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:	Bon Secours Health System CLG trading as Bon Secours Hospital Tralee
Centre ID:	OSV-0008815
Address of healthcare service:	Strand Street Tralee Co Kerry V92 P663
Type of Inspection:	Announced
Date of Inspection:	01/07/2025 to 02/07/2025
Inspection ID:	NS_0148

About the healthcare service

The Bon Secours Hospital Tralee (BSHT) is part of the Bon Secours Health System (BSHS). Established in 1922, the BSHT is a modern acute general hospital providing an extensive range of medical and surgical specialities. These include:

- general surgery
- a range of elective surgical specialities including breast, colorectal, ENT, maxillary facial, plastic surgery, vascular, orthopaedics, bariatric, and paediatric
- elective day cases
- general medicine
- cardiology
- dermatology
- neurology
- gastroenterology
- gynaecology
- ophthalmology
- rheumatology
- urology
- respiratory medicine
- pain medicine
- high-dependency care
- diagnostic services
- dentistry
- cosmetic and hair restoration clinic.

The hospital is primarily an elective hospital, however, acute admissions are accepted via GP referral to the Medical Assessment Unit (MAU) and Rapid Access Chest Pain Clinics which are operational Monday-Friday (excluding Bank Holidays).

The following information outlines some additional data on the hospital.

Number of beds	82 inpatient beds 37 day care 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.

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

*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.

† Unsolicited information is information not requested by HIQA but is received by HIQA from people who use services, their relatives, staff in the service or any member of the public.

- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during the inspection and information received after the inspection.

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
01/07/2025 02/07/2025	08:40 – 18:30hrs 08:45 – 14:30hrs	Mary Flavin	Marguerite Dooley Angela Moynihan

Information about this inspection

This inspection was undertaken to assess compliance with the *National Standards for Safer Better Healthcare* following the extension of HIQA's statutory remit into private hospitals[‡].

This inspection focused on eleven 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:

- High Dependency Unit (HDU)
- Medical Assessment Unit (MAU) and Rapid Access Chest Pain Clinic
- St Bridget's Ward (medical ward).

During this inspection, the inspection team spoke with representatives of the hospital's management team, quality patient safety, human resources (HR), and medical staff. Inspectors also spoke with a representative from:

- Infection Prevention and Control Committee/Antimicrobial Stewardship Oversight Committee
- Drugs and Therapeutics Committee
- Deteriorating Patient and Resuscitation committee
- Transition of Care Committee.

[‡]HIQA's statutory remit under the Health Act 2007 was extended on 26 September 2024 by amendments under the Patient Safety Notifiable Incidents and Open Disclosure) Act 2023 (the Patient Safety Act) to include private hospitals.
[§] 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.

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

Over the course of the inspection, inspectors visited the HDU, the MAU and Rapid Access Chest Pain Clinic, and St Bridget's Ward. The HDU was a six-bedded unit comprising of five single bays, and one single room with en-suite bathroom facilities. Additionally, the unit included one communal toilet and shower area designated for the five bays. At the time of inspection, five of the six beds on the unit were occupied, with one admission expected. The unit operates 24 hours a day, seven days a week, and accepts patients aged 16 years and above.

The MAU and Rapid Access Chest Pain Clinic had 13 spaces available for patient assessment and review. This included one single room with a toilet, one room containing four trolleys, one room containing two trolleys, and a room with six chairs and a toilet. At the time of inspection, there were five patients in the unit.

St Bridget's Ward was a 24-bedded medical ward, comprising of four double rooms and 16 single rooms. Among the single rooms, one was equipped with negative pressure, and one did not have en-suite facilities. At the time of inspection, 22 beds were occupied.

Inspectors observed staff actively engaging with patients in a respectful and kind way, taking time to talk and listen to them. Staff were observed promoting and protecting patients' privacy and dignity when delivering care. Patients who spoke with inspectors shared their experience of care they received in hospital. One patient described staff as "very efficient", while another referred to them as "fantastic". Inspectors observed staff in the clinical areas responding promptly to patients in need of assistance, with one patient noting that staff responded quickly whenever they used their call-bell. All patients interviewed reported that they were kept informed and up to date regarding their care during their hospital stay. All patients expressed satisfaction with the food provided, describing it as "top class" and "good choice of food". When asked about making a complaint, patients told inspectors they had no complaints. One patient mentioned that they were very happy and felt the care was great. Another patient said they had a very positive experience. Overall, patients were very complimentary about staff and the care

they received in the hospital, and this feedback was consistent with what inspectors observed throughout the inspection.

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes the standards related to workforce and use of resources.

The Bon Secours Hospital Tralee was found to be compliant with the four national standards (5.2, 5.5, 5.8, 6.1) assessed. Key inspection findings leading to the judgment of compliance with these four national standards are described in the following sections.

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

Inspectors found that the BSHT had established formal corporate and clinical governance arrangements in place to ensure the quality and safety of healthcare services provided. Organisational charts submitted to HIQA clearly outlined the responsibilities, accountability and oversight arrangements for management structures and governance committees. The hospital was managed by the BSHS.

Board of Directors

The Board of Directors was the governing body responsible for strategic direction, accountability, and oversight of the BSHS. The Board appointed a Group Chief Executive Officer (CEO) to direct its operations. The Group CEO was supported by an Executive Management Team (EMT). The Group CEO appointed a hospital CEO who was delegated with overall responsibility and accountability for the governance of healthcare services provided at the BSHT. The hospital CEO was a member of the Group EMT. The EMT was accountable to the Group CEO designate and Group CEO who were accountable to the Board.

Clinical Performance Committee

The Clinical Performance Committee (CPC) was a subcommittee of the Board and was established to provide the Board of Directors with assurance that excellence in care was

being delivered consistently across the hospital group. In particular, the committee was responsible for overseeing that appropriate clinical governance measures and controls were in place to support safe and effective service delivery. In accordance with its terms of reference, the chair of the committee was appointed by the Board. The committee met four times a year. Membership was multidisciplinary and included representatives from the group's executive leadership team, including clinical and operational leads. The clinical director (CD) and the hospital CEO were also members of the committee.

Hospital Management Team

The hospital CEO was supported by the hospital management team (HMT), which served as the senior executive decision-making body responsible for ensuring effective governance and oversight of the quality and safety of services within the hospital. Chaired by the hospital CEO, the HMT met weekly and reported to the Group CEO through the chair in line with its terms of reference. Membership of the HMT was multidisciplinary and included the CD, director of nursing (DON), head of finance, head of HR, head of mission, quality and risk manager, business development manager, clinical nurse manager (CNM) 2, and two representatives from hospital support services. Inspectors reviewed minutes of meetings which indicated that the HMT meetings were action-orientated, with clear mechanisms in place to monitor the implementation of agreed actions from one meeting to the next. However, it was noted that not all actions were assigned completion dates. The HMT attended bi-monthly performance meetings with the Group CEO and the Group EMT to review service delivery against performance expectations and targets. Additionally, the hospital CEO met with the Group CEO on a monthly basis, and the HMT participated in twice-yearly meetings with all hospital management teams across the group, facilitated by the Group CEO.

The hospital appointed a CD to provide leadership, management, and oversight of medical professionals and clinical services within the hospital. Together with the hospital CEO, the CD provided direction to the HMT on clinical matters, in line with evidence-based practice and clinical guidelines. The DON was responsible for the organisation and management of nursing services at the hospital and reported to the hospital CEO.

