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:	Croom Orthopaedic Hospital
Centre ID:	OSV-0001069
Address of healthcare service:	Corrabul Croom Co. Limerick V35 F434
Type of Inspection:	Announced
Date of Inspection:	11/02/2026 and 12/02/2026
Inspection ID:	NS_0185

About the healthcare service

Model of hospital and profile

Croom Orthopaedic Hospital has a long history of healthcare provision in the Midwest Region. Originally established as a workhouse in 1852, it later transitioned to a county hospital in 1923. In 1955, it became St. Nessan's Orthopaedic Hospital, before being re-designated as the Mid-Western Regional Orthopaedic Hospital in 2006.

Today, Croom Orthopaedic Hospital is a Model 2* specialist orthopaedic hospital, owned and operated by the Health Service Executive (HSE). It functions under the governance of the HSE Midwest Regional Health Area, which plans and delivers health and social care services to approximately 413,000 people across Limerick, Clare and North Tipperary. The Chief Executive Officer for the Midwest Acute and Older Peoples Services (hereinafter referred to as the CEO), leads acute hospital services and older adult care in the region and had overall responsibility and accountability for the operational delivery of healthcare services.

The Midwest Region operates a hub-and-spoke model, with University Hospital Limerick (UHL) serving as the central hub for key acute and critical care services. Within this structure, the hospital provides scheduled and specialist orthopaedic care as part of the Midwest hospitals integrated clinical directorate framework. The hospital primarily is governed through the perioperative care directorate of UHL, through which performance, quality and safety indicators are overseen and reported.

Elective orthopaedic activity in the hospital is delivered by consultant orthopaedic surgeons based at UHL and the hospital also receives post-acute and rehabilitative transfers from UHL. Recent years have seen investment in the hospital's development, including the opening of a modern theatre complex and a new 24-bedded inpatient unit, featuring all private en-suite rooms.

The hospital provides a range of services, including:

- elective in-patient and day-case orthopaedic surgery
- maxillofacial
- paediatric day surgery
- rheumatology
- pain management
- ambulatory care pathways, including musculoskeletal triage and trauma clinics
- outpatient care and diagnostics.

*A Model 2 hospital typically provides the majority of hospital activity including extended day surgery, selected acute medicine, local injuries, and a range of diagnostic services.

The following information outlines some additional data on the hospital.

Number of beds	44 inpatient beds 13 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.

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.

[†]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.

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
11/02/2026	*13:00 – 17:30*	Angela Moynihan	Geraldine Ryan Elaine Egan Kay Carlos Martina Glynn
12/02/2026	*08:00 – 14:30*	Angela Moynihan	Geraldine Ryan Elaine Egan Kay Carlos Martina Glynn

Information about this inspection

This inspection focused on nine national standards from five of the eight themes[‡] of the *National Standards for Safer Better Healthcare*, and 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 four clinical areas:

- St Patrick's ward (inpatient orthopaedic ward)
- Maigue unit (inpatient orthopaedic unit)
- St Anne's ward (surgical day ward)
- Theatre department.

The inspection team spoke with the following staff:

- representatives of the hospital's site operational team:
  - Operational Director of Nursing (DON)
  - Business Manager
- Director of Quality, Risk and Patient Safety
- Members of the Quality and Risk department in UHL
- Human Resource Manager
- Hospital patient flow representatives
- representatives from each of the following committees:
  - Infection Prevention and Control
  - Drugs and Therapeutics
  - Deteriorating Patient

Acknowledgements

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

[‡] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.
[§] Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration.
[**] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[††] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

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

Patients consistently reported high levels of satisfaction with the care they received describing staff as caring, responsive and kind. Those who spoke with inspectors stated that their treatment plans were clearly explained, they felt well informed regarding their care, call-bells were answered promptly and the quality of food provided was highly praised.

Across all clinical areas, patients characterised staff as "brilliant" and "very efficient", with others noting that staff were "friendly and so nice." Patients also highlighted the value of the "daily physio," describing it as very good, and commended healthcare attendants as "fantastic." In relation to their overall care and treatment, patients described the service as "10/10" reported that they received assistance when required and indicated that they "saw the doctors every day." One patient further commended the ward's post-operative pain management practices and expressed satisfaction with being able to mobilise on crutches shortly after surgery. Patients who spoke with inspectors demonstrated awareness of their discharge plans. Some patients awaiting rehabilitation or long-term care beds in the community stated that they were kept informed of the progress of these arrangements.

Patients reported that staff consistently maintained their privacy and dignity. However, a small number of individuals expressed dissatisfaction with the bed space available in shared patient rooms on St Patrick's ward. This is discussed in more detail under National Standard 2.7.

Patients across all clinical areas demonstrated varying levels of awareness regarding the formal complaints process. Some indicated that they were familiar with the formal procedure, while others reported that they would directly approach staff if they had concerns or wished to make a complaint.

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes the standards related to workforce, use of resources. Croom Orthopaedic Hospital was found to be compliant with two national standards (5.2 and 5.8) and substantially compliant with two national standard (5.5 and 6.1). Key inspection findings leading to these judgments on compliance 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.

Based on discussions with regional and local management and a review of relevant documentation, inspectors found that the corporate and clinical governance structures supporting the delivery of safe, high-quality healthcare were integrated, clearly defined and formalised. Organisational charts provided outlined management reporting lines and the reporting arrangements for governance and oversight committees at local and regional levels. These structures were confirmed through staff interviews and documentation received following the inspection.

Local Level

The day-to-day governance of hospital operations was overseen by the operational DON, supported by the hospital business manager. A designated clinical lead for trauma and orthopaedics provided clinical leadership and governance, reporting to the associate clinical director through the directorate structure. The hospital team was further supported by the Executive Management Team (EMT) based at UHL, which provided oversight and guidance to ensure the effective delivery of hospital operations and strategic objectives. Operationally there were two main structures at the hospital, the Operational Site Steering meeting and the perioperative care directorate site meeting.

Croom Site Operational Meeting

The purpose of this meeting was to provide transparent and accountable leadership for the management of the hospital. It served as the primary forum with oversight of operational matters affecting the effective functioning of the hospital. Management informed inspectors that the meeting was held monthly and chaired by the hospital's operational DON, in line with its terms of reference (TOR). The forum both received

and provided updates to department heads on service developments, staffing, risk management, feedback from committees at UHL, audit findings and departmental issues. Inspectors were informed that any issues that could not be addressed at this forum were either escalated to the EMT or the CEO in line with the TOR.

Perioperative care directorate-Croom hospital site meeting:

This monthly meeting, chaired by the general manager for the perioperative directorate, involved management participation from both the perioperative directorate in UHL and Croom hospital. Meetings were held on a monthly basis and recent minutes demonstrated that patient safety matters were routinely discussed. These included incidents, audit results, complaints, patient deterioration and infection prevention and control matters. In addition, operational topics such as theatre scheduling, service efficiencies, human resource management and mandatory training were included on the agenda. While actions were assigned they were not time-bound and it was unclear from the documentation whether progress on these actions was reviewed from one meeting to the next.

