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:	St Vincent's Private Hospital
Centre ID:	OSV-0008813
Address of healthcare service:	Merrion Road Dublin 4 D04 N2E0
Type of Inspection:	Announced
Date of Inspection:	17/06/2025 and 18/06/2025
Inspection ID:	NS_0150

About the healthcare service

Model of hospital and profile

St Vincent's Private Hospital is a private hospital located in South Dublin. It is a member of the St. Vincent's Healthcare Group. Services provided by the hospital include:

- medical
- in-patient services
- elective surgery
- high-dependency care
- diagnostic services
- paediatric services
- outpatient care.

The following information outlines some additional data on the hospital.

Number of beds	208 inpatient beds 60 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.

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(s)	Support Inspector(s)
17/06/2025	*13:00 – 17:45*	Laura Byrne	Angela Moynihan Elaine Egan Bairbre Moynihan
18/06/2025	*08:45 – 15:00*	Laura Byrne	Angela Moynihan Elaine Egan Bairbre Moynihan Maeve McGarry

Information about this inspection

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

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

The inspection team visited three clinical areas:

- Hawthorn Ward (Hepatobiliary)
- Cedar Ward (Oncology)
- Elderberry Ward (Medical/Surgical)

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

Acknowledgements

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

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

Inspectors spoke with a number of patients throughout the two days of inspection. Patients described their care in a positive manner, for example, that care was "exceptional" and staff were "wonderful". Patients reported that they found the ward clean and peaceful. Patients were complimentary about the staff and commented on the consistency of staffing, with the same staff caring for them regularly. They were also complimentary about staff communication. Patients reported that they were kept up to date on their plan of care. Positive feedback was received about the food

[†] 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.

choices on offer. Call-bells were observed within patients' reach and patients commented that staff responded in a timely manner when called.

Inspectors observed that clinical areas were calm and clean with spacious patient rooms. Additional facilities were available in the hospital such as a coffee shop and the hospital waiting area was inviting with light music playing in the background.

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes the standard related to workforce. St Vincent's Private Hospital was compliant in three national standards (5.2, 5.5 and 5.8) and substantially compliant in one national standard (6.1).

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

Corporate and clinical governance arrangements in St Vincent's Private Hospital (SVPH) for assuring the delivery of high-quality, safe and reliable healthcare were integrated, formalised, and clearly defined. Organisational charts clearly outlined responsibilities, accountability and oversight arrangements for management structures and governance committees. This was consistent with what inspectors were told by management and staff.

The St Vincent's Hospital Group (SVHG) board of directors provided oversight of the governance of the hospital. The board appointed a chief executive officer (CEO) who was delegated with overall responsibility and accountability for the governance and quality of healthcare services delivered. Terms of reference (TOR) reviewed indicated that the board met nine times per year and more frequently if required. Minutes of meetings and interviews reflected that meetings took place in line with the TOR and that issues in relation to SVPH, for example, recruitment and capital developments, were discussed at board meetings. The CEO compiled an annual report for the board.

St Vincent's Hospital Group Risk, Quality and Safety Committee (RQSC)

This group met quarterly and was attended by the SVPH CEO and members of the leadership team. Meetings followed a set agenda. The TOR outlined that minutes of these meetings were provided to the board and that the chair reported to the board. An update was provided by an SVPH representative at each meeting regarding quality and risk reports, organisational risk register - new and closed risks, organisational KPIs and clinical incidents.

Quality Improvement and Safety Committee (QIS)

The Quality Improvement and Safety Committee was the overarching governance committee where the four areas of focus of this inspection were discussed. Chaired by the director of quality, patient safety and risk, the committee met ten times per year and reported to the CEO and leadership team. The TOR indicated that the committee provided a framework underpinning the hospital's overall quality improvement efforts and were responsible for formulating the Quality Improvement and Patient Safety Programme in the hospital. It was evident from meeting minutes reviewed that audits, key performance indicators (KPIs) and monthly quality and risk reports were discussed at each meeting. A number of subcommittees with formal reporting arrangements to the QIS committee were in place, including; Infection Prevention and Control Committee (IPCC), Medication Management and Use (MMU) Committee and the Deteriorating Patient Committee (DPC). There was evidence that updates from these committees were a standing item at meetings. Updates were also provided from the consultants' forum. Actions identified at meetings had a named responsible person however these were not time bound. All members of the senior leadership team were members of the QIS committee along with representatives of the subcommittees and working groups.

Medication Management and Use Committee

The MMU committee was a subcommittee of the QIS committee, chaired by the pharmacy executive manager and met quarterly. There had been a gap of seven months between the September 2024 and April 2025 meetings and inspectors were informed that this was due to competing demands at that time. Inspectors were informed that meeting minutes were forwarded and an annual report provided to the QIS committee. The chair of the MMU committee was also a member of and attended the QIS committee. Meetings followed a set agenda, actions were identified and sometimes a responsible person identified but these were not time bound. Medication safety data was reviewed at each meeting. The antimicrobial stewardship subcommittee (AMSC) was a subcommittee of the MMU committee. An update from this group was a standing item on the MMU committee meeting agenda.

Infection Prevention and Control Committee (IPCC)

The IPCC, chaired by the director of nursing (DON), met every two months in line with the TOR. It was a subcommittee of the QIS committee and reported to the QIS committee twice yearly. Items discussed included audit, surveillance data and feedback from the subcommittees. Subcommittees of the IPCC included hygiene services, decontamination and the surgical site surveillance committee. IPC surveillance was a standing agenda item at the IPCC and while each agenda item had an identified responsible person, actions were not clearly identified or time bound.

