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 Galway
Centre ID:	OSV-0008816
Address of healthcare service:	Renmore Road Renmore Galway H91KC7H
Type of Inspection:	Unannounced
Date of Inspection:	24/03/2026 and 25/03/2026
Inspection ID:	NS_0197

About the healthcare service

Model of hospital and profile

Bon Secours Hospital Galway is a model 2S[1] private hospital. It is part of the Bon Secours Health System. The hospital is primarily an elective hospital, however, acute admissions are accepted, via General Practitioner (GP) referral, to the Medical Assessment Unit (MAU) and Rapid Access Cardiac Clinics (RACC). The hospital participates in a national 'Multi-Party Framework Agreement for the Provision of Private Hospital Capacity to Support Urgent and Emergency Care' by operating a 15-bedded frailty unit for patients requiring rehabilitation.

Services provided by the hospital include:

- acute medical in-patient services
- elective general surgery
- elective paediatric surgery
- orthopaedic surgery
- general medicine
- gastroenterology
- gynaecology
- neurology
- diagnostic services
- outpatient care

The following information outlines some additional data on the hospital.

Number of beds	93 inpatient beds 30 day-case beds

*A Model 2S hospital typically provides the majority of hospital activity including extended day surgery, selected acute medicine, and a range of diagnostic services aligned to the HSE framework Securing the future for smaller hospitals – a framework for development 2013.

[11] The Bon Secours Health System comprises five hospitals - Cork, Dublin, Galway, Limerick and Tralee.

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* 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) submitted by the provider, unsolicited information and other publicly available information since last inspection.

During the inspection, inspectors:

- spoke with people who used the Bon Secours Hospital Galway healthcare service to ascertain their experiences of receiving care and treatment
- spoke with staff and management working in the Bon Secours Hospital Galway 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.

[†]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.

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 Bon Secours Hospital Galway. It outlines whether there are 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 Bon Secours Hospital Galway receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centered and safe. It also includes information about the environment where people receive care.

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
24/03/2026	08:37 – 18:10	Yvonne Young	Marguerite Dooley Mary Flavin Úna Cahill
25/03/2026	08:55 – 14:50	Yvonne Young	Marguerite Dooley Mary Flavin Úna Cahill

Information about this inspection

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

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

The inspection team visited the following clinical areas:

- Medical Assessment Unit (MAU)
- St Mary's Ward (surgical ward accommodating adult and paediatric patients)
- St Clare's Ward (medical)
- Potel Ward (surgical and orthopaedics)
- Cardiac and Acute Care Unit

During this inspection, the inspection team spoke with staff, representatives of; the hospital management team, infection prevention and control, drugs and therapeutics, transitions of care, quality, risk and patient safety; the deteriorating patient, human resources and the consultant microbiologist.

Acknowledgements

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

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

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

Over the course of the inspection, inspectors inspected the MAU, the Potel ward, St Mary's ward, St Clare's ward and the Cardiac and Acute Care Unit (CACU).

At the time of inspection, St Mary's ward was a 19-bedded inpatient surgical ward serving paediatric and adult patients. The ward had ten single en-suite rooms including three two-bedded rooms and one three-bedded room. St Clare's ward was an adult medical ward with 24 inpatient beds. The ward had 13 single en-suite rooms, one 2-bedded, one 4-bedded and one 5-bedded room. The Potel ward was an adult surgical and orthopaedic ward with 26 beds. The ward had 11 single en-suite rooms, six two-bedded rooms and one three-bedded room. The single en-suite rooms included three rooms designated for sleep studies and two negative pressure rooms (a special type of room aimed at reducing the risk of airborne infections). The clinical areas had adequate communal toilet and bathroom facilities. The MAU had four single cubicles with glass sliding doors and one triage bay. The unit included one communal disabled access toilet.

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 discreet and efficient and when I ring the bell they come without delay", while another referred to them as "brilliant" and "very willing to help". Inspectors observed staff in the clinical areas responding promptly to patients in need of assistance and promptly responding to call-bells. Patients reported that they were kept informed and up to date regarding their care and medications and 'saw their doctor every day'. Parents of paediatric patients told inspectors they had been given information leaflets for reference after discharge and one parent said a nurse had scheduled a time to come back to talk them through post procedure care for their child and answer any questions they had.

All patients spoken to, expressed satisfaction with food provided, describing it as "excellent" and a "good choice of food". Most patients commented on how clean they found the hospital. While at the time patients spoken with had no complaints, they were knowledgeable about how to make a complaint. Patients said they would feel comfortable speaking directly with a staff member if they had concerns or wished to provide feedback. Patients also reported that information on how to make a complaint was accessible, noting that it was available on the hospital's website, and some patients referenced the patient information booklet.

Overall, patients who spoke with inspectors, were very complimentary about staff and the care they received in the hospital, and this feedback was consistent with what inspectors observed.

Capacity and Capability Dimension

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

The Bon Secours Hospital Galway was found to be compliant with two national standards (5.5, 5.8) and substantially compliant with two national standards (5.2, 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 Bon Secours Hospital Galway had established formalised corporate and clinical governance arrangements in place for assuring the quality, safety and reliability of healthcare services provided. Organisational charts clearly outlined the responsibilities, accountability and oversight arrangements for governance committees and management structures.

Board of Directors

The governing body for the hospital was the board of directors, and the board was responsible for accountability, strategic direction and oversight of the hospital group. A group chief executive officer (CEO) was appointed by the board to direct its operations, and the group CEO was supported by a group executive management team (EMT). The EMT was accountable to the group CEO, who was accountable to the board. The group CEO had appointed a hospital CEO who was delegated with overall responsibility and accountability for the governance of services provided at the hospital. The hospital CEO was a member of the group executive management team.

Hospital Management Team

Inspectors were informed that the hospital CEO was the most senior accountable officer

at the hospital and was supported by a hospital management team (HMT). The HMT was the senior executive decision-making committee in the hospital. In line with the terms of reference the HMT was responsible for ensuring appropriate governance and operational oversight of the quality and safety of services at the hospital and this included strategic planning. Chaired by the hospital CEO, the HMT met 30 times a year, but a meeting could also be convened for any urgent business. The HMT had oversight of departmental reports and reports furnished from sub-committees. Membership was multidisciplinary and included the clinical director, director of nursing (DON) and clinical services, finance manager, regional head of human resources, and the quality and risk manager. Inspectors reviewed a sample of 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 and that actions had been assigned an owner and a completion date. Terms of reference reviewed did not outline who the HMT was accountable to; nonetheless, inspectors were told the HMT reported to the group through the CEO and this was reflected in the committee reporting structure organisational chart. The HMT attended quarterly group performance meetings chaired by the group CEO. Inspectors saw records that demonstrated that the hospital reported on key operational issues and service delivery against performance expectations and targets.

The director of nursing and clinical services had responsibility for the oversight and management of nursing services in the hospital and reported to the hospital CEO. While the director of nursing did not directly report to the group chief nursing, quality patient and safety officer, they had an integrated working relationship in respect of local and group matters.

The hospital had appointed a clinical director who provided leadership and management and had clinical governance and oversight of the consultants and the resident medical officers (RMOs) in the hospital (RMOs were non-consultant doctors and reported to an RMO lead who reported to the clinical director). The clinical director was a member of the Bon Secours hospital group forum of clinical directors that met quarterly. In addition, the clinical director chaired a quarterly hospital medical advisory committee (MAC) comprised of consultants representing the various specialities within the hospital. The MAC had an advisory role and made recommendations to the HMT in line with evidence-based practice and clinical guidelines. The MAC also made recommendations on consultant appointments and the granting of admission privileges (this is where a senior doctor has the right to admit patients into the hospital).

Clinical Performance Committee

The clinical performance committee was a subcommittee of the Bon Secours Health System board of directors and according to terms of reference had been 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. The committee met quarterly and the chairperson, who was a consultant radiologist, was appointed by the board. Membership was multidisciplinary to include the hospital CD and representatives from the group's executive leadership team, clinical and operational leads.

During the inspection, hospital management when describing the hospital referenced the 'Model of Care for Anaesthesiology (2019)' and 'Securing the Future of Smaller Hospitals: A Framework for Development (2013)'. Both documents outline that model 2S hospitals, such as the Bon Secours Hospital Galway, primarily function as elective and lower acuity surgical centres.

Consultant anaesthetists attended the hospital to provide the anaesthetic service during scheduled surgery. Inspectors found that some improvements were required to formally document the weekend anaesthetic on-call cover in the hospital. The hospital had Monday to Friday anaesthetic cover for out of hours, plus an arrangement from consultant anaesthetic doctors based offsite to provide an on-call cover for up to 24 hours after the last surgical procedure was performed. (Inspectors were informed that surgery was scheduled one Saturday every month). However, there was not a formal document developed at the time of inspection outlining the arrangement.

The hospital had a named lead consultant anaesthetist, who oversaw the anaesthetic service provision for both adult and paediatric patients. Inspectors were informed that a number of consultant anaesthetists, including the lead anaesthetist, providing the on-call cover had significant experience with paediatric patients in both the Bon Secours Hospital Galway and a regional model 4 hospital. In 2025, a surgical and an anaesthetic lead for paediatrics were appointed. The hospital CEO and members of hospital management told inspectors that the hospital had a memorandum of understanding with a regional model 4 hospital for the transfer of paediatric patients should it be required.

At the time of inspection, the hospital did not have a consultant paediatrician, this was identified as a risk by management on the hospital risk register. Inspectors discussed in detail with hospital management the risk that this posed in relation to the provision of paediatric services and the mitigating control measures in place based on the size and complexity of the service as a model 2S hospital. Mitigating measures in place included a defined acceptance criteria for paediatric patients requiring surgery at the hospital, mandatory paediatric advanced life support (PALS) training for RMOs and mandatory paediatric emergency assessment, recognition, and stabilisation training (PEARS) for nursing staff providing care to paediatric patients. In addition, a paediatric early warning system was in place for the early recognition of a deteriorating child. While acknowledging the comprehensive mitigating measures in place to manage clinical

governance for paediatric patients, management should continue to implement remaining actions to address risks on the hospital risk register.

Admission inclusion criteria for the MAU in the hospital listed patients considered to be at low risk of deterioration with clearly defined exclusion criteria. Hospital management informed inspectors that patients who may have a requirement for high dependency or intensive care did not meet the hospital admission criteria and this was supported by documentation viewed by inspectors. The hospital had a service level agreement in place with a regional model 4 hospital for the critical transfer of patients requiring a higher level of care or speciality services.

Quality, risk and patient safety committee

The quality, risk and patient safety committee oversaw quality improvement and risk management activities in the hospital. The committee reported into the HMT, and organograms provided outlined an indirect reporting relationship with the group clinical performance committee through the nursing and quality forum. In accordance with the terms of reference, the committee was chaired by the quality and risk manager, co-chaired by the hospital CEO and met quarterly. The QRPS multidisciplinary committee was the overarching structure whose role it was to give assurances on the quality and patient safety of healthcare services provided at the hospital to the group clinical performance committee and the chief nursing, quality and patient safety officer.

The committee furnished a written annual programme of work to the hospital CEO and the group clinical performance committee. A written report was furnished to the quarterly group performance meetings, and a report was provided to the group quality and risk forum twice a month. Inspectors reviewed a sample of committee meeting minutes which indicated that the committee's work was action-orientated, with agreed actions monitored and followed up from meeting to meeting. Twelve subcommittees reported formally to the QRPS committee. These committees included infection control, drugs and therapeutics, nursing clinical practice and the deteriorating patient and resuscitation. In the event of a serious reportable event or serious incident, the quality, risk and patient safety committee would be responsible for convening a serious incident management team (SIMT) meeting to respond to and manage the incident in line with hospital policy. However, hospital management informed inspectors that there were no incidents that met the threshold to convene a SIMT in 2025 or in 2026 up to the time of inspection.

Transitions of Care

While there was no separate transitions of care (TOC) committee in the hospital, inspectors observed and viewed documentation that demonstrated effective oversight and monitoring of transitions of care. TOC was a standing agenda item at the QRPS committee meetings, with evidence that the TOC risk register was regularly reviewed.

There was a clinical operations team in place comprising of clinical nurse managers (CNM) at grade 3 that provided 24/7 cover. The CNM3s who reported to the assistant director of nursing were operationally responsible for managing issues relating to bed management and patient flow at the hospital, including admissions, discharges and transfers. A weekly multidisciplinary team (MDT) meeting was held to discuss patients with complex discharge needs to ensure supported discharge.

Infection Prevention and Control

Inspectors found that there were strong governance and oversight of infection prevention and control practices within the hospital. The IPC committee, which included the antimicrobial pharmacist, provided assurance to the QPRS committee, the HMT, the group infection control forum and ultimately to the group clinical performance committee that appropriate controls were in place to minimise the transmission of healthcare-associated infections in the hospital, thus reducing the risk of harm to patients.

The IPC committee was chaired by the quality and risk manager, co-chaired by a consultant microbiologist and met two to three times a year or more frequently if required in line with the terms of reference. The committee submitted both quarterly and annual reports to the QRPS committee. An annual report of the IPC programme of work was submitted to the HMT through the QRPS committee to assure continued oversight, and assurance that a comprehensive IPC programme was being implemented. Separate working groups such as sepsis, decontamination and outbreak management (when convened in response to an infection outbreak) reported to the IPC committee. Membership included hospital heads of departments and members of other relevant working groups, such as the theatre, drugs and therapeutics, decontamination and facilities.

Drugs and Therapeutics Committee

Inspectors saw from evidence provided that there were effective management and oversight of medication safety structures at the hospital. The drugs and therapeutics committee (DTC) was chaired by a consultant surgeon, met quarterly and reported to the QRPS committee. Membership was multidisciplinary and included key stakeholders responsible for the governance and oversight of medication management and therapeutic practices within the hospital to include representatives from pharmacy (including the antimicrobial pharmacist), QPRS, nursing, medical and anaesthetic consultants. The committee had responsibility for the oversight and monitoring of antimicrobial stewardship (AMS) in the hospital and AMS was a standing agenda

item at DTC meetings. The committee submitted quarterly and annual reports to QRPS. Inspectors reviewed a sample of minutes of the DTC meetings which indicated that the committee's activities were action-orientated, with agreed actions followed up from meeting to meeting.

Deteriorating Patient and Resuscitation Committee

Inspectors found that there were strong governance structures in the hospital in relation to the management of deteriorating patients. As per terms of reference the deteriorating patient and resuscitation committee oversaw and coordinated activities related to resuscitation practices and the management of deteriorating patients within the hospital. Chaired by the clinical practice development coordinator, the committee met quarterly and reported directly to the QRPS committee. Membership was multidisciplinary and included representation from consultants, RMOs, nursing, QRPS, clinical practice development team, CNM 2s and ward champions of resuscitation and deteriorating patient. Inspectors reviewed a sample of minutes of meetings which indicated that the committee was action-orientated, with each action assigned to a responsible individual with specified completion dates. The committee had oversight of audit activities related to early warning systems such as the Irish National Early Warning System (INEWS), the Paediatric Early Warning System (PEWS), Irish Maternity Early Warning System (IMEWS), sepsis management (adult and paediatric) risks and clinical incidents related to the management of deteriorating patients, relevant policies, staff education and training compliance. The committee also reviewed cardiac arrests, medical emergency activations, and critical transfers from the hospital. The sepsis working group reported into the deteriorating patient committee.

Overall, formalised corporate and clinical governance arrangements for assuring the quality and safety of the healthcare services provided were in place at the hospital at the time of inspection. An area noted for improvement was to document the governance and operationalisation of anaesthetic on-call arrangements.

Judgment: Substantially Compliant

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

The hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services.

Out-of-hours and on-call arrangements for medical staff in the hospital reflected that two non-consultant hospital doctors, termed by the provider as 'resident medical

officers' (RMOs) were on duty every night until 9pm and one RMO after 9pm. The hospital had a medical assessment unit (MAU) which was consultant-led providing access to a senior clinical decision-maker and a range of investigations for acute medical patients requiring urgent care. The MAU operated Monday to Friday (9am to 5pm). Referral of patients to the MAU was only through a general practitioner. Referrals were reviewed by a MAU consultant and accepted in accordance with the agreed inclusion and exclusion hospital criteria. This criteria was available on the hospital's website. The MAU had three dedicated medical consultants ensuring that one consultant was always present in the unit on a daily basis supported by one RMO. In addition, one physician associate[‡‡] who reported to the RMO lead was on duty in the MAU each day.

The MAU comprised four dedicated bays. On the day of inspection, the MAU was functioning well and there were effective management arrangements in place to manage patient flow throughout the unit and hospital. Operational oversight of day-to-day workings of the unit was the responsibility of the MAU CNM 2, who reported to a CNM 3. The hospital monitored triage times which was recorded as 95.7% for February 2026. It also monitored six-hour patient experience times monthly. 2025 audits reviewed by inspectors showed a total of 1,481 patients had been assessed in the MAU and of these, 1,046 patients had a patient experience time of less than six hours giving an overall six-hour compliance rate of 70.6%. Hospital management told inspectors that the six-hour performance levels were below a target of 95% primarily because of MAU attendances on occasions requiring a more complex diagnostic pathway. Quality improvement plans (QIPs) for key performance indicators that did not meet the hospital's benchmark target were seen by inspectors displayed on the QIP board in the MAU. Patients attending the MAU had a conversion to inpatient admission rate ranging from 68% to 88%. Overall, inspectors were satisfied that there were defined lines of responsibility and accountability with devolved autonomy and decision-making in place for the effective management of the MAU.

Several committees were responsible for managing clinical services relative to the focus of this inspection — infection prevention and control, medication safety, deteriorating patients and transitions of care. These committees included infection prevention and control, drugs and therapeutics, and resuscitation and deteriorating patient committees. Inspectors were satisfied with the infection and prevention control structures in place in the hospital. A consultant microbiologist was based offsite and staff had access to dedicated microbiology advice on a 24/7 basis. Inspectors saw evidence in a sample of minutes reviewed that the consultant attended scheduled IPC committee meetings in person and was remotely available to attend outbreak management meetings.

[‡‡] A physician associate is a non-doctor and non-nurse healthcare role in Irish hospitals, without prescribing powers or authority to commission diagnostic tests.

Deputising arrangements were in place in the event of leave, and these arrangements were set out in service-level agreements reviewed by inspectors.

The hospital had an annual IPC action plan that set out the IPC priorities to focus on in 2026. The IPC committee produced reports every three months for the hospital management team outlining progress with certain key performance indicators set out in the IPC plan. An end of year report for 2025 had been finalised by the team that evaluated whether objectives set out in its annual plans had been completed for the year. Evidence of progress with its objectives for 2026 was provided during this inspection – for example, the undertaking of surveillance and outbreak management, ongoing education and training and the provision of IPC advice to staff. The antimicrobial pharmacist provided detailed updates at each IPC committee meeting on the implementation of the hospital antimicrobial stewardship programme and targets.

The hospital had robust medication safety systems in place at the time of inspection. The hospital's pharmacy service was led by two chief pharmacists. Medication safety priorities were set out yearly as part of hospital's medication safety plan. Audit activity, incident tracking and trending, risk management, quality improvement projects and staff training in relation to medication safety for 2025 was detailed in the 'Drugs and Therapeutics Committee Annual Report 2025'.

Inspectors found a structured process was in place for managing deteriorating patients. The hospital had implemented a deteriorating patient and resuscitation programme for 2025 and developed a programme for 2026. While there was no dedicated lead for each of the early warning systems to include sepsis, the chair of the deteriorating patient and resuscitation committee was the overarching designated lead for the deteriorating patient including sepsis programme. The committee had responsibility for the oversight of the effectiveness of systems to recognise and manage the deteriorating patient. The committee was responsible for monitoring compliance with national standards, including the use of early warning systems for different patient cohorts, sepsis management protocols and policy development.

The multidisciplinary committee monitored and managed the hospital's deteriorating patient risk register. Evidence of progress with their objectives for 2025 and early 2026 was reviewed during this inspection; for example, cardiac arrest huddle audits, and audits in relation to sepsis, early warning systems, and simulated deteriorating-patient drills and associated post-drill evaluations.

Transitions of patient care within the hospital were found to be well managed. A clinical operations team comprised eight CNM3s who had responsibility for bed management and patient flow at the hospital attended daily morning huddles at 9am with hospital management and heads of departments. Issues relevant to patient flow such as activity, performance and identified risks were discussed and actions were implemented

to address. They also attended weekly multidisciplinary team meetings on St. Jarlath's ward where patients had the most complex discharge needs. This meeting was informed by the national frailty programme, and a service level agreement was in place. A dedicated resident medical officer worked exclusively in this ward along with a dedicated physician associate. Inspectors were provided with an audit report for transitions of care for 2026 and audits will be discussed in more detail in standard 5.8.

The hospital's average length of stay for medical (which included frailty patients) and surgical patients in 2025 was 5.23 days and 1.88 days respectively. At the time of inspection there were no patients who had completed their episode of care and were experiencing delayed transfers of care (DTOC). There was an agreed pathway through a service level agreement between the hospital and a regional model 4 hospital for critical care support for patients who become critically unwell and required transfer out to a higher level of care. The hospital had 59 unplanned transfers in 2025, five of which were deemed as critical transfers. At the time of the inspection, the hospital also had a service level agreement in place with a regional model 4 hospital for the provision of laboratory services.

In summary, the hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services in relation to the four areas of known harm.

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 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. Inspectors saw evidence that these performance data results were reviewed at monthly group performance meetings and by the relevant governance committees, each of which maintained oversight of its own clinical audits and reported into the quality, risk and patient safety committee, where audits remained a standing agenda item. The hospital management team (HMT) and the clinical performance committee had oversight of reports and findings from these committees. A range of different

measurements were collected that related to the quality and safety of healthcare services. This included data relating to compliance against national metrics, hospital activity (admissions, discharges, unplanned readmissions and transfers out from the hospital), patient-safety incidents, complaints, healthcare-associated infections, workforce, training and risks that had the potential to impact on the quality and safety of services.

Inspectors were provided with a transition of care audit schedule providing evidence that admissions to the Cardiac and Acute Care Unit (CACU) were monitored in conjunction with compliance against admission criteria. There was a total of 439 admissions to CACU for 2025 and 83 admissions up to 30 March 2026. Hospital wide audits were completed quarterly to assess policy compliance that every inpatient had a discharge summary completed. Compliance for audits completed were reported at 95% and above for 2025 and 2026. Hospital management informed inspectors that audits reflected improvements and a reduction in length of stay.