Nurse management meeting

Monthly nurse management meetings comprising separate clinical nurse manager (CNM) meetings and assistant director of nursing (ADON) meetings in the hospital were chaired by the DON. Documentation reviewed, along with discussions with staff, confirmed that these meetings were held consistently each month. Minutes examined showed that the four key areas of harm, incident and risk management and patient experience were discussed at this forum. Inspectors noted that actions were agreed, time-bound and reviewed at subsequent meetings. It was also evident that this forum both received updates from and provided updates to nurse management regarding service development, staffing and departmental issues that arose.

Regional Governance and Oversight arrangements

Executive Management Team (EMT)

In keeping with the hub-and-spoke configuration of the Midwest Region, the CEO was the senior accountable officer with overall responsibility and accountability for the governance and quality of health services delivered within the hospital as well as across all hospitals and older persons' services in the region. A well-established reporting structure was in place from the CEO to the Regional Executive Officer (REO) of the HSE Midwest and subsequently to the CEO of the Health Service Executive (HSE).

The Executive Management Team (EMT), chaired by the CEO had multidisciplinary membership and met monthly in line with its TOR. The purpose of the EMT was to

support and advise the CEO, providing effective leadership, expertise, and direction to ensure that the organisation delivered on the objectives and key performance requirements outlined in its service plan. Croom Orthopaedic Hospital was governed by four of the seven directorates. Meeting minutes reviewed and discussions with staff demonstrated attendance by the relevant clinical directors at EMT meetings, along with regular submission of reports to the EMT. The Chief Director of Nursing and Midwifery (CDONM) was also a member of the EMT, providing oversight of the nursing services at the hospital.

Clinical Directorate Structure

Clinical services at the hospital were delivered under the leadership and governance of the medicine, perioperative, operational services and diagnostics directorates. Each clinical directorate comprised a management team consisting of a clinical director, general manager and directorate DON. The clinical directorates were responsible for the operational functioning and management of the quality and safety and identified risks for the healthcare services under their remit. The perioperative directorate was the main directorate that the hospital interacted with. The medicines, operational services and diagnostics directorates also had defined reporting arrangement to the EMT and the clinical director for each clinical directorate also reported to the regional clinical director. Each directorate reported formally on the quality and safety of services under their remit to the Quality and Patient Safety Committee (QPSC).

Quality and Patient Safety Committee

The hospital was represented on the Acute and Older Persons Quality and Patient Safety Committee (QPSC) by nominated members of the directorate management team. The QPSC reported to the EMT and onwards to the CEO and was responsible for overseeing and assuring the quality and patient safety agenda across all hospitals in the Midwest Region. Each clinical directorate submitted a standardised quality and safety report to the QPSC on a quarterly basis which inspectors were provided with. The report included data on incidents, medication errors, perioperative risk register, complaints, audit activity, quality improvement plans and policy updates all of which were noted as standing items reported by the directorate.

The QPSC also received reports from three of the four high-risk oversight committees: the Hospital Infection Control Committee Meeting (HICCM), the Medication Safety Committee (MSC) and the Deteriorating Patient Steering Committee (DPSC). Governance of these priority risk areas for the hospital was exercised through these committee structures within which the hospital was represented via the established directorate framework.

Inspectors were informed that matters relating to transitions of care and clinical handover had recently been added to the QPSC agenda with issues requiring focused attention escalated through the directorate structure at this forum.

The hospital had recently established a multidisciplinary complex discharge committee which operated a dual reporting pathway to both the Delayed Transfers of Care (DTOC) group, UHL and the nominated Integrated Health Area Manager for the region. In addition, the hospital had recently developed a multidisciplinary Deteriorating Patient and Sepsis Steering Committee. This committee reported into the UHL DPSC through the DON of the hospital.

In the hospital, formal governance arrangements were established, and discussions with staff indicated that these structures were continuing to strengthen. This included the development of local committees dedicated to areas such as complex discharge planning and the management of the deteriorating patient.

Inspectors found that the EMT and key hospital committees, including the QPSC, HICCM, Drugs and Therapeutics Committee (DTC), MSC and the DTOC Committee convened in line with their respective TOR and operated using structured agendas. Actions arising from previous meetings were reviewed for the most part and while most action items were tracked, inspectors noted that some did not include defined timeframes for completion, for example with the DPSC, DTC meetings and local governance meetings in the hospital.

Overall, inspectors found that formal governance structures were in place to support the delivery of high-quality, safe and reliable care. A structured reporting pathway operated from the hospital to the EMT, governance committees and the directorates to the QPSC, then to the CEO, the REO, and ultimately to the CEO of the HSE.

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.

Through staff discussions and committee interviews, it was clear that hospital management had recently restructured existing committees and new committees had been established. These changes were made to support the achievement of the Midwest Regions overall strategic objectives and to strengthen management and oversight arrangements in key areas such as care of the deteriorating patient and discharge planning. Some of these arrangements were in their early stages of implementation and being embedded into the overall quality framework in the

hospital.

Infection prevention and control

UHL's Infection Prevention and Control Team (IPCT), led by a consultant microbiologist, actively supported staff in implementing best practice in infection prevention and control at the hospital as there was no dedicated onsite IPCT. Staff stated they were supported by a designated infection prevention and control clinical nurse specialist from UHL, who visited the hospital weekly and maintained daily phone contact. A consultant clinical microbiologist provided 24/7 on-call clinical guidance to the hospital as necessary. Inspectors were informed by hospital management that a formal IPC report from the IPCT to the hospital was not in place. However, the IPCT advised that they were in the process of developing this reporting structure.

Inspectors were informed that the HICCM was responsible for developing and approving the hospital's annual infection prevention and control programme and setting associated priorities and the 2026 programme was provided for review.

The hospital received support from an antimicrobial stewardship (AMS) pharmacist based at UHL. Inspectors were informed that the pharmacist visited every six weeks, monitored antimicrobial prescribing practices and reported findings to both the HICCM and the DTC. Management advised that a weekly multidisciplinary team meeting was held in UHL, during which complex cases including orthopaedic patients were discussed. These meetings involved input from the AMS pharmacist, microbiology, the surgical team and other relevant clinical disciplines to guide safe and effective care for these cohort of patients.

Medication safety

The hospital did not have a dedicated pharmacy service [‡‡]or on site clinical pharmacist and the existing management arrangements were provided through the UHL pharmacy service led by the pharmacy executive manager. Inspectors were informed that the hospital had previously been approved for two pharmacy posts however, these posts were subsequently removed under the pay and numbers strategy. This strategy is a government-approved framework that sets employment ceilings to control workforce size and pay costs.

The DTC, in UHL was the overarching committee responsible for overseeing the quality and safety of the pharmacy service and supporting medication safety practices. The DTC functioned as a subcommittee of the QPSC and had established, formalised reporting structures to that committee. The hospital's Medication Safety Programme was implemented by medication safety officers (MSOs), who attended

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

the hospital on a monthly basis to monitor medication safety practices, conduct audits and provide education. The MSOs reported directly to and were overseen by the pharmacist executive manager and reported to the DTC. Staff informed inspectors that they were able to contact the pharmacy department in UHL for advice or to raise concerns as required.