Deteriorating Patient Committee (DPC)

The DPC oversaw the provision of deteriorating patient services and met quarterly in line with the TOR. A consultant intensivist was the newly appointed chair from June 2025 and this was reflected in the draft 2025 TOR provided. The TOR outlined and management confirmed that the committee reported to the QIS committee and that reports and meeting minutes were sent to QIS committee. Agenda items included audit and evaluation of services, training and debriefing. Actions arising from meetings were identified but not assigned to a responsible person or time bound.

Patient Flow Committee

The patient flow committee met monthly as per the TOR. Chaired by the bed manager, this committee had a set agenda and reviewed incidents in relation to transitions of care, transfers from the public acute hospital, and KPIs, for example bed occupancy and length of stay. This committee was listed on the quality improvement and safety structure organisational chart as an operational user group which reported to the QIS committee, however, the reporting relationship was not outlined in the TOR. Inspectors were informed that the DON attended these meetings and could escalate issues as required from this meeting. Actions were identified at meetings along with responsible persons but these were not time bound.

It was evident that the MMU committee, IPCC, DPC and patient flow committee functioned in line with the TOR, operated to a defined agenda, included relevant multi-disciplinary members and had oversight of the quality and performance of areas within their remit. Meetings were overall well attended, multi-disciplinary and representative however hospital management acknowledged the challenge in getting medical representation in attendance for some committee meetings, for example the DPC and the QIS committee. Notwithstanding this, senior management reported that they could utilise the consultants' forum if required for information sharing and that they were trying initiatives such as video call options to increase ease of attendance.

Overall, inspectors found there were formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare at the hospital. Senior management described the lines of accountability and responsibility for each of the four areas of focus. However, actions that were identified at meetings of the QIS committee, DPC, IPCC, MMU committee and patient flow committee were not time bound.

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.

Effective management arrangements were in place in the hospital to support the delivery of high-quality, safe and reliable healthcare services in relation to the four areas of focus of this inspection; infection prevention and control, medication safety, acutely deteriorating patients and safe transitions of care.

Inspectors were informed that the senior leadership team meeting was an operational meeting held weekly and which discussed agenda items such as quality and safety, nursing department, human resources, finances, clinical services and facilities. The CEO, DON, and quality manager were all members of this team. Meetings followed a set agenda however, no time-bound actions with responsible persons were identified on the minutes reviewed.

Inspectors were informed that consultants working at the hospital were engaged under a privileging rights arrangement and that all consultants were listed on the specialist register of the Irish Medical Council. Non consultant hospital doctors (NCHDs) reported to consultants for clinical matters. Inspectors were informed that the consultants' forum, which met quarterly, was chaired by a consultant and was responsible for clinical governance for doctors. This group reported to the CEO and the QIS committee.

Nursing services in the hospital were managed and organised by the director of nursing who was supported in the role by assistant directors of nursing (ADONs). Clinical nurse managers (CNMs) of different grades were responsible for the management and oversight of the clinical areas and were operationally accountable to a CNM3 and upwards to the ADON. A CNM3 was assigned with responsibility for dealing with day-to-day operational issues and a CNM3 had responsibility for the service at night.

A daily hub meeting was held, attended by CNMs from across the hospital, which discussed operational information such as patient flow, infection outbreaks and staffing. A clinical nurse managers' meeting was held monthly. Minutes from this meeting in May 2025 showed that feedback from the consultants' forum, policy updates, new initiatives and an update on construction works were discussed. Actions were identified, some of these were assigned a responsible person but they were not time bound.

The SVPH Quality Improvement and Safety Programme was provided for 2025 which outlined hospital wide priorities, an action plan for 2025, the reporting structure and procedures of the various subcommittees. Each action identified had a responsible person and target timeframe for implementation.

The infection prevention and control team comprised an ADON, clinical nurse specialist (CNS) and an IPC trained enhanced nurse. A microbiologist, based in the co-located St Vincent's University Hospital (SVUH), was available during core hours Monday to Friday. Microbiology advice was available out of hours via phone. Staff in the ward confirmed that the IPC team visited daily. Inspectors were informed that weekly meetings were held with the SVUH IPC team for sharing of information. The hospital's IPCC developed an annual IPC programme which set out the priorities for the year, an overview of the IPCC programme and an action plan for 2025. All actions were time bound with a responsible person identified for their implementation. The 2024 annual infection prevention and control committee report, reviewed by inspectors, detailed the work undertaken by the IPCC and the hospital's performance in relation to infection prevention and control practices, surveillance and monitoring, and compliance with applicable KPIs. The hospital's performance in these areas are discussed further in national standards 2.8 and 3.1.

A clinical pharmacy service, overseen by the pharmacy executive manager, was provided to all clinical areas in the hospital. The clinical pharmacy team included an antimicrobial stewardship pharmacist. Medication supplies were managed by the pharmacy service and staff could access medications for patients out of hours through the CNM3. Medication safety was underpinned by a medication management committee programme and copy of this was provided for 2025. This programme outlined risks, pharmacy structure, committee structure, an action plan and objectives. It was approved by the MMU committee and the action plan had responsible persons identified and target completion dates. The 2024 Medication Safety Report, reviewed by inspectors, outlined the work undertaken in 2024 and detailed the hospital's performance in relation to medication incident reporting, audit results and compliance with applicable KPIs. The hospital's performance in these areas are discussed further in national standard 2.8.