Regular compliance audits and where relevant, QIPs, were completed for all early warning systems. Inspectors reviewed reports from January 2025 to February 2026 where monthly audit results were collated, compliance on the use of INEWS (1,087 patients) ranged from 94.5% to 100%. Escalation and response of INEWS was also audited, (65 patients) with compliance ranging from 78.3% to 85.5% in 2025. Audits on the overall use and compliance of PEWS (342 patients) from January 2025 to February 2026 showed a compliance ranging from 97.9% to 99%. The resuscitation and deteriorating patient committee and the QRPS committee had oversight of these audit results, and results were disseminated by QRPS to all clinical areas.

A sample of DTC meeting minutes studied by inspectors showed evidence that medication safety related training, audits and incidents were reviewed and discussed at committee meetings and written report had been submitted every three months to the QRPS committee. Compliance with the storage of high-risk medications audits ranged from 93.8% to 100% and medication labelling was 100%. Monthly nursing metrics also included elements of medication safety.

The hospital participated in a national point prevalence survey in 2025 related to restricted antimicrobial consumption. A local hospital audit noted compliance with reserve antimicrobials was 71% for 2025. A priority for 2026 was to increase the compliance to 80% which included targeted education for RMOs in relation to antimicrobial stewardship. In addition, a priority to address the ongoing challenge for the hospital related to the dosing of a specific antimicrobial in the perioperative and out-of-hours setting. Evidence reviewed by inspectors indicated that the hospital was monitoring healthcare-associated infection (HCAI) prevalence and results were reported to the hospital group on a monthly basis. Data from January 2025 to March 2026 stated all positive screens for multi-drug-resistant organisms (MDROs) were confirmed on pre-

admission screening or on admission screening, and there no reported MDROs HCAIs for January 2025 to March 2026. No hospital-acquired infections were detected for Carbapenemase-Producing Enterobacterales (CPE), Vancomycin-resistant Enterococcus (VRE), Methicillin-resistant Staphylococcus aureus (MRSA), or Extended-Spectrum Beta-Lactamase (ESBL). Inspectors reviewed meeting minutes that showed there was no healthcare acquired staphylococcus aureus reported with one reported healthcare-associated case for clostridium difficile infection recorded in 2025 which is below national targets.

Orthopaedic surgical site infections (SSIs) were monitored for all total hip and knee replacements and were within benchmarked targets. Inspectors also saw evidence of the monitoring of compliance of patient care bundles in the hospital. Hospital compliance for peripheral vascular catheter care, urinary catheter care and SSI care bundles was 98.8%, 100% and 97.4% respectively. All hospital data was bench marked against data from other hospitals within the group. Monthly hand hygiene audits were conducted in each clinical area. Inspectors reviewed a sample of these audits. Overall compliance for 2025 was 93.2% which was within national targets. The hospital participated in a national hand hygiene compliance audit in October 2025 showing an overall compliance of 94%.

There were formalised risk management structures and processes in place to proactively manage and minimise risks at the hospital. Risks were escalated through local governance structures and upwards to group level as required. The Bon Secours risk forum, a subgroup of the executive management team, reviewed and evaluated risks recommended for inclusion on the local hospital risk register every three months.

The QRPS committee was responsible for ensuring that all serious reportable events and serious incidents were managed in line with local hospital policy and national standards. The quality and risk manager tracked and trended patient-safety incidents and produced quarterly QRPS reports. These reports included activity, incidents, complaints and compliance against key performance indicators and were presented and discussed at the QRPS committee, the HMT and at group level. Committees for the four key areas of harm had oversight of risks within their area of responsibility with evidence that risks were reviewed quarterly, at the time of inspection all risks were rated low or medium. The hospital had established governance and oversight mechanisms for the management of audit findings, required actions, and associated recommendations. There was evidence of quality improvement plans developed if results fell below acceptable targets. Overall, inspectors were satisfied the hospital had effective systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

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 generally well planned, organised and managed to provide high-quality, safe and reliable healthcare. The human resources (HR) manager reported to both the group's chief people officer and the hospital CEO. The HR manager was also a member of the hospital management team (HMT). Succession planning was well organised and was the joint responsibility of the hospital CEO and the HR management team. Inspectors were provided with examples of how succession planning was being implemented at hospital level. The hospital had a vacancy review process and a range of workforce key performance indicators in place. Inspectors saw these were continually monitored and quarterly reports were submitted to the HMT meetings and monthly group HR management team meetings. Hospital absenteeism was monitored monthly and was recorded as 3.38% in 2025 and this was below a national target. Staff who spoke with inspectors were aware of, and had access to, occupational health services, the employee assistance programme and back-to-work interviews were conducted by the hospital.

Consultants operating within the hospital provided a range of medical and surgical specialities. Hospital management confirmed all consultants were registered on the relevant specialist division of the Irish Medical Council register. Consultants were not directly employed by the hospital but had a mixture of 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 hospital group policy, and its implementation was overseen by the hospital CEO, clinical director, and the clinical performance committee. Final approval of privileges rested with the hospital CEO, clinical director and the Bon Secours Health System board, and this was a standing agenda item at these 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 24/7 (with the exception of weekend cover of consultant anaesthetists, as referenced previously), with consultants available to support the RMOs who were on-site 24/7. During the out-of-hours period, there were two RMOs that were available on-site for clinical review of patients until 9pm and one RMO at registrar grade available after 9pm. Hospital management and clinical staff spoken with during the

[§§]Credentialing is a process in which healthcare services ensure that the healthcare workers who provide the clinical services are qualified to do so.
[***] Privileging is the process of determining clinical competence in a healthcare setting and deciding about what clinical services are permitted to be performed independently without supervision.

inspection were satisfied with these arrangements and outlined that they were sufficient to meet the current activity. The hospital was funded for 14 RMO whole time equivalent (WTE) posts, four of which were vacant at the time of inspection and being filled by agency. Inspectors were informed that three of these permanent posts would be filled and the individuals had a start date which would leave a residual RMO permanent vacancy of 0.88 WTE which would be covered by relief medical cover in the interim. The hospital had approval for four physician associates (PAs) and all posts were filled. Hospital management informed inspectors that the PAs operated within a clearly defined criteria - scope of practice and reported to the RMO lead.

The hospital had funding for 232.93 WTE nursing posts, inclusive of all nursing grades of which 6.55 WTE were unfilled. Inspectors observed in clinical areas visited that the CNM 2 operated in a supernumerary capacity facilitating strong oversight and operational management of their areas of remit. Hospital management informed inspectors that the actual versus approved WTE of each ward or unit was based on a 100% occupancy rate, of which the wards or units did not have, and this aligned with a national safe staffing framework. Inspectors were also informed the occupancy rate was measured every six months and staffing levels configured accordingly. At the time of inspection, the hospital had funding for 34.45 WTE healthcare assistant posts, of which all were filled.

The Cardiac and Acute Care Unit (CACU) was a level-1[†††] seven-bedded monitored care unit. CACU had an approved staffing complement of 17.69 WTE nursing posts, with an actual 14.2 WTE nurses in post and this was based on an occupancy rate of 49% for the year 2025 and 64% for February 2026. A number of nursing staff who worked in CACU had a postgraduate qualification relevant to critical care, coronary care and or cardiovascular nursing. In addition, it was mandatory for all nurses working in this unit to have advanced cardiac life support (ACLS) training completed.

St Mary's ward had an approved staffing complement of 19.56 WTE nursing posts, with 13.51 WTE nurses in post at the time of inspection. Hospital management informed inspectors that the WTE of 19.56 was based on a 100% occupancy rate and the average occupancy for St Mary's ward was 43%. The 13.51 WTE included two paediatric trained nurses. In addition, there was one approved WTE CNM 2 post and one WTE CNM 1 post and both were filled at the time of inspection. During the inspection, 3.96 WTE healthcare assistant posts were approved with 2.75 WTEs filled based on the occupancy rate. Staff in St Mary's routinely received paediatric surgical patients, within a defined scope of service-criteria.

The pharmacy department had an approved and filled staffing complement of 5.8 WTE posts. This comprised a mix of staff, senior and chief pharmacists, and pharmacy

[†††] A level-1 monitored care unit provides specialised care for stable patients who still require care but not constant nursing surveillance and monitoring of signs or cardiac rhythms.

technicians. One senior pharmacist was dedicated to antimicrobial stewardship. This team supported the delivery of pharmacy services across the hospital. The hospital had an infection prevention and control team in place, comprising two WTE clinical nurse specialists (at CNM 2 grade) with access to a consultant microbiologist available on a 24/7 basis.

There was strong evidence of oversight of mandatory and essential training in documents reviewed by inspectors. CNMs had oversight of staff attendance and the uptake of mandatory and essential training within their areas of responsibility. RMO attendance at essential and mandatory training was overseen by the RMO lead. Staff who spoke with inspectors confirmed that they had received formal induction training upon commencing employment at the hospital. Standard and transmission-based precautions across specialities ranged from 79% to 94% and hand hygiene ranged from 81% to 95%.

Compliance with basic life support training ranged from 89% to 100%. All RMOs and nursing staff assigned to the cardiac arrest team were required to be trained in ACLS and at the time of inspection 87% of nurses and 97% of RMOs had completed ACLS training. Medication education compliance among nursing staff was 82%. Compliance with training in the use of INEWS was 88% for nurses, 90% for healthcare assistants and 81% for RMOs. Sepsis education compliance was 98% for nurses and 81% for RMOs. Training compliance with national clinical handover guidance (ISBAR) was recorded as 97% for nurses and 100% for RMOs. Inspectors were informed that staff providing care for paediatric patients were required to have training in PEWS and RMOs were required to be trained in paediatric advanced life support (PALS). Compliance for PEWS was 92% for nursing staff and 83% for RMOs. Inspectors were informed that Irish Maternity Early Warning System (IMEWS) training had been recently introduced in the latter part of 2025 for staff involved in delivering care to obstetric patients who attended the infusion and minor operations clinic. Compliance for IMEWS training was 100% for nursing staff and 81% for RMOs. Furthermore, overall hospital compliance with Paediatric Emergency Assessment, Recognition, and Stabilisation (PEARS)[‡‡‡]for nursing staff was 92% and RMO compliance for PALS was 97%. Compliance with mandatory *Children First* training was greater than 95% across all staff disciplines and 100% in all clinical areas visited.

While it is acknowledged that the hospital receives a very defined cohort of paediatric patients that are considered to be low risk and that the number of paediatric patients being cared for was relatively small, inspectors found the limited number of nursing staff with a paediatric qualification had the potential to impact on the quality and safety

[‡‡‡] The Paediatric Emergency Assessment, Recognition and Stabilisation (PEARS) Provider Course is designed to increase the paediatric healthcare provider's knowledge and skills necessary to assess early signs of respiratory failure and shock, provide early emergent interventions, and alert the appropriate Advanced Life Support (ALS) response team.

of care provided to paediatric patients. This would be particularly the case during periods of scheduled and unscheduled leave. Hospital management had identified this as a potential risk, and it had been recorded on the hospital risk register. A number of measures had been implemented to mitigate this risk to assure hospital management that the current paediatric nursing resources was appropriate and that the training and competency framework was robust for the level and scope of paediatric care provided. This included the requirement of all staff nurses involved in the care of children to complete PEARS training and PEWS training on a two-yearly basis. Paediatric advanced life support training was also mandatory every two years for all RMOs covering inpatient wards and on-call shifts.

On St Mary's ward, 86% of nurses had completed PEARS training and inspectors saw evidence that the remaining staff had a training date scheduled. 100% of nurses had completed PEWS training, 100% of nurses and healthcare assistants had completed paediatric life support, 100% of nurses and healthcare assistants had completed training in *Children First.* 87.5% of nurses had completed sepsis training. In addition, inspectors observed training and competency frameworks in place for nursing staff on St Mary's ward which covered care of the paediatric patient. Maintenance of paediatric competence was supported through targeted continuing professional development, simulation of paediatric clinical emergencies, and the clear limitation of paediatric activity to selected surgical patients within defined admission, escalation and transfer arrangements.

Inspectors found that in general, workforce arrangements at the hospital were well planned, organised and managed to meet the service users' needs. There was evidence that hospital management proactively assessed workforce gaps and implemented actions to address them. An area identified for focus includes a continued review of the number of paediatric trained nurses to support paediatric care in the hospital.

Judgment: Substantially Compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred.

The Bon Secours Hospital Galway was found to be compliant with three national standards (1.6, 1.8, 3.3) and substantially compliant with two (2.7, 3.1) 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. Call-bells were available at each bedside and toilet to enable patients to request assistance, which inspectors observed being answered promptly. Inspectors saw staff assisting patients with meals. Staff were aware of the requirement to respect and promote the dignity, privacy and autonomy of service-users and were observed by inspectors communicating with patients in a respectful manner.

Patients on the ward areas visited were accommodated in a combination of multi-occupancy and single rooms, with en-suite toilet and shower facilities. The physical environment in the inpatient wards supported the delivery of care that respected and promoted the patient's dignity and privacy. Privacy curtains were used when providing care in multi-occupancy rooms. A dedicated room called the "Haven" room was available on St Clare's ward where private discussions could take place between healthcare staff, patients and their families.

Patients' healthcare records and patients' personal information was observed to be stored appropriately, in line with relevant legislation and standards. Any documentation kept at the end of patients' beds were kept in privacy folders. Computers both stationary and mobile, were observed to be in locked mode when not in use, and data protection and privacy signage was prominently displayed throughout the hospital. White boards for staff communication were placed in the nurses' stations and were not visible to the public.

Thank you cards with positive feedback from patients and families were observed in a number of areas. The hospital invited patients to participate in an anonymous feedback survey following their discharge. Responses were submitted via email and twice yearly reports were developed from collated results. The 2025 Hospital Patient Feedback Survey results for the hospital was an overall Net Promotor Score of 93 out of 100. This survey included questions about privacy being maintained.

Overall, staff working in clinical areas visited were observed communicating with patients in a manner that respected their dignity and privacy and were observed to support patients with their individual needs.

Judgment: Compliant

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

The hospital had effective processes in place to respond to feedback and complaints received from patients and or their families/carers. At the time of inspection, the hospital CEO was the designated complaints officer for the hospital, with overall responsibility for managing complaints and implementing any recommendations arising from complaint reviews, in accordance with hospital policy. The quality and risk manager had responsibility for reviewing and collating information in relation to complaints at the hospital. The complaints policy for the hospital outlined how complaints were managed at the hospital and set out the process and timelines for acknowledging and responding to complaints. The policy outlined processes if an independent review was required should a patient not be satisfied with the outcome of their complaint. The quality and risk manager and the hospital management team (HMT) had responsibility to monitor effectiveness and timeliness of the complaints management processes. Formal complaints were reviewed at HMT meetings, clinical performance committee meetings and QRPS committee meetings. Inspectors were informed that the hospital CEO met monthly with the Group CEO where formal complaints were discussed at a group level.

In speaking with staff, inspectors were informed that at departmental level local resolution of complaints was encouraged and there was tracking of verbal complaints on a document management system. Findings, if any, were included in a quarterly report that was submitted to the HMT. If local resolution could not be achieved complaints could be escalated to the CNM 3 of the clinical area and or the assistant director of nursing.

Inspectors saw evidence in clinical areas visited that feedback and learning from complaints was shared with staff through a variety of forums including ward or department dashboards, safety huddles, a daily hospital huddle, staff meetings and QRPS reports. Members of the QRPS committee told inspectors that complaints management information sessions were covered on induction, and formal training on complaints management had commenced and was available for all staff to attend with the aim to support a consistent and effective approach to managing complaints across the hospital. Data provided to inspectors demonstrated 97% of nurses and 100% of RMOs had completed both communications training and complaints management training.

Information on how to make a complaint was available in a patient handbook which was provided to patients on admission. Inspectors also observed information on how to provide feedback, make a complaint and on advocacy services in the clinical areas inspected. Patients who spoke with inspectors expressed a high level of satisfaction with the care they were receiving. All patients were invited to participate in patient experience surveys to complete following their discharge. Comment cards for patients to give feedback at the reception area were seen by inspectors.

A quality and safety culture wall displayed in the hospital provided information of patient feedback, complaints, advocacy services, and assisted decision making. Documentation regarding hospital complaints reviewed by inspectors showed that 21 formal complaints were received in 2025, and three formal complaints were received in the first three months in 2026. 81% of complaints received in 2025 and 100% of complaints in the first three months of 2026 were acknowledged within five working days. From January 2025 to March 2026, 100% of complaints were resolved within 30 working days.

Overall, there was strong evidence of oversight and management of complaints provided during this inspection and evidence that the hospital was responding promptly, openly and effectively to patient complaints.

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.

In general, the physical environment inspected and visited during this inspection supported the delivery of high-quality healthcare. On the days of inspection, the physical environment of the clinical areas visited and inspected were clean and well maintained.

The hospital had 46 single en-suite rooms which could be used for isolation. There were two negative pressure rooms. No outbreaks had been recorded for the hospital for 2025, but one norovirus outbreak, which had been closed within nine days, had been recorded for 2026. An outbreak management and control meeting had been initiated and mitigation strategies to limit transmission were put in place. Inspectors were provided with a copy of the outbreak summary report and outbreak meeting minutes that included timelines, mitigating factors implemented and learnings from the outbreak.

St Mary's ward was a 19-bedded ward which accommodated both adult and paediatric patients. On the second day of inspection the ward had five paediatrics patients all of which were assigned a single en-suite room. The placement of paediatric patients was discussed in detail with hospital management who outlined that works were near completion to place a swipe access door that would create audio-visual separation for eight single rooms where paediatric patients would be cared for. This was an action that was progressed following a previous pilot inspection. Inspectors observed these works in place. Inspectors also noted an exit door at the end of a corridor that did not require authorised swipe access to exit and therefore could be a potential risk to paediatric patients and adult patients. This was brought to the attention of hospital management who had been aware of this issue from a recent safety walk about and plans were in place to address this issue.

Inspectors observed access to resuscitation trolleys and emergency equipment in all clinical areas visited with evidence of daily and weekly checks. Staff had access to appropriate emergency response and management algorithms to manage various emergency situations. There was a separate paediatric specific resuscitation trolley on St Mary's ward which had appropriate equipment and guidelines to support the management of a deteriorating child.

Environmental cleaning was undertaken by dedicated hygiene staff allocated to wards and departments with access to additional cleaning out-of-hours if required. CNMs who spoke with inspectors expressed satisfaction with hygiene resources available. Oversight of environmental cleaning was the joint responsibility of a hygiene services manager and departmental CNMs. A dedicated specialist 'terminal cleaning'[§§§] team was available within the hospital and in addition hygiene services personnel could be contacted if additional cleaning was required. Cleaning of equipment was primarily the responsibility of healthcare assistants with oversight from nursing staff. Monthly environmental and equipment cleaning audits were conducted using a standardised tool. Compliance of environmental audits ranged from 93.4% to 98.4% between July 2025 and March 2026. Compliance of equipment cleaning audits was 100% from July 2025 to March 2026. Patient care equipment observed by inspectors on the days of inspection was noted to be visibly clean, and inspectors were provided with evidence of daily and weekly cleaning schedules. Inspectors observed the hospital's labelling system to identify equipment that had been cleaned. However, inspectors observed that due to limited storage facilities not all patient care equipment had been stored appropriately. For example, sharps boxes that were not in use were stored in the sluice room in one clinical area, and equipment was observed to be stored in a patient room and on a corridor in a second clinical area visited.

[§§§] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

Appropriate infection prevention and control signage relating to transmission-based precautions was observed in the clinical areas. Five patients in the hospital requiring isolation at the time of inspection were isolated appropriately. Personal protective equipment (PPE) was readily available in the clinical areas visited. A formal process was in place to ensure the appropriate placement of patients requiring isolation, with oversight provided by the infection prevention and control (IPC) team. Staff informed inspectors that a member of the IPC team visited clinical areas daily. Inspectors were provided with risk assessments relevant to recent building works, which included consideration of the risk of aspergillosis during recent refurbishment works.

Inspectors observed closed circuit television monitoring (CCTV) in use in main corridors of clinical areas inspected and signage notifying individuals was in place with the exception of three single rooms on the Potel ward designated for sleep studies. This was brought to the attention of hospital management and immediately addressed with signage put in place. Hospital management informed and provided inspectors with two policy documents and a copy of a sleep study patient information leaflet that outlined to patients that sleep studies are video and audio recorded to allow correlation of clinical findings and how records are stored. Audio and visual recordings were restricted to patients having sleep studies and managed in line with the supporting policy documents.

Staff in all clinical areas inspected reported good access to maintenance services via an electronic system with prompt response to logged issues. There was appropriate segregation of waste and linen. Hazardous materials and waste were observed to be stored safely and securely. Best practice posters were in place in the sluice rooms and inspectors were informed that educational sessions had taken place in the hospital in relation to the practice of safe disposal of bodily fluids. Staff spoken with were knowledgeable about correct procedures to dispose of bodily fluids. Wall mounted blood spill kits with user information posters were available in the sluice rooms.

Inspectors observed that sufficient physical spacing was maintained between beds in the multi-occupancy rooms. Wall-mounted alcohol-based hand-sanitiser dispensers with hand-hygiene signage were strategically located throughout the clinical areas inspected and hand-hygiene sinks conformed to national requirements.

There was no piped suction at bed spaces on St Clare's ward, this was recorded as a risk on the hospital risk register and inspectors saw evidence of the plan to install piped suction in the hospital's capital programme of work schedule later in 2026. Portable suction was available and patients who were a high-risk of aspiration were not placed on St Clare's ward and were accommodated on St Jarlath's ward.

Drug fridges were available in all clean utility rooms with evidence of daily temperature recorded. High-risk and 'sound-alike-look-alike-drugs' (SALADs) posters were observed

in clinical areas and staff had access to prescribing guidelines. Medicines were generally stored appropriately and securely. However, inspectors noted insulin stored in the fridge in one clinical area visited where the patient had been discharged. This was brought to the attention of staff who addressed it immediately.

Overall, the physical environment of the clinical areas visited on the days of inspection were clean and well maintained. However, at the time of inspection audio-visual separation of paediatric and adult patients on St Mary's ward was being progressed, and one exit door did not have authorised swipe access on St Mary's ward. There was no piped suction on St Clare's ward which was included in the 2026 capital work schedule, and due to limitations on storage space inappropriate storage of patient care equipment was observed in some of the clinical areas inspected.

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 in place to identify, monitor analyse and respond to information relevant to the provision of safe services related to the four key areas of harm.

Risk Management

The quality, risk and patient safety committee (QRPS) had responsibility to review and manage risks that impacted the quality and safety of healthcare services in the hospital. Risks that were assigned a risk rated score of 12 and above triggered an automated alert to the quality and risk manager who would review the risks. However, a risk could be escalated to the quality and risk manager if there was a concern despite the risk rating score. Risk management in the hospital was supported by the group risk management policy and risk management programme. As per policy, high-rated risks or where necessary controls fell outside the risk owner's direct control were escalated to the group corporate risk register. This QRPS programme set out the key priorities and actions deemed necessary to support the delivery of safe, high-quality care in the hospital. Inspectors were told that measures to support this, included structured quality assurance activities, hospital metric meetings, hospital committee quality meetings, and departmental quality monitor walkabouts. Inspectors reviewed the hospital risk register, which was updated quarterly, in relation to the four key areas of harm and noted that all risks recorded were categorised as low to moderate risks. 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 quality and risk manager. Risks

recorded on the hospital risk register had corresponding existing controls and additional actions required to manage and reduce these risks.

Infection Prevention and Control

As per hospital policy, which aligned with national guidelines, patients were screened

on admission to the hospital for multi-drug-resistant organisms (MDROs) such as *Methicillin-resistant Staphylococcus Aureus* (MRSA) and *Carbapenemase-Producing Enterobacterales* (CPE). A sample of patient healthcare records and transfer documentation reviewed by inspectors confirmed that patients' MDRO and other transmissible infection status had been documented and recorded. In the clinical areas visited, staff reported that an IPC nurse specialist visited clinical areas daily Monday to Friday, and consultant microbiologist advice was available on a 24/7 basis. A member of the IPC team attended the daily morning hospital huddle, and this provided an opportunity to identify, escalate or discuss IPC issues or risks. Inspectors observed patients who required transmission-based precautions were isolated according to hospital policy.

Deteriorating Patient

There was evidence that national early warning systems for the relevant cohorts of patients to support the recognition, response and management of a deteriorating patient had been implemented in the hospital. They included the INEWS, PEWS and IMEWS. A sample of healthcare records reviewed by inspectors showed that the escalation protocol for the deteriorating patient was in line with hospital policy and where an escalation had been required, protocol had been adhered to. Evidence was provided that the $ISBAR_3$ communication tool was used when escalating the care of the deteriorating patient. The most current version of the national sepsis screening tool for adults was in use, and the paediatric sepsis screening tool was available for use on St Mary's ward where surgical paediatric care was provided. Hospital protocol stated that the clinical operations CNM3 had to be alerted if a sepsis screen had to be initiated. Staff spoken to in clinical areas were very knowledgeable about escalation and response protocols for a deteriorating patient and also about the initiation and use of sepsis screening tools. In addition, monthly simulation training drills relating to recognising and managing sepsis in adult and paediatric patients, the management and escalation of the deteriorating patient, paediatric cardiac arrest and other surgical and medical emergencies were scheduled for staff. Inspectors were provided with and observed a copy of the schedule displayed in clinical areas. Inspectors discussed the absence of a weekend consultant anaesthetic on-call arrangement with hospital management, who outlined measures to mitigate any actual or potential risk based on the size, complexity and model of the hospital (2S). These measures included, consultant anaesthetic cover for twenty-four hours following the last surgical case in

the operating department (there were scheduled elective day surgeries on one Saturday every month). Service level agreements were in place to transfer to a higher level of care when required. Hospital management told inspectors that the hospital had a low threshold to escalate and transfer paediatric patients to a higher level of care if required.

RMOs were rotated to the operating theatre where consultant anaesthetists facilitated training on the acquisition and demonstration of competency in basic and intermediate airway management skills. A clinical practice competency booklet was signed by the consultant following the RMO rotation once competency was deemed to have been achieved. Inspectors were provided copy with a copy of this booklet. Inspectors saw evidence that the paediatric patients scheduled for surgery on the morning of day two of this inspection had been seen pre-operatively by a consultant anaesthetist and by their named consultant. Out-of-hours there were two RMOs on duty every night Monday to Sunday until 9pm, and thereafter one RMO from 9pm. RMO's could contact the primary admitting consultant in the event of clinical deterioration of their patient. In addition, ACLS training was completed by relevant staff, and it was mandatory for all RMOs on-call to have completed paediatric advanced life support (PALS) training. Compliance with both PALS and ACLS training was recorded as 97% for RMOs. A daily cardiac arrest huddle was convened where the role of team members was identified. In addition, a daily clinical huddle was convened where concerns about patients or other clinical issues could be escalated.

The hospital had a 'Level-1[****]' seven-bedded CACU unit where cardiac monitoring of seven patients could be facilitated. In the event that remote cardiac monitoring was required for patients accommodated on in-patient wards, a dedicated telemetry 'red' phone was carried by ward staff to facilitate timely communication from CACU. Inspectors were informed that if required, arterial lines for specialised monitoring, and central lines for monitoring or the administration of medications, could be inserted and monitored in the CACU. Inspectors discussed with hospital management the process in place relating to the training and maintaining competency levels of staff who assisted with these procedures and provided follow up care and monitoring, as these procedures may be an infrequent occurrence. Evidence of supporting policy documentation was provided to inspectors covering the insertion, care and management of arterial lines and central venous access devices.

Transfers of Care

The hospital had systems and processes in place to support the efficient flow of patients and transfer of patients within, to and from the hospital. Although there was

[****] level 1 unit as per the "Joint Faculty of Intensive Care Medicine of Ireland (2025)" where level 1 care is defined as ward-based care where patients are monitored closely but do not require high dependency (Level 2) or intensive care unit (Level 3) life support

no transitions of care (TOC) committee, transition of care was a set agenda item at the QRPS committee meetings. Inspectors saw evidence that the hospital conducted case reviews on all unplanned transfers, and all patients requiring transfer had an "inter hospital transfer care bundle" completed. Inspectors attended a daily multi-disciplinary hospital huddle which included attendance by members of the hospital management team, where there were opportunities to escalate any matters of concern. Monthly audits were completed to provide the hospital management with assurance of the appropriate use of CACU in accordance with specific inclusion and exclusion criteria outlined in a policy document. For example, CACU was the only clinical area where non-invasive ventilation was delivered to patients. Inspectors were informed by hospital management and viewed a policy document outlining that all scheduled patients for surgery were clinically pre-assessed prior to admission.

The hospital had a service level agreement in place with a regional model 4 hospital to provide in-patient capacity (15 beds) for a cohort of frail elderly patients. These patients were accommodated on St Jarlath's ward and had a longer length of stay due to higher acuity and care needs. Weekly multi-disciplinary team meetings were convened with input from speech and language therapists, dieticians, physiotherapists and occupational therapists. St Jarlath's ward had dedicated nursing staff, a dedicated resident medical officer and a physician associate who were assigned to this clinical area.

Medication Safety

A clinical pharmacy service was provided to all clinical areas, and compliance with pharmacy-led medication reconciliation was 92% in 2025 for patients on admission. Pharmacy-led medication reconciliation was not routinely available for patients on discharge, while this was identified as a risk by the DTC and placed on the hospitals' risk register, there were no formal plans in place at the time of inspection to expand medication reconciliation to all patients on discharge. The hospital had a number of risk reduction strategies relating to medication safety in place, for example an 'alert label' to identify high-risk concentrated electrolytes. Inspectors were told any risks identified were used to inform the hospital's medication safety programme. Analysis of 'trending' incidents resulted in the development of quality improvement plans, with improvements noted and examples were provided to inspectors. Quality initiatives such as opioid usage in orthopaedic patients where the effectiveness and need for opioids in orthopaedic patients was reviewed, direct oral anticoagulants counselling where patients and their families had access to an educational video through an information card with a quick reference code. Another example included an antimicrobial patient information leaflet, '5-minute med safety'.

Medication trolleys in the clinical areas inspected were swipe access only, and authorised access was limited to nursing staff. SALAD and high-risk medications posters

aligned with the acronym 'PINCH'[††††] were on display in clinical areas. Staff had access to prescribing guidelines on computer desk-tops, tablet computers and through applications such as 'medicines' complete. The hospital had a policy document specific to high-risk medication support in CACU. However, inspectors noted a medication algorithm relating to a specific high-risk medication in the CACU required review, this was brought to the attention of hospital management. Inspectors were informed and provided with a procedural sedation policy document which outlined the expanded role of the nurse, the training requirements and the requirements to meet competency. Inspectors discussed with hospital management what determined a suitably qualified supervisor. Hospital management were assured of their process in place.

PPPGs

The hospital had a defined process, overseen by the QRPS committee, for the development and approval of policies, procedures, protocols and guidelines (PPPGs). Staff could readily access hospital and group PPPGs which were stored on an electronic document management system on the hospital's intranet. The hospital and group had a range of PPPGs in place that addressed the four key areas of harm. All policies reviewed on the day of, and those supplied post inspection were approved and up to date.

Overall, the hospital had processes in place to mitigate risk of harm to patients. While there was not a consultant anaesthetic on-call cover available for the full seven days of the week, based on the size, complexity and model of the hospital (2S), hospital management should continue to review this arrangement. An area for focus included a medication algorithm relating to a specific high-risk medication in the CACU required review, and medication reconciliation was not available to all patients on discharge.

Judgment: Substantially Compliant

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

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 with the purpose of identifying, reporting, managing, and responding to patient-safety incidents in line with national legislation and guidelines. This process was supported by a group policy titled '*Incident Management Sentinel Event and Notifiable Incidents Policy'* (the hospital referred to incidents that resulted in moderate harm as 'sentinel events'). The QRPS committee and the HMT provided governance and oversight of patient-safety incidents. Quality and risk incident management reports were submitted and presented at the quarterly group performance review meetings.

Inspectors reviewed documentation in relation to patient-safety incidents. It was evident that incidents were reviewed in line with policies as well as set targets for the completion of reviews. The documentation outlined learning outcomes, actions required and progress with actions. Action plans developed in response to the report findings had persons responsible assigned and associated timelines. There was oversight of patient-safety incidents related to the four key areas that were the focus of this inspection at the relevant governance committees.

Patient-safety incidents were tracked and trended and analysed for themes by the quality and risk manager, an annual report was developed and submitted to HMT. There was a total of 347 clinical incidents reported in 2025 and 53 in the first two months of 2026. Two incidents in January 2025 were categorised as sentinel incidents. Hospital management stated there was a positive culture of incident reporting within the hospital. Staff with whom inspectors spoke with were knowledgeable about how to report, manage, and respond to patient safety incidents. Feedback and learnings that were identified from incidents was circulated by the relevant committees to the QRPS committee and disseminated through daily hospital and departmental huddles, medication memos, monthly CNM and quality and risk meetings, individualised ward or department monthly QPULSE reports, quality boards, staff communication white boards and formalised training sessions.

Inspectors saw evidence of how learning was shared in clinical areas inspected, such as examples of 'near misses' and 'good catches' being recorded and reported. Inspectors were informed that medication patient-safety incidents 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. There were 1,122 medication safety incidents reported in 2025, the majority of which were low severity MERP A or B. Incidents related to legibility of prescriptions, drug dose and frequency of administration. This figure included twelve adverse drug reactions, 1,066 "near misses", eight MERP Category D incidents and one MERP Category E incident. For the first two months in 2026, 349 medication safety incidents were reported. This figure

included 342 "near misses" and seven MERP C incidents. The number of medication safety incidents for the year 2025 and for January and February 2026 were below the hospital benchmark of three per 1,000 occupied bed days (1.1 for 2025 and 0.7 for the first two months in 2026). Inspectors saw evidence that data from these incidents were tracked and trended and analysed for themes and the most frequently reported incidents related to near misses, omissions, incorrect dosage or strength. Case reviews were completed for MERP C and above incidents, and these were available for inspectors to review. The drugs and therapeutic committee provided oversight of all medication safety incidents and reviewed the effectiveness of actions and measures implemented to improve medication safety within the hospital.

Inspectors reviewed the annual 2025 quality and risk report and were informed that all hospital readmissions, returns to theatre and all unplanned or critical transfers were monitored and measured, and that a case review was completed on each incident. A falls committee, who reported to the QRPS committee, had been established whose purpose was to review all falls related incidents and develop quality improvements and falls reductions strategies. This included tracking and trending the incidents and analysis for trending themes. Quality improvement focussed on multifactorial falls risk assessments, post-fall multidisciplinary team review meetings, safe seating for patients, environmental checks, occupational therapy lead movement and music engagement work and dementia-friendly initiatives. Other examples of quality improvement included a change in the theatre to ward handover of patient's post-surgery, ward or unit based clinical simulations to manage deteriorating patients, and the implementation of hypo-glycaemia boxes.

In summary, inspectors were satisfied that the hospital effectively identified, managed, responded to and reported on patient-safety incidents.

Judgment: Compliant

Conclusion

HIQA conducted an unannounced inspection of the Bon Secours Hospital Galway to monitor compliance with nine of the national standards from the National Standards for Safer Better Healthcare with a focus was on the four key areas of known harm. Inspectors found the hospital to be compliant with five national standards (5.5, 5.8, 1.6, 1.8, 3.3), and substantially compliant with four national standards (5.2, 6.1, 2.7, 3.1).

Capacity and Capability

Overall, there were formalised clinical and corporate governance structures in place in the Bon Secours Hospital Galway. However, there was no formal document outlining the weekend consultant anaesthetic on-call cover in the hospital. There were effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services in relation to the four areas of known harm in the hospital. Inspectors were satisfied that there were defined lines of responsibility and accountability with devolved autonomy and decision-making in place for the effective management of the medical assessment unit. The hospital had systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. Workforce arrangements at the hospital were planned, organised and managed to meet the service's needs. However, an area for continued focus was review of the number of nursing staff with paediatric qualifications.

Quality and Safety

Inspectors found many examples of good culture across the hospital and committed staff providing good care and routinely checking on the quality of care provided to patients in the clinical areas visited. It was quite evident to inspectors that hospital management and staff promoted a culture of kindness and respect for people accessing and receiving care at the hospital. There were effective processes in place at the hospital to respond to feedback and complaints received from patients and their families. The physical environment of the clinical areas visited was clean and well maintained. Areas for focus were identified in relation to storage of equipment, no piped suction on St Clare's ward (there was evidence of an installation plan) and the placement of paediatric patients on St Mary's ward (works were in place to create audio-visual separation between adults and children). A variety of outcome measures were used by the hospital to evaluate the effectiveness of the healthcare services provided at the hospital. Patient-safety incidents were effectively identified, managed, responded to and reported on. Incidents were tracked and trended and used to improve care. Effective risk management processes in place with controls to mitigate risks of harm were evident.

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	Substantially 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 1.8: 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

Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant