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 Blackrock Clinic
Centre ID:	OSV-0008887
Address of healthcare service:	Rock Road, Blackrock, Co. Dublin, A94 E4X7
Type of Inspection:	Announced
Date of Inspection:	23/09/2025 and 24/09/2025
Inspection ID:	NS_0163

About the healthcare service

Model of hospital and profile

The Blackrock Clinic (BRC) is an acute private hospital located on Rock Road, Blackrock, Co. Dublin. It operates under the governance of the Blackrock Health Group Board of Directors. The hospital is recognised for its specialist services in cardiology, advanced cardiac care, cardiothoracic surgery, ophthalmology, orthopaedics, oncology, urology, vascular medicine and surgery, respiratory care, neurosurgery, gynaecology, plastic surgery and gastroenterology.

In addition to adult care, BRC provides scheduled surgical services for patients under the age of 16 years. Paediatric procedures include orthopaedics, scoliosis surgery, ophthalmology, ear, nose and throat, and dental interventions. Inspectors were informed that BRC has maintained a long-standing formal agreement with a children's hospital to support the delivery of scoliosis surgery. In 2024, the scope of this agreement was expanded to increase service capacity and improve access to specialist care for paediatric patients.

The hospital has a co-located emergency department and rapid cardiac care unit. These services operate from 8am to 6pm Monday to Friday, and from 10am to 5pm on Saturdays, Sundays and Bank Holidays. No appointment is required to attend the emergency department, which caters to patients aged 16 years and older. Services provided by the hospital included:

- elective surgery
- day procedures
- emergency care
- medical services
- paediatric surgery
- cancer care
- diagnostic services
- outpatient care.

The following information outlines some additional data on the hospital.

Number of beds	164 inpatient beds 68 day case beds

How we inspect

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

During the inspection, inspectors:

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

*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.

there is appropriate oversight and assurance arrangements in place and how people who work in the service are managed and supported to ensure high-quality and safe delivery of care.

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
23/09/2025	08:50 – 17:30	Angela Moynihan	Geraldine Ryan Elaine Egan Emma Cooke Lorenza Cafolla
24/09/2025	08:20 – 14:00	Angela Moynihan	Geraldine Ryan Elaine Egan

Information about this inspection

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

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

The inspection team visited five clinical areas:

- Emergency department, including the Rapid Cardiac Care Unit
- Patrick Fitzgerald unit (PFU) (general medical and surgical unit)
- William Stokes unit (WSU) (cardiology and cardiothoracic surgery unit)
- Abraham Colles unit (ACU) (orthopaedics, spinal, gynaecology and plastic surgery unit)
- Theatre department (lower ground floor).

The inspection team spoke with representatives of the Senior Management Team (SMT), Quality Improvement and Risk Management, Human Resources, Clinical Staff and attended an operational-tiered huddle meeting on day two of the inspection.

Acknowledgements

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

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

Inspectors spoke with several patients in the emergency department who described their experience as being very positive. Patients reported being seen promptly, with necessary radiology investigations arranged quickly. They expressed appreciation for the staff, it was apparent they were comfortable and demonstrated awareness of their plan of care.

[†] 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.

In the units visited, patients consistently described staff as kind and caring and reported receiving high-quality care. They stated they were kept well-informed about their treatment plans and saw their consultants regularly. One patient commented, "I get physio twice per day and I am up and walking already, which I am happy about." Another patient expressed satisfaction with the availability of nursing and medical staff and told inspectors that their "treating consultant was wonderful and available to answer my questions."

Inspectors spoke with two patients who had been admitted for a number of days. Both patients reported a high level of satisfaction with the care provided, highlighting effective communication and expressing appreciation for being consistently informed about their ongoing and future plan of care.

Overall feedback was complimentary, one patient noted that the complaints process was outlined digitally in their room, whereas others indicated they would raise any concerns directly with the nurse in charge. Overall, all patients who spoke with inspectors provided positive feedback regarding the care they received.

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 the standards related to workforce, use of resources (national standard 6.1). The hospital was found to be compliant with two national standards (5.2 and 5.8) and substantially compliant with two national standards (5.5 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.

Inspectors found that the corporate and clinical governance arrangements for assuring the delivery of safe, high-quality healthcare services were integrated, clearly defined and formalised.

Organisational charts detailed the management and the reporting arrangements for governance and oversight committees in the hospital. The governance arrangements

outlined to inspectors were consistent with those detailed in the hospital's organisational charts and the Board governance manual provided prior to inspection.

The Board of Directors (the Board) held overall responsibility for providing comprehensive leadership, governance and oversight of the hospital. It was evident in meeting minutes reviewed and from discussions with management that the Board met at least six times annually, was accountable for approving and monitoring the hospital's quality and patient safety programme and ensured formal governance structures were in place, with clearly defined accountability and responsibility arrangements.

The group chief executive officer (CEO) was a member of the Board and delegated responsibility for the day-to-day management of the Group. The group CEO held overall accountability for the hospital's operations, compliance and performance. The Senior Management Team (SMT) supported the group CEO in the effective execution of hospital operations and the implementation of the Board-approved strategy. Led by the hospital CEO, the SMT was accountable to the group CEO and, ultimately, to the Board. The SMT provided both strategic and operational leadership and reported directly to the hospital CEO.

The Board had a number of subcommittees, including the Clinical Governance Committee which had responsibility for providing assurances to the Board that the hospital had appropriate and effective systems and processes in place for the quality of patient care and safety within the Group. The chair of the Clinical Governance Committee reported to the hospital CEO and to the group clinical director, who was a member of the Board.