Consultant Forum

The CD, the hospital CEO, and the hospital consultants formed the Consultant Forum. In accordance with the terms of reference, the Consultant Forum was jointly chaired by the hospital CEO and the CD, and met five times a year. The forum provided a structured platform for consultants to contribute to hospital policy development and strategic operational planning, while also serving as a formal channel for communication between consultants and hospital management. The Consultant Forum reported to both the CD and the hospital CEO, who in turn reported relevant matters back to the HMT. Inspectors reviewed minutes of meetings which indicated that the Consultant Forum was action-

orientated, with clear mechanisms in place to monitor the implementation of agreed actions from one meeting to the next. However, it was noted that not all actions were assigned completion dates.

Quality and Patient Safety Committee

The Quality and Patient Safety Committee (QPSC) held overarching responsibility for the coordination and oversight of quality improvement and risk management activities across the hospital. In accordance with the terms of reference, the committee was chaired by the CD, and met on a quarterly basis. The committee reported into both the HMT and the CPC providing assurance on the quality and safety of healthcare services delivered at the hospital. Membership of the committee was multidisciplinary and comprised of key stakeholders involved in the governance and operational oversight of quality, safety, and risk within the hospital. The committee submitted both quarterly and annual reports to ensure continued oversight and accountability. Inspectors reviewed minutes of meetings which indicated that the committee's work was action-orientated, with agreed actions monitored and followed up from meeting to meeting. At the time of inspection 16 subcommittees reported formally to the QPSC. These included the Infection Prevention and Control - Antimicrobial Stewardship Oversight Committee, Drugs and Therapeutic, the Deteriorating Patient and resuscitation, and Transition of Care. In the event of a serious reportable event (SRE) or serious incident, the QPSC was responsible for establishing a dedicated team to respond to and manage the incident in accordance with hospital policy and best practice guidelines.

Infection Prevention and Control – Antimicrobial Stewardship Oversight Committee

The Infection Prevention and Control – Antimicrobial Stewardship Oversight Committee, chaired by the hospital CEO, reported directly to the QPSC. In line with the terms of reference, the committee met on a quarterly basis. Its membership was multidisciplinary and included key stakeholders involved in the governance and operational management of infection prevention and control within the hospital. Members included representatives from the Antimicrobial Stewardship Team (AST), a consultant microbiologist, consultants, DON, occupational health, QPS, head of hospital sterile services department, household supervisor, and members of the Infection Prevention and Control Team. The committee reported quarterly to the QPSC and submitted an annual report to the HMT supporting ongoing oversight and accountability. Inspectors reviewed minutes of meetings which indicated that the committee's activities were action-orientated, with agreed actions followed up from meeting to meeting. According to the committee's terms of reference and the organogram provided to inspectors, the AST and the Sepsis Working Group reported quarterly to the Infection Prevention and Control – Antimicrobial Stewardship Oversight Committee.

Drugs and Therapeutic Committee

The Drugs and Therapeutic Committee (DTC), chaired by a consultant, reported directly to the QPSC. In accordance with its terms of reference, the committee met three times a year. Membership was multidisciplinary and included key stakeholders responsible for the governance and oversight of medication management and therapeutic practices within the hospital. Members included representatives from pharmacy, QPS, nursing, non-consultant hospital doctor (NCHDs), and anaesthetics. The committee submitted quarterly and annual reports, providing assurances on the safe and effective use of medicines. Inspectors reviewed minutes of meetings which indicated that the committee's activities were action-orientated, with agreed actions followed up from meeting to meeting. Subcommittees reporting to the DTC included, the Medication Safety Committee (MSC). The AST maintained a reporting line to the DTC, while formally reporting to the Infection Prevention and Control – Antimicrobial Stewardship Oversight Committee. Upon review of the committee's terms of reference, inspectors noted that the DTC was stated to report to the Quality and Risk Committee. However, this committee did not appear on the organogram provided to inspectors. Senior hospital management clarified that the current organogram accurately reflected the governance structure, whereby the DTC reports directly to the QPSC. Accordingly, the terms of reference for the DTC will require amendment to accurately reflect the current reporting structure and governance arrangements.

<u>Deteriorating Patient and Resuscitation Committee</u>

The Deteriorating Patient and Resuscitation Committee oversaw and coordinated activities related to resuscitation practices and the management of deteriorating patients within the hospital. The committee was chaired by a consultant cardiologist and reported directly to the QPSC. In line with its terms of reference, the committee met on a quarterly basis. Membership was multidisciplinary and included representation from consultants, NCHDs, nursing, QPS, clinical practice development team, pharmacy and a paediatric day patient representative. Inspectors reviewed minutes of meetings which indicated that the committee was action-orientated, with each action assigned to a responsible individual. However, it was noted that not all actions included specified completion dates. Subgroups reporting to the committee included, the Irish National Early Warning Score (INEWS) Working Group, and the Sepsis Working Group. Upon review of the committee's terms of reference, inspectors noted that the Deteriorating Patient and Resuscitation Committee was stated to report to the Quality and Risk Committee. However, this committee did not appear on the organogram provided to inspectors. Senior hospital management clarified that the current organogram accurately reflected the governance structure, whereby the committee reports directly to the QPSC. Accordingly, the terms of reference for the Deteriorating Patient and Resuscitation Committee will require amendment to accurately reflect the current reporting structure and governance arrangements.

Transitions of Care Committee

The Transition of Care Committee (TOCC) was a newly established committee, having held its first meeting in June 2025. The committee was responsible for overseeing and coordinating activities related to standards of internal transfers, shift and inter-departmental handovers, external patient transfers, and patient discharge processes within the hospital. Chaired by the CD, the committee reported directly to the QPSC. In line with its terms of reference, the committee was scheduled to meet three times a year. Its membership was multidisciplinary, with representation from consultants, NCHDs, nursing, QPS, clinical practice development team, and Allied Healthcare Professionals. Inspectors reviewed minutes of meetings which indicated that the committee's work was action-orientated, with actions assigned to responsible individuals and accompanied by clear timeframes for completion.

The hospital provided elective paediatric day case surgical services to a defined cohort of patients, with clearly documented acceptance criteria set out in a dedicated hospital policy. Inspectors were informed of the hospital's integrated corporate and clinical governance arrangements in place to support the safe delivery of paediatric services. A consultant anaesthetist had oversight of anaesthetic services for both adult and paediatric populations. Hospital management confirmed that a paediatric consultant was available to be present on-site on days when elective paediatric surgery was undertaken if they were required.

In summary, the hospital had established formal corporate and clinical governance arrangements to support the delivery of high-quality, safe healthcare services. The hospital should ensure that all actions arising from meetings are assigned specific completion dates. Some terms of reference also need updating so they accurately reflect the current reporting structures and governance arrangements.

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.

Inspectors found that there was effective management arrangements in place to support and promote the delivery of high quality, safe and reliable healthcare services within BSHT.

The Infection Prevention and Control - Antimicrobial Stewardship Oversight Committee provided oversight, and support for the infection prevention and control

team in the implementation of the infection and prevention control programme for 2025. This programme set out goals and objectives for the year. The actions within the programme are aligned with the National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services (2017). This plan outlined key areas of focus, including surveillance activities, outbreak management, auditing and monitoring, education, policies procedures protocols and guidelines (PPPGs), healthcare-associated infections, and risk. Additionally, the infection prevention and control team implemented a structured risk assessment programme for 2025, aligned with the team's strategic goals for the year. This programme included a comprehensive assessment identifying all infection prevention and control-related risks across the hospital. Inspectors reviewed the infection prevention and control 2024 annual report. The report identified overall achievements and challenges, and highlighted key findings, including surveillance data on healthcare-associated infections and the measures implemented to prevent their occurrence.

The Infection Prevention and Control - Antimicrobial Stewardship Oversight Committee provided governance, oversight, and strategic support to the AST in the implementation of the antimicrobial stewardship annual action plan 2025. This plan outlined key areas of focus, including antimicrobial consumption, monitoring of reserve antimicrobials, documentation-related key performance indicators (KPIs), and the review of antimicrobial safety incidents. Inspectors reviewed the 2024 reports submitted by the antimicrobial stewardship subcommittee. These reports outlined both achievements and ongoing challenges and highlighted specific goals for 2025 within the broader antimicrobial stewardship programme. The report also included key audit findings, programme outcomes, and the strategic plan for antimicrobial stewardship covering the period 2025 to 2028. The AST membership included 0.4 whole time equivalent (WTE)[§§] antimicrobial pharmacist and one WTE consultant microbiologist. The consultant microbiologist was primarily based off site but was available 24 hours a day, which included out-of-hours cover. They attended on site for key activities such as quarterly governance meetings and as needed for clinical or operational matters.

The hospital's pharmacy was led by an executive pharmacy manager, and the DTC provided oversight of medication safety and associated risks, and also supported the medication safety team in implementing the medication-related incident reporting annual report 2024. This report informed the development of the hospital's medication safety strategy for 2025. Inspectors reviewed the 2024 annual report on medication-related incidents, which identified key issues, areas for improvement, and learning opportunities. The report detailed medication-related incidents,

[§§] Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.

pharmacy interventions, and pharmacy department near-misses reported throughout 2024. The committee played an active role in the development and review of relevant PPPGs within the hospital. Hospital pharmacy services were available on site during core working hours, and nursing administration had access to the pharmacy stock outside of these hours.

The hospital had implemented a deteriorating patient and resuscitation programme for 2025, aligned with national best practice guidelines. The chair of the deteriorating patient and resuscitation committee was the designated lead for the programme. National early warning systems (EWS)[***] such as the INEWS and Paediatric Early Warning Score (PEWS) were in use for the appropriate patient cohort. Clinical communication was supported through the use of the Identify, Situation, Background, Assessment and Recommendation/Read Back/Risk (ISBAR3)[†††] tool to ensure clear and structured handover. At the time of inspection, inspectors were advised that a designated consultant served as the clinical lead for the use of INEWS within the hospital. Oversight of the effectiveness of systems to recognise and manage the deteriorating patient was maintained by the Deteriorating Patient and Resuscitation Committee. This committee was responsible for monitoring compliance with national standards, including EWS usage, and sepsis management protocols. The committee also played an active role in the development and review of relevant PPPGs within the hospital.

The hospital had implemented a transition of care programme for 2025, aimed at strengthening continuity and safety in patient care. The programme was led by the chair of the TOCC, who was the designated lead for its implementation. The programme provided structured oversight of standards relating to internal patient transfers, shift and interdepartmental handovers, external transfers, and patient discharge processes. The TOCC held responsibility for monitoring adherence to these standards and played an active role in the development, review, and ongoing improvement of related PPPGs within the hospital. A daily morning huddle was held in the hospital from Monday to Friday, during which issues relating to patient flow, clinical acuity, and identified risks were discussed.

Clinical and operational oversight of the MAU and Rapid Access Chest Pain Clinic was maintained from Monday to Friday (8.30am to 8.00pm) by a designated consultant, who served as the clinical lead for the unit. This consultant reported to

[***] Early Warning Systems (EWS) are used in acute hospitals settings to support the recognition and response to a deteriorating patient

[†††] Identify, Situation, Background, Assessment and Recommendation/Read Back/Risk (ISBAR3) communication tool is a structured framework which outlines the information to be transferred in a variety of situations, such as bedside handover, internal or external transfers (for example, from nursing home to hospital, from ward to theatre), communicating with other members of the multidisciplinary team, and upon discharge or transfer to another health facility.

the CD and ultimately to the CEO of the hospital. They were supported by an NCHD and by a CNM 2, who reported to the assistant director of nursing (ADON) and subsequently to the DON. The unit operated in line with defined inclusion and exclusion criteria, as outlined in a hospital policy specifying the medical conditions appropriate for assessment within the unit. Inspectors were informed that the referral pathway for patients meeting MAU inclusion criteria was through direct GP referrals. On the day of inspection the MAU was observed to be functioning effectively, with robust management arrangements in place to support the efficient flow of patients through both the unit and the wider hospital. The hospital conducted monthly monitoring of triage times for patients in the MAU. This will be discussed further under national standard 3.1.

In summary, inspectors found that there was effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services within the hospital.

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 collected and collated data relating to patient safety incidents, complaints and compliments, workforce metrics, risk management, and a range of national KPIs associated with the quality and safety of services provided. Collated performance data and KPIs were reviewed at meetings of the relevant governance committee before being reported to the QPSC, with oversight extending to the HMT.

The hospital had formalised risk management structures and processes in place to proactively identify, assess, manage, monitor, and escalate risks. Risks identified at clinical area level were managed and monitored by the CNM and the ADON. The CNM's had implemented corrective action to mitigate actual or potential risks to patient safety. Where risks could not be managed locally, they were escalated to the QPSC, which liaised with the quality and risk forum, a subcommittee of the CPC. Risks were discussed quarterly at the QPSC meetings, and moderate risks were escalated to the hospital's corporate risk register. A designated risk lead had oversight of the hospital's corporate risk register. Risk management meetings were held three times a year and chaired by the CD, during which all risks were reviewed. High-rated or serious risks that could not

be managed at hospital level were escalated to the group risk register via the CEO. Quarterly meetings were held with the group risk lead to review and discuss all risks. Risks were escalated to the group CEO through both the hospital CEO and the CPC. Risk management was a standing agenda item, reviewed quarterly at the QPSC, the HMT, the CPC, and during performance review meetings. The hospital also maintained a risk register for each committee, aligned with the four areas of harm. This will be discussed further under national standard 3.1.

At the time of inspection, the hospital had established governance and oversight mechanisms for the management of audit findings, required actions, and associated recommendations. The hospital collected data across a wide range of clinical indicators related to the quality and safety of healthcare services. Collated data was assessed against relevant benchmarks, including national guidelines, hospital activity levels, incident management outcomes, service user feedback, workforce management, and training compliance. These data results were reviewed by the relevant governance committees, each of which maintained oversight of its own clinical audits and reported into the QPSC, where audits remained a standing agenda item. Reports and findings from these committees were escalated to the HMT and the CPC. Inspectors reviewed a range of metrics, audits, and KPIs, with supporting evidence of quality improvement plans (QIPs) aimed at addressing compliance issues. Learning from findings was disseminated to staff through line management structures, local education sessions (including lunch and learn), and via quality boards, to promote continuous improvement and shared learning.

The hospital had systems in place to identify, report, manage, and respond to patient safety incidents. All incidents were logged at the clinical area level and escalated to the QPS manager for further review. All incidents were tracked and trended by the QPS department to support risk identification, learning, and continuous improvement. The QPS department produced quarterly and annual quality and risk management reports. Findings and recommendations from these reports were escalated to the HMT and the CPC. The QPSC maintained overall oversight and management of all patient safety incidents occurring within the hospital. In the event of an SRE or serious incident, the committee was responsible for convening a dedicated response team to manage and investigate the incident, in line with national legislation, policy and guidelines. Patient safety incidents will be discussed further under national standard 3.3.

The hospital collected patient experience data following discharge through a hospital wide patient experience survey. In addition, comment cards were made available throughout the hospital to enable patients to provide real time feedback on their experience. The QPS department was responsible for monitoring, reviewing, and responding to patient feedback. Patient feedback reports were generated by the QPS department and discussed at the QPSC. Reports were escalated to the HMT and the CPC for oversight and action. An annual patient experience report for 2024, reviewed by

inspectors, had been completed, and incorporated patient experience data from across all hospitals within the BSHS. Formal complaints were managed through the CEO's office. Complaints management processes will be discussed further under national standard 1.8.

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 at the hospital were planned, organised and managed to provide high quality, safe and reliable healthcare.

The HR manager reported to both the Chief People Officer of the BSHS and the hospital CEO, and was a member of the HMT. The hospital had a dedicated NCHD liaison assistant, who worked as part of the HR team. This role provided practical and administrative support to NCHDs upon commencing their posts at the hospital. NCHDs who spoke with inspectors described the NCHD liaison officer as an invaluable source of support, particularly during the initial stages of their employment. They noted that the liaison officer assisted them with both hospital on boarding and broader relocation needs upon arrival in the country.

Succession planning was the joint responsibility of the CEO and the HR management team. Inspectors were provided with examples of how succession planning was being implemented at hospital level during interviews with members of the senior management team. The hospital had a range of workforce KPIs in place. These were continuously monitored, with quarterly reports generated and discussed at both the HMT meetings and the monthly HR management team meetings for the BSHS.

The hospital's absenteeism rate for May 2025 was 2.94%, representing an increase from 2.38% in May 2024. The current rate remains below the HSE's target absenteeism rate of ≤4%. Staff who spoke with inspectors were aware of, and had access to, occupational health services and the employee assistance programme. Inspectors were informed that back-to-work interviews were being conducted by the CNMs at ward level.

Workforce

At the time of inspection, the hospital had 58 consultants with practicing privileges[‡‡‡], operating across a range of medical and surgical specialities. Hospital management confirmed that all consultants were registered on the relevant specialist division of the Irish Medical Council Register. Consultants were not directly employed by the hospital,

[‡‡‡] Privileging is the process of determining clinical competence and deciding about what clinical services are permitted to be performed independently without supervision.

but were granted privileges to practice within the facility. Types of privileges included admitting privileges, non-admitting visiting privileges, and consulting outpatient privileges. A formalised process was in place for the credentialing[§§§], privileging, and re-credentialing of consultants. This process was governed by a BSHS policy, and its implementation was overseen by the hospital CEO, CD, and the CPC. Final approval of privileges rested with the Board of the BSHS, and this was a standing agenda item at board meetings.

Each patient had a named consultant, who served as the primary point of contact for all matters relating to their clinical care. Out-of-hours consultant cover was provided through an on-call rota, with consultants available to support the NCHD on duty. Consultant staff were supported by NCHDs at registrar, senior house officer (SHO), and resident medical officer (RMO) grades, ensuring 27/7 medical cover. At the time of inspection, the hospital was approved four registrar posts, with three posts filled. There were 11 SHO posts, of which eight were filled, and six RMO posts, with five posts filled. Inspectors were informed that the hospital was in the process of on-boarding 10 WTE NCHDs to further support medical staffing across clinical areas.

The hospital was approved for 232.075 WTE nursing posts, inclusive of nursing management and all other nursing grades. At the time of inspection, four WTE nursing positions remained unfilled. Inspectors were informed that these vacancies were temporarily covered through in-house redeployment of nursing staff, and that a recruitment campaign was underway to fill the posts on a permanent basis. Nursing staff were supported by health care attendants (HCAs). At the time of inspection the hospital was approved for 28.45 WTE HCA posts, of which all were filled.

The MAU and Rapid Access Chest Pain Clinic had an approved staffing complement of 3.8 WTE staff nurse positions, of which 2.5 WTE were filled. The unit also had a CNM 1 in post. 1.38 WTE HCA posts were approved and filled. There were no vacancies in consultant or NCHD positions.

The HDU had an approved staffing complement of 14.32 WTE staff nurse positions, with 15.25 WTE staff nurses in post at the time of inspection. One approved WTE CNM 2 position was filled, while only 0.62 WTE of the approved two WTE CNM 1 positions was filled at the time of inspection. The approved 1.83 WTE HCA positions were filled.

St Bridget's Ward had an approved staffing complement of 19.8 WTE staff nurse positions, of which 18.64 WTE were filled. In addition two nursing interns were allocated to the ward. One WTE CNM 1 and one CNM 2 positions were approved and filled. The approved 6.62 WTE HCA positions were also filled at the time of inspection.

[§§§]Credentialing is a process in which healthcare services ensure that the healthcare workers who provide the clinical services are qualified to do so.

The pharmacy department had an approved staffing complement of 9.23 WTE posts, all of which were filled at the time of inspection. The staffing establishment comprised a mix of staff grade pharmacist, senior pharmacists, pharmacy technicians, pharmacy assistants, and included one senior pharmacist dedicated to antimicrobial stewardship. This multidisciplinary team supported the delivery of safe and effective pharmacy services across the hospital.

The hospital had an infection prevention and control team in place, comprising one WTE CNM 3 position and 16 hours a week clinical nurse specialist (CNS). The AST included a 0.4 WTE antimicrobial pharmacist, with access to a consultant microbiologist available on a 24/7 basis to support the safe and appropriate use of antimicrobial agents across the hospital.

CNMs had oversight of staff attendance and uptake of mandatory and essential training within their areas of responsibility. NCHD attendance at essential and mandatory training was overseen by the NCHD consultant lead, working alongside the HR NCHD liaison officer. Staff who spoke with inspectors confirmed that they had received formal induction training upon commencing employment at the hospital. Training records provided to inspectors during inspection, as well as through documentation submitted pre-onsite, indicated a high level of compliance with essential and mandatory training requirements. For example, the overall hospital rate for training on standard and transmission-based precautions among nursing staff was 94%, with HCAs' attendance recorded at also 94%. Hand hygiene training compliance was 100% for nursing staff, 98% for HCAs, and 100% for NCHDs. Compliance with basic life support training was recorded at 87% for nursing staff, 100% for HCAs, and 100% for NCHDs. Overall hospital medication education compliance among nursing staff was 94%. Compliance with training in the use of INEWS was 97% among nursing staff, 97% for HCAs, and 100% for NCHDs. Training compliance with national clinical handover guidance (ISBAR) was recorded as 93% for nursing staff, 97.3% for HCAs, and 100% for NCHDs. Clinical areas visited by inspectors had a compliance rate of over 95% in all mandatory and essential training. Compliance with mandatory children first training was 100% across all disciplines. NCHDs and nursing staff assigned to the cardiac arrest team were required to be trained in advanced cardiac life support (ACLS). At the time of inspection, hospital compliance with ACLS training was 95.2% for nursing staff and 77% for NCHDs. Inspectors were informed that staff providing care for the paediatric day care services were required to have training in PEWS. In addition, staff involved in delivering elective paediatric day case surgical services were also required to be trained in paediatric advanced life support (PALS).

In summary, inspectors found that workforce arrangements at the hospital were appropriately planned, organised, and managed to meet service needs and to support the delivery of high-quality, safe, and reliable healthcare.

Judgment: 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 Bon Secours Hospital Tralee was found to be compliant with five national standards (1.6, 1.7, 1.8, 3.1, 3.3) and substantially compliant with two (2.7, 2.8) assessed. Key inspection findings leading to the judgement of compliance of these seven national standards are described in the following sections.

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

Inspectors noted that staff adopted a person-centred approach to care, treating patients with respect while upholding their dignity, privacy and autonomy. Staff interactions with patients were observed to be kind and respectful. All of the clinical areas visited during this inspection contained a number of single rooms, ensuring privacy for patients. Staff were observed knocking on patient room doors before entering, demonstrating respect for patient privacy and dignity. Privacy curtains were used to maintain patients' privacy in multi-occupancy rooms. One patient who spoke with inspectors reported that they were brought into a private room for their assessment, further supporting patient confidentiality. Call-bells were available at each bedside to enable patients to request assistance, and patients who spoke with inspectors confirmed that call-bells were answered promptly. Inspectors observed staff assisting patients with meals in a respectful manner that supported patients' needs while promoting their independence.

Healthcare records and personal information were securely maintained in all clinical areas visited. Computers were observed to be locked when not in use, and data protection and privacy signage was prominently displayed throughout the hospital. The Hospital Patient Feedback Survey for January and February 2025 reported that 84.5% of patients felt their privacy was maintained while discussing their condition. Inspectors observed that recommendations had been implemented to improve this further, including the

strengthening of privacy protocols to enhance patient confidentiality during clinical interactions.

In summary, hospital management and staff recognised the importance of respecting and promoting the dignity, privacy and autonomy of patients receiving care within the hospital.

Judgment: Compliant

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

There was evidence that hospital management and staff promoted a culture of kindness, consideration and respect for patients receiving care in the clinical areas visited during inspection. Inspectors observed staff actively listening and effectively communicating with patients in a kind and sensitive manner, taking into account their individual expressed needs and preferences. For example, one patient who spoke with inspectors described a recent change to their medication regimen, stating that the new prescription and all associated changes were clearly explained. The nurse had taken the time to go through each medication in detail with the patient, ensuring they understood the purpose and instructions for each. Staff were also observed responding promptly to patients and demonstrating attentiveness to their individual needs. For example, an inspector witnessed a nurse responding immediately to a call-bell and assisting a patient with the specific support they had requested, reflecting a responsive and patient-centred approach to care. Patients who spoke with inspectors were complimentary of the staff and the care provided to them. Complimentary feedback from patients in the Hospital Patient Feedback Survey for January and February 2025 highlighted that staff were described as kind, understanding, and supportive, with several patients commenting that "everyone was so lovely and kind" during their care experience. Thank you cards from patients and families were also observed in a number of areas, reflecting positive patient feedback. Inspectors noted that patients appeared comfortable discussing any issues or concerns with staff. The philosophy of care, along with the hospital's mission, vision, and values, were clearly displayed across the hospital.

In summary, inspectors found that management and staff actively promoted a culture of kindness, consideration and respect for patients receiving care within the hospital.

Judgment: Compliant

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

Inspectors found that the hospital had established systems and processes in place to support the effective management of complaints.

At the time of inspection, the CEO was the hospital's designated complaint officer, with overall responsibility for managing complaints and implementing any recommendations arising from complaint reviews, in accordance with the BSHS policy. Formal complaints

were reviewed at weekly HMT meetings and at the quarterly CPC and QPSC meetings. The hospital CEO also met monthly with the Group CEO, where formal complaints were discussed at group level. Verbal complaints were managed locally by the CNM with escalation to the ADON if local resolution was not achieved. All verbal complaints were logged on the hospital's complaints management system, where they were tracked and trended by the QPS manager, with findings reported quarterly. Feedback and learning from complaints were shared with staff through a variety of forums, including safety huddles, monthly staff meetings, and lunch and learn sessions. Inspectors were informed that formal training on complaint management had commenced for departmental heads, with plans in place to extend this training to all staff to support a consistent and effective approach to managing complaints across the hospital.

Information on how to make a complaint or give a compliment was readily available on the hospital's website, in patient information leaflets observed by inspectors throughout the hospital, and in the patient information booklet provided on admission. Patients who spoke with inspectors expressed a high level of satisfaction with the care they were receiving. Those who had concerns or wished to make a complaint stated that they would feel comfortable speaking directly with a staff member. Patients also reported that information on how to make a complaint was accessible, noting that it was available on the hospital's website, and one patient specifically referenced the patient information booklet provided on admission.

Documentation reviewed by inspectors showed that the hospital received 26 formal complaints in 2024, and six formal complaints year-to-date in 2025. All complaints in both years were acknowledged within five working days, in line with the HSE policy. In 2024, 100% of complaints were resolved within the HSE target timeframe of 30 working days, and 83% of complaints year-to-date in 2025 were resolved within this timeframe. This performance exceeded the national KPI target of 75% resolution within 30 working days.

The hospital provided a patient experience survey for individuals to complete following discharge. Comment cards were also available at the reception area, and were observed by inspectors during the inspection. Inspectors noted that quality improvement initiatives had been implemented in response to patient feedback, including the pathfinder an initiative that enhanced internal signage to improve patient experience. A visible quality and safety culture wall displayed in the hospital provided information on patient feedback, complaints, advocacy services, and assisted decision making. Inspectors also observed that information leaflets with quick response (QR) codes were available, enabling patients to access details on the National Advocacy Service. A staff member who spoke with inspectors reported having engaged the services of an independent advocacy organisation on two occasions over the past two years.

In addition, inspectors observed a compliment Friday poster on display, which showcased individual compliments received through patient feedback, reflecting the hospital's commitment to recognising and promoting positive patient feedback.

In summary, inspectors found that the hospital had systems and processes in place to respond openly and appropriately 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.

During the inspection, inspectors noted that the physical environment in the clinical areas visited was secure, well maintained, and clean, although there was some evidence of general wear and tear. Inpatient ward areas were equipped with adequate shower and toilet facilities. However, inspectors found that en-suites in the single rooms of St Bridget's Ward were stepped and not suitable for all service users. They also noted that there was only one wheelchair accessible shower and toilet located on the corridor. Additionally, the patient toilet and shower in the HDU were reported to be small and not wheelchair accessible. Staff informed inspectors that this issue had been escalated to the hospital's risk register.

Patients who spoke with inspectors consistently described the hospital as very clean, and the CNMs expressed satisfaction with the cleaning resources available. Oversight of cleaning standards and daily schedules was jointly maintained by the hygiene service manager and the relevant CNMs, each within their respective areas of responsibility. Cleaning of patient equipment was assigned to HCAs. Inspectors observed that patient equipment was clean and noted the use of a green tagging system to identify and indicate equipment had been cleaned across the clinical areas visited. CNMs maintained oversight of equipment cleanliness in their areas. Terminal cleaning was undertaken by designated household staff, and environmental and equipment cleaning audits were carried out, these are discussed in further detail under national standard 2.8.

Inspectors noted that hazardous materials and waste were generally stored safely and securely, with the exception of the sluice room in the HDU, which was unlocked at the time of inspection and accessible to patients. Sharps were disposed of in a safe manner, and sharps containers were kept in the temporary closed position when not in use. Medications were securely stored within the clinical areas. Clean and used linen were appropriately segregated, and supplies and equipment were stored correctly in most

areas, with the exception of the MAU, where inspectors observed dirty linen stored alongside sterile products. This was brought to the attention of staff to be addressed and actioned. Overall, adequate storage space was available in the clinical areas visited, which helped maintain a clutter free environment. Inspectors observed that sufficient physical spacing was maintained between beds in the HDU and trolleys in the MAU. However, in the double rooms on St Bridget's Ward, the required minimum distance of one meter between beds was not consistently achieved.

Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available for both staff and visitors. Hand hygiene signage was clearly displayed across the clinical areas visited, and hand hygiene sinks in these areas were found to be compliant with national requirements.[****] However, inspectors noted that some sinks located within older infrastructure, such as the former day ward used for paediatric day cases, were non-compliant with current requirements.

Appropriate infection prevention and control signage relating to transmission-based precautions was observed in the clinical areas visited. Personal protective equipment (PPE) was readily available outside single rooms where patients requiring transmission-based precautions were accommodated, as well as along the corridors in clinical areas. A formal process was in place to ensure the appropriate placement of patients requiring transmission-based precautions, with oversight provided by the infection prevention and

[****] Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf.

control team. Staff informed inspectors that a member of the infection prevention and control team visited clinical areas daily and attend hospital huddles, where patients requiring isolation could be identified and prioritised. At the time of inspection, the hospital had 43 single rooms available for use. Inspectors were provided with risk assessments relevant to recent building works, which included consideration of the risk of aspergillosis during the refurbishment of the catherisation laboratory (Cat Lab) in March 2025.

In summary, inspectors found the physical environment and patient equipment was observed to be clean and well maintained. The environment supported the delivery of high-quality, safe, reliable care and contributed to protecting the health and welfare of patients receiving care in the hospital. However:

- not all en-suite facilities were suitable for all service users
- physical distancing of one meter between beds was not consistently achieved in some areas
- the storage of dirty linen in the MAU was inappropriate
- the sluice room in the HDU was accessible to patients.

Judgment: Substantially Compliant

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

The hospital had systems and processes in place to monitor, analyse, evaluate, and respond to information from a variety of sources (including KPIs, audit findings, risk assessments, patient safety incident reviews, complaints, and patient experience surveys) in order to support the continuous improvement of services and to compare and benchmark the quality of services provided against local, group, national, and international performance indicators.

A 2024 annual report reviewed by inspectors demonstrated that the Infection Prevention and Control - Antimicrobial Stewardship Oversight Committee was actively monitoring and evaluating infection prevention practices in clinical areas. Inspectors were also provided with the IPC annual programme for 2025, which outlined planned audit and surveillance activities for the year. The IPC team reported quarterly to the QPSC, providing monthly surveillance data on healthcare-associated infections,[††††] including methicillin-resistant *Staphylococcus aureus* (MRSA), healthcare-associated *Staphylococcus aureus* bloodstream infections, *Clostridioides difficile*, extended-spectrum beta-lactamase-producing organisms (ESBL), and vancomycin-resistant *Enterococcus* (VRE). The reports also included surgical site infection (SSI) rates for Total Hip Replacement (THR) and Total Knee Replacement (TKR) procedures, as well as data on device-associated infections, such as catheter-associated urinary tract infections, intravascular catheter-related bloodstream infections, and peripheral venous cannula (PVC) infections.

Performance outcomes in 2024 reflected strong infection control measures. No cases of MRSA or ESBL were recorded during the year, with this achievement continuing year-to-date in 2025. Rates of new *Clostridioides difficile* cases for both 2024 and 2025 to date remained below the national target of two per 10,000 bed days. However, the hospital recorded two cases of VRE in both 2024 and 2025 year-to-date, exceeding the hospital annual target. A QIP reviewed by inspectors to reduce VRE rates were action-orientated, assigned to responsible individuals, and time-bound. In line with hospital policy, patients were screened for multi-drug resistant organisms (MDROs) including *Carbapenemase-Producing Enterobacterales* (CPE), VRE, and ESBL. Screening compliance was audited monthly, and results from January to April 2025 demonstrated good compliance.

SSI rates for THR and TKR replacements were audited monthly by the IPC team and reported quarterly to the QPSC. TKRs recorded a 0% infection rate in 2024 and year-to-date in 2025. For THRs, the hospital recorded an infection rate of 1.12% in 2024, slightly exceeding the hospital target of 1%. However, in 2025, a 0% infection rate was recorded for THRs. Rates of catheter-associated urinary tract infections and intravascular catheter-related bloodstream infections remained below hospital targets for both 2024 and 2025 year-to-date. PVC audits, however, showed an increase in infection rates from 0.05% in January 2025 to 0.44% in March 2025. A QIP reviewed by inspectors to reduce PVC infection rates were action-orientated, assigned to responsible individuals, and time-bound.

[††††] Health Service Executive. Performance Assurance Process for Key Performance Indicators for HCAI AMR in Acute Hospitals. Dublin: Health Service Executive. 2018. Available on line from: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/performance-assurance-process-for-kpis-for-hcai-amr-ahd.pdf.

The hospital maintained a comprehensive surveillance program for PVC, central line, urinary catheter, and surgical site care infections, using monthly-audited care bundles. Compliance remained consistently high across all areas, with minor shortfalls addressed through action-orientated, time-bound QIPs assigned to responsible individuals. Inspectors reviewed the 2024 and year-to-date 2025 QIP reports, confirming that all areas of non-compliance were appropriately managed.

The Infection Prevention and Control - Antimicrobial Stewardship Oversight Committee had oversight of findings from environmental and equipment cleaning audits, hand hygiene audits, and audits of compliance with infection prevention guidelines and protocols. Inspectors noted that the schedule for the frequency of environmental and equipment cleaning audits, as submitted to them, had not been consistently adhered to across all clinical areas at the hospital. This was discussed with hospital management at the time of inspection. However, audit results for the clinical areas visited by inspectors during inspection achieved the target compliance rate of greater than 85% for 2024 and year-to-date 2025. In addition, these clinical areas were compliant with the HSE's target of 90% for hand hygiene practices, with the exception of the MAU, which had not conducted hand hygiene audits at the time of inspection. Overall hospital compliance with hand hygiene practices was reported as 99% for 2024 and 97.1% year-to-date in 2025.

The AST was responsible for implementing and monitoring the AMS programme. Key findings from the hospital's AMS programme for quarter 1 (Q1) 2025 were submitted to inspectors. These demonstrated evidence of ongoing monitoring and evaluation of antimicrobial stewardship practices across the hospital. Inspectors noted that this included monitoring antimicrobial consumption, reviewing the duration of surgical antibiotic prophylaxis, accessing compliance with the reserve policy on the use of meropenem, evaluating the quality of antimicrobial prescribing, and promoting the use of the oral route for antimicrobials where clinically appropriate. QIPs were developed when audit results fell below the expected standards.

There was evidence of ongoing monitoring and evaluation of medication safety practices at the hospital. Medication audits were conducted using the nursing and midwifery quality care metrics, with findings reported to the DTC. Inspectors reviewed audit results from clinical areas visited during the inspection, which demonstrated compliance rates ranging from 79.9% to 100%. QIPs were developed when audit results fell below the expected standards. QIPs reviewed by inspectors were action-orientated, assigned to responsible individuals, and time-bound. A medication management KPI report covering 2024 to June 2025 was reviewed by inspectors. This identified common areas for improvement, including ensuring documentation of the start date on all medication orders and improving compliance with the hospital's medication reconciliation policy. In addition, medication environmental audits were carried out, with re-audit undertaken where results did not meet the required standard. Staff informed inspectors that audit

feedback was shared with staff during ward meetings, safety huddles, lunch and learn sessions, and clinical handover.

The Deteriorating Patient and Resuscitation Committee had oversight of the hospital's compliance with national guidance on the use of the INEWS, PEWS, and sepsis management. Performance data relating to the escalation protocol for the deteriorating patient was collected through the nursing and midwifery care metrics tool. Monthly audits were completed and reported to the Deteriorating Patient and Resuscitation Committee on a quarterly basis.

Audit results reviewed by inspectors demonstrated varying levels of compliance across the relevant programmes. INEWS audits showed an overall compliance rate of 86.2% in quarter 4 (Q4) 2024, which increased to 93.1% in Q1 2025. At the time of inspection, inspectors noted that no INEWS audits were available for the MAU. Compliance with the PEWS system was reported at 99% for 2024 and 98.1% in Q1 2025. QIPs were developed when audit results fell below expected standards. QIPs reviewed by inspectors were action-orientated, assigned to responsible individuals, and time-bound. Staff reported that audit feedback was shared during ward meetings, safety huddles, lunch-and-learn sessions, and clinical handover.

Sepsis management was monitored through audits undertaken by the Sepsis Working Group, which reported into the Deteriorating Patient and Resuscitation Committee and also into the Infection Prevention and Control – Antimicrobial Stewardship Oversight Committee. Quarterly reports on sepsis formed part of the hospital's infection prevention and control reports. Sepsis audit compliance was reported as 37% for 2024, increasing to 54.8% in Q1 2025, and further improving to 83.7% in Q2 2025. Inspectors acknowledged the progress made but noted further improvement was required to achieve full compliance. QIPs to increase compliance with sepsis, reviewed by inspectors were found to be action-oriented, assigned to responsible individuals, and time-bound.

The TOCC was responsible for overseeing and coordinating activities related to standards of internal transfers, shift and inter-departmental handovers, external patient transfers, and patient discharge processes within the hospital. The hospital monitored a range of performance data, including bed occupancy rates, hospital admissions and readmissions, average length of stay for medical and surgical patients, transfers, return to theatre cases, and MAU triage times.

The ISBAR3 communication tool was used to support structured communication during nursing handovers. Audit results demonstrated an overall compliance rate of 97% for 2024, and across clinical areas visited during inspection compliance ranged between 96.8% and 100%. Inspectors also noted that the MAU carried out an annual audit of ISBAR3, which demonstrated 100% compliance in 2024, with the 2025 audit scheduled for September. In addition, the ISBAR3 communication tool was also used during NCHD

handovers. Audit results demonstrated an overall compliance rate of 80% in 2024, increasing to 82% in Q1 2025. This was under the hospital target of 100%. QIPs were developed when audit results fell below expected standards.

At the time of inspection the hospital was tracking and trending the number of unplanned external transfers. A report submitted to inspectors showed that 43 unplanned external transfers were recorded in 2024, of which 11 were critical and 32 were non-critical. In Q1 2025, there were 12 unplanned external transfers, comprising five critical and seven non-critical cases. All critical transfers undergo a concise chart review. Unplanned transfers are reviewed at the HMT meetings, as well as at morbidity and mortality meetings. Actions and learnings are shared with the relevant departments and further discussed during hospital learning sessions.

Compliance with the hospital discharge policy was audited monthly across the hospital. Audit results reviewed by inspectors showed an overall compliance rate of 89.83% in 2024 and 90.33% in Q1 2025. These results were below the hospital target of 100%. In addition, audits were carried out on patient discharge summaries. Results reviewed by inspectors demonstrated an overall compliance rate of 95.62% in 2024 and 93.9% in Q1 2025, both of which were above the hospital target of 90%. Surgical readmission rates were monitored and reported on a quarterly basis. The hospital's overall surgical readmission rate for 2024 was 0.39%, and 0.53% for Q1 2025 which was well below the hospital benchmark of 3%.

Staff in one of the clinical areas visited by inspectors were aware of the hospital's findings from the patient experience survey and were able to provide examples of changes in practice that had been introduced in response to patient feedback, with the aim of improving the overall experience of people receiving care in the hospital.

In summary, inspectors found that assurance systems were in place to systematically monitor and evaluate healthcare services within the hospital. However, areas for improvement were identified:

- ensure the frequency of audits is consistent with the audit schedule for environmental and equipment cleaning
- improve compliance in areas where audit results do not meet expected standards, including INEWS, sepsis, ISBAR3, and hospital discharge policy
- hand hygiene audits to be conducted across all areas of the hospital, including the MAU.

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 systems and processes in place to identify, evaluate, and manage immediate and potential risks for people using the service.

Risk management in the hospital was supported by the BSHS risk management policy and the BSHS risk management programme. The QPSC also developed the hospital's QPS programme, which set out key priorities and actions to support the delivery of safe, high-quality care. To support this work, structured quality assurance activities were undertaken quarterly, including hospital metric meetings, hospital committee quality meetings, and departmental quality monitor walkabouts. The QPSC reported to the HMT and the CPC, there by ensuring that quality and safety objectives were aligned with overall hospital governance structures.

Inspectors reviewed the hospital's risk registers in relation to the four areas of harm and noted that all risks were categorised as low to moderate. On review of the hospital's corporate risk register, inspectors observed that all moderate risks related to the four areas of harm had been captured at that level. However, no risks in these categories had been escalated to the hospital group risk register at the time of inspection. Inspectors also reviewed risk registers in the clinical areas visited. Staff informed inspectors that these were updated annually by the CNM, in conjunction with the QPS manager.

The Infection Prevention Control-Antimicrobial Stewardship Oversight Committee had oversight of the infection prevention and control risk register. At the time of inspection, seven risks on the register were rated as moderate. Inspectors reviewed the hospital's infection prevention and control goals for 2025, which included risk assessments for each of these risks. Risks assessments contained clear controls, were action-oriented, assigned to a responsible person, and time-bound. Inspectors were told that the infection prevention and control risk register was reviewed quarterly, which was consistent with the risk assessments observed.

Patients were screened on admission for MDROs and MRSA, in line with hospital policy which was based on national guidance. The hospital's patient information management system supported the identification and appropriate management of patients requiring MDRO screening, by alerting staff to patients who had been previously admitted with known MDROs. A sample of patient healthcare records and transfer documentation reviewed by inspectors confirmed that patients' MDRO and other transmissible infection status was appropriately recorded. In the clinical areas visited, staff reported that an infection prevention and control nurse visited daily from Monday to Friday, and that microbiology support was available on a 24/7 basis. Inspectors were also informed that a member of the infection prevention and control team attended the daily morning hospital

huddle, where issues or risks relating to infection prevention and control could be identified and discussed.

At the time of inspection, there were no active infection outbreaks in the hospital. Staff reported that, should an outbreak occur, a multidisciplinary outbreak control team would be convened, tailored to the area and type of outbreak. Inspectors reviewed an outbreak report for influenza A from January 2025, which was detailed and comprehensive, outlining the control measures implemented to mitigate actual and potential risks to patient safety.

The DTC had oversight of the medication safety risk register, which was maintained by the pharmacy department. At the time of inspection, the register contained 63 risks, of which 59 were rated low and four were rated moderate. Moderate rated risks were reviewed quarterly, while low rated risks were reviewed annually. This was consistent with what inspectors observed on the register. Inspectors observed four risks relating to medication safety on the hospital's corporate risk register. These were associated with medication reconciliation, prescribing, and administration. Inspectors noted that controls were in place, which were action-orientated, assigned to a responsible person, and time-bound.

A clinical pharmacist provided services to all clinical areas visited during the inspection. However, pharmacy-led medication reconciliation was undertaken only on patient admission and not on discharge, where responsibility lay with the discharging doctor with the support of a pharmacist if required. Inspectors found that pharmacy-led medication reconciliation was carried out in two of the clinical areas visited, while in the MAU, this process was completed by nursing staff. Inspectors were informed by staff that a medication reconciliation standard operating procedure (SOP) had been approved by the HMT in June 2025, which supported the actions identified on the risk register in relation to medication reconciliation and reduced the associated risk rating to low.

Across the clinical areas visited, all medications were stored securely in fingerprint operated locked systems. Staff were observed implementing strategies to support the safe use of high-risk medications. Inspectors noted the display of posters identifying high-risk medications in line with the acronym 'A PINCH'[‡‡‡‡]. In addition, a sound-alike look-alike medications (SALADs) list was also available in the clinical area. The hospital's local medication management policy, together with policies for high-alert medications and for SALADs, were reviewed by inspectors and found to be in date. Staff in the areas inspected had access to medicines information through printed posters, desktop computers, and up-to-date prescribing resources. Antimicrobial guidelines, prescribing guidelines, and copies of the British National Formulary (BNF) were available at the point of medication preparation.

The Deteriorating Patient and Resuscitation Committee had oversight of the deteriorating patient risk register. At the time of inspection, 30 risks on the register were rated as low, and all were reviewed quarterly at committee meetings. The INEWS and the Sepsis 6 care bundle were in place to support staff in recognising and responding to the deterioration of patients. The PEWS was used to support the recognition and escalation of care for deteriorating paediatric day-case surgical patients. Staff informed inspectors that a paediatrician consultant and an anaesthetic consultant were present in the hospital when paediatric day-case surgeries were undertaken. Out-of-hours and on-call arrangements for medical staff in the hospital reflected that one NCHD was on duty five nights per week, and two NCHDs were on duty two nights per week. In the event that concerns required escalation, an on-call consultant was contactable by phone to provide support.

In the clinical areas inspectors visited, staff demonstrated a good understanding of INEWS and the escalation process. The ISBAR3 communication tool was used during clinical handover. Daily huddles took place in the morning and at night during which any concerns regarding patients showing signs of clinical deterioration can be escalated. A cardiac arrest huddle was also held twice a day. A sample of healthcare records reviewed by inspectors showed that the escalation protocol for the deteriorating patient was in line with hospital policy. Inspectors reviewed hospital policies on INEWS, PEWS, and sepsis, and found them to be in date.

The TOCC had oversight of the transition of care risk register. At the time of inspection, there were eight risks recorded, five risk rated low and three risk rated moderate. All risks were reviewed quarterly at committee meetings. Inspectors observed three transition of care related risks on the hospital's corporate risk register. These related to inadequate patient handover, medication errors during transfer of patients, and discharge processes. Inspectors noted that controls were in place, which were action-oriented, assigned to a responsible person, and time bound. Safe transitions of care were supported by hospital and group policies relating to patient admission, discharge, and patient handovers. Policies reviewed by inspectors were found to be in date.

All scheduled patients were pre-assessed prior to admission. The average length of stay for medical patients was 4.91 days, which was below the HSE's target of ≤7 days, and the average length of stay for surgical patients was 2.62 days, also below the HSE's target of ≤4.5 days. Inspectors were informed by staff that patients with a hospital stay exceeding 10 days were discussed at the daily hospital huddle.

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

Performance in the MAU was closely monitored. Inspectors observed that the percentage of patients admitted or discharged within six hours of registration was displayed within the unit. Compliance was recorded at 42% in January 2025, increasing to 48% in April 2025, but remained below the national target of 75%. The MAU also monitored admission rates, with results showing that 54.77% of patients were admitted in Q1 2025, slightly above the national target of 52%. QIPs were in place for any KPI that did not meet the hospital's benchmark target. These were displayed on the QIP board in the MAU, which inspectors observed.

The hospital had a range of policies in place that addressed the four areas of harm: infection prevention and control, medication management, the deteriorating patient, and safe transitions of care. In addition, inspectors reviewed other policies including those relating to risk management, complaints management, and healthcare records management. PPPGs were developed by the relevant departments and reviewed at the appropriate committee meetings for approval. The QPS department had oversight of all policies, which were signed by either the hospital CEO or the CD. All PPPGs were accessible to staff in the clinical area via the hospital's computerised document management system.

In summary, inspectors found that the hospital had systems in place to identify and manage potential risks of harm associated with the four areas of harm.

Judgment: Compliant

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

The hospital had a patient safety incident management system in place to identify, report, manage, and respond to patient safety incidents in line with national legislation and guidelines. This process was guided by the BSHS incident management framework policy. Governance and oversight of patient safety incidents was provided by the QPSC, and the HMT. Quality and Risk Incident Management Reports were submitted and presented at the quarterly group performance review meetings.

Patient safety incidents occurring in the hospital were tracked and trended by the quality and risk manager. The Quality and Risk Incident Management Report for 2024 and Q1 2025, reviewed by inspectors, showed that a total of 440 incidents were reported in 2024 across 11 metrics, while 325 incidents were reported in Q1 2025 across 17 metrics. No SREs were reported in 2024 or Q1 2025. The high level of incident reporting were viewed as a positive indicator of a strong patient safety culture. Staff who spoke with inspectors were knowledgeable about how to report, manage, and respond to patient safety incidents. Staff told inspectors that feedback on incidents was provided informally by the CNM in the clinical area and shared through hospital huddles, handover, and staff ward meetings. Inspectors observed a poster on the hospital's culture of safety wall outlining the process for reporting an incident.

Medication patient-safety incidents that occurred in the hospital were categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. Data submitted to inspectors by the hospital showed that 120 medication safety incidents were reported in 2024, with 37 incidents reported in Q1 2025. Both figures were below the hospital benchmark of three per 1,000 occupied bed days. The most frequently reported incidents related to omissions, incorrect doses, and prescribing errors. The DTC provided oversight of all medication safety incidents and reviewed the effectiveness of actions and measures implemented to improve medication safety within the hospital. Inspectors were informed by staff that feedback on medication safety incidents was provided to the clinical areas through lunch and learn sessions, medication safety tips, newsletters, direct feedback to individuals, ward handovers, and staff meetings.

In summary, inspectors found that the hospital had systems in place to effectively identify, manage, respond to and report on patient safety incidents.

Judgment: Compliant

Conclusion

An announced two-day inspection of Bon Secours Hospital Tralee was carried out on the 1 and 2 July 2025 to access compliance with 11 national standards. This inspection focused on five of the eight themes of the *National Standards for Safer Better Healthcare*, with particular attention given to four key areas of known harm, these being infection prevention and control, medication safety, the deteriorating patient, and safe transfers of care.

Capacity and Capability

There was evidence of corporate and clinical governance arrangements in place to assure the delivery of high-quality, safe, and reliable healthcare. However, a number of terms of reference required revision to accurately reflect the hospital's reporting structures and governance arrangements. The hospital had effective management structures to support and promote the delivery of high-quality, safe, and reliable healthcare services. There was evidence the hospital had established effective and systematic arrangements to monitor and evaluate the quality, safety, and reliability of care. There was structured oversight of performance against key indicators, particularly within the four areas of harm. Evidence reviewed by inspectors demonstrated that data from these monitoring processes was actively used to inform quality improvement initiatives and enhance both patient safety and the overall care experience. Workforce arrangements were planned, organised, and managed to ensure the delivery of high-quality, safe, and reliable care.

Quality and Safety

Inspectors noted that staff demonstrated a person-centred approach to care, treating patients with respect while upholding their dignity, privacy and autonomy. Interactions between staff and patients were observed to be kind, respectful, and compassionate. The hospital had systems and processes in place to respond openly and appropriately to complaints and concerns raised by people using the service. In addition, inspectors observed that the hospital showcased individual compliments received through patient feedback, reflecting its commitment to recognising and promoting positive patient experience. The physical environment in the clinical areas visited was generally secure, well maintained, and clean, supporting the delivery of high-quality, safe, and reliable care, contributing to the protection of patients' health and welfare. However, inspectors noted that the recommended one meter physical distancing was not consistently maintained in some areas. Not all en-suite facilities were suitable for all service users, and storage issues for linen were identified in one of the areas visited. The hospital had systems in place to monitor, evaluate, and continuously improve the care and services provided. Nonetheless, improvements were required in areas where audit results did not meet the expected standard. Specifically, the hospital should ensure that the frequency of hygiene audits is consistent with the audit schedule, and that hand hygiene audits are conducted across all areas of the hospital. The hospital also had systems and processes to identify, evaluate, and manage immediate and potential risks to people using the service. A patient safety management system was in place to identify, report, manage, and respond to patient safety incidents in line with national legislation and guidelines.

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	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.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially Compliant
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.	Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant