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:	Blackrock Health Galway Clinic
Centre ID:	OSV-08883
Address of healthcare service:	Doughiska, Galway. Eircode: H9 HHT0
Type of Inspection:	Announced
Date of Inspection:	25/02/2026 and 26/02/2026
Inspection ID:	NS_0187

About the healthcare service

Model of hospital and profile

Blackrock Health Galway Clinic (referred to hereafter as the 'Galway Clinic') is an acute private hospital in Galway. It operates under the governance of the Blackrock Health Group Board of Directors. Blackrock Health has three hospitals and a diagnostic clinic in Ireland, Blackrock Clinic Dublin, Hermitage Clinic Dublin and Galway Clinic. Limerick Clinic is a diagnostic service which is under the governance of the Galway Clinic.

Services provided in the Galway Clinic include a range of clinical and support services in the following:

- out-patient department
- emergency care
- five inpatient wards:
    - Freyer Ward - orthopaedic ward
    - John Paul II – medical ward
    - Mother Teresa Ward - surgical ward
    - O' Malley Ward - cardiac ward and coronary care unit (CCU)
    - Our Lady of Knock - oncology ward
- daycare (including oncology, radiology, radiotherapy)
- ICU
- eight operating theatres

The following information outlines some additional data on the hospital.

Number of beds	144 inpatient beds plus 31 day case beds plus emergency department (ED) capacity of 14 – trolleys

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare Version 2* 2024 (National Standards) as part of 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 information submitted by the provider, unsolicited information and other publicly available information.

During the inspection, inspectors:

- spoke with people who used the healthcare service to ascertain their experiences of receiving care and treatment
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the hospital
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors during the inspection
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during the inspection and information received after the inspection.

About the inspection report

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

*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.

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
25/02/2026	08.45 – 17.30 hrs	Patricia Hughes	Linda Daffy Elaine Egan Martina Glynn Geraldine Ryan
26/02/2026	08.15 - 13.40 hrs		Same as above

Information about this inspection

The 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 four clinical areas:

- emergency department (ED)
- Freyer ward - orthopaedic ward
- John Paul II – medical ward - respiratory conditions
- Operating theatre

Inspectors also visited Mother Teresa ward (surgical ward) to consider the arrangements in place for paediatric patients.

During this inspection, the inspection team spoke with representatives of the hospital's executive management team, quality and risk, human resources and clinical staff.

Acknowledgements

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

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

Overall patients reported favourably on the services provided, including the quality of care, responsiveness of staff, communication, cleanliness and the quality of food. Patients reported satisfaction with the quality of food and range of choice on offer

[†] HIQA has assessed nine National Standards for Safer Better Healthcare from five of the eight themes taken under the two dimensions of 'capacity and capability and 'quality and safety'.
[‡] Using Early Warning Systems in clinical practice helps 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 covers communication during internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

with one commenting "food is great and I can get it at any time". Patients described staff as "brilliant", "lovely" and "attentive". Other patients said "I got pain relief when I needed it", and 'I feel well informed about my treatment plan'. Inspectors Patients spoken with were not aware of the complaints procedures but said that they would speak to a staff member in the first instance if they had a concern.

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 (National Standards 5.2, 5.5 and 5.8) is being provided. It also includes a standard related to workforce (National Standard 6.1).

The hospital was found to be substantially compliant in National Standard 5.2, and compliant in National Standards 5.5, 5.8 and 6.1. Key inspection findings, informing judgements on 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.

At the time of inspection, inspectors found that the corporate and clinical governance arrangements for assuring the delivery of safe, high-quality healthcare services were integrated, defined and formalised with a few areas noted for attention as set out below.

Organisational charts outlined the management and the reporting arrangements for governance and oversight committees in the Galway Clinic with some exceptions however, there was some inconsistency in the names of committees and depiction of the direct reporting relationships was not always aligned to those as set out in the terms of reference for the committees. Inspectors confirmed the governance arrangements with hospital management during the inspection.

Board of directors

Inspectors viewed the board governance manual dated November 2024. It set out the terms of reference and the modus operandus for the board and corporate governance for all of the hospitals in the Blackrock Health group. It included an overview, the corporate governance structures, the terms of reference, roles and

responsibilities of the board, and miscellaneous board governance matters. It had five board sub-committees: audit and risk, building and development, clinical governance, finance, resourcing and remuneration. It was to be reviewed annually and updated every three years if there were no annual changes required. The board was to meet a minimum of six times per year and at least once per quarter. The board meetings were held on rotation across the three hospital sites. Sample agendas and minutes dated November 2024, May 2025 and November 2025 for meetings held on the Galway Clinic site were reviewed by inspectors. The sample agenda included a hospital half-year update from the respective hospital visited. Sub-committee meeting minutes were approved, CEO summary reports from all three hospitals were reviewed including a patient's story or complaint, and clinical and financial governance were also listed items. On review of minutes it was clear that the quorum for meetings was met and strategic matters were discussed. Minutes were comprehensive and action-oriented.

The board of directors (the board) delegated responsibility and accountability for the hospital group's operations, compliance and performance to the group CEO.

There was also a group clinical governance committee in place. Its terms of reference were due for review since August 2025. It held responsibility for providing assurances that the Galway Clinic had appropriate and effective systems and processes in place for the quality of patient care and safety. Membership included the group clinical director (chairperson), group CEO, a non-executive director from the board and the group head of quality and patient safety. This committee was scheduled to meet every two months, review the clinical reports from each of the three hospitals in the group and to report to the board.

Executive management team (EMT)

The EMT, led by the CEO at the Galway Clinic, provided strategic and operational leadership on site. The CEO of the Galway Clinic was accountable to the group CEO and the board. The wider EMT comprised the chief operating officer (COO), director of nursing, clinical director, patient safety executive, head of facilities, chief information officer, chief finance officer, and the head of human resources. The radiology services manager (RSM) on the Limerick Clinic site (which operated during the daytime and provided diagnostic services only) reported to the COO in the Galway Clinic. The RSM also attended some key meetings held in the Galway Clinic.

The terms of reference for the EMT were last revised in September 2024 however, there was no review date listed. The EMT was scheduled to meet monthly and report to the board. Meetings were chaired by the hospital CEO. There was a standard agenda for meetings which included follow-up on previously agreed actions, and updates from each of the executive members. Inspectors viewed three

sets of minutes of the EMT meetings held in January and February 2026 and noted and heard that the EMT met weekly rather than monthly (as per the terms of reference). The meetings were well attended, the minutes were comprehensive and action-oriented with the responsible person and target dates noted.

The medical advisory committee (MAC), which had a role in the approval of granting of practising privileges to consultants reported to the CEO of the Galway Clinic. The clinical director at the hospital who was a member of the MAC also reported to the CEO of the Galway Clinic.

Quality and Clinical Governance Committee

The terms of reference for the hospital's 'quality and clinical governance committee' were last revised in September 2025. There was no review date listed. It was referred to as the 'clinical governance and quality committee' on the hospital's committee reporting structure organogram, dated 2025 and later as the 'clinical governance committee' on agendas. It was scheduled to meet monthly for a minimum of nine meetings per annum and report to the board. The organogram depicted the reporting relationship to the CEO of the Galway Clinic. It was chaired and co-chaired by the clinical director and patient safety executive respectively. This was the overarching committee at hospital level through which other hospital committees reported upward to the EMT. Membership included the hospital CEO, chief operating officer, director of nursing and three consultants. It also had an incident review sub-group.