Through discussions with management and review of relevant documentation, inspectors found that the arrangements for overseeing medication safety were not fully effective. Review of the UHL-based Medication Safety Committee (MSC) meeting minutes showed that the hospital had not been represented at these meetings, despite the MSC addressing audit findings, medication incident management and other safety issues directly relevant to the hospital. Following the inspection, management provided inspectors with a detailed risk assessment outlining existing controls and additional time-bound measures designed to strengthen oversight of medication safety within the hospital. This plan included:

- reviewing the provision of clinical pharmacy input in the hospital
- assistant director of nursing (ADON) and clinical skills facilitator (CSF) representation at the monthly MSC meetings
- involving the clinical skills facilitator in education and audit activities
- staff training and education sessions on medication management and incident reporting.

This is further discussed under national standard 3.1.

Deteriorating patient

Inspectors met with the recently appointed nominated lead for the deteriorating patient in the hospital and the DON. A recently established Deteriorating Patient and Sepsis Committee had been developed in the hospital to strengthen the management and oversight of deteriorating patients within the hospital. This committee, chaired by an ADON, operated under the governance of the Deteriorating Patient Steering Committee (DPSC) in UHL, which the DON attended on a quarterly basis. The newly developed committee in the hospital was meeting in line with its TOR, also on a quarterly basis and its membership was multidisciplinary. Management informed inspectors that the committee was in its early stages and continuing to develop its oversight function. Key agenda items included audit results relating to the deteriorating patient, implementation and performance of the Irish National Early Warning Score §§(INEWS), updates on the Irish Paediatric Early Warning System*** (PEWS) and progress on staff training and education.

Transitions of care

A recently established multidisciplinary complex discharge committee was convened in the hospital and was meeting every second week chaired by a hospital ADON. A

review of the committee's TOR confirmed that meetings followed a structured agenda and reported to the DON and upwards to the DTOC committee in UHL. Inspectors were informed by staff that an ADON was appointed on a daily basis to manage and oversee bed management in the hospital and described the daily reporting relationship to UHL around bed availability and the hospitals daily reporting structures that were in place to manage beds. The hospital had an onsite medical social worker who assisted with discharge planning which included coordinating and organising community services to support patients following discharge.

Overall, the hospital had established effective arrangements to support the achievement of its planned objectives, with evidence of engagement across all levels of service delivery. This was particularly demonstrated in three of the four areas of focus assessed during the inspection. Notwithstanding this:

- the management and oversight arrangements in place for medication safety require continued and sustained attention to ensure that the additional measures introduced deliver the intended improvements in the oversight of medication safety in the hospital.

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 for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The hospital reported on a range of KPIs and there was evidence that information from this process was being used to improve the quality and safety of healthcare services at the hospital.

Monitoring performance

At local level, a broad range of clinical quality and safety data was collected and collated in line with national HSE reporting requirements. This included information on compliance with national metrics, hospital activity, patient-safety incidents, audit findings, complaints, healthcare-associated infections, workforce indicators, training compliance and identified risks that had the potential to impact service quality and safety. At executive level, it was evident that performance information was reviewed through established governance structures, including the QPSC, the EMT and reporting processes to the Regional Executive Officer.

§§ INEWS is an early warning system to assist staff to recognise and respond to clinical deterioration in adults.
*** PEWS is an early warning system to assist staff to recognise and respond to clinical deterioration in children

Risk management

Inspectors found that the hospital had effective risk-management structures and processes in place, aligned with the HSE Integrated Risk Management Policy. Risks were identified, monitored and managed at clinical area, hospital and clinical directorate level. Review of risk registers and discussions with clinical staff and management demonstrated that risks had appropriate control measures in place which were regularly reviewed and updated. Risks that could not be fully managed locally were escalated to the relevant clinical directorate risk register, overseen by the director of quality risk and patient safety through the QPSC. High-rated risks were escalated to the corporate risk register, reviewed by the director of quality risk and patient safety and reviewed at the Executive Performance Management meeting every two months. This is further discussed in national standard 3.1.

Incident management

Patient-safety incidents and serious reportable events were reported to the National Incident Management System (NIMS) in line with the HSE Incident Management Framework. Each clinical directorate was supported by a risk advisor and a Serious Incident Management Team (SIMT), responsible for ensuring the effective management of identified risks and incidents. SIMTs approved recommendations arising from patient-safety reviews, which were logged and monitored by the QPSC. Patient-safety incidents were managed at directorate level with oversight by the SIMT.

Inspectors reviewed the hospital's 2025 incident-management data, including the figures and types of incidents reported, which formed part of the annual incident-management overview report for the Midwest hospitals submitted to both the QPSC and the EMT. Inspectors noted that two serious reportable incidents were recorded in 2025 and management demonstrated that these were managed in accordance with the HSE Incident Management Framework. This is further discussed under national standard 3.3.

Audit activity

The hospital did not have a local audit committee; however, management informed inspectors that the hospital was included in the regional audit steering committee, which provided governance and oversight of clinical audit and was chaired by the director of quality risk and patient safety. An annual audit plan was in place, and inspectors were provided with evidence of audits conducted regularly in the hospital. Examples included environmental, hand-hygiene, care-bundle, medication-safety,

INEWS, PEWS and ISBAR3[†††] audits, as well as quality-care metrics relating to patient discharge. Where improvements were required, time-bound action plans were generally in place and audit results were displayed in the clinical areas visited. Inspectors were provided with examples of quality-improvement plans that had been implemented and observed improved compliance in the targeted areas. For example, environmental audit compliance in St Anne's ward increased from 82% in December 2025 to 86% in January 2026, with an additional improvement plan introduced to further enhance compliance in subsequent months. Management also outlined plans to strengthen audit structures and increase participation by the hospital and the perioperative directorate in the clinical audit activity overseen by the regional audit steering committee. Following the inspection, hospital management provided inspectors with an updated organogram outlining the local audit committee reporting structure which will be an area of focus during future inspections of the hospital.

Feedback from people using the service

Inspectors found that the hospital had effective oversight of patient feedback to inform service improvements. In response to the National Inpatient Experience Survey 2024, the hospital had developed three high-level quality-improvement plans focused on increasing awareness of how to provide feedback, improving meal choices and ensuring patients could speak to someone about their worries.

The hospital had an active Patient Experience Committee, chaired by the DON, which met every two months to discuss patient feedback and progress on improvement plans. The business manager also participated in the regional patient experience steering committee, chaired by the director of quality risk and patient safety, where matters relating to patient experience and complaints were reviewed. Further detail is provided under National Standard 1.8.

In summary, the hospital had effective and systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Judgment: Compliant

[†††] ***** ISBAR3 – Identify, Situation, Background, Assessment, Recommendation, Read Back, is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

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

HIQA found that hospital management had effective arrangements in place to plan, organise and oversee staffing levels in order to support the delivery of high-quality, safe healthcare. A focused approach to mandatory training was required to ensure that all staff maintain the competencies necessary to deliver safe, high-quality care. The hospital did not have an on-site Human Resources (HR) department and staff recruitment was coordinated through UHL. Line managers at the hospital were supported by UHL HR department in addressing issues as required.

