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:	The Royal Hospital Donnybrook
Centre ID:	OSV-0007267
Address of healthcare service:	Morehampton Rd. Dublin 4 D04HX40
Type of Inspection:	Unannounced
Date of Inspection:	24/02/2026 and 25/02/2026
Inspection ID:	NS_0192

About the healthcare service

Model of hospital and profile

The Royal Hospital Donnybrook (RHD) is a model 1* publicly funded voluntary hospital which operates in partnership with the Health Service Executive (HSE) and is funded through HSE Dublin and South East Regional Health Area (RHA)†. It provides inpatient and outpatient rehabilitation and a continuing care service and is comprised of the following areas:

- SPARC unit (Short-term Post-Acute Rehabilitation Centre) is used to provide up to 6 weeks rehabilitation for people aged 65 years and over.
- The General Rehabilitation unit (GRU) is used to provide rehabilitation programmes for people aged 65 years and over for up to 8 weeks.
- Stroke/Neuro rehabilitation (Neuro) accepted patients both under and over 65 years of age.
- The respite ward had five inpatient respite care beds.

The following information outlines some additional data on the hospital.

Number of beds	89 inpatient beds

How we inspect

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

* A Model 1 hospital are community and or district hospitals and do not have surgery, emergency care, acute medicine (other than for a select group of low risk patients) or critical care.
† The Regional Health Area HSE Dublin and South East provides health and social care services to South-East Dublin, Carlow, Kilkenny, South Tipperary, Waterford, Wexford and most areas of Wicklow.

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.

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.

[‡]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.

2. Quality and safety of the service

This section describes the experiences, care and support people using the service receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centred and safe. It also includes information about the environment where people receive care.

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector	Support Inspectors
24/02/2026	*09.00 -16.00*	Elizabeth Maume	Bairbre Moynihan Sorcha Burns
25/02/2026	*09.00 -16.00*	Elizabeth Maume	Bairbre Moynihan Sorcha Burns

Information about this inspection

This inspection focused on nine national standards from five of the eight themes[§] of the *National Standards for Safer Better Healthcare*. The inspection focused in particular, on 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 two clinical areas:

[§] 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.

- SPARC – Short-term Post-Acute Rehabilitation Centre
- Stroke/Neuro rehabilitation ward

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

Acknowledgements

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

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

During the inspection inspectors spoke with patients in the clinical areas visited who were complimentary about the care that they received. They used phrases such as "the care is very good here" and "the nurses and doctors are all very nice". Patients reported that they were kept informed about their plan of care and that they received physiotherapy and occupational therapy. They reported that they were satisfied about visiting arrangements, that the food was good and that staff were very responsive to call bells. Some of the patients who spoke to inspectors were not aware of how to make a complaint but said that they would speak to a nurse if they needed to make a complaint.

Capacity and Capability Dimension

Inspection findings related to the capacity and capability dimension are presented under national standards 5.2, 5.5 and 5.8 from the theme of leadership, governance and management and under national standard 6.1 from the theme of workforce. The Royal Hospital Donnybrook was compliant in one national standard (5.5), substantially compliant in one national standard (6.1) and partially compliant in two national standards (5.2 and 5.8).

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

The governance arrangements for assuring the delivery of high quality, safe and reliable healthcare, in relation to the four areas of focus of this inspection, were not providing the necessary oversight for hospital management to be assured about the quality and safety of care. Deficiencies were identified in clinical governance of the neuro rehabilitation unit, and the governance, management and oversight of policies, procedures, protocols and guidelines (PPPGs) and infection prevention and control.

Clinical governance of the rehabilitation service was provided by the medical director who reported to the chief executive officer (CEO) with the exception of the neuro/rehabilitation service. This service was under the governance of a neuro rehabilitation consultant however, at the time of inspection there was a vacancy of 0.2 whole-time equivalent[§§] (WTE) consultant cover which resulted in there being no clinical governance of the service. In addition, eight out of the 12 policies reviewed on the days of inspection were identified as being out of date.

Immediately following this inspection, inspectors sent a high-risk letter to the hospital manager seeking assurance on the:

- clinical governance arrangements for the neuro rehabilitation service
- governance and oversight of PPPGs.

In their response hospital management stated that they had formally escalated the risk in relation to clinical governance to the HSE and that in the interim admissions to the service were suspended. In addition, they submitted eight up-to-date policies. HIQA wrote to the integrated health area (IHA) manager seeking assurances on the clinical governance arrangements who in their response provided assurances that an interim consultant in neuro rehabilitation medicine was to commence shortly.

The CEO had overall accountability and responsibility for the delivery of safe and reliable services within the hospital and reported to the board of management. The CEO had a working relationship with the IHA for Dublin South and Wicklow. Hospital management described the corporate and clinical governance

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

arrangements in place at the hospital. The governance structures outlined to inspectors were not consistent with the organisational chart that were provided to inspectors on day two of inspection and on the hospital's website.

Hospital Management Team

The Hospital Management Team (HMT) was the main governance committee with overall responsibility for the hospital. The terms of reference (TOR) indicated that the function of the HMT was to provide strategic, operational and clinical leadership to ensure the delivery of safe, effective, patient-centred, and high-quality rehabilitation services. The committee was chaired by the CEO, met monthly and reported to the board. Reports submitted to the HMT included Quality and Safety, Operational Performance and Strategic Development. Inspectors requested agendas and minutes from the last three meetings held and received minutes from July, August, and September 2025. No evidence was provided that a meeting was held between September 2025 and February 2026. The TOR stated that the committee would monitor clinical quality indicators, review adverse incidents and risk reports and develop and approve operational policies. There was no evidence in the minutes reviewed by inspectors that these were included in the discussions or reports. Furthermore, inspectors identified that some risks on the risk register had not been reviewed since 2023. This will be further discussed under national standard 5.8. Overall, the HMT was not functioning in line with the TOR and providing governance and oversight for clinical quality, patient safety, and risk management as outlined in the TOR.

Clinical Governance Steering Group

The Clinical Governance Steering Group (CSCG) was chaired by the director of nursing (DON) met quarterly and reported to the Clinical Governance Committee CGC, a subcommittee of the board. The TOR stated that the purpose of the group was to develop, deliver, implement and evaluate a comprehensive quality and safety programme and ensure that all clinical PPPGs are introduced or reviewed. The membership and attendance at CGSG was multi-disciplinary in nature and had representation from hospital wide senior managers, for example, health and social care professionals (HSCPs), nursing and risk management. The TOR outlined that for example, reports were submitted on incidents, infection control, medication management and the deteriorating patient. Inspectors requested minutes from the last three meetings. One set of minutes was received from May 2025. Inspectors observed that PPPGs were not an agenda item and no evidence was provided that PPPGs were introduced or reviewed as outlined in the TOR. As discussed under national standard 5.2, inspectors identified that a number of policies were out of

date on the days of inspection. Overall, this group was not functioning in line with the TOR or providing the oversight of PPPGs.

Quality and Safety (Q&S) Committee

The TOR stated that the Q&S Committee was chaired by the risk, health and safety manager, met three monthly and reported to the board. The purpose of the committee was to provide oversight and assurance on the safety, effectiveness and quality of care delivered to patients. Meeting minutes from the last three meetings held were requested. Minutes received indicated that the committee met in February and November 2025. The minutes from the meeting dated November 2025 referred to items discussed at the previous meeting in 2023 and the minutes dated February 2025 stated that the next meeting was planned for March 2026. The frequency of meetings was not in line with the TOR however inspectors observed from the two sets of minutes provided that infection prevention and control (IPC), incidents, medication management, audits and training compliances were discussed.

Infection Prevention and Control

At the time of the last inspection in August 2024 a Hygiene Infection Prevention and Control Committee (HIPCC), a multi representative committee, was in place. On this inspection inspectors were informed that the committee was no longer operational. This deficit in clinical governance of the IPC programme had not been identified by senior management. Instead, senior management stated that responsibility and accountability for IPC was with the DON. The IPC clinical nurse specialist reported to the CGSG and met with the DON monthly. In the absence of the HIPCC there was no forum for members of the previous committee for example, catering, maintenance and cleaning contractors, to provide updates. Notwithstanding this, both the CEO and the DON provided assurance to inspectors on the days of inspection that the arrangements in place for governance of IPC were effective.

Medication Management Group

The medical officer for the hospital was the clinical lead for medication safety and chaired the committee which met monthly. Following the inspection the TOR and minutes from the last three meetings were requested. The TOR was not provided, and one set of meeting minutes were received.

Agenda items for the meeting included review of medication incidents, updates to the electronic prescribing platform, policies and audits. The committee submitted a quarterly report to the CGSG.

Minutes from the meeting received reflected the agenda. For example, there was evidence that both medication incidents and policies were discussed. Inspectors were informed that the committee met monthly with the community pharmacy group that provided the pharmacy service to the hospital and observed that a meeting with the community pharmacy group was referenced in the minutes for October 2025.

Deteriorating Patient Working Group

The TOR stated that the Deteriorating Patient Working Group, chaired by the medical officer, was scheduled to meet six times per year and submitted a report to CGSG twice a year. The group met three times in 2025 which was not in line with the TOR however the meeting minutes provided evidenced that the meeting was structured, agenda items reflected the TOR and actions were assigned and were reviewed from meeting to meeting.

Delayed Discharge Oversight Group

Inspectors were informed that this group was chaired by the CEO. This did not align with the TOR which stated that the head of social work was the chair. The TOR outlined that the group reported to the senior management team and hospital executive management neither of which were reflected in the organisational structures outlined to inspectors. The TOR outlined that the purpose of the group was to review patients who were medically fit for discharge but remain in hospital due to delays in placement, funding approvals, or community support services which aligned to minutes provided after the inspection. The TOR stated that the group was to meet every two months however, meeting minutes provided to inspectors after the inspection showed that the group met twice in 2025.

Incident Management Group (IMG)

The CEO was the senior accountable officer for the management of patient safety incidents. The TOR stated that the group provided regular reports to the HMT. This was not reflected in HMT minutes observed by inspectors, however the TOR for the CGSG stated that the Incident Group reported to the CGSG and this was reflected in the set of minutes observed by inspectors. The purpose of the group as outlined in the TOR was to oversee the review, management and learning from clinical and non-clinical incidents occurring within the hospital and membership of the group was multidisciplinary. The IMG was scheduled to meet monthly. Inspectors were unable to validate if the group was functioning as agendas and

minutes from the last three meetings were requested and not received. Incident and Risk Management Reports which were submitted to the CGSC were observed by inspectors. Each report covered a two-month period and there was trending of incidents per ward and per month and they included two of the four areas of focus of this inspection - medication safety and infection prevention and control.
In summary, the governance arrangements in the hospital were either not functioning or not fully functioning for senior management to be assured of the delivery of high quality, safe and reliable healthcare:

- high risks were identified in relation to the clinical governance for the neuro rehabilitation service regarding lack of clear clinical governance arrangements and oversight of PPPGs
- the HMT, CGSG, Q&S were not providing the governance and oversight as outlined in the corresponding TOR
- the organisational chart on the hospital's website and the one provided to inspectors on the day of inspection were not aligned to what inspectors were told on the days of inspection
- none of the governance and oversight committees were meeting in line with their TOR: HMT, CGSG, Q&S, medication management, deteriorating patient working group, delayed discharge oversight group and incident management group
- the multi representative group HIPPIC was no longer operational and there was no evidence of discussion or participation at other committees.

Judgment: Partially Compliant

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

Management arrangements were in place to support and promote the delivery of high quality, safe and reliable healthcare.

The medical director was supported during working hours by a medical officer and NCHDs at both registrar and senior house officer (SHO) grade on rotation from St. Vincent's University Hospital (SVUH) and St Michael's Hospital (SMH). Out-of-hours cover for all rehabilitation patients was provided by an on-call NCHD who was located off-site. Hospital management provided assurances that the on-call arrangement was sufficient.

Nursing services in the hospital were managed and organised by the DON who was supported by an assistant director of nursing (ADON) assigned to the rehabilitation service. Clinical nurse managers (CNMs) were responsible for the management and oversight of the clinical areas and were operationally accountable to the ADON to whom there was an escalation pathway. CNMs on the wards visited reported that they escalated issues relating to staffing to the clinical site managers (CSMs). The CSMs were a clinical nurse manager 2 (CNM2) grade and one was on site during both core working hours and out of hours.

Infection, prevention and control

The IPC CNS met with the DON monthly. The IPC CNS was a member of the Quality and Health and Safety Committee where IPC was an agenda item. Two IPC link *** nurses were in place, one on Stroke/Neuro ward and one on General Rehabilitation ward who supported the IPC CNS in carrying out monthly hand hygiene audits. No protected time was provided to the link nurses to carry out the role. Microbiology and laboratory support was provided by SVUH as required.

Medication safety

Pharmacy services were provided by a contracted community pharmacy group, external to the hospital. On the inspection in August 2024, it was identified that there was no clinical pharmacy service. This remained unchanged on this inspection. In the interim to support this deficit the medical officer managed and coordinated medication safety in the hospital which resulted in a reduction in the time they had available to attend to patients. The impact of this deficit will be outlined under national standards 6.1 and 3.1.

Deteriorating patients

The medical officer was the deteriorating patient lead for the hospital. The hospital had implemented the Irish National Early Warning Score (INEWS). This will be discussed under standard 3.1.

Transitions of Care

*** Infection prevention and control link nurse is a link between the clinical areas and the infection control team. A key part of their role is to help increase awareness of infection control issues in their ward.

The ADON for the rehabilitation unit was the lead for patient flow and bed management within this service.

Overall, while a deficit was identified in the lack of a clinical pharmacist which will be addressed under national standards 6.1 and 3.1, effective management arrangements were in place to support and promote the delivery of high quality, safe and reliable healthcare.

Judgment: Compliant

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

Hospital management had some systematic monitoring arrangements in place for identifying opportunities to continually improve the quality, safety and reliability of services provided. However, deficits were identified in the oversight of the risk register, timely review of incidents at Serious Incident Management Team (SIMT) and medication management audits.

Audit Activity

There was evidence of audit activity taking place in the hospital. Audit results were discussed at the Nursing Quality and Practice Development meeting, attended by the DON. Good results were identified in environmental, PPE and hand hygiene audits in the clinical areas visited. However, medication management audit results ranged from 51.1% - 71.1% on the Stroke/Neuro and 57.8% to 71.7% on Sparc ward. The electronic audit platform assigned responsibility to individual managers for the development of quality improvement plans (QIPs). Results and QIPs for all rehabilitation wards were overseen by Nursing Quality and Practice Development. A disimprovement in overall medication management results was identified from 63.1% in August to October 2025 to 57.1% from November 2025 to January 2026. QIPs were in place but were not time bound.

Medication audits were an agenda item at the Medication Safety Group. Audits were completed, for example, on intravenous antibiotic usage on Sparc ward between July and December 2025. While the audit contained 'interventions required', including

that a business case had been submitted for a clinical pharmacist, these actions were not time bound.

Transitions of care was an agenda item at the Deteriorating Patient Working Group and all unexpected transfers to an acute hospital were reviewed by the group. Unscheduled transfers of care were audited for 2024 and 2025. Results indicated that there was 35% increase in patients admitted to an acute hospital bed in 2025. However, further analysis of the reason for this increase were not detailed in the report or it did not contain a time bound action plan.

While quality boards were in place in the clinical areas, inspectors observed that the data displayed was from 2024 on the Stroke/Neuro ward and Sparc ward had no audit results displayed.

Risk Management

A corporate risk register was in place. Inspectors were informed that the CEO, operations manager and risk, health and safety manager met quarterly to review the corporate risk register which was in line with local policy. However, a review of the risk register identified that some risks had not been reviewed since 2023. Furthermore, actions and review dates were not completed. This is not in line with hospital policy or the HSE Enterprise Risk Management Policy 2023.

Patient-safety incidents

Management stated that incidents were logged on the National Incident Management System (NIMS)[†††] in line with the HSE's Incident Management Framework. An Incident Management Report, a two monthly incident trending report was generated by the risk, health and safety manager in which incidents were categorised by ward and themes.

SIMT

A Serious Incident Management Team (SIMT) reported to the CSCG, met as required and was chaired by the risk, health and safety manager. The TOR requested after the inspection were not provided. Three sets of minutes were provided for April, June and September 2025. Meeting minutes indicated in April and June 2025 that there was a delay in bringing incidents to SIMT. However, the minutes did not indicate the category of incident and in the absence of the TOR, it is not clear how often SIMT should meet and if an unscheduled SIMT should have been convened. This will be further discussed in national standard 3.1.

Feedback from People Using the Service

Patient experience was an agenda item at the Q&S and CGSC. The hospital had conducted a Rehabilitation Service User Experience Survey in July and August 2025. The survey highlighted key strengths along with areas for improvement.

In summary the hospital had some systematic monitoring arrangements in place for identifying opportunities to continually improve the quality, safety and reliability of services provided. Notwithstanding this, the following was identified:

- the corporate risk register was not reviewed in line with the hospital's policy or national policy
- meeting minutes indicated that there was a delay in bringing incidents to SIMT
- audit findings in relation to medication management disimproved and the action plan to address the findings was not time bound
- time bound action plans were not always developed in response to findings
- information on display on quality boards on Stroke/Neuro ward was out of date and Sparc ward had no data displayed on its quality board.

Judgment: Partially Compliant

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

Workforce arrangements were in place to support and promote the delivery of high-quality, safe and reliable healthcare with the exception of access to an onsite clinical pharmacist and deficits in mandatory training on Sparc ward.

The human resource manager was a member of the HMT and provided a monthly report to the CEO to whom they reported. The hospital was responsible for their own recruitment and reported minimal vacancies with no vacancies in both nursing at all grades and HSCPs on the days of inspection. The total staff approved whole time equivalents (WTEs) was 299 with 288 in place at the end of January 2026 and 9.5 WTE in the recruitment process. This aligned to what inspectors were told in the clinical areas visited and on review of the duty rosters.

[†††] The National Incident Management System (NIMS) is a management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

Inspectors were informed that the hospital had received approval for one WTE consultant in neuro rehabilitation medicine. This post was vacant at the time of inspection, however, inspectors were informed and assurances were provided after inspection that a recruitment process for this post had commenced. In the interim correspondence received from senior management in the region indicated that a local general practitioner had agreed to provide clinical governance for the neuro rehabilitation service and that the hospital's medical director would be available to provide advisory input as required. To ensure continued and appropriate consultant oversight of the neuro rehabilitation service, the hospital had secured an interim consultant in neuro rehabilitation medicine via an agency to provide 20 hours per week of consultant neuro rehabilitation input until the substantive consultant takes up post.

As discussed earlier in the report there was no clinical pharmacist for the rehabilitation service. This was also a finding at the previous inspection. In the compliance plan the hospital stated that funding had been approved for 0.5 WTE pharmacist under the neuro rehabilitation service. However, the recruitment for this post was unsuccessful and the post remained vacant at the time of inspection. Inspectors were informed that a business case was being prepared for an increase to this post. As a result, the medical officer had assumed an increased role in the area of medication safety, reducing their time with patients. Further impacts as a result of this deficit are discussed under national standard 3.1.

Staff uptake of essential and mandatory training

The human resource department had oversight of mandatory training compliance. Inspectors reviewed training compliance for the two wards visited. Sparc ward compliance with basic life support (BLS) training for nurses was 67%, medication management was 91% and heart saver training for HCAs was 17%. On Stroke/Neuro ward, heart saver training was 89%, BLS was 91% and medication management was 91%.

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

- there was no onsite clinical pharmacist
- deficits were identified in basic life support and heart saver training on Sparc ward.

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. The Royal Hospital Donnybrook was compliant in one national standard (1.6) substantially compliant in one national standard (1.8) and partially compliant in three national standards (2.7, 3.1 and 3.3).

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

It was evident through observation and discussions with staff members and patients that patients' dignity, privacy and autonomy was respected and promoted. Staff were observed communicating with and providing care to patients in a manner that respected their privacy and dignity. Inspectors spoke to a number of patients who did not highlight any concerns regarding privacy.

Privacy curtains were in place and staff reported that curtains were pulled during all personal care which was confirmed by patients who spoke with inspectors. Inspectors were shown areas on the wards that staff could use for conversations of a sensitive nature. Inspectors heard relaxing music playing while patients were having their meals in the large bright dining rooms. Patients also had access to a garden area. While there were no end-of-life patients on the wards visited, inspectors observed the available facilities for end of life care if required. Overall, observations on the days of inspection indicated that patient's dignity and privacy were respected and promoted.

Judgment: Compliant

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

The hospital had systems and processes in place to respond effectively to complaints and concerns. Notwithstanding this, the hospital was not measuring their performance against the HSE KPI relevant to complaints.

The DON was the designated complaints officer. The HSE's Management of Service User Feedback for Comments, Compliments and Complaints policy 'Your Service Your Say'‡‡‡ had been adapted for local use and was observed by inspectors. Resolution of complaints at the point of contact was encouraged with staff empowered to resolve complaints if they could and escalate those that remain unresolved. This aligned to the process described by staff in the clinical areas visited. The number of formal complaints was reported to be low with none to date in 2026 and a small number in 2025. The hospital was not measuring its performance against the HSE key performance indicator (KPI) of resolving at least 75% of complaints within the recommended 30 days. Ward managers discussed all complaints with the ADON and evidence reviewed confirmed that complaints were recorded in a folder at ward level. Complaints and compliments were an agenda item on the CGSG. While patients spoken to by inspectors were unaware how to make a complaint inspectors observed HSE 'Your Service Your Say' leaflets and complaint and compliment boxes on the wards visited. The hospital patient information booklet observed by inspectors contained information on how to make a complaint. Inspectors were informed that all patients received this booklet on admission. Of the six patients spoken to on the days of inspection two had received a booklet and three reported that they knew how to make a complaint if they needed to, however, all patients who spoke with inspectors reported that they had nothing to complain about. In both clinical areas visited inspectors observed posters advertising advocacy services. In summary, systems and processes were in place to respond effectively to complaints and concerns raised by people using the service. However:

- the hospital was not measuring their performance against the HSE KPIs in relation to complaints management.

Judgment: Substantially Compliant

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

The physical environment did not always support the delivery of high quality, safe,

‡‡‡ 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.

reliable care and protect the health and welfare of service users.
The Stroke/Neuro ward had capacity for 32 patients with an occupancy of 24 patients on the day of inspection and Sparc ward had no vacancies with 30 patients on the day of inspection. On both wards patients were accommodated in both multi occupancy and single rooms.

The Stroke/Neuro ward had three four-bedded bays, three three-bedded bays, two two-bedded bays and five single ensuite rooms. Each single room had a ceiling hoist. Female patients had access to three toilets and two showers and the same number was available for male patients. All toilets and showers were clean however wear and tear was noted for example, flaking paint, scuffing on floors and damage from old signage. It was also noted that one single room had a broken window that was secured with tape. Inspectors were informed that this had been escalated to the maintenance department two weeks previously and had not been addressed at the time of inspection.

There were three sluice rooms on the Stroke/Neuro ward, one of which inspectors were informed was not used regularly. Ward managers reported that there was a water flushing schedule for Legionella and it was carried out by the external cleaning contractor. This was confirmed by a cleaning operative who stated that the weekly flushing took place on Mondays, and the signed schedule was observed by the inspector. There was evidence in meeting minutes that legionella sampling was discussed at the CGSG. The remaining two dirty utility rooms each had a bedpan washer, one was noted to be within its service date and the service on another was overdue.

Linen was stored in linen presses on the corridor and there was appropriate segregation of dirty and clean linen stock. It was noted however that there was inappropriate storage in areas of the ward, for example, boxes on the medication preparation areas in both clean utility rooms and large pieces of equipment, such as hoists and wheelchairs, were stored in two empty bed spaces with the curtains pulled.

On Sparc ward the patient accommodation was made up of three single ensuite rooms and six five-bedded bays each of which had a toilet and shower. Wear and tear were observed on the floors in all rooms and some of the walls. There was a large sluice room with a bedpan washer which was within the service date. Commodes were observed to be clean. There was inappropriate storage of equipment and stores with equipment stored on corridors and boxes stored on the floor in the clean utility rooms.

A finding at the inspection in August 2024 was that clinical hand wash sinks did not comply with the required specifications[§§§]. Following the last inspection, through the compliance plan, senior management indicated that 43 clinical hand wash sinks required replacing. Inspectors requested an update on the number of sinks that were replaced and this was not provided. Senior management stated that funding had been sought to replace all non-compliant sinks and this had been escalated to the HSE. However through a review of documentation available to inspectors there was no evidence that this was discussed at any governance meeting. Inspectors observed that some clinical hand wash sinks in both wards were compliant with the required specifications, For example, the multi-occupancy bays in the Stroke/Neuro ward. However, there were many instances where sinks were not compliant. For example, in two of the dirty utility rooms in the Stroke/Neuro ward and a clean utility room.

The cleaning arrangements aligned with the hospital's policy. Environmental cleaning was provided by an external cleaning company. Ward managers reported that cleaning equipment was everyone's responsibility, with a cleaning record kept in the nurse's station which was updated weekly and observed by the inspector. Patient bed spaces were cleaned daily and deep cleaned on discharge. There was a deep clean cleaning schedule with one room cleaned daily. The schedule was up to date when reviewed by the inspector. Privacy curtains were disposable and were changed by porters every six months. This was in line with what inspectors observed on the days of inspection. Cleaning operatives attended the ward from 9am to 3pm daily and out of hours cleaning was provided by two operatives on an as required basis.

Senior management through the compliance plan committed to replacing the call bell system following the inspection in August 2024. On this inspection inspectors identified that this was actioned. A new call bell system was installed in Sparc and Stroke/Neuro wards. A sample of call bells checked evidenced that they were functioning on the two wards on the days of inspection.

While the clinical areas were clean on the days of inspection, the following was identified:

- the design of a number of clinical hand wash sinks did not conform to requirements. This was identified on the inspection in August 2024 and hospital management did not provide evidence when requested on the progress with the replacement schedule
- inappropriate storage of equipment in patient bay areas, on corridors and in clean utility rooms
- wear and tear on walls and floors

- a broken window in one single room which had been escalated to maintenance but not addressed.

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

While the hospital had some systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services these were not fully effective as inspectors identified deficits on inspection which not been managed by senior hospital management. For example, the impact of the lack a clinical pharmacist attending onsite resulted in multiple findings on inspection in relation to medication safety.

Risk Management

As discussed under standard 5.8 there was lack of oversight and management of the corporate risk register. A risk included on the corporate risk register relating to the focus of this inspection was that due to patient complexity requiring high levels of medication there is a risk of medication errors that could lead to lower patient safety. While control measures were in place, these had not been reviewed since March 2023 and the action plan and review date were blank. This risk was increased by the lack of a clinical pharmacist. Local risk registers were observed in the wards visited. Ward managers reported that they completed their own risk assessments which they discussed with the risk health and safety manager before placing a risk on the register. This aligned to the process outlined in the policy. They reported that the register is reviewed three to six monthly with assistance from the risk, health and safety manager. There was evidence that the risks had been reviewed recently and that there were control measures in place. There was also evidence that while older risks had been reviewed, no new actions had been implemented.

Infection Prevention and Control

Screening for Multi Drug Resistant Organisms (MDROs) was not routinely carried out on admission to the hospital. All patients' infection status was determined at pre admission stage as part of the pre admission assessment carried out by both the

[§§§] Infection Prevention and Control (IPC) National Clinical Guideline No. 30, Department of Health (2023). NCEC National Clinical Guideline No. 30 Infection Prevention and Control Volume 1. Available at: http://health.gov.ie/national-patient-safety-office/ncec/

rehabilitation coordinator and the medical director who reviewed patients in St Vincent's University Hospital (SVUH) twice weekly. A referral form was also available on the website and infection status was a data set on the form. During the course of the inspection, inspectors were informed that patients colonised with specific MDROs were not admitted to the hospital. However, following inspection, hospital management clarified that patients are admitted with MDRO colonisation where clinically appropriate and where safe isolation facilities and risk mitigation measures can be implemented to protect all patients within the service. The older persons inpatient rehabilitation service operational policy was provided to support this practice.

Ward staff told inspectors that if an MDRO was suspected advice was sought from the IPC CNS and or NCHD and swabs were sent to the microbiology laboratory in SVUH. Ward staff reported that they were supported by the IPC CNS and that swab results were reviewed daily.

Inspectors observed that there were single ensuite rooms available for use if a patient required isolation, however, none were in use for this purpose on the days of inspection. This aligned to both the process described by hospital management and to the policy. An outbreak management committee was convened in the event of an outbreak. This was reflected in minutes reviewed by inspectors.

Medication Safety

As previously discussed under national standard 5.5 and 6.1 there was no clinical pharmacy service in the hospital. The hospital had processes in place relating to the safe and accurate transfer of information relating to medications on admission and discharge. The admissions policy was reviewed by inspectors and outlined that prior to admission from another hospital an up-to-date prescription was received a day in advance of the patient's transfer and was uploaded onto the electronic prescribing system by the community pharmacy including administration times. The process was confirmed at interview by the CNMs, the rehabilitation coordinator and the medical officer who was the medication lead for the hospital. Inspectors were informed that in the absence of a clinical pharmacist, medication reconciliation**** was carried out by medical staff who reviewed the prescription and compared it against the digital prescription. Inspectors were informed that medication reconciliation was not completed on discharge and that a prescription was generated electronically on the hospitals paperless medication system and inspectors were informed that this eliminated the requirement to transcribe a discharge prescription.

**** Medication reconciliation is the formal process of establishing and documenting a consistent, definitive list of medicines across transitions of care and then rectifying any discrepancies.

Some processes were in place in the clinical areas visited for safe storage and administration of medications. Individually labelled medication packs with doses arranged by administration time were delivered weekly from the external community pharmacy. These were stored in a locked trolley. Each pack contained the patient's name, the medication name and dose. However, the medication management policy stated that the patient's name and their identification number or date of birth should be on each patient's medication pack, and inspectors observed that only the patient's name was on the pack. This was brought to the attention of senior management. An electronic tablet was used by nurses to access the patient's drug kardex. Medication fridges held only necessary medications, and the temperature was checked daily.

While there was no evidence of risk reduction strategies in relation to high risk medications observed by inspectors, staff who spoke with inspectors were aware of sound-alike-look-alike (SALAD) medications. While staff had access to drug prescribing guidelines at the point of care on both wards visited, these were dated 2021. An intravenous medication guidance poster dated 2020 was available on both wards. Arrangements were in place for ordering and accessing medications out of hours and these aligned with the relevant policy. The Medication Management and Medicines Reconciliation Policies were both in date and reflected processes that were observed by inspectors in the clinical areas visited and were outlined by staff.

Transitions of Care

A number of admission pathways were identified during the inspection as described below. These aligned with what staff told inspectors and also with the Standard Operating Procedure (SOP) and the Inpatient Services Rehabilitation Policy. Admissions from acute hospitals to the Older Person's Rehabilitation Unit (SPARC and GRU) were predominantly from St Vincent's University Hospital (SVUH). A comprehensive rehabilitation and care needs assessment was carried out on all accepted referrals by the rehabilitation coordinator or medical officer. This assessment, which was observed by inspectors, had been incorporated into the electronic healthcare record. Specific needs were identified as part of the assessment in relation to areas such as medications and equipment needs, for example, specialised seating or bariatric equipment. The timing and day of transfer to the hospital was coordinated by the rehabilitation coordinator based on bed availability.

The decision to admit to Stroke/Neuro Ward was made by the two overseeing stroke consultants who rotated through the service. These consultants were based in SUVH.

A comprehensive transfer document for use between the acute setting and the hospital, developed by the hospital was observed by inspectors in a patient's electronic healthcare record. On discharge the multidisciplinary team (MDT) completed a discharge form to ensure the safe and accurate transfer of information which was also observed by inspectors. Information included a record of the patient's infection status, medications on discharge and reference to any medications which had been stopped or withheld.

Nursing staff used The Identify, Situation, Background, Assessment, Recommendation/Read back/Risk ($ISBAR_3$) communication tool[††††] for clinical handover and for escalating care in the event of a deterioration in a patient's condition, an example of which was observed by inspectors on the electronic health care record. The MDT held regular meetings where issues relating to discharge were discussed. Records of these meetings were observed by inspectors in the electronic healthcare record.

Deteriorating Patient

It was a requirement that all patients admitted to the hospital were medically stable and fit for discharge from acute care to reduce the risk in relation to the sudden deterioration of a patient. This requirement was reflected in the hospital's Admissions SOP and the Inpatient Services Rehabilitation policy. As previously mentioned, the hospital had introduced the Irish National Early Warning System (INEWS) in 2024. Inspectors observed that INEWS had been incorporated into the electronic healthcare record platform that had recently been installed in the hospital. Inspectors were informed that if a patient triggered a high score, they were reviewed during core working hours by one of the NCHDs onsite and out of hours the nursing staff would phone the on call NCHD. Nursing staff also had the option of contacting the National Ambulance Service (NAS) directly in the event of an emergency that required immediate transfer to an acute hospital.

The Identify, Situation, Background, Assessment, Recommendation/Read back/Risk ($ISBAR_3$) communication tool[‡‡‡‡] was used when escalating a patient who was unwell. Staff who spoke with inspectors were aware of the process to follow in the event of a deteriorating patient and this aligned to the relevant policy. Patient's

[††††] Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk ($ISBAR_3$) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

observations were recorded in line with the local policy and there was evidence on the electronic healthcare records observed by inspectors of appropriate escalation in line with protocol.

Emergency equipment was available and accessible in both clinical areas visited including resuscitation trolleys an Automated External Defibrillator (AED). The trolleys were checked weekly and the AED daily however it was noted that a QR code linked to the risk department recorded if the trolley was checked and therefore ward managers did not have real time oversight if the checks had not been carried out.

Oxygen was available at all bed spaces but only some had a regulator attached to the oxygen point which would pose a challenge in an emergency situation if a patient required supplementary oxygen. Each ward had access to a portable suction machine.

Policies, Procedures, Protocols and Guidelines (PPPGs)

Inspectors were informed that PPPGs were managed by the office of the CEO and that all polices for review were ratified by the hospital management team (HMT). This was not reflected in the TOR, agendas and minutes of HMT. This was discussed under national standard 5.2. As previously discussed under standard 5.2 inspectors identified that of the 12 policies reviewed on the days of inspection, eight were identified as being out of date. This was included in the high risk letter which was sent to senior management who in their response provided up to date copies of PPPGs.

The hospital had some systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services; however, the following was identified:

- a medication safety risk had not been reviewed on the corporate risk register since 2023
- a single patient identifier only was used on the patient's individual medication packs
- risk reduction strategies in relation to high risk medications and SALADs were not in place
- drug prescribing guides and intravenous medication guidance were out of date
- the majority of policies reviewed on the days of inspection were out-of-date
- the QR code used when checking the emergency equipment was linked to the risk department therefore ward managers did not have oversight of the routine

checks
- not all oxygen points at patients' bed spaces had a regulator attached to the oxygen point.

Judgment: Partially Compliant

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

The hospital had some systems and processes in place to ensure that patient-safety incidents were identified, managed, reported and responded to effectively, however, serious reportable events (SREs) discussed at Serious Incident Management Team (SIMT) identified potential care gaps and no reviews were commissioned as a result.

Staff who spoke with inspectors were knowledgeable about how to report an incident and were able to describe incidents that were previously reported, for example, medication errors. Staff confirmed that learning from incidents were shared at staff huddles. Reported incidents were tracked and trended by the risk, health and safety manager and a report was prepared every two months. Medication incidents were an agenda item at the Medication Management Group. Inspectors were informed by senior management of a report in relation to IPC incidents that was sent to the wards. This was requested in the clinical areas, from management and following inspection and was not provided.

Incident reports were an agenda item at the Q&S committee. A review of the SIMT minutes reflected that Preliminary Assessment Forms were completed. Meeting minutes reviewed indicated that there were potential gaps in care in serious reportable events reported, however, no reviews had been commissioned in line with the HSE Incident Management Framework 2020 (IMF). Furthermore, recommendations were documented in the meeting minutes, but these were not time bound or assigned an action owner.

While clinical incidents were reported into the National Incident Management System (NIMS)[§§§§] the hospital was not monitoring their performance against the national

§§§§ The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

key performance indicator of 70% of incidents reported to NIMS within 30 days from date notified.

Overall while the hospital had some systems and processes in place to ensure that patient-safety incidents were identified, managed, reported and responded to effectively the following was identified:

- no reviews were commissioned in response to SREs despite gaps in care being identified
- recommendations made in response to the gaps in care were not time bound or assigned to an action owner
- senior management were not monitoring their performance against the HSE KPI of 70% of incidents reported to NIMS within 30 days.

Judgment: Partially Compliant

Conclusion

HIQA carried out an unannounced inspection of The Royal Hospital Donnybrook Service to assess compliance with national standards from the *National Standards for Safer Better Healthcare.* This inspection focused on four areas of known harm: infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall, the hospital was found to be compliant in two national standards (1.6 and 5.5), substantially compliant in two national standards (6.1 and 1.8) and partially compliant in five national standards (5.2, 5.8, 2.7, 3.1 and 3.3).

Capacity and Capability

The hospital had defined accountability and reporting arrangements for the senior management team. Notwithstanding this, the governance arrangements for assuring the delivery of high quality, safe and reliable healthcare, in relation to the four areas of focus of this inspection were not providing the necessary oversight for hospital management to be assured about the quality and safety of care. Deficiencies were identified in clinical governance of the neuro rehabilitation unit, and the governance, management and oversight of policies, procedures, protocols and guidelines (PPPGs) and infection prevention and control. High risks were identified on the days of inspection, and these were escalated to hospital and regional senior management with assurances provided that they were being addressed.

Management arrangements were in place to support and promote the delivery of high quality, safe and reliable healthcare. Hospital management had some systematic monitoring arrangements in place for identifying opportunities to continually improve the quality, safety and reliability of services provided. However, deficits were identified in the oversight of the risk register, timely review of incidents at SIMT and medication management audits.

Workforce arrangements were in place to support and promote the delivery of high-quality, safe and reliable healthcare with the exception of access to an onsite pharmacist and deficits in mandatory training on Sparc ward.

Quality and Safety

Inspectors observed staff interacting in a kind and caring manner towards people using the service. Staff working in the hospital were committed to promoting a person-centred approach to care. Patients who spoke with inspectors were positive about the care they received in the hospital and complimentary of staff. It was evident that a person-centred rehabilitation approach to care was promoted.

Complaints management structures were in place, and management had sought feedback from those using the service through a patient satisfaction survey, however the hospital was not measuring its performance in relation to effective complaints management against the HSE national target.

The physical environment did not fully support the delivery of high quality, safe, reliable care. For example, clinical areas visited showed signs of general wear and tear and there was inappropriate storage.

While the hospital had some systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services these were not fully effective as inspectors identified deficits on inspection which not been managed by senior hospital management. For example, the impact of the lack of a clinical pharmacist resulting in multiple findings on inspection in relation to medication safety.

The hospital had some systems and processes in place to ensure that patient-safety incidents were identified, managed, reported and responded to effectively, however, serious reportable events (SREs) discussed at SIMT identified potential care gaps and no reviews were commissioned as a result.

Following this inspection, HIQA will, through the compliance plan submitted by hospital management as part of the monitoring activity, continue to monitor the

progress in implementing actions to bring the hospital into full compliance with the national standards assessed during inspection.

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

Compliance Classifications

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

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

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

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Partially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Partially Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially 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.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Partially Compliant

Compliance Plan for The Royal Hospital Donnybrook

Inspection ID: NS_0192

Date of inspection: 24 and 25 February 2026

Compliance plan provider's response:

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

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

The governance structure within the rehabilitation service has been reviewed following the inspection findings to strengthen oversight, accountability, and alignment with operational practice.

1. The organisational chart has been revised and finalised to accurately reflect the current reporting structures and governance arrangements within the hospital.

2. The Terms of Reference (TORs) for the Hospital Management Team (HMT), Clinical Governance and Steering Group (CGSG), Quality and Safety (Q&S) Committee, and Incident Management Group were reviewed and updated to clearly define governance responsibilities, reporting relationships, meeting frequency, quorum requirements, membership, and escalation pathways.

A schedule of meetings has been established to ensure that the HMT, CGSG, Q&S Committee, and Incident Management Group meet in accordance with their approved TORs. Attendance, actions, and governance oversight will be monitored continuously through committee work plans and minutes, with regular reporting to the appropriate governance structures to provide assurance that the committees are fulfilling their oversight responsibilities as outlined in their TORs.

3. The Deteriorating Patient Working Group Terms of Reference (TOR) which specifies six meetings per year will be formally reviewed following an operational gap in 2025, where only three meetings occurred.

Action will be taken to ensure future adherence to this six-meeting schedule. Realigning practices to meet this documented frequency will eliminate the discrepancy between policy and practice, fully securing operational oversight and governance compliance.

Additionally, the Delayed Discharge Oversight Group Terms of Reference (TOR) will be updated to formally designate the Chief Executive Officer (CEO) as the meeting Chair. Furthermore, operational meeting schedules will be formalised on a monthly basis. This targeted amendment will strengthen executive governance, optimize patient flow tracking, and enhance strategic discharge planning.

4. Infection and Prevention and Control

Infection Prevention and Control (IPC) governance arrangements and reporting have been clarified. Formal outbreak meetings continue to occur during outbreaks, with regular operational meetings between the Operations Manager and cleaning service provider in place to oversee environmental hygiene standards.

The Director of Nursing meets with IPC Clinical Nurse Specialist on a monthly one to one basis to review IPC performance, discuss emerging risks, surveillance, monitor progress against improvement actions and provide strategic oversight.

IPC updates are formally escalated through the Clinical Governance Steering Group, Operational Management meetings and Health & Safety committee. Therefore, the Hygiene and Infection Control Group committee was ceased.

To support the ongoing environmental safety, the IPC CNS undertakes comprehensive environmental infection audit 3 monthly. Findings are shared with relevant unit managers, catering manager, cleaning manager and maintenance manager and monitored through action plans to ensure timely resolution of identified issues.

5. A hospital-wide governance review of Policies, Procedures, Protocols, and Guidelines (PPPGs) has commenced. A centralised tracker will be implemented to actively monitor policy review dates, assigned policy owners, and ratification status. This mechanism will ensure that all institutional policies remain current, auditable, and strictly aligned with national guidance.

6. Clinical governance for the neuro-rehabilitation service is now established under a locum consultant, who started on May 15, 2026 pending the appointment of a permanent consultant. The funding for an appointment of a 1.0 WTE Neuro

Rehabilitation Consultant has been approved. A third round of advertising via agency is to commence shortly after failure to secure appointment following 2 rounds.

Timescale:

(1) June 30, 2026: completed
(2) July 07, 2026: completed
(3) August 31, 2026
(4) N/A
(5) July 1 – September 30, 2026

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

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

Systems for monitoring quality and safety have been strengthened to support the timely identification, reporting, review and escalation of incidents. The Risk Manager reviews all hospital incidents and identifies and tracks trends.

1. Incident Management

The Risk Manager, through the Quality and Safety Committee and Health and Safety Committee escalates increase in specific incidents and develops quality improvement plans and communicates hospital wide.

Incident reporting will continue to be monitored through the National Incident Management System (NIMS), with routine review of incident trends, reporting timeframes and actions to ensure timely escalation of significant incidents through the appropriate governance structures. Incident data will be analysed to identify emerging risks, inform quality improvement initiatives and provide assurance regarding patient safety.

An education programme will be commenced for nursing staff to reinforce their responsibilities for the timely recognition and reporting of incidents using the National Incident Management System (NIMS).

The programme includes guidance on incident categorisation, timely reporting, escalation processes, and the importance of accurate documentation to support organisational learning and patient safety. A hospital wide education day is planned in October 2026 to further enhance this programme.

A live incident management dashboard is available to all staff, providing real-time access to incident data to support the ongoing monitoring of incident trends, reporting compliance, actions and emerging risks. The dashboard is reviewed regularly by the Risk Manager to identify learning opportunities, inform quality improvement initiatives, and ensure that significant incidents are escalated through the appropriate governance structures in a timely manner.

In addition, a quality and safety noticeboard, located in a prominent staff area and updated monthly, provides staff with visual key audit findings, incident trends, quality improvement updates and performance reports, promoting shared learning, staff awareness and engagement with quality and safety across the service. Compliance with incident reporting requirements will be monitored through regular audit of NIMS reporting, with findings reported through the Quality and Safety Committee to the Senior Management Team to ensure oversight and continuous improvement.

2.1 Quality boards within each clinical area have now been reviewed monthly by Unit Managers with oversight provided by the Quality and Practice Development Department to ensure data displayed is current, accurate and meaningful to staff and patients.

2.2 Medication management audit findings have now been reviewed through the Medication Safety Group with time-bound quality improvement plans developed, monitored and escalated through governance structures where required.

2.3 Compliance with the Risk Management Policy will continue to be monitored through routine oversight by the Risk, Health and Safety Manager, the Quality and Safety Committee and the Hospital Management Team to provide assurance that corporate risks are effectively managed and reviewed on an ongoing basis.

2. Risk Management

The corporate risk register review process has commenced to strengthen the current system. This is expected to be completed by September 30, 2026. Part of the review is to address gaps where specific corporate risks lacked active review dates since 2023.

The Risk Manager, in collaboration with relevant risk owners, will ensure risks are reviewed in line with the hospital risk management policy, including review dates, control measures, internal risk management protocols and escalation processes.

Compliance with the Risk Management Policy will continue to be monitored through routine oversight by the Risk, Health and Safety Manager, the Quality and Safety Committee and the Hospital Management Team to provide assurance that corporate risks are effectively managed and reviewed on an ongoing basis.

Timescale:
(1) July 31, 2026 - October 31, 2026
(2) 2.1 & 2.2 – May 31, 2026: completed
(3) September 30, 2026

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

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

The hospital has reviewed the environmental findings identified during inspection and actions have been initiated to address identified deficits.

1. Environmental maintenance issues identified during the inspection, including the damaged windows, were escalated to the Maintenance Department and included within the hospital prioritisation schedule. All identified window repairs have now been successfully completed.

2. All sluice equipment servicing requirements have been fully reviewed, with all outstanding maintenance and servicing now completed. In collaboration with the Infection Prevention and Control (IPC) Department and the Maintenance Manager, ongoing maintenance schedules have been strengthened to ensure continuous regulatory compliance.

3. Unit Managers have been reminded of their responsibilities regarding appropriate storage practices and environmental oversight. Regular environmental walk-around and audits are being completed to ensure corridors, utility rooms and clinical spaces remain free from inappropriate storage.

4. The replacement of non-compliant clinical hand wash sinks remains an identified infrastructure priority for the hospital. A request for HSE Capital and Minor Capital funding has recently been accepted to address the non-compliant sinks identified throughout the rehabilitation service. The associated environmental and IPC risks remain recorded and actively monitored on the corporate risk register pending completion of the replacement programme.

5. Interim mitigation measures remain in place, including ongoing IPC environmental audits, hand hygiene monitoring, enhanced cleaning oversight, and regular review by the IPC department and senior management team.

6. A phased environmental refurbishment programme is underway to address wear and tear on walls, flooring and clinical areas. Additionally, an unused space is being converted into a larger staff breakroom, which will free up valuable ward space for medical storage.

7. The hospital will continue seeking HSE minor capital funding to progress risk-prioritised infrastructure improvements.

Timescale:
(1) June 15, 2026: completed
(2) May 31, 2026: completed
(3) Ongoing Audit
(4-7) July 1 – Dec 31, 2026 to Q1 of 2027

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.

The hospital has reviewed systems relating to medication safety, infection prevention and control, emergency preparedness and policy governance following inspection findings.

1. Emergency preparedness arrangements have been strengthened through the introduction of portable emergency grab bags replacing the previous emergency trolley system. All seven units have now been provided with

emergency bag on May 5, 2026. The revised system includes portable oxygen and replacement of all suction equipment across the hospital to support timely response in emergency situations.

2. Audit of emergency grab bag will commence in the month of July 2026. Frequency of audit will be determined post initial audit. In addition, all clinical areas are carrying out a weekly enhanced QR code monitoring system to strengthen real-time oversight, accountability and traceability of emergency equipment checks at ward level and is overseen by Unit CNM2 and CNM2 in Quality.

3. Medication safety risks are reviewed through the Medication Safety Group and corporate risk management processes under the oversight of the Medical Director and Risk Manager. A business case for an onsite clinical pharmacist has been submitted to HSE on July 17, 2026 for approval.

4. The issue regarding single patient identifiers on medication packs was escalated directly to the external pharmacy provider in March 2026. The hospital is currently awaiting the implementation of the provider's corrective action plan. In the interim, nursing staff have been advised to escalate any future omissions through the internal incident management process to ensure continuous risk monitoring.

5. Risk reduction strategies for high-risk and SALAD medications will be reviewed and implemented across clinical areas. Drug prescribing guidance and intravenous medication guidance documentation have been updated and made available at ward level and both policies are available in SharePoint.

6. A centralised governance process for PPPGs is being introduced. Policy owners will now be assigned responsibility for policy review, updating and ratification, with oversight maintained through the governance structure and policy tracker.

7. Oxygen point infrastructure across clinical areas is being reviewed by the Maintenance Department with associated costs and upgrade requirements currently being assessed.

Timescale:
(1) May 5, 2026: completed
(2) July 1 – December 31, 2026
(3) Dec 31, 2026 to Q1 2027
(4) September 31, 2026

(5-7) July 1 – September 30, 2026

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

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

Incident management and oversight processes have been strengthened following the inspection findings.

All Serious Reportable Events (SREs) and significant incidents are reported, reviewed and managed in accordance with the HSE Incident Management Framework (2020). This is completed for both residential and rehabilitation services.

Incidents discussed at the Serious Incident Management Team (SIMT) will undergo a formal review process, with action plans developed for all recommendations arising.
Action plans will identify responsible persons, agreed completion dates and monitoring arrangements to ensure timely implementation and evaluation of effectiveness.

The Risk Manager will provide regular reports to the Director of Nursing, the Clinical Governance Steering Committee (CGSC), the Quality and Safety Committee and the Clinical Governance Committee (CGC). Incident trends, Serious Reportable Events (SREs), learning outcomes, action plan progress and outstanding recommendations will also be presented to the Board to provide organisational oversight and assurance.

The hospital has strengthened the monitoring of incident reporting through the National Incident Management System (NIMS) and the live incident management dashboard. Incident reporting timelines, trends, actions and emerging risks will be monitored to ensure compliance with the HSE Key Performance Indicator (KPI) for reporting incidents within 30 days and to support the timely escalation of significant incidents through the appropriate governance structures.

1. A structured debrief process will be undertaken following Serious Reportable Events and other significant incidents, where appropriate, to support staff, identify learning and inform quality improvement. Learning from incidents will be shared through ward meetings, safety huddles, governance committees and the Quality and Safety noticeboard. An education programme will be delivered across all departments to reinforce the importance of timely incident recognition, reporting and escalation, the appropriate use of NIMS, and the role of SIMT in supporting organisational learning and improving patient safety.

2. An aggregate review committee has been commissioned to review all PU3 from January 2025 to June 2026. The review team has been established and developed in beginning of July 2026. The initial meeting is scheduled for July 23, 2026. This team will review data from both rehabilitation and residential services in relation to SIMT. The trends, incident themes and learning from both areas will be discussed to identify opportunities for quality improvement and to promote consistency in practice across all services.

Timescale:

(1) October 31, 2026
(2) July 31, 2026