A standing agenda was used for the quality and clinical governance committee and listed the following for discussion: quality, risk and patient safety, complaints, accreditation, policies, procedures and guidelines update, new equipment, safety committee updates, and new procedures. Minutes of the three most recent meetings were reviewed by inspectors. They were well attended and a time-bound and action-oriented approach with evidence of follow-through from meeting to meeting was demonstrated in the meeting minutes.

A structured reporting framework ensured that local committees relating to infection prevention and control, medication safety, the deteriorating patient and transitions of care reported to the clinical governance and quality committee. These are discussed further under National Standard 5.5.

Infection prevention and control (IPC)

The infection prevention and control (IPC) committee met quarterly. It was chaired by the consultant microbiologist and membership reflected relevant representation from across the multidisciplinary team including the hospital's clinical director. The

terms of reference had no review date listed. It reported to the quality and clinical governance committee through to the EMT and the board.

Medication Safety

The hospital had both a drugs and therapeutics committee (DTC) and a medication safety committee in place with separate terms of reference for each, however there was no review dates listed for these. Inspectors heard how the medication safety committee reported to the DTC however, that was not clear from the committee organogram provided and this was brought to the attention of hospital management. The DTC was chaired by a consultant and co-chaired by the chief pharmacist. It had appropriate multidisciplinary membership including an antimicrobial surveillance pharmacist. It was scheduled to meet four times a year. It reported to the local quality and clinical governance committee which reported to the EMT which in turn, reported to the board.

The deteriorating patient

The hospital had a deteriorating patient committee (DPC) in place since June 2025. It had terms of reference which were listed for annual review. The purpose of the DPC was described as provision of strategic oversight, coordination, and governance for initiatives aimed at improving the early recognition and timely response to clinical deterioration in hospitalised patients. The scope extended to all inpatient care areas and included all systems and tools for detecting and responding to physiological deterioration, and analysis of data from the cardiac arrest team and related audits or incident reviews. It was chaired by a consultant and membership reflected relevant representation from across the multidisciplinary team. The terms of reference indicated quarterly meetings while the agenda described fortnightly meetings. It reported to the local quality and clinical governance committee which reported to the EMT which in turn, reported to the board.

Transitions of care

There were various committees in place at the hospital which dealt with transitions of care. Hospital management explained that a newly formed transitions of care committee was chaired by the director of nursing and was reporting to the quality and clinical governance committee. The hospital also had a bed management group and an emergency department user group. The bed management committee had in-date terms of reference. According to its terms of reference, it was scheduled to meet four times a year. Inspectors heard that it met weekly to review admissions to the hospital and on a daily basis to review specific patient needs prior to discharge home. It was chaired by the admissions and bed manager. Membership reflected relevant representation from across the multidisciplinary team.

Inspectors heard how the hospital had a rolling requirement from one of its local HSE hospitals for the use of 15-20 beds. Transfer of such patients was via consultant to consultant and this was overseen by the clinical director. Transfer generally took place from the emergency department in the HSE hospital and the patient had to be deemed stable for ambulance transfer and be presenting with a condition requiring treatment and care that was within the capacity and capability of the Galway Clinic for example, a surgical procedure. Inspectors heard how both of the respective hospital management teams met on a fortnightly basis to review such arrangements. This is discussed further under National Standard 3.1.

Inspectors noted that the hospital had an in-date safeguarding policy and a designated liaison person in place and inspectors spoke with hospital management who provided assurances on its use.

Serious incident management team (SIMT)

This is discussed under National Standard 3.3.

In summary, inspectors found that the Galway Clinic had effective governance arrangements in place to support the delivery of safe, high-quality healthcare at the hospital at the time of inspection. Evidence from documentation and staff meetings showed that the committees described above regularly reviewed and monitored performance data, healthcare quality, and compliance with established metrics. There is, however, an opportunity for improvement in documentation relating to

- consistency in use of names of committees
- alignment with terms of reference
- alignment across terms of reference and associated organograms in respect of reporting relationships
- ensuring that all terms of reference have due dates for review.

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.

This inspection was focussed on the four areas of known harm namely, infection prevention and control (IPC), medication safety, the deteriorating patient and transitions of care. The hospital had local governance committees in place for each of these areas.

Infection prevention and control (IPC) committee

The IPC committee had its own risk register which was reviewed and updated at IPC meetings. The committee used a standing agenda which included the following items: hand hygiene, surveillance reports, end of year report including outbreak reports, plan for 2026, education programme, screening including for carbapenemase *enterobacterales* (CPE), updates from facilities and engineering (water update, ventilation, building works), updates from managers, and antimicrobial stewardship updates. Inspectors viewed minutes of the three most recent meetings held in August and November 2025 and in February 2026. While attendance was noted to vary from meeting to meeting, overall it was satisfactory. A time-bound and action-oriented approach with evidence of follow-through from meeting to meeting was demonstrated in the meeting minutes. The core IPC team met monthly. The IPC nurse had oversight of environmental, equipment and hand hygiene audits. Inspectors saw evidence of regular audits and heard how the hospital uses a quality improvement system to support audit activity however, inspectors noted that audits at ward level were not always accompanied by a corresponding action plan or follow-up where required. Inspectors raised this with the IPC team on inspection and found that action plans were in place. Inspectors viewed the end of year IPC report for 2025 and the annual year plan for 2026. The hospital hand hygiene audit results were over 90% throughout 2025 and in 2026 up to the time of inspection.

Medication Safety

Inspectors viewed the drugs and therapeutics committee agenda which covered updates from the medication safety committee, development of risk registers and annual review, and a proposed structure for a hospital group drugs and therapeutics committee. Inspectors viewed the minutes of three meetings held in April, July and September 2025 and noted good attendance at each. A time-bound and action-oriented approach with evidence of follow-through from meeting to meeting was demonstrated in the meeting minutes. The hospital had processes in place for an annual review of its formulary and for new medications to be added.

The medication safety committee was chaired by the chief pharmacist. It was scheduled to meet a minimum of three times per year. Inspectors viewed the agendas for the meetings held in April 2025 and in January 2026, which listed the following items: medication safety events report 2024 and 2025, updates on medicine reconciliation data, plans for audit and data collection, pharmacist intervention data, pharmacy review data dashboard, nursing doses not administered report, items referred from diabetes users group, medication safety bulletins, key performance indicators (KPIs) for clinical governance report – changes for 2026, HSE communication relating to medication safety, accreditation feedback, feedback from

the Irish Medication Safety Network conference and the 2026 meeting schedule. The minutes of the meetings held in April 2025 and in January 2026 indicated a problem with provision of minutes for previous meetings. Inspectors enquired into this and were informed that this was now resolved with a designated minute taker. Otherwise, a time-bound and action-oriented approach with evidence of follow-through from meeting to meeting was demonstrated in the available meeting minutes. Inspectors heard how the use of electronic prescribing (in all inspected areas apart from the operating theatre), audit activity, and pharmacists visiting wards were all making a positive impact on patient safety through safer prescribing, education of staff, and stock control and review.