In line with the clinical directorate structure, the perioperative directorate had an assigned HR business manager and a designated liaison person in place to support the hospital with its specific workforce requirements across various specialties. Inspectors noted that staffing was a standing agenda item at the perioperative directorate performance meetings held with the CEO. Minutes of these meetings reviewed demonstrated that discussions routinely addressed staffing needs, vacancies and absenteeism. The absenteeism rate for the hospital was monitored on a monthly basis and reported to the EMT. Management reported that the absenteeism rate for December 2025 was 11.2% which was above the HSE's target of 4% or less and outlined processes in place to monitor and manage this.

Workforce

Hospital management confirmed that there were 13 whole-time equivalent (WTE) consultant posts at the hospital, all of which were filled at the time of inspection. Inspectors were informed that there were arrangements in place for consultants not on the relevant specialist division of the Irish Medical Council register which aligned with those recommended by the HSE. At the time of the inspection, medical consultants at the hospital were supported by an approved complement of 30.2 WTE non-consultant hospital doctors (NCHDs) and all posts were fully staffed. During out-of-hour periods one NCHD was available onsite for patient reviews, supported by the UHL on-call teams.

Management highlighted the absence of a clinical pharmacy service and outlined the associated challenges in monitoring and promoting medication safety practices across the hospital as there was no WTE pharmacy post in place. Management stated that a business case had been completed for the perioperative directorate which, if approved, would increase the WTE allocation for the directorate. This is discussed further under national standard 5.5 and 3.1.

There were 128.05 whole-time equivalent (WTE) approved nursing posts in the hospital inclusive of management and other nursing grades. On the days of

inspection, 115.85 WTE nursing posts were filled, with 12.2 WTE posts vacant (9.53%). A recruitment campaign was underway and inspectors were informed that recruitment processes were in place for 5.5 WTE posts to progress the filling of these roles. Nursing staff were supported by 16.0 WTE healthcare assistants (HCAs), of which 14.9 WTE posts were filled and by 49 WTE multitask attendants, which 42 posts were filled. Inspectors were informed that the clinical areas visited during the inspection had their full complement of nursing and HCA staff.

Management reported that the Safer Staffing Framework had been implemented on the inpatient wards. Inspectors were advised that shortfalls in nursing and HCA staffing were managed through redeployment from other clinical areas, the provision of overtime and the use of agency staff where necessary.

Staff training

Inspectors were informed that nursing staff uptake with mandatory and essential training was overseen by CNMs. NCHDs attendance was recorded on the National Employment Record System. Oversight of mandatory training was discussed at the monthly performance meetings with the CEO and documentation provided to inspectors confirmed this. Staff confirmed that formal induction training was provided upon commencement of employment for new staff. A review of training records conducted by inspectors showed varying levels of compliance across staff groups. Overall, nursing staff demonstrated high uptake across mandatory training areas with high levels of compliance in medication safety, INEWS, PEWS, sepsis training, hand hygiene and basic and advanced life support, where completion rates generally ranged from 88–100%. Lower compliance was noted in paediatric life support (85%) and in standard and transmission-based precautions and outbreak management, where uptake ranged from 77–100%. NCHD compliance was more mixed, with strong uptake in sepsis training and hand hygiene but lower completion in basic life support (64%), advanced cardiac life support (70%), paediatric life support (75%) and INEWS (74%). Healthcare assistant records demonstrated consistently high compliance, with training uptake exceeding 90% across all mandatory areas, including standard and transmission-based precautions, basic life support, hand hygiene, and outbreak management.

Overall, management had workforce arrangements in place to support the delivery of high-quality, safe and reliable healthcare. However:

- hospital management should ensure that all clinical staff complete mandatory and essential training relevant to their scope of practice. This includes standard and transmission-based precautions and outbreak management for nursing staff, and basic life support, advanced cardiac life support, paediatric life support and INEWS training for NCHDs.

Judgment: Substantially Compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred. Croom Orthopaedic Hospital was found to be compliant with three national standards (1.6, 1.8 & 3.3), substantially compliant with one national standard (3.1) and partially compliant with one national standard (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.

It was evident through observation and discussions with staff that they were aware of and actively upheld, the need to respect and promote the dignity, privacy and autonomy of patients. Staff demonstrated a person-centred approach to care and were observed by inspectors to interact with patients in a respectful, kind and compassionate manner. For example, inspectors observed staff responding promptly to call bells and assisting patients with care needs and mobility requirements as needed. Inspectors observed that staff knocked before entering patient rooms, demonstrating respect for privacy. All patients were offered menu choices and patients who inspectors spoke with reported satisfaction with the meals provided.

Inspectors observed that patients' personal information in the clinical areas visited was for the most part, protected and appropriately stored. However, the absence of privacy covers for end-of-bed notes in St Patrick's ward was identified. This was brought to the attention of the CNM, who advised that this would be addressed. Healthcare records were stored in closed trolleys within the nurses' station.

Closed Circuit TV (CCTV) was in operation in public areas. Inspectors observed that while signage notifying patients and visitors of CCTV use was present at the hospital entrance, corresponding signage was not displayed inside the hospital. This was raised with management who confirmed that appropriate internal signage would be installed.

Patients in the Maigue unit were accommodated in single en-suite rooms, supporting the maintenance of privacy, dignity and confidentiality in the delivery of care. In addition, patients had access to a dedicated day room for use by patients and

visitors as well as secure access to an enclosed garden, providing a private and therapeutic outdoor space.

St Patrick's ward comprised multi-occupancy two-and four-bedded bays, each equipped with privacy curtains around individual bed spaces. Patients had access to individual call bells and the majority reported that their privacy, dignity and autonomy were maintained. However, two patients expressed dissatisfaction with the limited personal space and inadequate storage within their immediate surroundings. This is further discussed under National Standard 2.7.

In the theatre department, privacy curtains were in use in the anaesthetic area. Staff were observed appropriately assessing and reassessing patients postoperative status in the recovery area whilst maintaining the patients privacy and dignity.

Overall, there was evidence that hospital management and staff at the hospital were aware of the need to respect and promote the dignity, privacy and autonomy of people 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.

Inspectors found that the hospital had established systems and processes to manage both formal and informal complaints, as well as mechanisms to learn from them and oversee the implementation of resulting recommendations. The hospital's business manager was the designated complaints officer with responsibility for managing and overseeing the complaints process. A Patient Advocacy and Liaison Service [‡‡‡](PALS) representative also supported staff in resolving issues at the point of contact; however, at the time of inspection, management stated they had been temporarily redeployed to UHL. Clinical staff reported that they had access to the UHL PALS manager if required.