Inspectors were informed and documentation confirmed that 24 hour anaesthetic registrar cover was available onsite and a rota was in place for 24/7 cover from an intensive care consultant. Laboratory testing was carried out in the laboratory in SVUH and staff had access to these results through an information technology (IT) system in the ward. A first responder team, critical care outreach team and emergency response team were in place for management of deteriorating patients and emergencies. A deteriorating patient committee action plan was provided which outlined key priorities for 2025 however actions were not assigned to a responsible person or time bound.

Patients were admitted to the hospital on an elective basis or transferred from SVUH. There was no emergency department at the time of inspection but construction was ongoing on a new emergency department. Inspectors were informed that representatives from SVPH attended the monthly SVUH bed management meeting where an update was provided by senior management on issues impacting patient flow between the two hospitals.

Overall, hospital management had effective arrangements in place to achieve planned objectives that involved all levels of the service provided.

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.

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 collated a range of patient-safety indicators, which were reviewed at senior management level. This information provided the relevant governance committees with assurances about the quality and safety of healthcare services provided in the hospital.

Monitoring Performance

Arrangements were in place to monitor the hospital's performance. KPIs that were monitored included, for example, healthcare associated infections, average length of stay, bed occupancy, inpatient falls, emergency calls, patient satisfaction, complaints and medication incidents. Oversight of the KPIs was provided by the QIS committee. Evidence was provided of regular KPI reporting from each of the governance

committees with oversight of the four areas of harm that were the focus of the inspection.

Risk Management

Formalised risk management structures and processes were in place to proactively manage and minimise risks at the hospital. An up-to-date "guideline to the risk management policy" was available to guide staff. A corporate risk register was in place. Risks in relation to the four areas of focus of this inspection and workforce were recorded on the risk register. These are further discussed under national standard 3.1. Inspectors were told that staff could escalate risks that could not be managed in their individual department to the organisational risk register and upwards to the SVHG risk register as necessary. Inspectors were informed that the corporate risk register was discussed at the leadership team meeting quarterly. Risks reviewed by inspectors in relation the four key areas of harm had been reviewed in June 2025. However this was not reflected in the leadership team meeting minutes from that date. The organisational risk register was a standing agenda item at the hospital group RQSC meetings.

Incident Management

Incidents were logged on an incident management system. The CNMs had oversight of all incident notifications for their clinical area. A clinical incident review team meeting was held each week and incidents were discussed and decisions made with regard to follow up actions. Evidence was provided that incidents were tracked and trended and this was shared with CNMs. This is further discussed under national standard 3.3.

Inspectors were informed that there were no open serious incident reviews and that a serious incident review team met every two months. The hospital had an up-to-date sentinel events policy which outlined the reporting, procedures and timelines for reviewing sentinel events. The incident management and near miss identification and management procedure outlined that sentinel events should be reported to senior management within 24 hours and inspectors were informed that this practice was in place. This is further discussed under national standard 3.3.

Audit

Governance subcommittees for the four key areas of harm had oversight of audit results in their areas of responsibility and results were reported to the QIS committee. It was evident through a review of documentation that multiple audits were taking place in relation to the four areas of focus for this inspection and these are discussed further under national standard 2.8.

Overall, there was evidence of monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services relevant to the size and scope of the hospital.

Judgment: Compliant

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

Workforce arrangements were planned, organised and managed at the hospital to provide high-quality, safe and reliable services. However, some deficits were identified in relation to mandatory training compliance.

Consultants were supported by NCHDs. Inspectors were informed that patients' named consultants were the primary source of contact during the day and that outside core working hours a "house doctor" was available onsite.

Inspectors identified that there were no deficits in nursing or healthcare assistant (HCA) staffing in the three clinical areas visited on the days of inspection. Local management informed inspectors that vacant shifts were filled by ward staff with the occasional use of agency staff. CNMs confirmed they were satisfied with their level of staffing and that cover was available for unplanned leave in most circumstances. Enhanced care was provided as needed with additional HCAs. Inspectors were informed that 2.5 whole-time equivalent (WTE) staff nurse vacancies on Cedar Ward had been advertised. One staff nurse position was vacant on Elderberry Ward but the CNM confirmed that there was no impact of this vacancy.

Each ward had an allocated pharmacist. Pharmacy staffing included one pharmacy executive manager, three chief 2 pharmacists, 16 WTE senior clinical pharmacists, ten of whom were allocated to the inpatient wards, and 20 WTE pharmacy technicians. No deficits were reported in pharmacy staffing. The human resource department tracked staff absenteeism rates. This was reported as 4.13% from Jan-March 2025 which was marginally above the hospital's target of 4%. This figure was 4% for 2024 and 3% for 2023. Management stated that back-to-work interviews were conducted with staff on return from unplanned leave. Occupational health supports were available and staff had access to an employee assistance programme (EAP), if required.

A strategic workforce plan was provided for 2025 which outlined the goals for workforce recruitment and retention, induction of new staff and human resource KPIs. Inspectors were informed that a staff survey was carried out every two years.

Oversight of mandatory training was with individual line managers at the time of inspection, however inspectors were informed that the hospital was transitioning to a hospital wide electronic system for recording and tracking mandatory training. A list of mandatory training courses was available and included topics such as standard precautions, hand hygiene and basic life support (BLS). Training compliance records for the whole hospital were provided and showed good compliance for nurses' training in medication safety, Irish National Early Warning System (INEWS) and clinical handover. However, there was some areas that could be improved with standard and transmission-based precautions and personal protective equipment (PPE) both at 72%, hand hygiene was 81% and BLS was 77%. Sixty-three per cent of HCAs had up to date training in standard and transmission-based precautions and PPE, 65% in hand hygiene and 77% in BLS. CNM3s were trained in the Irish Maternity Early Warning System (IMEWS).