The deteriorating patient committee (DPC)

Inspectors viewed the agendas for three meetings held in September and two in November 2025. The following items were listed for discussion, sepsis, deteriorating patient policy, emergency department rounds (consultant and nursing personnel), Irish National Early Warning System (INEWS) and sepsis training and compliance, documentation of a deteriorating patient event, and audit activity. Inspectors viewed the minutes and noted that only between seven and 10 of the nineteen members attended any of three meetings. Inspectors heard that attendance was under discussion at the meeting although a resolution was not yet reached. Minutes of the meetings demonstrated an action-oriented approach with some evidence of follow-through from meeting to meeting, though these were not always time bound. Inspectors spoke with staff who outlined the activities of the committee including review of the use and escalation of the early warning systems, incidences of in-hospital cardiac arrests, sepsis events and amendments to protocols. The hospital was using the latest version of the HSE guidelines on sepsis. The DPC had organised a lunchtime education session on the elements of the early warning system and documentation by the multidisciplinary team in the event of escalation. Committee members explained that work was underway to use the electronic health records for the purpose of look-back audits. The committee reported a strong culture of staff raising concerns where indicated. Incidents were reported to the patient safety executive and were presented at the quality and clinical governance committee.

Transitions of care

Inspectors viewed the hospital's policy titled 'Implementing Effective Communication' which was in place and had been due for review in January 2026. It referenced the communication tool, Identify, Situation, Background, Action and Recommendation (ISBAR), clinical handover, communicating critical results, verbal orders, telephone orders, and models of communication in use throughout the organisation (including

staff meetings, email, intranet, leadership walk-arounds, annual awards ceremony and the staff newsletter).

Hospital management spoke about the service level agreement in place with a local acute hospital to provide 15 -20 beds for patients as the Galway Clinic had the capacity to facilitate this request given that their occupancy ranged between 70-75%. This arrangement was renewed on a two-monthly basis. Staff outlined the process and inclusion and exclusion criteria for such patients although there was no specific document to support this apart from the general admission policy. This is discussed further under National Standard 3.1. Transfer of each patient was arranged via direct consultant to consultant communication. A virtual round took place every Monday between the responsible team at the Galway Clinic and the responsible team from the local referring hospital. Hospital management described a 'strong collaborative' working relationship between the two hospitals where both hospital management teams met every two weeks and they concluded that the arrangements were safe and were working well.

The bed management team met weekly and reported on operational matters including the number of inpatients, day cases, ICU patients, delayed transfers of care and beds needed for the following week. They also communicated on any concerns from the week, quality improvements underway, consultant leave arrangements, ward staffing and ensuring bed availability for scheduled day cases and admissions as well as for unscheduled admission. Inspectors heard how the hospital also liaised with local HSE-based services for safeguarding, public health, palliative care and local and regional hospices as well as community-based occupational therapist (OT), physiotherapist and or intervention services.

The emergency department was open seven days a week during daytime hours only. It was open from 10 am to 6 pm on Monday to Friday and from 10 am to 5 pm on Saturdays, Sundays and bank holidays. Although activity was low while inspectors were inspecting the area, staff explained that there had been 24 presentations the previous day of which, six patients had been admitted after medical review.

Formal clinical handover reports took place at ward level at least twice a day in respect of all patients, between nursing staff at the time of shift change. The communication tool, Identify, Situation, Background, Action and Recommendation (ISBAR) was used to underpin such handover. Inspectors heard and saw that a series of online huddles took place during the day as follows, level one huddle, took place at 8.45 am (Monday to Friday) between the DON, ADON and the bed manager, a level two huddle at 9.00 am, as above, plus department managers and the chief operations officer (COO) and a level three huddle at 9.30 am of all the executive team. The clinical nurse manager undertook point of care rounding each day at 11 am and this was recorded on the electronic healthcare record. There were

also consultant rounds and patient safety huddles throughout the day. A consultant and senior nurse undertook an evening round in the emergency department and the night nurse manager undertook a round to each ward at night with the registered medical officer (RMO) on-duty. Where a transfer out to another hospital was required, the Galway Clinic had a service level agreement with a private ambulance company. In the case of emergency transfers, the hospital also used the time critical inter-hospital 'protocol 37' service.

Staff in the inspected areas reported high visibility of the senior nurse on 24/7 site-duty.

In summary, inspectors found through meetings with lead representatives of the committees, review of documentation and in discussion with staff in the inspected areas that the Galway Clinic had effective management arrangements in place to support and promote the delivery of high quality, safe and reliable healthcare services.

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 a range of policies which were accessible via the hospitals electronic management system to support staff in the provision of safe, high quality care. Inspectors found that there was active and regular audit in all of the inspected areas with regard to the four key areas of known harm. Quality boards in each of the inspected area were used to display recent nursing metrics along with quality improvement plans in progress. Leadership rounding was conducted monthly and included a conversation with a patient whose consent was sought in advance. This is discussed further under National Standard 1.8.

There was evidence in the wards of regular auditing of hand hygiene, equipment cleaning, environment cleaning, nursing metrics, quality of care, patient experience and satisfaction, ISBAR, clinical handover and care bundles in relation to peripheral vascular catheters, and achieving scores of over 90% in each of the three months prior to this inspection. There was also evidence of the use of audit to drive quality improvement for example, following an increase in the number of delirium-related episodes in 2024, there was a focus on multidisciplinary team education and increased communication with the next of kin. By mid-year 2025, the ward re-audited outcomes and reported a reduction in the number of delirium episodes,

pharmaceutical interventions, falls and extended stays.

Screening for infection was undertaken in line with national guidelines. The IPC team were notified of surgical site infections by ward staff or the consultant. Inspectors noted that IPC audits were undertaken in the inspected clinical areas by the IPC team and quality improvement plans arising from these were developed in conjunction with the ward manager, the quality team and the nurse practice unit. Inspectors observed the results on display in Freyer ward of a sepsis audit of all admissions to ICU with a diagnosis of sepsis in 2025 compared to those in 2024. The 2024 results had led to the development of a quality improvement plan to improve compliance with the 'Sepsis 6'. On re-audit in 2025, 100% of patients with suspected sepsis had their vital signs recorded in line with hospital policy on a INEWS chart, 76% had their blood cultures sampled, 65% had IV fluids commenced and 76% had commenced on antimicrobials, all within one hour and all these elements were an improvement on the 2024 results. Hand hygiene results on Freyer ward were over 90% in December 2025, and also in January and February 2026.

Inspectors noted that the clinical nurse manager in the operating theatre department together with support from the nurse practice unit conducted monthly medication safety audits. This was also done in the emergency department. Results were tracked and trended and were submitted to the medication safety committee for review. Corrective actions were put in place by the ward managers.

Eighty nine percent of eligible nurses in the emergency department were up-to-date in their training for use of the Manchester Triage System. The most recent (February 2026) audit of compliance with the standard of triaging patients within 15 minutes of registration at the hospital resulted in a score of 79% and the average time for a medical review from registration including the triage was 60 minutes. The hospital was also monitoring response to escalation of INEWS scores and inspectors noted that these were improving.

Inspectors heard how a 'teach back' initiative had been implemented in the emergency department as a quality improvement plan in response to complaints raised by patients relating to communication, particularly around discharge advice and or fee schedules. This involved asking the patient to tell the staff member what they understood from what they were told. This helped eliminate gaps in understanding.

In relation to transitions of care, all patients presenting to the emergency department had a discharge summary completed on discharge and a hard copy was issued to the patient's GP on the next working day.

In summary, inspectors found that there was systematic monitoring arrangements in place at the Galway clinic 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.

Inspectors met with members of the human resources (HR) team. The head of HR reported to the hospital CEO and was a member of the EMT. At the time of inspection, the hospital had 773 employees (nurses, healthcare assistants, catering, cleaning and administrative staff and other ancillary staff) in post. Each business area of the hospital had a business partner. Annual staff turnover was 9.8% and sickness absence was maintained at less than 4% (both in line with expected norms). At the time of inspection, 160 consultants had practising privileges at the hospital and all but a small number of long term consultants were on the specialist register of the Irish Medical Council (IMC). Hospital management provided assurances that appropriate oversight arrangements were in place for those not on the specialist register.

Hospital management outlined the processes and arrangements in place for consultants to be granted practising privileges, which were aligned to the hospital's group strategy and succession plans. The hospital received applications from consultants and the hospital also ran advertising campaigns when seeking consultants with specific expertise. Applications were initially reviewed by HR for qualifications, work history and experience to date against the needs of the hospital. They were then presented to the medical advisory committee (MAC) by the CEO and clinical director for consideration and approval. The final decision to offer privileges rested with the hospital CEO. Inspectors heard that all consultants had the required onboarding checks undertaken as part of the approval process including reference checks solicited by the hospital. Each consultant submitted an annual appraisal document which was reviewed before sign-off by the clinical director. The HR department also sought confirmation each year of continued registration with the IMC. A formal meeting took place between the consultant and the clinical director every three years prior to renewal of practising privileges which were approved by the medical advisory committee (MAC) and the hospital CEO. Hospital management outlined the situation in which and how privileges may not be renewed or could be withdrawn. In the case of a need to withdraw privileges by the hospital, hospital management provided assurances that, where indicated, the Irish Medical Council

would be informed. Consultant staff were supported by registered medical officers who reported to the clinical director at the Galway clinic and provided on-site 24/7 cover.

The patient's named consultant was the primary point of contact for patient concerns 24/7. Inspectors reviewed the staff complements assigned to the inspected clinical areas and found that the areas were staffed in accordance with planned rosters. Nursing personnel and health care assistants reported to the ward nurse manager who reported to a department manager or assistant director of nursing who in turn reported to the director of nursing. Staff reported general satisfaction with staffing levels and patients reported satisfaction with care and timeliness of response to requests for assistance, medication and meals.

The IPC team comprised 1 wholetime equivalent (WTE) consultant microbiologist, 1.8 WTE IPC nurses, 0.4 WTE anti-microbial pharmacist, 0.2 WTE surveillance scientist and two IPC link nurses from each department. Staff reported 24/7 access to the consultant microbiologist.

The hospital had an approved complement of 8.5 WTE pharmacists (which included delegated responsibility for the aseptic unit and for antimicrobial surveillance). The pharmacists provided medication safety talks at the staff induction programme. In addition, there was an approved complement of 8.5 WTE pharmacy technicians. All approved posts were filled at the time of inspection.

Staffing in the inspected areas

The approved and in-post complement of staff in the emergency department comprised one WTE CNM2, one WTE CNM1, eight WTE staff nurses and 1.82 WTE healthcare assistants (HCAs). There was also 3.75 WTE clerical staff in the emergency department covering registration, discharge, insurance and fees as well as general telephone calls. There was a named consultant lead in place for the emergency department who provided cover for four days per week from 10 am to 6pm. The remaining days were covered by individual consultants drawn from a pool of consultants who exercised their practising privileges for up to a day a week. The emergency department was staffed by a CNM2 or CNM1 from 9 am to 5pm plus 3-4 nurses from 09.30am to 9pm, seven days a week and by two consultants on Monday to Friday and a minimum of one consultant on–duty at weekends and on bank holidays. There was one registered medical officer on-duty in the emergency department each day from 1pm until all patients were either seen and either discharged or admitted to a ward bed that evening. There was HCA and clerical cover seven days per week. The emergency department had access to an occupational therapist and a physiotherapist Monday to Friday. There was a pharmacist allocated to cover the emergency department and security personnel

based at the main reception provided support to the emergency department if required.

The approved and in-post complement of staff in the operating theatre department totalled 73.45 whole-time equivalent staff (WTE) comprising one WTE CNM3, six WTE CNM2s, three WTE CNM1s, 50.45 WTE staff nurses, 10 WTE HCAs, one WTE clerk and two WTE staff members responsible for the stores. Inspectors spoke with staff and noted that they reported satisfaction with their jobs and were eager to engage with the process of inspection. The staff held safety huddles twice a day and the clinical nurse manager (CNM3) held staff meetings every two months.

The approved and in-post complement of staff on Freyer ward comprised one WTE CNM2, one WTE CNM1, 20.29 WTE staff nurses and five WTE HCAs. Inspectors viewed the rosters on Freyer ward for the two weeks prior to the inspection and found no gaps. There were five to six nurses on day duty each day and three nurses on night duty, seven days a week. The approved and in-post complement of staff on John Paul II's ward comprised one WTE CNM2, one WTE CNM1, 18.22 WTE staff nurses and four WTE HCA's. The approved and in-post complement of staff on Mother Teresa's ward comprised one WTE CNM2, one WTE CNM1, 21 WTE staff nurses and five WTE HCA's.

The hospital did not have a medical social worker or dietician on staff at the time of inspection. Inspectors heard however, that the occupational therapist (OT) liaised with the HSE OT in the community and with the community intervention team where access to a medical social worker was available if required. Cleaning staff were employees of the hospital and inspectors heard that there was continuity of staff in the clinical areas. Staff could also contact the 'hotel accommodation services' for additional help if required. Overall, staff in the inspected areas reported high visibility and support from the senior nurses on 24/7 site-duty. There was also a member of the EMT on-call out-of-hours.

Inspectors heard how staff were supported with orientation and structured induction on taking up posts at the hospital. The pharmacy staff provided talks on induction covering high alert medicines, 'sound alike, look alike drugs' (SALADs) and use of the hospital's electronic healthcare record and drug management system. The practice development department also provided ongoing in-service training covering medication management, epidural care and use of syringe drivers. The hospital provided support for formal educational opportunities.

Inspectors viewed training records for compliance with mandatory training relating to the four key areas of known harm, within the previous 24 months. Inspectors found that overall, compliance levels by nursing staff, health care assistants and medical staff was good. There is room however, for improvement in compliance with most

mandatory training among the health and social care professionals. Inspectors heard that the hospital also provided the ALERT (Acute Life Threatening Events, Recognition and Treatment) course for relevant staff. Inspectors spoke with health care assistants and household staff who outlined the training they received on induction which included hand hygiene and manual handling and they demonstrated good knowledge of the importance of infection prevention and control, isolation, terminal cleaning and the correct use of cleaning equipment and cleaning agents. Healthcare assistants spoke about in-house study days they had attended which covered new developments, policy changes and talks from the physiotherapist. Staff also had access to HSELanD, the national online learning and development portal.

The hospital had a staff wellness programme and there was a calendar of social and health promotion events in place for staff. The hospital sponsored some health promotion and activity based events for staff. Hospital staff had access to an externally provided employee assistance programme and occupational health service.

Overall, inspectors found that the hospital planned, organised and managed their workforce to achieve the service objectives for high quality, safe and reliable healthcare. Although the proportion of health and social care professionals is small relative to the hospitals' workforce, there is room for improvement within this group for compliance with manadatory training. Approved complements of staff were filled, staff expressed satisfaction with staffing levels and patients reported satisfaction with the timeliness of response from nursing and other staff at ward level.

Judgment: Compliant

Quality and Safety Dimension

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

Inspectors found that the hospital was compliant in three of the national standards under the Quality and Safety dimension (National Standards 1.6, 1.8 and 3.3) and substantially compliant in two of the National Standards (2.7 and 3.1). Key inspection findings, informing judgements on compliance with these five national standards are described in the following sections.

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

Inspectors found that the dignity, privacy and autonomy of patients was respected and promoted at the Galway Clinic.

Inspectors noted the provision of a television and newspapers for patients in the waiting area in front of the reception in the emergency department (ED). A range of patient information leaflets were on display including information on hand hygiene, infectious diseases including measles, access to patient advocacy and fee schedules, although these were all in English.

In-patients had a choice of meals and there was an-all day 'room service' for meals and snacks which patients could request directly from the kitchen using the patients' bedside communication system. Staff told inspectors that they checked to make sure that patients knew how to use this system and helped them if they were unable to do it for themselves. Patients were offered ear plugs if they were noise-sensitive at night.

Inpatients were complimentary of their care, the staff and the facilities. They reported that staff knocked on the door prior to entry (to a single room). Inspectors spoke with patients being cared for in two-bedded and in four-bedded wards. They all had access to their call bells and knew how to use them. Call bells were observed to be responded to promptly and patients reported satisfaction to inspectors with the response times and with the level of assistance provided as required by staff when needing to use the toilet or shower facilities. They reported satisfaction with their care and protection of their privacy. Inspectors found that curtains were used appropriately to provide privacy and dignity to patients during provision of care. Patients reported satisfaction with the quality of food and range of choice on offer with one commenting "food is great and I can get it at any time". Patients described staff as "brilliant", "lovely" and "attentive". Other patients said "I got pain relief when I needed it", and 'I feel well informed about my treatment plan'. Inspectors observed a patient requesting an ice bucket from physiotherapy department for pain relief, and staff responded immediately to their needs. Inspectors spoke with parents who were present with their children and they expressed their satisfaction with the provision of care, staffing and facilities. Staff were observed speaking with patients in a kindly and helpful manner. Healthcare records of patients were stored safely in the clinical areas.

On the first day of inspection, inspectors noted an opportunity for improvement relating to the route taken by patients from the day surgery unit to the operating theatre via the recovery area, and in the placement of patients waiting to be taken into the operating theatre. Staff discussed various options to enhance the dignity,

privacy and autonomy of all patients using the theatre facilities and committed to seeking to improve the experience of patients.

Inspectors observed the presence of post boxes on John Paul II ward for patients to drop in their completed patient feedback and satisfaction survey cards. Inspectors heard how the Galway Clinic also issued an online feedback survey to every patient who supplied an email address for correspondence. Responses were managed through the hospital's electronic management system. Freyer ward's rating was 9.1 out of 10 with 81% of respondents saying that they would recommend the hospital to others. Inspectors noted that themes of responses and actual recommendations offered by patients were shared with staff and were used to bring about continuous quality improvements.

In summary, inspectors found that at the time of inspection, it was evident, through observation, speaking with patients and with staff, and from a review of documents including patient information and feedback surveys that dignity, privacy and autonomy of patients was respected and promoted.

Judgment: Compliant

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

The hospital had effective systems and processes in place to receive and manage complaints. It had an in-date complaints policy in place and a designated complaints officer in post. Hospital management explained that in addition to this, a patient council was being developed across the hospital group to provide the patient's opinion on provision of a range of services. Leadership rounding took place monthly led by the patient safety executive and also attended by one to two board members during their twice yearly site visits. Board members met with patients who consented and inspectors heard that leadership rounding informed quality improvement plans.

Inspectors found that staff were knowledgeable on the complaints process and they outlined how verbal complaints could often be resolved at the point of care. Complaints management was aligned to national guidance in terms of acknowledgment of receipt of written complaints, tracking and trending, and target intervals for resolution of complaints or ongoing updating of patients as to the progress of the investigation of the complaint. An appeals process was outlined in the complaints policy. Processing of complaints was managed with use of the

hospitals' electronic system.

Inspectors viewed the hospitals 'Better together – nothing about us - without us – your voice matters' patient complaint and advocacy leaflet which included a contact email address for the patient safety executive, reference to independent advocacy services and contact details for both HIQA and an accreditation body used by the hospital. Complaints were reviewed and tracked weekly by the quality, incident and risk management team. They were reported to the hospital's quality and clinical governance meeting and also to the board's clinical governance meeting and from there to the board on a two monthly basis. Inspectors viewed data from the patients' complaints dashboard for 2025. The hospital had received 102 complaints, all of which were closed at the time of inspection. Inspectors saw that 93% of the clinical complaints and 100% of the non-clinical complaints had been closed within 30 days. The hospital had identified the top five themes of complaints as follows: communication issues, safe and effective care, access, dissatisfaction of care or service, and dignity and respect. The hospital had developed a quality improvement initiative in the emergency department focusing on the teach-back communication method in response to communication-related complaints.

The designated complaints officer presented complaints data and shared the learning at a weekly quality forum open for all staff to attend and to the relevant key governance committees where indicated. Inspectors saw and heard of several quality improvements made on foot of complaints. These related to reducing risk of falls, reducing risk of and management of delirium, improved care of intravenous lines and early recognition and management of sepsis.

In summary, inspectors found that service users' complaints and concerns were responded to promptly, openly and effectively with clear communication and support provided throughout this process.

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.

The emergency department comprised a reception area, a triage room, staff office, a nurse's station, toilet facilities and a resuscitation area equipped for adults and children. There were four single rooms located within the ED, all with negative pressure facilities. Only one of these rooms had a clinical wash-hand basin. There was one clinical wash hand-basin located on the corridor outside of these rooms. In addition to the single

rooms, there was a total of eight cubicle areas including a plaster area. there were two trolleys in the resuscitation area. The children's area in the resuscitation area of the emergency department was not visually separate from the adult area which is not in line with recommended practice. This is discussed under National Standard 3.1. A wash-hand basin on the corridor located opposite the door to the sluice room was in need of re-grouting and the sink outlet was rusty. Inspectors noted that fresh supplies of continence wear was stored in a cupboard within the dirty utility. These issues were brought to the attention of the CNM2. The CNM2 arranged review by the facilities personnel and hospital management provided assurances that the issue of clean stores in dirty utilities were being managed that day. There was appropriate segregation of clean linen and management of sharps. Overall, the department was clean and tidy however, there was no documentation held at department level as to when or if the environment had been cleaned, instead it was held by household staff in another location. This was brought to the attention of the clinical nurse manager and the records were restored in the emergency department before the inspection was complete.

Although there was no patient requiring isolation at the time, inspectors noted the availability of appropriate laminated signage for use on doors when needed. There was adequate supplies of hand hygiene rub and personal protective equipment available. The minimum physical distancing of at least one metre was in place. Healthcare records were securely stored at the central station and nurses had access to computers on wheels which could be used at the bedside to record notes and observations.

Medicines were stored safely and securely and there was a dedicated medicine preparation area within the treatment room which was accessible by security fob. Risk reduction strategies (High risk medicines alert systems and 'sound alike, look alike' (SALAD) lists) were on display. Access to online medicine information was via the computer at the main nurses' station in the emergency department and while close to the treatment room, it was separate and away from it when it should be available at the point of medicine preparation. Staff however demonstrated access to, and use of same. Daily temperature checks on the drug fridge were recorded manually each day, with no gaps, as viewed by inspectors.

Inspectors noted the display of infographics relating to use of the communication tool, ISBAR. Emergency telephone numbers were on display and easily accessible. The resuscitation trolley included access to oxygen, suction and an automated external defibrillator (AED) for adults and children and was maintained in a clean and safe manner. Inspectors noted that the record of checks on the equipment and supplies was maintained with no gaps. Panic buttons were strategically located within the department.

Freyer ward was a 31-bedded ward used for elective orthopaedic care. It had nine single rooms, five two-bedded rooms and three four-bedded rooms. Each room had en-suite facilities including a shower and there was one additional room off the corridor containing a toilet, wash hand-basin, shower and a bath. The main entrance to the ward was open although the doors automatically closed in the event of the fire alarm sounding. The clean and dirty utility rooms on the ward were accessible to staff only using swipe access. The ward appeared bright, clean and tidy. Rooms in use for isolation had the appropriate signage displayed and the doors were closed. There was a supply of PPE available outside all rooms. All patients on the ward had individual call bells and there was oxygen and suction access at each bedside. Linen and stores were appropriately stored. The clinical nurse manager had oversight of the frequency and quality of cleaning. Inspectors also viewed the record of water flushing (to prevent legionella) in place at ward level and there were no gaps. Medications were securely and safely stored. Fridge temperatures were monitored in line with hospital policy.

John Paul II was a 26-bedded medical ward used mainly for patients with respiratory conditions and occasionally for post-operative patients. It had 12 single rooms and seven two-bedded rooms. All rooms had en-suite facilities. Two of the single rooms had anterooms. IPC signage was placed on doors of rooms where patients were being isolated and the doors were closed. There was no designated cleaners' room on this ward and the cleaners' trolley was located on the ward.

Mother Teresa's ward was a 31-bedded surgical ward used for patients requiring ear nose and throat (ENT), gynaecology, breast and urology related surgery. This was the ward where children were admitted to post-surgery. This is discussed further under National Standard 3.1. The ward comprised nine single rooms, five two-bedded rooms and three four-bedded rooms. All rooms had en-suite toilet, hand wash and shower facilities.

The operating theatre (OT) department comprised a 31-bedded 'same day surgery' ward, a six-bedded holding bay, six operating theatres, five of which were in use on the day of inspection and an 11-bedded bay for post anaesthetic care (PACU). Inspectors reviewed the equipment lists and noted that these did not include anaesthetic trolleys, drawers, glove and apron dispensers in the scrub rooms, or the lights in the theatre spaces. Inspectors heard how the hospital had a replacement programme in place for renewal of trolley wheels as required. The department was found generally clean and tidy with minor exceptions however, it was noted that there was no evidence of assurance of cleaning by the clinical nurse manager. These issues were brought to the attention of the clinical nurse manager (CNM) on duty.

Not all clinical hand wash sinks (as noted in emergency department and Freyer ward) were found to be compliant with national guidance. Hospital management were aware of this and had a replacement programme in place. Disposable privacy curtains were

changed in line with hospital policy and the date of change was noted on them. The hospital utilised bed moving machinery which facilitated bed movement by one staff member. Cleaning schedules were signed and up-to-date in all inspected areas. Inspectors noted a 'I am clean' tagging system in use on some but not on all equipment and when raised with ward mangers, inspectors heard how equipment that is in frequent use on a daily basis is cleaned by the user after each use and for equipment that is less frequently used, the 'I am clean tag' is applied. Macerators on John Paul II ward and in the emergency department did not have dates of service or date of service due, noted on them.

In summary, inspectors found that the inspected areas were clean and tidy and while the hospital provided healthcare in a physical environment which broadly supported the delivery of high quality, safe, reliable care and protected the health and welfare of service users, the following presents an opportunity for improvement:

- not all clinical hand hygiene sinks were in compliance with national guidance and it is acknowledged that the hospital has a replacement programme in place to address this.

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

Inspectors viewed the hospitals corporate risk register. It contained details of risks classified under the following seven headings, quality and risk, allied health services, nursing, finance, human resources, facilities, and health informatics. Each risk was risk-rated, had controls and risk owners identified and in place.

Inspectors found that staff at ward level were knowledgeable about processes and structures supporting risk management in their wards, the maintenance and annual review of the risk register and the reporting to the quality improvement and risk management team. Ward-based risk registers were displayed on quality boards at ward level. These were reviewed on an annual basis or more frequently if required.

Infection Prevention and Control

Patients completed a questionnaire on admission to outline any current or previous infections. All patients were screened on admission for meticillin-resistant *staphylococcus aureus* (MRSA) and patients were screened for *carbapenemase enterobacterales* (CPE), in line with national guidance. All inpatients whose length of stay exceeded seven days were offered re-screening for CPE. At the time of

inspection, all patients requiring isolation were being isolated in single rooms.

The IPC committee had oversight of a range of key performance indicators including surgical site infections. Hospital management provided assurances on how the incidence of surgical site infections was being monitored, trended, analysed and where quality improvement plans were put in place with effect and with ongoing surveillance.

Medication Safety

Staff explained that medication reconciliation was conducted using two sources of information including the patient. For patients admitted directly via the emergency department, contact was made with the patient's pharmacy for verification purposes and for those admitted electively, they were asked to bring in their list of medications from their pharmacy or their GP. The hospital pharmacists also carried out medicine reconciliation and reviewed all use of high risk medicines. Reconciliation was recorded in a designated section of the electronic records. Antimicrobial ward rounds were conducted at the hospital.

Medicine cupboards were appropriately stocked and were found to be clean and tidy. 'Sound-alike' and 'look alike' drug (SALADs) lists and high-risk medicine lists were noted on display in the clinical areas. Access to up-to-date medicines information was located at the nurse's station in the emergency department as opposed to at the point of medicine preparation. The SALADs had yellow labels attached and high risk medicines had red labels attached. Inspectors viewed evidence of risk assessments being carried out in relation to access and location of a small number of high risk medicines. Up-to-date medicines information was available online.

Inspectors noted that drug fridges were secured and their temperatures were monitored and recorded with no gaps.

Inspectors saw health care records on Freyer ward and John Paul's ward that did not have documented evidence of medicine reconciliation. Inspectors heard that patients are risk-assessed for priority for medicine reconciliation, for example, those aged 70 years or over and patients on poly-pharmacy. Inspectors heard that doctors also conduct medicine reconciliation. Inspectors heard how self-administration of inhalers worked in practice and noted that it was supported by the hospital's medication administration policy and the medication storage policy, both of which had been due for review in January 2026. Inspectors noted the presence of outdated hard copies of medicines information while staff explained that medicines information is sought via the hospitals computer system and 'app' and staff demonstrated their access to this information.

Pharmacy services at the hospital operated Monday to Friday. Documented arrangements were in place for the need for exceptional access to pharmacy out-of-hours and this was undertaken by two nurses including the assistant director of nursing on site-duty. Such events were reviewed by the pharmacist the following day to address any deficit in supply, if indicated and staff outlined an example whereby a policy change was made in respect of supply of medication for a designated clinical area.

Staff outlined an example of how once a new drug was added to the formulary, education was provided to the relevant clinical staff by a multidisciplinary team in advance of its use to ensure patient safety.

Inspectors heard how hospital management were liaising with a local HSE hospital to ensure safe transitions of care for patients who were suitable for transfer into the Galway Clinic and who may be on medication regimes for conditions unrelated to the reason for the hospital admission but which required specific levels of monitoring of blood results. Hospital management explained how this had been identified as a potential risk and how they were assured that all necessary actions were being taken to mitigate risk in the interests of patient safety. This was achieved by ongoing collaboration between the clinical director at the Galway Clinic and the management team of the transferring hospital.

Inspectors heard how the hospital had allocated some pharmacy cover to each ward with the aim of improving medication safety, increase medication reconciliation and to be more available for any questions and queries from nursing staff. The numbers of pharmacist interventions recorded had increased since this service was introduced in 2025 and there were fewer reports of medication delays since the introduction of this. Inspectors heard that pharmacists cover three to four wards each and in the event of absence, the pharmacist may still review stock levels and prescriptions on the system and are available by telephone. There was evidence of sharing the learning when a pharmacist had presented at a national study day on the risk of permanent skin staining due to extravasation of intravenous iron infusion, which the hospital, through its medication safety committee, was reviewing in terms of informed consent.

Nursing personnel at ward level conducted monthly medication safety audits. These were reviewed and trended by the nurse practice development and any areas for attention were brought to the attention of the ward manager for remedial actions and or increased awareness.

The hospital had a competency programme in place for pharmacy technicians who had delegated responsibility for ward supply top-ups and other duties and reported to the pharmacist.

The deteriorating patient

The hospital used the Manchester triage system for triaging adults presenting to the emergency department. Inspectors heard and saw that the hospital was using the Irish National Early Warning System on all adults from the point of assessment in the emergency department throughout their episode of care. Inspectors noted that the INEWS was designed for use on non-pregnant adults and on previously pregnant patients from 42 days after birth or miscarriage. Inspectors enquired from staff as to how pregnant or recently pregnant women were identified on admission. Staff explained that the hospital did not provide care to pregnant women however, inspectors found no evidence whereby staff routinely check if a patient attending the emergency department or the other inspected areas was asked about a pregnancy which may have ended in the previous 42 days including a miscarriage. There is an opportunity for hospital staff to further review the initial assessment to ensure identification of this patient cohort. The age appropriate national Paediatric Early Warning System (PEWS) was used for paediatric patients.

The emergency department did not have a separate designated paediatric area for the assessment of unwell children that may present however in such cases, staff explained that the hospital would aim to stabilise in the main resuscitation area and transfer out as appropriate. Audio-visual separation of children receiving care in ED is recommended by the Irish Association for Emergency Medicine. There was a Broselow trolley (containing properly sized medical supplies and dosage instructions for children up to the age of approximately 12 years) in place with up-to-date evidence of daily checks and there were clear algorithms for escalation to the appropriate personnel on display in the area. The emergency telephone number for the Irish Paediatric Acute Transport service (IPATS) and the paediatric ICU and critical care retrieval services was clearly on display in this area. There was a resuscitation trolley and AED in each inspected area together with an emergency 'hypo-box'.

The hospital used the 'INEWS 2' system and its use was supported by in-date policies on the deteriorating patient and on sepsis. Patient care was recorded directly onto the hospital's electronic patient record. Escalation and modification of parameters were outlined in the relevant policies. Inspectors viewed a range of healthcare records and found that key information in relation to the four areas of known harm was recorded in all of them apart from medicine reconciliation by a pharmacist which was charted in some while others had this completed by the registered medical officer (RMO) and some charts had no record of medicine reconciliation. Escalation of INEWS was also noted to have been actioned as required.

Transitions of Care

Inspectors noted that the hospital had an out-of-hours policy in place to guide staff in the event that unscheduled patients arrived at the Galway Clinic out-of-hours.

Inspectors viewed documentation templates used for clinical handover of patients on Freyer ward including at shift handover. The template was set out under the headings of ISBAR. Inspectors commend this practice.

Inspectors visited Mother Teresa ward and spoke with a small number of children and their parents who all reported satisfaction with the service. Inspectors viewed the documented pathway of care for children which was aligned to the practice in place on the day of inspection.

The hospital had a process in place to address incidences of absconsion should these occur. Patients at risk of absconsion, for example, older patients with some cognitive issues, were highlighted with staff at the huddles each day.

Inspectors attended a 'huddle' on St. John Paul 11 ward on the second day of inspection. It was led by the clinical nurse manager and attended by five staff nurses. Each patient was discussed and relevant information highlighted to the team. It concluded after each person was invited to ask any question they may have and all staff were reminded to be vigilant about cannula care.

Other risks

Inspectors followed up with staff and with hospital management on other matters brought to their attention and found that the hospital were assured that they had effective systems and processes in place to mitigate risk.

General paediatric services were not provided at the hospital and there was no paediatrician with practising privileges at the hospital. Children aged four to 16 years of age were however, admitted to the hospital under the care of surgeons for elective surgery. Inspectors heard how the ward had two paediatric trained nurses on the staff and inspectors noted that one was on-duty on the day of inspection and that the paediatric trained nurses were routinely allocated to the care of the children who were admitted for non–complex surgery. On average, three children were admitted to the ward once a week for surgery. There was a child safety statement on display at the entrance to Mother Teresa's ward where children were cared for, and inspectors noted that the hospital had a child protection and welfare policy in place. Inspectors heard that the entrance to the ward was lockable by the CNM2 if indicated (for adult or child) however, hospital policy required a parent or guardian to remain with a child at all times while in hospital. There was a paediatric emergency trolley and a Broselow pack (properly sized medical supplies and dosage instructions for children up to the age of approximately 12 years) stocked on the

ward. Inspectors viewed staff training records on this ward and noted that there was good levels of compliance with training in the Children First Act, paediatric emergency, assessment, recognition and stabilisation (PEARS), paediatric advanced life support (PALS) and paediatric early warning systems (PEWS). Staff were familiar with escalation procedures in response to concerns relating to children and in transfer pathways to ICU and to an external hospital with designated paediatric facilities. Three paediatric early warning system charts were reviewed for key data relating to the four areas of known harm and inspectors noted that this was recorded in all instances. In the case of a child whose early warning scores or other concerns were escalated, the paediatric RMO and the anaesthetic consultant reviewed the child. Staff, within the last year, had participated in simulated drills in relation to children, for example, scenarios regarding a deteriorating patient and a missing child.

The current 'consent for operation / procedure / treatment' dated 07 November 2025 was viewed by inspectors and noted that it was valid for a period of three months from the date of signing.

Policies procedures and guidelines (PPGs)

Inspectors viewed a range of PPGs relating to infection prevention and control which were all in date. Some of the PPGs relating to medication safety had recently passed their review dates. Policies were in place to support use of the early warning systems and guidance on the deteriorating patient. Inspectors also viewed in-date policies and procedures relating to the assessment and management of pain in children, safeguarding, consent and use of photography in the theatre setting and a missing child policy.

The hospital had a GP liaison officer who worked off-site and met with GPs outlining services available to patients should they opt to come to the Galway Clinic. Inspectors noted however, that there was no specific documented inclusion and exclusion criteria in place for patients presenting to the emergency department or for patients being transferred in from a local acute hospital. While children aged five years and over could be seen with minor injuries, the hospital did not provide services for children with minor illness, these were directed instead to the local hospital providing paediatric services. There were two pathways of care for adults, the generic emergency department route and the rapid cardiac care (RCC) unit which was located next to the emergency department.

In summary, inspectors found that the service provider broadly had systems in place to protect service users from the risk of harm associated with the design and delivery of healthcare services. The following are opportunities for improvement:

- ensuring access to up-to-date medication information at the point of medicine preparation
- the level and record keeping of medicine reconciliation
- provision of documented inclusion and exclusion criteria relating to the emergency department and in relation to transfer-in of patients from a local acute hospital
- improve the assessment of patients (who may have been pregnant within the precious 42 days – and so may require a specific early warning system)
- visual and audio separation of paediatric patients.

Judgment: Substantially Compliant

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

The hospital had established systems in place to identify, report, manage and respond to patient safety incidents. Inspectors viewed the Blackrock Health Incident Management Pathway and noted that was in line with that of the HSE and that it aligned to the practices in place as described by staff to inspectors.

The hospital used an electronic reporting system for staff to report all incidents and near misses. Reports were reviewed on a weekly basis by the patient safety executive. Inspectors heard how hospital management were monitoring a downward variation in incident reporting levels compared to the previous year to seek to understand any trends and contributing factors while reinforcing reporting expectations with managers to continue to promote a strong, safety reporting culture.

Inspectors spoke with staff and found that they were knowledgeable on the requirement to report incidents and near misses and gave examples of incidents and how these were managed and what changes as a result.

Inspectors also followed up on a small number of unsolicited reports of information. The hospital management team provided details and assurances that incidents were reported and investigated in line with the hospital group's incident management framework. Reports of safety events were followed up with use of an after action review (AAR) and hospital management advised that category one incidents were reviewed externally. Incidents were reviewed at the monthly quality and clinical governance meeting and a summary report was presented at the bi-monthly board

meeting. Learning was shared with all staff at the weekly quality meeting led by the patient safety executive and at the daily staff huddles.

Inspectors heard from staff and management how learning was shared from the tracking and trending of incidents relating to infection prevention and control. The IPC team visited wards on a regular basis. They reported monthly to the board on key performance indicators.

While medication safety incidents were reviewed by the patient safety executive, they were also reviewed by the medication safety committee and were categorised using the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) classification. Staff spoke of an example where such reviews resulted in a trend being noted and how corrective actions including education and ongoing monitoring were implemented to address the issue which was then mitigated.

In summary, inspectors found that the hospital were identifying, managing, responding to and reporting on patient-safety incidents.

Judgment: Compliant

Conclusion

HIQA conducted an announced inspection of Blackrock Health Galway Clinic (BHGC) on 25 and 26 February 2026 to assess compliance against the *National Standards for Safer Better Health*. Inspectors found that the hospital was compliant in three national standards under the capacity and capability dimension (National Standards 5.5, 5.8 and 6.1) and substantially compliant in one, National Standard 5.2. Inspectors found that the hospital was compliant in three of the national standards under the Quality and Safety dimension (National Standards 1.6, 1.8 and 3.3) and substantially compliant in two of the National Standards (2.7 and 3.1).

Capacity and capability dimension

At the time of inspection, inspectors found that the Galway Clinic had effective governance and management arrangements in place to support the delivery of safe, high-quality healthcare. Evidence from documentation and staff meetings showed that the committees regularly reviewed and monitored performance data, healthcare quality, and compliance with established metrics. There is, however, an opportunity for improvement relating to the use of consistent names of committees, alignment across terms of reference and associated organograms in respect of reporting relationships, ensuring that all terms of reference have due dates for review,

production of minutes of meetings for the medication safety committee and attendance at the deteriorating patient committee. The hospital had committees dealing with the four key areas of known harm and these were found to be functioning effectively to support high quality care in these areas. Inspectors noted active and regular audit with associated quality improvement plans being used to drive continuous improvement. The clinical areas had their approved complements of staff and in the case of short-term absences, staff reported the assistance of the nursing manager who redeployed staff if necessary. Sick leave levels and turnover were within the accepted norms. Staff expressed satisfaction in their jobs.

Quality and safety dimension

Inspectors found that the dignity, privacy and autonomy of patients was respected and promoted at the Galway Clinic. Patients at ward level expressed their satisfaction with the services received, their care, the facilities, the staff and maintenance of their privacy and dignity.

Inspectors found that the hospital had a clear process in place for receipt, management and learning from complaints. Close-out of complaints was timely as evident from a review of the 2025 complaints.

Inspectors found that the inspected areas were clean and tidy and while the hospital provided healthcare in a physical environment which supported the delivery of high quality, safe, reliable care and protected the health and welfare of service users however, up-to-date medication information was at the point of medicine preparation in the emergency department and not all clinical hand hygiene sinks in the inspected areas complied with national guidance. Hospital management explained that it has a replacement programme in place to address this.

Inspectors found that the service provider broadly had systems in place to protect service users from the risk of harm associated with the design and delivery of healthcare services. The following opportunities for improvement were identified: the level and record keeping of medicine reconciliation, provision of documented inclusion and exclusion criteria relating to the ED and in relation to transfer-in of patients from a local acute hospital, review the assessment of patients (who may have been pregnant within the previous 42 days – and if so, may require a specific pregnancy related early warning system), audio-visual separation of paediatric patients. Inspectors found that the hospital were identifying, managing, responding to and reporting on patient-safety incidents.

Overall, the hospital performed well on this inspection. Staff and patients expressed good levels of satisfaction and it was evident that staff were supported by hospital management and the board to provide high quality, safe services.

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	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