Hospital management stated they encouraged and supported point-of-contact resolution of complaints, with issues managed locally by the CNM in each clinical area. Discussions with staff and a review of meeting minutes confirmed that complaints were routinely discussed at various hospital forums, including site operational meetings and nurse management meetings. Staff in the areas visited

[‡‡‡] The Patient Advocacy and Liaison Service (PALS) team acts as a point of contact between patients, their families or carers and the hospital to assist in addressing concerns about any aspect of care or service in the hospital.

demonstrated good knowledge of the complaints management process and referenced the hospital policy 'Your Service Your Say' §§§ on complaints management. Staff in the clinical areas visited had completed complaints management training on HSELanD and management reported that further training was scheduled for April 2026.

Management told inspectors that complaints were logged onto a management system within the hospital. The director of quality risk and patient safety in UHL had oversight of the effectiveness of the complaints management process and provided monthly reports to the CEO and the EMT. Complaints were also reviewed at the quarterly QPSC meetings in UHL. The hospital received 32 formal complaints in 2025 and reported that the hospital achieved the HSE target, with greater than 75% of complaints resolved within the 30-day timeframe in 2025. Additionally, the hospital received 102 compliments from patients and had a process in place to share this positive feedback with staff.

Hospital management stated that complaints were reviewed at the Patient Experience Committee meetings every second month in the hospital and additionally at the Complaints YSYS Steering Committee meetings every six weeks with representatives from the Midwest Region acute hospitals, which were attended by the hospital business manager. Additionally, the perioperative directorate had designated complaints officers with responsibility for overseeing complaints management within the directorate.

Management provided inspectors with a breakdown of the complaints received in 2025, along with the associated quality improvement plans (QIPs) developed in response. They described QIPs that had already been implemented, including initiatives to improve public transport access for patients and families travelling to the hospital and the expansion of designated parking facilities on site. Management also outlined priority improvement areas for 2026 which included the roll-out of enhanced communication training for staff, development of improved discharge information for patients and the development of a hospital website.

Patients who spoke with inspectors demonstrated varying levels of awareness regarding the formal complaints process; however, all indicated they were comfortable raising concerns with staff if required. Patients reported high levels of satisfaction with care delivery, food and communication with clinical teams. Inspectors observed posters and leaflets on how to make a complaint displayed across all clinical areas visited and feedback boxes strategically placed in the

§§§ Health Service Executive. Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints. Dublin: Health Service Executive. 2017. Available online from https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf.

hospital. Furthermore, information on independent patient advocacy services was available in all clinical areas.

Overall, inspectors found that systems were in place to respond effectively to complaints and feedback.

Judgment: Compliant

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

Inspectors visited St Patrick's ward, the Maigue unit, St Anne's ward (surgical day ward), and the theatre department during the announced inspection. The physical environment across these clinical areas varied, and hospital management acknowledged the need for infrastructural upgrades in St Patrick's ward. While a refurbishment programme had commenced and was due for completion in March 2026, it was limited to non-patient areas and did not extend to the patient areas of the ward.

St Patrick's ward accommodated 20 patient beds, arranged across four four-bedded bays and two two-bedded bays, three with en-suite facilities. The ward contained five patient showers and six patient toilets in total all of which inspectors found to be clean and operational on the day of inspection.

While the ward environment was clean, the ageing infrastructure posed significant challenges in relation to effective cleaning, maintenance, storage and availability of space. Inspectors observed that a large amount of equipment was stored along the wards narrow corridor due to limited storage capacity within the ward and patient bedrooms. This presented a risk to patient safety, particularly during emergencies where rapid access to essential emergency equipment is required. Clinical staff and patients reported that, following a patient's return from theatre, furniture in the immediate area often had to be removed to accommodate necessary patient-monitoring equipment further highlighting spatial constraints in the ward. Physical distancing in the multi-occupancy room was challenging and private conversations could be easily overheard. This was evident on the days of inspection. Inspectors were informed by clinical staff that piped oxygen was not available on the ward due to ageing infrastructure however, mobile oxygen was readily available to support patient care. Hospital management and clinical staff acknowledged the risks associated with these issues and confirmed that they were recorded on the hospital risk register with mitigating controls in place and escalated to the perioperative risk register, both of which were provided to inspectors during the inspection.

Notwithstanding this, it was clear that staff made every effort to uphold patients' dignity and privacy in St Patrick's ward.

In contrast, the Maigue unit was a modern, spacious, surgical orthopaedic ward consisting of 24 single rooms with en-suite bathroom facilities, two with ante-room access. At the time of inspection all 24 rooms were occupied. The unit had direct secure access to a contained external garden and a bright day room. Additionally, a therapy room was located in the unit. Inspectors found that the en-suite areas were clean and well-maintained. Swipe-access control was in place at the unit entrance, as well as for all utility and clinical rooms.

St Anne's ward which underwent a refurbishment in recent years had 13 patient trolleys for surgical day procedures, including paediatric cases. The ward had swipe-access entry, a shared waiting area with the Outpatients Department and adequate toilet and shower facilities. Inspectors found the unit clean, tidy and with sufficient storage. Inspectors observed that the flooring was in poor condition and management advised that a plan was in place to address the identified issue. Inspectors also visited the new theatre department, which comprised a holding bay, four operating theatres, and eight recovery bays, including two enclosed bays for isolation or paediatric use. The department was clean and well maintained. Inspectors were advised that inadequate sterile-product storage remained a risk however this was not an identified issue on the day of inspection. A risk assessment had been added to the department's risk register with mitigating controls and hospital management reported that a storage solution had been identified.

Inspectors were informed that healthcare assistants (HCAs) and nurses were responsible for cleaning equipment. There was a green tagging system in place to identify equipment that had been cleaned which inspectors observed in use. Inspectors noted equipment to be clean in all the clinical areas visited and cleaning schedules were in place and up to date. All clinical areas had dedicated cleaners and cleaning was completed by the clinical staff at night.

Inspectors were informed that CNMs and the cleaning supervisor oversaw cleaning processes. Staff reported that cleaning resources were sufficient except in St Anne's ward, where management stated that a plan was in place to address the shortfall. The hospital employed both in-house and contracted cleaning staff, all of whom demonstrated good knowledge of environmental hygiene and infection-prevention practices. CNMs also reported that maintenance requests were addressed in a timely manner. A legionella risk assessment had been carried out in August 2025.

Inspectors observed that waste, including hazardous waste and linen was segregated and stored appropriately and all sharps containers had the temporary

closure mechanism in place. Emergency equipment was in place in all clinical areas visited and daily and weekly checklists were documented as completed.

Clinical staff reported that infection-prevention signage for isolation precautions was available. However, no patients required isolation on the days of inspection. Staff were observed wearing appropriate personal protective equipment in accordance with public health guidance. Wall-mounted alcohol-based hand-sanitiser dispensers were strategically placed and readily accessible in clinical areas and posters on correct hand-washing technique were displayed. Hand-hygiene sinks conformed to national requirements in all areas with the exception of St Patrick's ward.

In summary, the physical environment in the Maigue unit, St Anne's ward and the theatre department was generally well designed, with modern infrastructure in place. In contrast, St Patrick's ward displayed several infrastructural deficiencies, including visible wear and tear on floors and walls and some hand-hygiene sinks did not meet national standards. Limited storage space for equipment posed potential risks to patient safety. Despite ongoing efforts by staff, which inspectors acknowledged, these environmental shortcomings created risks related to infection prevention and control and compromised patient privacy and confidentiality.

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 arrangements in place to ensure proactive identification, evaluation, analysis and management of risks to the delivery of safe care.

Risk management

Management informed inspectors that the DON, supported by the business manager, was responsible for overseeing risk management processes within the hospital. Clinical staff reported that they managed risks in their areas in accordance with the HSE Enterprise Risk Management Policy. Inspectors reviewed local risk registers and noted that controls and mitigating actions were clearly documented for identified risks. Examples of risks documented on the clinical risk registers observed by inspectors included the absence of clinical pharmacy services and infrastructure-related issues. CNMs confirmed their responsibility for implementing and monitoring these actions with support from the UHL quality and risk department who attended the hospital regularly to assist staff to manage identified risks.

Minutes of meetings demonstrated that the operational site meeting and monthly nurse management meetings provided routine oversight of patient-safety risks at local level. Management stated that risks that could not be addressed within clinical areas were escalated to the hospital risk register and where appropriate, to the perioperative risk register. At the time of inspection there was three high-rated risks (lack of clinical pharmacy services, outdated infrastructure and non HBN compliant sinks) on the hospital risk register that related to the four areas of known harm and inspectors observed that these risks had been escalated to the directorate risk register as per policy.

Inspectors were informed that high-rated risks beyond directorate control were escalated to the EMT and recorded on the corporate risk register. Documentation reviewed by inspectors included examples such as infection-related risks arising from infrastructure and staffing levels. Inspectors found evidence that the corporate risk register had documented associated mitigating actions and controls in place and were subject to regular review by the CEO and the director of quality risk and patient safety.

Infection prevention and control

Management and clinical staff outlined that in line with national guidelines patients admitted to the hospital were screened for multi-drug resistant organisms (MDROs). An electronic alert system notified staff of patients with a previous history of confirmed MDRO. Inspectors observed that MDRO status was documented for all patients whose healthcare records were reviewed. Management reported that the Infection Prevention and Control Team (IPCT) audited compliance with *carbapenemase-producing Enterobacterales* (CPE) screening and that recent audit results showed low compliance, at 68% in October 2025. A new oversight process had since been introduced and management reported significant improvement in the weeks preceding the inspection, with audit results indicating compliance levels between 80% and 92%. Inspectors also noted that audit findings were shared and discussed at both local and regional governance meetings.

No infection outbreaks were reported at the time of inspection. Inspectors reviewed the most recent COVID-19 outbreak report relating to events in June and July 2024 and were satisfied that the outbreak had been investigated appropriately. Staff confirmed they had access to a microbiologist for clinical advice when required.

The IPCT also produced an end-of-year report summarising infection prevention and control performance, including surveillance outcomes, monitoring activities and key performance indicators, which was submitted to the EMT and CEO. In addition, the IPCT reported surveillance and monitoring activities to the HICCM on a quarterly basis. Inspectors were also provided with a sample quarterly update submitted to

the QPSC and the perioperative directorate, confirming the reporting structures in place.

Management informed inspectors that care-bundle compliance audits were undertaken in the hospital. Care bundles consist of a small number of evidence-based practices designed to improve patient outcomes when implemented reliably. Inspectors observed care-bundle audit results displayed in several clinical areas and management reported that findings were discussed at nurse management meetings. However, documentation reviewed by inspectors, including HICCM minutes and quarterly perioperative IPC reports, indicated that oversight of care-bundle compliance was not routinely discussed for the hospital at regional forums.

Medication safety

As discussed in National Standard 5.5 the hospital did not have a pharmacy-led clinical pharmacy service which had been escalated to the perioperative risk register, with controls implemented to mitigate potential risks to patient safety. Following the inspection, the hospital submitted a detailed risk assessment outlining additional measures and actions to further enhance oversight of medication management and safety in the hospital.

From the sample of healthcare records reviewed and discussion with staff, inspectors identified that a formal medication reconciliation process was not undertaken in line with hospital policy. While clinical staff described informal processes to verify patient medications, these practices were not formally documented and did not align to the hospital's medication reconciliation policy.

Medication stock control was undertaken weekly by a pharmacy technician. Inspectors were informed that out-of-hours access to medications was managed by the ADON and no issues accessing medicines outside core hours were reported by clinical staff.

Staff described applying risk-reduction strategies for high-risk medicines aligned with the APINCH**** framework. A sound-alike look-alike drugs (SALADs) list was in place and underpinned by hospital policy. Inspectors also found that the hospital's medication management policy, prescribing guidelines, including antimicrobial guidelines and medication information were up-to-date and accessible at the point of prescribing. Medicines were, for the most part, stored securely and in compliance with national guidance, including the secure storage of potassium and opioids. Medication fridge temperatures were monitored across all clinical areas inspected.

Deteriorating patient

Measures were in place to identify and reduce the risk of harm arising from delays in recognising and responding to patient deterioration. Management described the arrangements in place in the hospital for responding to a patient who deteriorates, including the out-of-hours arrangements. They also informed inspectors that they were in the process of developing a routine medical review process for a specific cohort of patients. Staff used the most up-to-date national early warning tools appropriate to each patient cohort. The Irish National Early Warning System (INEWS) and the ISBAR3[††††] communication tool supported timely identification, escalation, and management of clinical deterioration. The Paediatric Early Warning System (PEWS) was in use on the surgical day ward for paediatric patients. Staff demonstrated a clear understanding of INEWS and PEWS escalation protocols, ensuring prompt assessment and intervention for patients with triggering scores. Inspectors were provided with several transfer protocols for patients requiring a higher level of care and clinical staff were knowledgeable about the protocols in place. National sepsis guidelines were accessible to staff and the Sepsis-6 care bundle was in place to support the timely recognition and management of suspected sepsis. Sepsis screening forms, including paediatric versions were available in all clinical areas.

Inspectors reviewed a sample of healthcare records across all clinical areas and found that INEWS entries were consistently completed and aligned with the required monitoring frequencies. Emergency equipment, including adult and paediatric resuscitation devices and equipment was available and appropriate for each age group in the areas inspected as required. Oxygen points were present at each bedside, with the exception of St Patrick's ward.

Management and staff outlined several new initiatives introduced to strengthen the hospital's response to deteriorating patients. These included routine case reviews and shared learning sessions with clinical teams, simulation-based training and major haemorrhage protocol simulations within the theatre department. An onsite clinical skills facilitator provided additional support for staff training and competency development. Inspectors were also informed that a formalised cardiac arrest huddle was under development at the time of the inspection to further enhance coordinated and timely emergency responses.

Transitions of care

At the time of inspection, hospital management reported ten cases of delayed transfers of care, representing 4.4% of total inpatient beds available in the hospital.

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

[††††] ISBAR3 – Identify, Situation, Background, Assessment, Recommendation, Read Back, is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

Each patient had a predicted discharge date documented. The average length of stay was monitored and for surgical patients in the hospital, this was 5.48 days (HSE target less than or equal to 4.5 days). Management described additional measures that had recently been implemented in the hospital in recent weeks in an effort to reduce the number of delayed discharges in the hospital and the region. Inspectors were informed that the hospital was in the process of gaining access to the HSE's national reporting portal for delayed transfers of care.

Systems and policies supported safe patient discharge and transfer during and outside core hours. Hospital management reported and staff confirmed that each morning in the hospital a meeting was held with an ADON to gather updates on anticipated discharges, admissions and identify any delayed transfers of care. The hospital attended a daily meeting with the representatives from hospitals within the Midwest Region where they reviewed and reported on key operational priorities such as delayed patient discharges, planned discharges and admissions and any operational issues that affected bed utilisation. In addition to these daily processes, a recently established multidisciplinary complex discharge committee meeting was held in the hospital every two weeks to review and take action on cases involving delayed discharges at a local level.

Inspectors were informed and observed that when patients were transferred from UHL to the hospital, a nursing transfer form was completed and a telephone handover was provided using the ISBAR format. Clinical staff advised that patients transferred with their medical record and remained under the care of their treating consultant in UHL.

At ward level, daily safety huddles took place where any issues that may impact on patient safety was discussed. Inspectors attended a safety huddle and a multidisciplinary huddle which confirmed this. Nursing documentation reviewed contained a comprehensive discharge planning section, which included requirements for complex discharge along with a discharge checklist. Staff informed inspectors that discharge prescriptions and discharge summaries were completed on the day of discharge and the patient was given a copy of these, with a copy also being sent to the GP. Management informed inspectors that the hospital was in the process of implementing a digital solution to enhance the completion of discharge information for patients.

In the theatre department, an inspector observed and discussed with staff the patient pathway, from pre-operative preparation through to post-operative recovery. The use of the ISBAR communication format was consistently applied at each transition of care observed by the inspector. Patient flow within the department followed a standardised process, beginning with pre-operative assessment, continuing through the surgical procedure, and concluding in the post-operative recovery area. At each stage of the patient journey, staff demonstrated adherence to

key safety protocols using hospital-approved safety checklists. These included critical steps such as patient identification, site verification and consent.

Inspectors reviewed a range of policies procedures and guidelines and noted all were up to date. Staff had access to a range of up-to-date infection prevention and control, medication safety, transitions of care and deteriorating patient policies procedures and guidelines via a document management system.

Overall, the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of harm. However:

- oversight of care bundle compliance was not routinely discussed for the hospital at the regional forum (HICCM)
- a formal medication reconciliation process was not undertaken in the hospital and the practices described and observed were not formally documented and did not align with policy requirements

Judgment: Substantially Compliant

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

The hospital had effective patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents in line with national legislation, policy and guidelines. Staff who spoke with inspectors were knowledgeable for the most part about how to report patient-safety incidents.

It was evident from discussions that the quality and patient safety staff in UHL systematically tracked and analysed reported incidents, identifying trends and sharing findings with the relevant directorates. A hospital specific patient-safety incident overview report was not completed however quarterly directorate reports submitted to the QPSC contained details of incidents reported for the hospital. Documentation reviewed by inspectors, along with discussions with clinical staff, identified that clinical areas did not routinely receive a track-and-trend analysis of incidents reported; however, staff reported and demonstrated that they were able to extract this information directly from the incident-management system. The CNM in the clinical areas reported that they had oversight of all incidents reported. Staff stated that learning from incidents was discussed at handovers and huddles and at the monthly nurse management meetings in the hospital.

Inspectors reviewed the hospital's 2025 incident-management data, including the figures and types of incidents reported. Management informed inspectors that incident reporting rates in the hospital were low and outlined plans to strengthen reporting, including additional staff training, education and an awareness drive was

an area of focus for 2026. 270 incidents were recorded in 2025 in the hospital with one of the most frequently reported patient-safety incidents were for example, medication incidents where 24 were reported in 2025. 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‡‡‡‡) and were also logged on NIMS. From documentation reviewed and from meetings held with management it was evident that medication incidents were reviewed monthly at the MSC and quarterly at the DTC and the QPSC meetings as discussed further in national standard 5.5.

Management stated and meeting minutes reviewed indicated that incidents related to the deteriorating patient were trended and discussed at the Deteriorating Patient Steering Committee meeting and at the quarterly QPSC meetings. Inspectors were informed of a recent quality improvement initiative that was introduced in the hospital, where a retrospective review of a number of patients who were transferred out was routinely completed with findings reported to the perioperative directorate and the clinical staff.

Patient-safety incidents related to transitions of care were reported and these incidents and associated risks were reviewed by the perioperative directorate.

As discussed in national standard 5.8, there were Serious Incident Management Teams (SIMT) at directorate and at executive levels, who had oversight for ensuring that patient-safety incidents were effectively managed. The SIMT role within each directorate was to oversee the management of category 1 and category 2 incidents from notification of incident to completion of the review. In 2025 there was two serious reportable events and comprehensive reviews of adverse incidents had been completed in the hospital. One additional comprehensive review was in progress at the time of inspection. It was evident that all preliminary assessment reports and internal reviews commissioned were discussed at the relevant governance committee, clinical directorate and monitored by the quality and patient safety department and SIMT. A SIMT log was maintained by each clinical directorate to track and monitor each incident on the log. Management informed inspectors that all recommendations arising from reviews were formally approved at the individual clinical directorate level and subsequently discussed at the QPSC meetings. In addition, the recommendations log was regularly reviewed at these meetings to monitor progress, ensure accountability and track implementation status.

Overall, the hospital had a system in place to identify, manage, respond to and report patient-safety incidents using an agreed taxonomy in line with national legislation, standards, policy and guidelines.

Judgment: Compliant

Conclusion

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

Capacity and capability

Inspectors found that the hospital's corporate and clinical governance arrangements for delivering safe, high-quality healthcare were integrated, clearly defined and formalised. Effective management structures supported the consistent delivery of safe and reliable care; however, management and oversight of medication safety was not fully effective. The proposed plan to strengthen medication-safety governance is expected to further enhance these arrangements. Systematic monitoring processes were in place to identify opportunities for continuous improvement in quality, safety and reliability. Workforce arrangements were also effectively managed to support the delivery of high-quality care with a focus on increasing training compliance in some areas required.

Quality and safety

Inspectors found strong evidence of a caring culture, with staff consistently demonstrating kindness, respect, and a commitment to maintaining patients' dignity, privacy and autonomy. Effective processes were in place for managing complaints and concerns. However, one clinical area had significant infrastructural deficiencies that posed potential risks to patient safety. Systems supported the monitoring, evaluation, and continuous improvement of healthcare services, including well-established risk-management and patient-safety incident reporting processes, with further training planned to strengthen incident reporting in the clinical areas. Patients who spoke with inspectors were highly positive about their experience and praised both staff and management in the hospital.

‡‡‡‡ The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) is an independent body composed of 27 national organizations. In 1995, the United States Pharmacopeial Convention (USP) spearheaded the formation of the National Coordinating Council for Medication Error Reporting and Prevention: Leading national health care organizations are meeting, collaborating, and cooperating to address the interdisciplinary causes of errors and to promote the safe use of medications.

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.	Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant

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.	Compliant

Compliance Plan for: Croom Orthopaedic Hospital

Inspection ID: NS_0185

Date of inspection: 11 and 12 February 2026

Compliance plan provider's response

National Standard	Judgement
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.

St Patrick's Ward

St Patrick's ward displayed several infrastructural deficiencies, including:

- visible wear and tear on floors and walls,
- Inspectors were informed by clinical staff that piped oxygen was not available on the ward due to ageing infrastructure;
- Physical distancing in the multi-occupancy room was challenging and private conversations could be easily overheard. This was evident on the days of inspection.
- Hand-hygiene sinks that did not meet national standards.
- Limited storage space for equipment

Actions

St Patricks Ward Renovation works completed in the last 12 Months.

Location ID

- 38040 Store room converted to Clinical room

- 38010 Staff Locker Room refurbished
- 38012 Staff Toilet converted to Sluice Room
- 38014 Cleaners room converted to new Sluice room
- 38016 Ward Pantry Refurbished
- 38024 Old Sluice room converted to Staff toilet and shower

Flooring repairs were carried out week commencing the 16th March 2026. **Completed**

Painting works have commenced on St Patrick's ward and are ongoing. **Date for completion: June end 2026**

St. Patricks Ward manages patient requirements for oxygen with portable oxygen supply. The appropriate medical gases and dangerous good reviews have been completed. A DGSA audit has been completed. A process is in place for the monitoring and management of the medical gases in St. Patricks. It is documented and managed on the risk register **Completed**

Review of Clinical wash hand basins has been completed, with 6 sinks requiring replacement. Replacement works, will proceed across 2026 subject to access to rooms. **Date for completion: December end 2026**

Review of all equipment on the ward to see if any can be removed from the clinical area. **Date for completion: June 2026**

St Anne's ward

- Inspectors observed that the flooring was in poor condition
- Shortfall in cleaning resources in St Anne ward was reported.

Actions

Flooring repairs were carried out week commencing the 16th March 2026. **Completed**

Hygiene services department are introducing a cleaning shift overnight. **Date for completion: August 2026**

Operating theatres sterile-product storage

- Inspectors were advised that inadequate sterile-product storage remained a risk however this was not an identified issue on the day of inspection.

Actions

A risk assessment has been completed, included on the department's risk register with mitigating controls.

Room identified for additional storage and this will require the relocation of a clinical Engineering workshop. Designs been carried out at present **Date for completion: December end 2026**

Infection prevention and control

- Documentation reviewed by inspectors, including HICCM minutes and quarterly perioperative IPC reports, indicated that oversight of care-bundle compliance was not routinely discussed for the hospital at regional forums.

Actions

The IP&C team have commenced providing Croom site with a quarterly report to include KPI data, incidents, training updates, outbreak information & audits which will include a snap shot of PVC audits to support the local audits. These reports and the local audits will be discussed at HICCM and regional forums by the DON for the site. **Completed**

Privacy & Dignity St Patrick's Ward

- The absence of privacy covers for end-of-bed notes in St Patrick's ward was identified.
- Physical distancing in the multi-occupancy room was challenging and private conversations could be easily overheard

Actions

Privacy measures for end-of-bed notes were implemented during the HIQA visit and remain in place. **Completed**

Patient Advocacy Liaison Managers to undertake quarterly patient feedback exercises on St. Patricks Ward on their experience of privacy and dignity. **Date for completion: July end 2026**

Existing practice of utilising the meeting room in the Maigue Ward for private patient/ family meetings or discussion will be formalised into a SOP.

Patient information posters will be developed to inform patients that they can request a private meeting. **Date for completion: May end 2026**

Signage

- Inspectors observed that while signage notifying patients and visitors of CCTV use was present at the hospital entrance, corresponding signage was not displayed inside the hospital.

Actions

Internal signage has been installed. **Completed**

Perioperative Care directorate-Croom Hospital site meeting:

- While actions were assigned, they were not time-bound and it was unclear from the documentation whether progress on these actions was reviewed from one meeting to the next.

Actions

The format of the minutes of the Perioperative Directorate/Croom Hospital site meeting have been updated to ensure they are time bound with actions being reviewed. **Completed**

UHL-based Medication Safety Committee (MSC)

- UHL-based Medication Safety Committee (MSC) meeting minutes showed that the hospital had not been represented at these meetings, despite the MSC addressing audit findings, medication incident management and other safety issues directly relevant to the hospital.

Actions

Review of the representation from the Croom site at UHL-based Medication Safety Committee has been completed. Agreed representation: assistant director of nursing (ADON) and clinical skills facilitator (CSF). Representatives have commenced attendance at the monthly MSC meetings. **Completed**

Oversight arrangements in place for medication safety

- The management and oversight arrangements in place for medication safety require continued and sustained attention to ensure that the additional measures introduced to deliver the intended improvements in the oversight of medication safety in the hospital.

Actions

Weekly medication management audits are being completed by senior nurse management. The results of same will be discussed at the nurse management meetings (CNM, ADONM & audit committee) **Date for completion: May end 2026**

To formalise the frequency of the medication safety officers visits to the Croom site. **Date for completion: May end 2026**

Pharmacy to review the provision of a clinical pharmacy service to the Croom site. **Date for completion: June end 2026**

Audit activity

- The hospital did not have a local audit committee;

Actions

Audit committee to re-established in Q2 **Date for completion: June end 2026**

Absenteeism rate

- Management reported that the absenteeism rate for December 2025 was 11.2% which was above the HSE's target of 4% or less and outlined processes in place to monitor and manage this.

Actions

HR to provide on-site workshop to support line managers and staff with return-to-work plans. **Date for completion: May end 2026**

To ensure that Performance achievement has commenced for staff.
Date for completion: September end 2026
To continue with the referral of staff to EAP & the Occupational Health Department as required. **Ongoing**

Monthly HR reports are being provided to line managers. **Completed**

HR to complete an audit of line manager awareness and compliance with absenteeism documentation of the absenteeism management policy. **Date for completion: June end 2026**

To progress the recruitment campaigns for the various departments with approved vacancies. **Date for completion: June end 2026.**

Mandatory and essential training

- Hospital management should ensure that all clinical staff complete mandatory and essential training relevant to their scope of practice. This includes standard and transmission-based precautions and outbreak management for nursing staff, and basic life support, advanced cardiac life support, paediatric life support and INEWS training for NCHDs.

Actions

IP&C team to roll out Face to face training on transmission-based precautions and outbreak management. **Date for completion: May end 2026**

Local deteriorating committee to review, agree and complete a gap analysis on the staff who are required to have basic life support, advanced cardiac life support, paediatric life support and INEWS. **Date for completion: April end 2026**

Training plan to be developed to address the Gap analysis. **Date for completion: May end 2026**

Training plan implemented to address the Gap Analysis **Date for completion: December end 2026**

Incident reporting rates

- incident reporting rates in the hospital were low.

Actions

Incident and Risk Management department to provide training. **Date for completion: May end 2026**

Timescale: