection, the role was being filled in an acting capacity. Inspectors were informed that this post had been advertised and that permanent appointment to the post was expected in the weeks following inspection. Open disclosure was a standing agenda item at Quality and Safety Executive Committee meetings. Hospital management had not yet designated open disclosure clinical and managerial champions, as recommended in the HSE Open Disclosure Policy 2025. The role of champions, as in the HSE policy, is to lead and advocate for open disclosure within the hospital and support staff in carrying out disclosure correctly.

Management reported that patients involved in an adverse event affecting them would be reviewed in line with the HSE's Incident Management Framework 2020 and provided with support and information regarding access to external supports in such an event. Inspectors saw evidence in clinical documentation that open disclosure had taken place following an incident. However, evidence was not seen by inspectors that information on open disclosure and supports available in the service was readily available in the form of information leaflets, posters, or other communications.

Completion of open disclosure was tracked and trended. This tracking was based solely on the completion of the open disclosure section of the national incident management system (NIMS) form. The hospital submitted its annual open disclosure report for 2024 to the Department of Health, as required in the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023. Based on completion of the NIMS form, it reported 100% compliance with open disclosure in category 1 incidents and 86% compliance with open disclosure in category 2 incidents. However, the report suggested that the hospital was not consistently updating NIMS to reflect the sharing of incident review reports. Hospital management reported to HIQA inspectors that the review reports had been finalised and accepted by the hospital management (who had commissioned the report). They also reported they had been shared with families. However, a provisional audit report based on a sample of incidents reported from September to December 2024 indicated that no review reports had been recorded as shared. Hospital management considered that this related to data entry rather than an absence of sharing. Evidence seen by HIQA inspectors suggested that patients and relatives were kept informed and involved in the investigations relating to category 1 incidents and informed of their outcome.

Staff who spoke with inspectors were aware of their responsibilities with regard to open disclosure. The following percentage of staff had received relevant training for this role: 99% for each category of nurses, healthcare assistants and consultant doctors, 83% of non-consultant hospital doctors and 86% of health and social care professionals. The Quality and Patient Safety Department delivered 20 well-attended face-to-face open disclosure training sessions between 2024 and 2025. While managers were aware of their obligation to support staff following incidents, and described doing this informally, managers who spoke with inspectors reported that they had not received training in this role, such as the ASSIST ME model for staff support promoted as part of the HSE Incident Management Framework.

The hospital should continue to ensure ongoing oversight of the open disclosure process and should develop systems to ensure systematic updating and verification of all related data at each stage, to guarantee accurate recording and completion of the process.

Overall, inspectors found that while the hospital was in the early stages of implementing the HSE Open Disclosure Policy 2025 it had made progress, particularly in promoting a culture of open disclosure and delivering staff training. Systems were in place to support open disclosure following adverse events, and evidence indicated that patients and families were kept informed during reviews. However, the following opportunities for improvement were noted:

- appointment of a designated lead for open disclosure should be progressed

- the hospital should progress with the appointment of open disclosure champions in line with relevant guidelines
- systems should be implemented to ensure NIMS is updated to reflect the sharing of incident review reports with those affected
- information on open disclosure and supports available in and outside service should be available in the form of information leaflets, posters, or other communications for service users

Judgment: Substantially Compliant

Conclusion

HIQA carried out a targeted unannounced inspection focused on seven national standards from five of the eight themes of the National Standards for Safer Better Healthcare. The inspection focused in particular, on three key areas of known harm, these being: medication safety, the deteriorating patient (including sepsis) and transitions of care.

Inspectors found that the hospital demonstrated effective management arrangements that supported the delivery of safe, high-quality and reliable healthcare services. Clear accountability structures and oversight mechanisms enabled timely decision-making and coordinated responses to changes in patient activity and acuity. Management maintained a strong focus on the three priority areas of known harm, which were central to this inspection.

Under the Capacity and Capability dimension, the hospital was compliant with standard 5.5 and partially compliant with standard 6.1. While management arrangements were functioning effectively, significant workforce challenges persisted. Nursing vacancies in the emergency department and reliance on agency staff posed potential risks to patient safety. A comprehensive clinical pharmacy service was not being delivered; the hospital reported that this was affected by reduction in pharmacist numbers since 2023. Compliance with mandatory training, particularly in basic life support and medication safety, was below expected levels, and staff absenteeism rates exceeded the HSE target. Further improvement is required to ensure sustainable staffing and full compliance with essential training requirements.

Under the Quality and Safety dimension, the hospital was compliant with standard 1.6, substantially compliant with standards 3.3 and 3.5, and partially compliant with standards 2.2 and 3.1. While systems were in place to support nursing care planning and documentation, these were not consistently implemented across all wards. Care plans were not always individualised to reflect assessed needs, and gaps were identified in areas such as pain management, oral hygiene, nutrition, and bedrail assessments. Compliance with nursing quality-metrics varied, and some quality improvement plans lacked targeted actions. Further improvement was required to ensure that nursing care is appropriately assessed, personalised, delivered and evaluated in accordance with patients' initial and ongoing needs.

Inspectors found that while systems were in place to manage risks and support safe care, improvements were required. A clinical pharmacy service was not available to a significant proportion of patients, limiting access to medicines reconciliation and

review. In addition, the lack of HDU and ICU capacity posed a risk to timely escalation for patients requiring higher levels of care.

The hospital continued to experience delays in issuing discharge letters, which could impact continuity of care. While initiatives such as safety huddles, early warning systems, and risk-reduction measures related to high-risk medications were in place, further action was needed to address these identified risks and ensure consistent compliance with national standards.

Inspectors noted that while the hospital was in the early stages of implementing the HSE Open Disclosure Policy 2025, it had made progress in promoting a culture of open disclosure and delivering staff training. Systems were in place to support disclosure following adverse events, and evidence indicated that patients and families were kept informed during reviews. However, opportunities for improvement were observed in areas such as appointing a designated lead, establishing open disclosure champions, ensuring accurate data entry on NIMS, and making information on open disclosure readily available to service users.

HIQA will, through the compliance plan submitted by hospital management continue to monitor the progress in implementing the actions identified bring the hospital into full compliance with National Standards.

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 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	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 healthcare needs, while taking account of the needs of other service users	Partially Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant
Standard 3.5: Service providers fully and openly inform and support service users as soon as possible after an adverse event affecting them has occurred, or becomes known and continue to provide information and support as needed.	Substantially Compliant

Compliance Plan for Connolly Hospital Blanchardstown

Inspection ID: NS_0181

Date of inspection: 22.10.2025 and 23.10.2025

Introduction

This document sets out a compliance plan for healthcare service providers to outline action(s) completed or intended to be completed following an inspection by HIQA whereby the service was not in compliance with the *National Standards for Safer Better Healthcare Version 2 (2024)*.

Any substantially compliant judgments indicate that some action is required to bring the service into full compliance. These actions should be addressed locally and do not form part of this compliance plan.

This compliance plan only relates to:

- standards that were deemed **partially compliant or non-compliant** by HIQA

The compliance plan should be completed and authorised by a representative of the service provider with responsibility to act on behalf of the service, for example, the service's Chief Executive Officer, Chief Officer, or other relevant designated manager.

It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frames. The compliance plan should detail how and when the service provider will comply with the national standards.

Instructions for use

The healthcare service provider must complete this plan by:

- outlining how the service is going to come into compliance with the relevant national standard(s)
- outlining timescales to achieve compliance.

The provider's compliance plan should be SMART in nature:

- **Specific** to the non-compliance identified with the national standard(s)
- **Measurable** so that progress towards compliance can be monitored
- **Achievable**
- **Relevant**

- **Time bound** – The proposed actions outlined in the compliance plan should be accompanied by clear delivery dates and key milestones (where appropriate)

Healthcare Service Provider's responsibilities

- Service providers are advised to focus their compliance plan action(s) on the overarching systems that they have, or will put, in place to ensure compliance with a particular national standard, under which a partially compliant or non-compliant judgment has been made.
- Service providers should change their systems as necessary to bring them into compliance rather than focusing on the specific failings identified.
- The service provider must take action within a **reasonable** time frame to come into compliance with the standards.
- It is the service provider's responsibility to ensure they implement the action(s) within the time frame as set out in this compliance plan.
- Subsequent action and plans for improvement related to urgent risks already identified by HIQA during the inspection and responded to by the service provider should be incorporated into this compliance plan.

As part of the continual monitoring to assess compliance, HIQA may ask the service provider before and during subsequent inspections to provide an update on how it is implementing its compliance plan.

Continued non-compliance

Continued non-compliance with the national standards resulting from a failure by a service provider to put in place appropriate action(s) to address the areas of risk previously identified by HIQA may result in increased monitoring activity including further inspection activity, seeking compliance plans and assurance reports from the provider. It may also result in further escalation in to the relevant accountable person(s) in line with HIQA policy.

Long-term and medium-term work to meet compliance with the standards

HIQA recognises that substantive and long-term work may be required to come into compliance with some national standards and that this may take time and require significant investment. An example of this may be in relation to non-compliance and risks identified with infrastructure. In such cases, the medium- and long-term solutions should be outlined to HIQA with clear predicted time frames as to how the

service provider plans to improve the level of compliance with the relevant national standard.

HIQA requires assurance and details of

- how mitigation of risk within the existing situation will be addressed
- information on medium and long term mitigation measures to manage risks and improve the level of compliance with standards

Compliance descriptors

The compliance descriptors used for judgments against standards are 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.

Compliance plan provider's response:

National 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.

Pg. in Report	Location	Risks Identified during inspection	Actions required to improve compliance 2026	Person Responsible	Timeframe
11	Emergency Department	*Nursing vacancies in the emergency department had the potential to impact on patient safety*	To address nursing shortages, including within the emergency department, the hospital have implemented a structured and proactive recruitment strategy focused on accelerating the pace of hiring and reducing vacancy duration. Key measures include: 1. Establishment of ongoing Nursing recruitment panels to enable faster appointment when vacancies arise. 2. Targeted recruitment campaigns focused on attracting nursing candidates during high engagement periods. 3. Newly graduated nurses with 6 months qualification experience to have the opportunity to rotate to the Emergency Department.	Director of Nursing HR Manager	Ongoing

			4. Engagement with Education Providers, supporting early identification of suitable applicants. Since the time of inspection in October 2025, 4.0 WTE Nursing staff have commenced within the Emergency Department, with plans for on-boarding of an additional 6.0 WTE by start of Q3 2026.		
Pg. in Report	**Location**	**Risks Identified during inspection**	**Actions required to improve compliance 2026**	**Person Responsible**	**Timeframe**
11	Pharmacy	*Pharmacy workforce was not delivering comprehensive clinical pharmacy*	• Pharmacy Executive Manager to develop and submit a service development plan by April 2026 for uplift in staff levels for workforce expansion in order to provide cover to all areas currently not receiving a clinical Pharmacy service in the hospital. Risk mitigation measures are in place with Pharmacists deployed to wards based on needs assessment, prioritisation given to high-risk areas (e.g. complex polypharmacy, high-risk medicines) such as critical care and heamato-oncology and the main pharmacy dispensary. Within each area Pharmacist resources are prioritised based on clinical risk and patient acuity. For those wards without a clinical pharmacy service a responsive model is in place whereby wards without dedicated cover can access pharmacy input from the main dispensary on a case by case basis. • This risk is now captured on the hospital Corporate Risk Register; progress on identified actions will be	Chief Pharmacist	Q2 2026

			monitored by the Pharmacy Executive Manager with oversight by the General Manager at regular intervals. • Pharmacy team to re-implement clinical pharmacy local KPI measurement commencing Q2 2026 in order to support data-driven prioritisation of services and also to enable performance monitoring & service optimisation within existing resources.		
11	Hospital wide	*Compliance with basic life support training was low across staff groups which could pose a risk to patient safety, particularly in emergencies where timely and effective resuscitation is critical*	• Heads of Departments to review the BLS training requirement needs in each area. • BLS Training sessions are scheduled 3 times per week at present with capacity to train 18 staff members weekly. Once the training record validation exercise has been completed, the hospital will review the need to increase training capacity through use of external training provider. Target to achieve >80% compliance across all required staff disciplines by Q1 2027. • The Resuscitation Training Officer will inform Heads of Department of non-attendance at training in order ensure maximum utilisation of available places. • Clinical Director to validate HR records for medical and surgical staff compliance with mandatory training by Q2 2026. BLS sessions for consultants to be arranged commencing April 2026.	Clinical Director & Director of Nursing	• Q2 2026 • Q1 2027 • Q2 2026
Pg. in Report	**Location**	**Risks Identified during inspection**	**Actions required to improve compliance 2026**	**Person Responsible**	**Timeframe**

11	Hospital wide	*Recording of attendance at medication safety training did not facilitate oversight of the percentage of relevant staff trained*	• The hospital have introduced a training module for all medical and nursing staff on vancomycin & gentamycin management. Compliance with completion rates will be overseen by the Mandatory Training Committee and EMT. • The hospital will also implement a structured programme of medication safety sessions at grand rounds four times a year.	Clinical Director. Chief Pharmacist & HR Manager	Ongoing
11	Hospital wide	*Absenteeism rates were above the HSE target of less than or equal to 4.0*	• The HR Executive Manager to circulate information to all staff by April 2026 on the application of the HSE Managing Attendance Policy via the HR Newsletters and Internal Communications email updates. Information and supports on managing attendance will be included in the newsletter and circulated to all staff (next edition due for circulation Q2 2026). • The HR Executive Manager has established a dedicated training programme targeted at both new and existing managers, commencing May 2026. The programme is designed to support in the management of absence to include: holding Return to Work meetings, Occupational Health referral pathways, sharing of EAP supports and roster optimisation to facilitate staff wellbeing. • HR will continue to run regular 'HR Clinics' to support staff in awareness and implementation of HR processes including available supports for staff wellbeing.	HR Manager	Q2 2026

			• Internal audits to commence by the HR Team in Q2 2026 to assess compliance of Return to Work meetings post staff absence. Quality Improvement plan to be developed based on results.		

National Standard	Judgment
Standard 2.2: Care is planned and delivered to meet the individual service user's initial and ongoing assessed healthcare needs	Partially Compliant

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

Pg. in Report	Location	Risks Identified during inspection	Actions required to improve compliance 2026	Person Responsible	Timeframe
15	Hospital wide	*Patient assessment tools were not consistently completed following an identified need (e.g. nutrition and hydration, bed rails)*	• CNM 2 or deputy will meet with the newly established Link RGNs at planned monthly meetings and review local data collected using the Link RGN data collection tools on the areas of nutrition & hydration, delirium, medication safety, continence promotion and management of incontinence, and, pressure ulcer prevention. • An action plan will be devised by the CNM2 and relevant Link Nurse for specific areas of non-compliance at the monthly meeting.	Director of Nursing	Q2 2026

			• Results and action plans to be shared by the CNM2 or deputy with ward nursing staff at ward huddles with minutes documented. • Oversight of results and implementation of quality improvement plans by ADON's with review at monthly ward 1:1 meeting with CNM2. • The Executive Led Quality & Safety Walkaround tool will be updated for Q2 2026 to include a spot check of nursing assessment documentation and care plans. Feedback will be shared directly with the CNM(s) during the walkaround(s).		
Pg. in Report	**Location**	**Risks Identified during inspection**	**Actions required to improve compliance 2026**	**Person Responsible**	**Timeframe**
16	Hospital wide	*Care plans reviewed were not always adequately individualised to reflect the assessed condition and needs of each patient, such as their communication needs*	• A Recording Clinical Practice Link RGN, which will be at an Enhanced Nurse level and CNM 1, will be established in each clinical area by end of Q2 2026. • The Nurse Practice Development Team will devise a data collection tool for recording of clinical practice by end of April 2026. • This Link RGN will complete 4 data collections per month to review nursing assessment and care planning documents to ensure they are individualised and reflective of patient's current needs. The CNM1 will feedback directly to individual RGN's regarding any identified areas for improvement.	Director of Nursing	Q2 2026

			• Oversight of implementation by CNM2 and ADON with review at monthly ward 1:1 meeting with CNM2. • The Executive Led Quality & Safety Walkaround tool will be updated for Q2 2026 to include a spot check of nursing assessment documentation and care plans. Feedback will be shared directly with the CNM(s) during the walkaround(s).		
16	Hospital wide	*Care plans were not consistently reviewed and updated to reflect patients initial and ongoing assessed needs*	• The Recording Clinical Practice Link RGNs will audit care plans weekly to ensure that they have been updated to reflect patients' ongoing needs. • Care plans that have not been updated will be highlighted by the Recording Clinical Practice Link RGNs to the ward CNM 1 or deputy. The CNM1 will feed back to individual RGNs regarding areas for improvement. • Oversight by CNM2 and ADON with review at ward 1:1 meeting with CNM2. Trends in areas of non-compliance to be collated and targeted training to be provided by CNM 2, with oversight by ADON at monthly ADON/CNM meetings. • The Executive Led Quality & Safety Walkaround tool will be updated for Q2 2026 to include a spot check of nursing assessment documentation and care plans. Feedback will be shared directly with the CNM(s) during the walkaround(s).	Director of Nursing	Q2 2026

Pg. in Report	Location	Risks Identified during inspection	Actions required to improve compliance 2026	Person Responsible	Timeframe
16	Hospital wide	*Quality improvement plans with defined actions were not developed for all metrics that fell below the target level of compliance to address concerns specific to that area.*	• Individual ward/department quality care metric results are reviewed monthly by the CNM and ADON for each area. • Trends evident over a 3 monthly period that result in compliance less than 90% (green) will require a quality improvement plan (QIP) to be established. • Monthly quality care metric results will be discussed on the 2nd Tuesday of each month at the Nursing Executive Meeting. Metrics to be placed as a standing agenda item for all nursing executive meetings. • The Director of Nursing to discuss progress on QIPs and analysis of metric trends at ADON 1:1 Meetings.	Director of Nursing	Ongoing

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

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

Pg. in Report	Location	Risks Identified during inspection	Actions required to improve compliance 2026	Person Responsible	Timeframe
21	Hospital wide	*A clinical pharmacy service was not provided to a significant proportion of patients in the hospital*	• Pharmacy Executive Manager to develop and submit a service development plan by April 2026 for uplift in staff levels for workforce expansion in order to provide cover to all areas currently not receiving a clinical Pharmacy service in the hospital. Risk mitigation measures are in place with Pharmacists deployed to wards based on needs assessment, prioritisation given to high-risk areas (e.g. complex polypharmacy, high-risk medicines) such as critical care and heamato-oncology and the main pharmacy dispensary. Within each area Pharmacist resources are prioritised based on clinical risk and patient acuity. For those wards without a clinical pharmacy service a responsive model is in place whereby wards without dedicated cover can access pharmacy input from the main dispensary on a case by case basis. • This risk is now captured on the hospital Corporate Risk Register; progress on identified actions will be monitored by the Pharmacy Executive Manager with oversight by the General Manager at regular intervals	Chief Pharmacist	Q2 2026

			• Pharmacy team to re-implement clinical pharmacy KPI measurement commencing Q2 2026 in order to support data-driven prioritisation of services and also to enable performance monitoring & service optimisation within existing resources.		
21	Hospital wide	*There was an identified lack of HDU and ICU beds leading to delayed admissions to higher levels care when required*	• Interim plan: An area within the hospital has been identified for conversion to a HDU; a working group has been established, chaired by General Manager, and staffing plan is in place. Planned to open by Q3 2026. • Long term plan: New ICU development currently in design phase. A working group has been established. Estimated timeline for completion Q4 2027.	Chief Operations Officer	• Q3 2026 • Q4 2027
21	Hospital wide	*CCOT availability outside core hours remained limited*	A Business Plan for the continued phased expansion of the Critical Care Outreach Team (CCOT) to a 7 day service will be developed by the Assistant Director of Nursing for submission to the hospital's employment control committee by Q2 2026.	Director of Nursing	Q2 2026
Pg. in Report	**Location**	**Risks Identified during inspection**	**Actions required to improve compliance 2026**	**Person Responsible**	**Timeframe**
21	Hospital wide	*Discharge letters were not being issued to all patients in a timely manner.*	• Clinical Director to meet regularly with all speciality consultant leads regarding completion of discharge summaries to commence Q2 2026. • Training on completion of discharge summary documentation to be delivered to all new medical and surgical staff at each induction.	Clinical Director	Q2 2026