There was some variance in training compliance for nurses and healthcare assistants across the clinical areas visited. For example, training compliance for BLS and standard and transmission-based precautions ranged from 50% to 100%. All wards visited had compliance of over 94% for hand hygiene training.

A review of training records for doctors showed good compliance with BLS training, however training compliance in PPE was 72% and in hand hygiene was 77%. INEWS training was not mandatory for doctors and this was confirmed by staff during interviews. This is discussed further under national standard 3.1.

Housekeeping staff had training compliance of 86% and above for all relevant training areas. Health and social care professionals (HSCPs) were noted to be 64% trained in BLS, 81% in standard and transmission-based precautions, 80% in PPE and 84% in hand hygiene.

Overall, the workforce arrangements were organised and managed to provide high-quality, safe and reliable services, however the following was identified

- low compliance levels for some mandatory training courses, for example, training in hand hygiene, standard and transmission-based precautions and BLS.

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.

St Vincent's Private Hospital was compliant with three national standards (1.6, 1.8 and 3.3), substantially compliant with three national standards (1.7, 2.7 and 2.8) and partially compliant with one national standard (3.1).

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

It was evident through observation and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients. 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 and no concerns regarding privacy were highlighted.

Staff were aware of measures required to promote patient privacy, for example, speaking in a low volume on the phone or shutting down computers after use. Inspectors observed that staff respected privacy, for example, by ensuring to close the office door when communication huddles were in progress and by knocking before entering a patient's room. Privacy curtains were in use in the shared bays and inspectors observed that the placement of beds in the rooms promoted privacy. Staff outlined how patients requiring additional privacy, such as for end-of-life care, were accommodated in single rooms. A family room was available on Cedar Ward and staff on Elderberry Ward reported that they had access to a family room on another ward if needed.

Patient information was stored and protected appropriately, for example, the digital whiteboard in use displayed anonymised data.

Patients commented that they were kept informed of their plan of care. The "Get up, Get dressed, Get moving" campaign information was on display in Hawthorn Ward and staff confirmed that this was promoted on the ward.

Overall, on the days of inspection, service users' dignity, privacy and autonomy was respected and promoted.

Judgment: Compliant

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

The service promoted a culture of kindness, consideration and respect. Patients told inspectors that staff were responsive when they needed assistance. Patients informed inspectors and inspectors observed that staff responded to call-bells in a timely manner. Staff were observed providing assistance to and interacting with patients in a kind, respectful and caring manner. There was evidence of staff attending to individual patient's needs, such as the use of a warming device for patient care wipes on Cedar Ward.

A patient charter and a mission statement were on display throughout the hospital. Hawthorn Ward had a unit philosophy on display. The service was actively seeking feedback from patients, for example, a survey seeking feedback was sent by text message to patients following discharge. Documentation received evidenced that the patient satisfaction survey was discussed at the QIS committee and an overview was outlined in the annual quality and risk report.

Patient information leaflets were on display, for example, hand hygiene information and discharge advice. A patient and visitor handbook was available and contained information about admission, discharge and hospital facilities. Information on staff, feedback, medication safety, infection prevention and falls was displayed on patients' television screens in the ward areas. A sign was observed at the hospital reception with the details of the person in charge of the service for that day. A translator machine was available for use by staff who needed to communicate to relevant patients.

Inspectors were informed that patients did not have access to advocacy services onsite. Management stated that patients could contact a hospital patient safety forum. However, posters and leaflets were not evident in the hospital offering this service.

Overall, staff and management of the hospital promoted a culture of kindness consideration and respect. However:

- information on independent advocacy services was not available or accessible to patients.

Judgment: Substantially Compliant

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

The hospital had identified the director of quality, patient safety and risk as the designated complaints manager. Posters were on display in the ward area with information on how to provide feedback. Patients were not aware of the complaints process when asked by inspectors but did comment that they would talk to staff if they had any issues. Staff had access to an up-to-date policy on complaints management. A procedure was in place for local complaint resolution in the clinical areas and complaints were recorded in the clinical area via an incident report form. If complaints could not be resolved in this manner they were escalated by ward management to the ADON or CNM3.

There was evidence that the number of formal complaints was monitored monthly. The hospital was tracking compliance with the KPI of closing complaints within 30 days and this was 100% for January, February and April, and 90% for March 2025. A complaints and compliments overview for 2024 was reported in the annual quality and risk report and showed that 92% of the complaints received were meeting this KPI. A complaints report for 2024 and year to date 2025, reviewed by inspectors, showed that complaints were categorised and had associated action plans.

There was evidence of the service taking action in response to complaints. For example, Elderberry Ward staff had implemented a quality improvement plan (QIP) in response to complaints about uncomfortable chairs. This led to the purchase of new chairs, which were observed by inspectors, and management reported that no further complaints had been received in this trend.

Overall, there was evidence that the hospital had systems and processes in place to respond effectively to complaints and concerns raised by people using the service.

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 observed that the physical environment in the areas visited supported the delivery of high-quality, safe, reliable care.

The wards had a mixture of single and twin occupancy rooms. All patients requiring isolation were accommodated in a single room. In total nine patients between all ward areas inspected required isolation during the days of inspection. Fourteen positive pressure isolation rooms were available if required, six of these located on Cedar Ward. All rooms had en-suite facilities and there was space for storage of personal items and patient furniture at each bed space in shared rooms. Appropriate isolation signage was in use. In one case a door to an isolation room was open and this was attributed to a decision made by the IPC team based on a patient's risk of falling. Appropriate PPE was available.

The wards were clean and free from clutter. Routine environmental cleaning was completed by cleaning staff from 8am to 8pm. A phone number was available for out-of-hours cleaning requests. A colour-coded system was in place for cleaning cloths and cleaning staff were knowledgeable about the cleaning processes in place. Cleaning schedules were kept up to date and there was evidence of regular oversight of these by cleaning supervisors and ward managers. Inspectors were informed that terminal cleaning was completed when a patient was discharged. A schedule was in place for the changing of curtains in the wards.

Inspectors observed that equipment was clean in the clinical areas visited. HCAs were assigned with responsibility for cleaning equipment. A system was in place to identify equipment which had been cleaned, for example, the use of tags and checklists and these were kept up to date. Evidence of a daily equipment cleaning checklist was maintained in the wards and this was maintained by a healthcare assistant with oversight by the clinical nurse manager. Staff reported they had adequate access to maintenance services who were responsive to requests.

Hand-hygiene sinks in the clinical area met the required specifications[††]. Staff had access to wall-mounted alcohol based hand sanitiser dispensers throughout the ward areas. Hand-hygiene information was included on the back of staff identification badges and displayed in the wards.

Inspectors observed that sharps waste material was correctly stored and there was appropriate segregation and storage of linen and waste. Stock and equipment were stored appropriately in most cases however, there were some exceptions. For example, in Cedar Ward the door to the cleaner's storage room was not locked and the cleaning trolley was located inside containing chemicals and in Elderberry Ward

[††] National Clinical Guidance No. 30-Infection Prevention and Control (IPC). Available online from https://www.gov.ie/en/publication/a057e-infection-prevention-and-control-ipc/#national-clinical-guideline-no-30-infection-prevention-and-control-ipc-full-report-volume-1.

cleaning products were stored in a dirty utility room which was not locked. These were brought to the attention of management during the inspection.

In summary, inspectors found the physical environment supported the delivery of high-quality, safe, reliable care. However, the following was observed:

- doors to the cleaner's storage room on Cedar Ward and the dirty utility in Elderberry Ward were not locked and contained chemicals and cleaning products.

Judgment: Substantially Compliant

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

Inspectors found that there were systems in place at the hospital to monitor, evaluate and continuously improve the healthcare services and care provided. The hospital collected a range of different measurements related to the quality and safety of healthcare services provided. This included data relating to hospital activity, patient-safety incidents, complaints, hospital-acquired infections, workforce, training and risks that had the potential to impact on the quality and safety of services. Collated performance data was reviewed at meetings of the relevant governance committee such as the QIS committee, IPCC and MMU committee.

The hospital was tracking rates of hospital-acquired healthcare associated infections (HCAI) such as *Clostridioides difficile* infection, Carbapenemase-Producing *Enterobacterales* (CPE), Vancomycin Resistant *Enterococcus* [‡‡](VRE), Methicillin-resistant Staphylococcus *aureus* [§§] (MRSA) and *Staphylococcus aureus* (SA). The hospital was within its set KPI target for each infection type with the exception of CPE which was 0.02 per 1000 bed days, marginally outside of the target of 0 for 2024. Actions taken in response included introduction of drain disinfection for all CPE occupied rooms on discharge along with a double terminal clean. No further cases of CPE were detected to the date of inspection in 2025.

Surgical site infection surveillance was taking place for patients who had undergone orthopaedic surgery, mastectomy and whipple procedures. As a result of this surveillance programme which highlighted areas where rates were above targets, a

[‡‡] Vancomycin Resistant *Enterococci* (VRE) are bacteria that live in the bowel. VRE can cause an infection if it gets into your bladder, kidneys or blood.
[§§] Methicillin-resistant *Staphylococcus aureus* (MRSA) infection is caused by a type of staphylococcus bacteria that has become resistant to many of the antibiotics used

surgical site surveillance committee had been established in 2023 and a new pre-operative protocol had been commenced.

The IPC team completed regular audits of the environment, patient care equipment, commode hygiene, hand hygiene and the application of transmission-based precautions in single rooms. Issues identified on audits were logged on the audit reports with photos of the non-compliances and results were communicated to ward management and displayed on notice boards in the ward. CNMs were knowledgeable on actions taken when audit results fell below targets and recommendations were clearly outlined on some audit reports, for example commode audits. However, documented QIPs or action plans were not included with the audit reports provided for environment, hand hygiene or equipment audits. Some issues identified on recent audits, for example, the recording of date of opening on disinfectant wipes or the appropriate storage of linen, were observed by inspectors as being in place during the inspection.

Monthly hand-hygiene audit compliance for clinical areas visited met the hospital's target of 90% for 2025 with the exception of one result of 80% on Elderberry Ward in March 2025 and one result of 86.7% on Cedar Ward in January 2025. There was evidence of improvements in response to audit findings. For example, on Elderberry Ward an issue noted on the March audit were instances of staff wearing a wristwatch, however a repeat audit showed compliance of 100% in April 2025 and staff on Elderberry Ward were observed to be bare below the elbow on the day of inspection.

A monthly audit of medication appropriateness review within 24 hours showed compliance with the target of 80% for 2024 and January 2025. Pharmacy were completing controlled medication and high alert drug storage audits. Compliance was above target and this was in line with the findings on the days of inspection. A stock management and drug security audit was completed by pharmacy in May 2025. The total score for this audit was not calculated but one area of non-compliance was noted regarding the medication fridge not being locked on Hawthorn Ward. However inspectors observed that this was locked on the day of inspection.

Monthly antimicrobial prescribing rates were recorded and annual audits completed. Monthly updates on antimicrobial prescribing were communicated by pharmacy via an "antimicrobial of the month" initiative and this was observed by inspectors on Elderberry Ward. An audit on current antimicrobial prophylaxis use in the intra-operative period was completed by the AMS pharmacist. An action plan was included along with a plan for circulation of these results to governance committees such as the IPC committee and the clinical audit group.

Inspectors were informed that the INEWS documentation was audited in one section in nursing documentation audits. Although scores for this section were 100% for the most recent three audits for each clinical area visited, issues in relation to the INEWS were highlighted on the audit reports for example, gaps in the documentation of the observations at the specified frequency. This was also observed during the inspection and is discussed further under national standard 3.1.

Patients who were escalated for a deterioration were being tracked by the DPC and trended by ward of origin and transfer destination. Emergency calls were tracked along with the response and outcome. A database of deteriorating patients was maintained.

Audits of communication effectiveness in nursing handover across a number of inpatient areas in September 2024 and February 2025 showed compliance above 92.6%. A review of communication and handover effectiveness for interdepartmental handovers showed 100% compliance from January to March 2025. Inspectors were informed that an audit of communication effectiveness at nursing handover using the identify, situation, background, assessment and recommendation (ISBAR) tool was being completed for 2025.

Examples of QIP's were provided in a number of areas, for example, a QIP on the inclusion of the new sepsis icon on the interactive whiteboard was in progress.

Overall, the hospital had systems in place to systematically monitor and evaluate the services with many examples provided of audits completed to continuously monitor practice and improve the quality and safety of the service. However:

- it was unclear from documentation provided that action plans were developed in response to IPC audit findings for example, equipment and environment audits.

Judgment: Substantially Compliant

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

The hospital had some systems in place to protect service users from the risk of harm associated with the design and delivery of healthcare services. However, deficits were identified in the management of the risk of deteriorating patients and the use of the INEWS in line with national guidance.

As discussed under national standard 5.8, the hospital had a corporate risk register in place. Examples of risks relating to the four areas of harm included the risk of incomplete handover, medication shortages, prescribing errors and infection outbreaks. Existing and additional controls were documented along with a responsible person identified. Individual patient risk assessments were carried out in the clinical area for example IPC risk assessments and falls risk assessments.

Building works were in progress in relation to the development of a new Emergency Department. Daily risk assessments were carried out and evidence of these were provided for three dates in June. An aspergillosis risk assessment was provided from January 2025.

Hospital management informed inspectors, and the local guideline for the use of the early warning score indicated, that the hospital was aligned to the National Clinical Guideline No.1, Irish National Early Warning System. The hospital had implemented the INEWS and staff were knowledgeable of this in the clinical areas inspected. While nurses were trained in the INEWS, it was not mandatory training for doctors. This is not in line with national guidance. Hospital management had not identified this as a risk. This knowledge gap presented a risk that a deteriorating patient would not be managed in line with national guidance.

Inspectors reviewed a sample of patients' INEWS charts. It was observed that, while the majority of INEWS entries were appropriately recorded and adhered to the required observation frequency, in the case of two INEWS charts reviewed, observations were not documented at the frequency required by the escalation protocol. Appropriate frequency of observations and documentation of modified escalation protocols was brought to the attention of ward and hospital management.

Paediatric patients aged 14 and up were admitted on a planned basis. A risk assessment and suitability screen was carried out on each patient with a consultant approval required prior to admission. The hospital admission policy supported this practice. In addition, approval was required from pharmacy and radiology departments. This was discussed with hospital management who responded that the risk assessment process in place was working well and that only patients who met the criteria were admitted to the service. However, although a system was in place for planning these admissions, there was no Paediatric Early Warning System (PEWS) in use. This is not in line with national guidance for patients aged 14-16 years.

Emergency on-call contact information was on display in the ward area and provided to staff on their staff identification badge. Resuscitation equipment was available and a sample of records reviewed confirmed that appropriate checks of this equipment were carried out. Oxygen and suction equipment was available at bed spaces. SVPH had a first responder system in place for deteriorating patients, supported by a critical care outreach service who reviewed deteriorating patients Monday to Friday. In addition, a system was in place for responding to emergency calls where staff attended from the co-located St Vincent's University Hospital to support SVPH staff.

The hospital had a local sepsis screening form and sepsis sticker for the healthcare record. Information on sepsis was on display in clinical areas visited.

An IPC risk assessment was completed on admission and screening was completed for MRSA, CPE, VRE and COVID-19 based on an IPC admission screening guide. Staff were alerted to IPC risks via a symbol on the digital whiteboard, a sticker on the patient's identification band and on the healthcare records. There was evidence from a review of a sample of healthcare records that staff had risk assessed patients on admission for multi-drug resistant organisms (MDROs). Staff in the clinical area had access to a guidance document which outlined the MDRO alert procedures, screening and infection control practices on the ward. Staff had access to antimicrobial stewardship guidelines.

No outbreak of infection was reported on the days of inspection. Monitoring of outbreaks was taking place and there had been one outbreak of Influenza A in 2025 and one outbreak of COVID-19 in 2024. Evidence of an outbreak report for 2025 being completed were provided to inspectors which outlined the outbreak background, actions taken and date of outbreak closure.

Medications were appropriately stored in locked medication rooms in each ward with keypad access. Controlled medications were appropriately stored and there was evidence of checks on each shift. A sample of these were reviewed and were observed to be accurate. There was evidence of good medication safety practices such as separate storage and labelling of sound-alike look-alike (SALAD) medications and high risk medications, for example the use of high risk labels on insulin.

Staff had access to a medication fridge in each clinical area with remote monitoring of temperatures. Up-to-date online medicines information, intravenous medication information, SALAD medications lists and high alert medications lists were available in each ward inspected. This was supported by the local policy which was up to date. The MMU committee issued alerts on medication safety, an example of which shown to inspectors from April 2024.

A policy was in place for the use of patient's own medications and this aligned with the practice described to inspectors in the clinical areas. There was a storage area for each patient for the patient's own medications and inspectors observed a sample of these which were locked.

Pharmacists completed a medication appropriateness review for all patients. A review of healthcare records in the clinical areas evidence that this process was completed. Inspectors were informed that out of hours this was completed by nursing staff or doctors however there was some discrepancy amongst staff interviewed about the responsibility for this process at weekends and this process was not described in the policy on medicines reconciliation.

Inspectors were informed that the ISBAR communication tool was in use in some areas throughout the hospital but it was not standardised and some staff were continuing to use alternative communication methods. ISBAR was not in use for shift handover and no evidence was observed of ISBAR documented in medical notes for communication with regard to deteriorating patients. Three different authorised structured communication tools were outlined in the hospital's INEWS guideline. Although no impact was identified with this arrangement on the days of inspection and no incidents were reporting in regards to handover, this could potentially risk the clarity of information transfer for escalation of deteriorating patients. Hospital management reported they were transitioning to the ISBAR format but that the progress of this transition varied across the hospital.

Medical admission inclusion and exclusion criteria were outlined in the hospital's admission policy. Daily huddles took place in the ward area at which new admissions, upcoming discharges and follow up plans were discussed. All patients in the wards visited had a predicted date of discharge documented on the ward digital whiteboard system.

A number of standardised forms for the internal and external handover of patients such as a nursing verbal handover form and the critical care support referral form were available. One form, a "Patient Nursing Discharge Plan", did not contain a section for documented MDRO status but staff reported they could add this detail if required. A public to private handover form was in use for recording the verbal handover of patients transferring from the public hospital and this included the patients MDRO status.

Access to policies, procedures and guidelines was via an online system. Staff had access to a suite of local policies in relation to equipment decontamination, infection prevention and control, medication management, risk management, complaints and incident management which were all up to date. Policies were managed by the respective committees and inspectors were informed that any new policies were approved by the QIS committee.

While the hospital had some systems in place to identify and manage potential risk of harm associated with the four areas of harm. The following was identified:

- doctors were not trained in the INEWS which is not in line with national guidance
- the PEWS tool was not in use for patients aged 14-16 years
- in two instances observations were not carried out at the frequency outlined in the EWS escalation protocol.

Judgment: Partially Compliant

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

The hospital had systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The hospital collated a range of patient-safety indicators, which were reviewed at senior management level.

Systems were in place to identify, report, manage and respond to patient-safety incidents. Staff who spoke with inspectors were knowledgeable about the systems in place and their role in reporting and managing patient-safety incidents. Patient-safety incidents were reported directly onto an IT system. The CNM had oversight of all incidents from their clinical area and these were sent to the quality department for review. Staff had access to an "Incident and Near Miss Identification and Management process" document which outlined incident reporting for staff.

Tracking, trending and analysis of incidents was completed by the quality department and presented in a monthly report to the QIS committee. Incidents were trended by type and location. CNMs in the ward areas were aware of their trends. Inspectors observed evidence of incident tracking and trending on display in Hawthorn Ward.

A quarterly medication event report was presented at the MMU committee. This detailed trending of KPIs, for example, the reporting culture and medication event

rate per 1000 patient bed days, types of medication incidents and the level of harm. Incidents were tracked in relation to high alert and SALAD medications.

Relevant incidents were discussed as a standing agenda item at the IPCC meetings and feedback from the risk grading meeting was discussed in relation to IPC incidents. Incidents were not logged in relation to the INEWS scoring, escalation and response routinely but information in relation to deteriorating patients such as tracking of alerted patients and outcomes for patients whose care was escalated were tracked and trended. These were discussed at the DPC meetings. Incidents relating to transfers of care were discussed at the patient flow committee meetings.

Learning from incidents was shared, for example via an IPC shared learning notice, and these were observed in the clinical area. Inspectors were informed that staff were also kept informed via daily ward huddles, and lunch and learn events. Staff in the clinical area described monthly newsletters from pharmacy with medication safety information.

There was evidence that QIPs were commenced in response to incident trends. For example, a QIP on gentamycin prescribing had been launched in response to a trend noted in medication errors on Hawthorn Ward. A trend had been identified in incidents with regard to challenging patient behaviours and a QIP put in place which included staff training and signage.

Overall, the hospital effectively identified, managed, responded to and reported on patient-safety incidents.

Judgment: Compliant

Conclusion

Formalised governance arrangements for assuring the delivery of high-quality, safe reliable healthcare were in place. Senior management described the lines of accountability and responsibility for each of the four areas of focus and these aligned to documentation provided.

The management arrangements supported the operational functioning of the hospital and promoted the delivery of safe, high-quality healthcare services. The hospital had monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services and these were systematic. The workforce arrangements in the hospital were planned, organised and managed to ensure the delivery of high-quality, safe

and reliable healthcare. However, gaps were identified in the uptake of mandatory training which are discussed under national standard 6.1.

It was evident through observation and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients. Staff and management of the hospital promoted a culture of kindness consideration and respect. Patient's views were sought on discharge with areas for action identified. However, patients did not have access to independent advocacy services.

The hospital had systems and processes in place to respond openly and effectively to complaints and concerns raised by people using the service. The physical environment supported the delivery of high-quality, safe, reliable care. Systems were in place to monitor, evaluate and continuously improve the healthcare services. While in many areas the hospital protected service users from the risk of harm associated with the design and delivery of healthcare services, the hospital had not identified a risk in relation to deteriorating patients and practice in this area was not in line with national policy. Policies and procedures reviewed by inspectors were up to date and staff were knowledgeable of how to access them and their content. Systems were in place to identify, manage, respond to and report patient-safety incidents.

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

Compliance Classifications

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

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

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

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	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 1.7: Service providers promote a culture of kindness, consideration and respect.	Substantially Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high	Substantially Compliant

quality, safe, reliable care and protects the health and welfare of service users.	
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan for: St Vincent's Private Hospital

Inspection ID: NS_0150

Date of inspection: 17 and 18 June 2025

Compliance plan provider's response:

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

1. INEWS Training for all NCHD's

S (Specific):
Ensure INEWS training is provided for all NCHD's in line with national guidance.

M (Measurable):
Monitor mandatory training for NCHD's as part of overall hospital INEWS compliance
• Q3 2025 - NCHD training grant only provided on completion & upload of training certificate.
• Monitor compliance of NCHD escalation protocol through pre-existing and ongoing monthly MDT HCR audit.

A (Achievable):
Since July 2025 – SVPH has implemented INEWS training for all NCHD's.
Training comprises completion of HSELand online learning module and Hospital Induction.

R (Relevant):
Relevant stakeholders; CEO, Leadership Team, Chief RMO & NCHD group.

2. PEWS Implementation for 14-16 year olds

S (Specific):
Plan for care provision to 14-16 yr old patient population.

A (Achievable):
Discussion with CEO and Leadership Team following HIQA inspection and subsequent draft report regarding ongoing suitability of SVPH admitting 14-16 year olds - CEO decision to cease admission of 14-16 year old as inpatients.

CEO to formally communicate changes to all stakeholders
Director of Clinical Operations and Director of Quality, Patient Safety & Risk to review feasibility of this age cohort within the outpatient setting.
Amend/update admissions policy to reflect changes relating to no <16yr old admissions.
Develop a pathway for emergency transfer to CHI in the unlikely situation where an <16yr old deteriorates in the OPD setting.

M (Measurable):
Bed management to monitor to ensure compliance with change in practice

R (Relevant)

CEO, Leadership Team, Bed Management, Consultants, Nursing & Medical Teams

3. Observation Frequency Compliance

S (Specific):
Observations are recorded at the required frequency as per compliance with national guidelines.

M (Measurable):
Monitor compliance as part of pre-existing & ongoing nursing documentation audits performed monthly by Nurse Practice Development team.
Monitor compliance as part of pre-existing & ongoing internal hospital tracer programme conducted by Quality Dept.

A (Achievable):
Quality & NPDU Highlight importance of accurate recording and timely escalation as per national guideline in hospital wide newsletters(Q4)

Provide feedback on audit findings at relevant team meetings (CNM meeting & NCHD meetings)

R (Relevant):
Nursing & Medical teams.

4. Standardise ISBAR Communication

S (Specific):
Fully imbed ISBAR as the standard communication tool hospital wide in line with national guideline.

M (Measurable):
Monitor compliance through pre-existing & ongoing audits.

A (Achievable):
ISBAR Working Group established 15/08/25 to embed ISBAR as the communication tool for:

Transfer of vital clinical information for all deteriorating patients (ISBAR)

Communication tool for all clinical handovers (ISBAR3)
ISBAR included in INEWS training on HSELand module required for all new staff on induction.

Included in INEWS orientation training for all staff since May 2022 – continuing.

Aim complete transition to ISBAR hospital wide by end Q2 2026.
Cease use of other communication tools. ISBAR included in INEWS training on HSELand module required for staff on induction

Standardise transfer communication sheet on handovers.

R (Relevant):
Relevant stakeholders; CEO, Leadership Team, All clinical teams.

Timescale:

1. INEWS Training for all NCHD's
Implementation plan complete and training ongoing.

2. PEWS Implementation for 14-16 year olds
Communication from CEO of change in practice regarding admitting underage patients (Q4 2025).
Director of Clinical Operations and Director of Quality, Patient Safety & Risk to review feasibility of this age cohort within the outpatient setting. (Q4 2025).

3. Observation Frequency Compliance
Effective immediately as part of existing and ongoing audits.
Highlight importance of compliance in upcoming Newsletters Q4.

4. Standardise ISBAR Communication
Currently in process of phasing out use of other communication tools.
From Q1 2026 ISBAR will be the only communication tool accepted for the transfer of clinical information. Previous other communication tools will be phased out. Aim by end of Q2 2026 All clinical staff will only use ISBAR as the communication tool of choice.