The Quality Improvement and Risk Management (QIRM) Committee was the overarching structure for quality and safety in the hospital. This forum was chaired by the head of quality and patient safety and the hospital CEO was a member of the committee. The committee chair provided two-monthly executive summaries to the chair of the Clinical Governance Committee, to the group clinical director and upwards to the Board.

It was evident that hospital management attended quarterly governance meetings with the affiliated paediatric hospital to support oversight and collaboration in paediatric service delivery. Additionally, the hospital had established a formal Paediatric Service Committee to support the paediatric services in the hospital. Inspectors were provided with a draft copy of the terms of reference which outlined the purpose, objectives and membership composition of the committee.

The Board and all hospital committees met as outlined in their terms of reference, had formalised agendas and it was evident from a review of minutes of meetings provided, that actions were assigned and reviewed from meeting to meeting.

In summary, effective governance arrangements were in place to support the delivery of safe, high-quality healthcare at the hospital. A structured reporting framework ensured that each governance committee reported to the QIRM Committee, the Clinical Governance Committee, the CEO, and ultimately to the group CEO and the Board. Evidence from documentation and staff interviews showed that these committees regularly reviewed and monitored performance data, healthcare quality, and compliance with established metrics.

Judgment: Compliant

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

Effective management arrangements were in place to support and promote the delivery of high-quality, safe, reliable healthcare services.

Through staff discussions and committee interviews, it was clear that hospital management had recently restructured existing committees and established several new ones. These changes were made to support the achievement of the Group's overall strategic objectives and to strengthen management and oversight arrangements in key areas such as infection prevention and control, medication safety, care of the deteriorating patient and the safe transition of patients between care settings. Some of these arrangements were in their infancy and being embedded into the overall quality framework in the hospital.

Infection prevention and control

The hospital's Infection Prevention and Control Team (IPCT) actively supported staff in implementing best practices for infection control. A consultant clinical microbiologist was available and on-call 24/7 to provide guidance to clinical teams. The IPCT reported on surveillance and monitoring activities to the Infection Prevention and Control Committee (IPCC). In addition, quarterly updates were provided to the QIRM Committee, and two-monthly reports, including key performance indicator (KPI) data, were submitted to the Clinical Governance Committee. Inspectors were informed that the IPCC was responsible for developing and approving the hospital's annual infection control strategy and set priorities for the year. Progress against this strategy was formally reported to the QIRM Committee, Clinical Governance Committee, and via the CEO to the Board.

An Antimicrobial Stewardship (AMS) pharmacist was in post and served as a member of the IPCC. At the time of inspection, an AMS Committee was in the process of being established. Inspectors were provided with a draft terms of reference (ToR), which outlined the committee's key responsibilities. These included reviewing guidelines and policies, leading AMS initiatives, monitoring antimicrobial usage, delivering education and training, and auditing AMS practices.

Medication safety

The hospital's clinical pharmacy service[††] was led by the head of pharmacy and supported by the Drugs and Therapeutics Committee (DTC). This committee was responsible for ensuring medications were used safely and that the pharmacy service maintained high standards of care. The DTC had a defined and formalised reporting relationship to the QIRM and Medical Advisory Committees to the CEO and upward to the Board. The DTC recently established a subcommittee, the Medication Safety Committee (MSC). A business case for two additional pharmacy resources was in progress to further support and enhance medication safety oversight and practices in the hospital at the time of inspection.

Deteriorating patient

The hospital's approach to managing deteriorating patients was overseen by the newly established Deteriorating Patient Committee (DPC), chaired by a consultant anaesthetist and co-chaired by an intensive care unit registrar. This committee convened every two months to provide oversight and guidance on best practices for the care of the deteriorating patient programme[‡‡] within the hospital.

Inspectors reviewed the committee's ToR and confirmed that meetings followed a structured agenda. The DPC was a subcommittee of the QIRM Committee. At the time of inspection, a dedicated Sepsis Committee was being developed to further strengthen the hospital's oversight of deteriorating patients. Minutes from DPC meetings demonstrated that action items were consistently assigned to specific individuals, with progress tracked and reviewed at subsequent meetings. While it was not evident that a formal report from the DPC was submitted to the QIRM Committee, inspectors noted that key staff attended both committee meetings and committee representatives interviewed confirmed this.

To further support this area, a Cardiopulmonary Resuscitation (CPR) Committee was also in place. Its chair was a member of the DPC, and the CPR Committee formally reported to the QIRM Committee. Inspectors were informed of this reporting structure and verified it through meeting minutes. Discussions on deteriorating

[††] Clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.
[‡‡]The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the HSE. Early Warning Systems (EWS) improve recognition and response to signs of patient deterioration. A number of EWS designed to address individual patient needs are in place in acute hospitals.

patients included shared learnings and improvements, such as reviews of code blue events, mock arrest drills, resuscitation trolley contents, life support equipment updates, algorithm revisions, training oversight reports, and development of improvement plans based off audit results, incidents and feedback. These efforts were also evident in the units and departments visited and described by clinical staff.

Transitions of Care

A recently established hospital transitions of Care (TOC) Committee was convened monthly. A review of the committee's ToR confirmed that meetings followed a structured agenda and functioned as a subcommittee of the QIRM Committee. While no formal report was submitted to the QIRM Committee, it was noted that key staff members attended both committee meetings and this was confirmed by committee members.

Hospital management stated that the majority of admissions were scheduled private admissions. While no formal bed management committee was in place, the hospital had established systems to manage and oversee scheduled care patient flow. This is discussed further under national standard 3.1.

The emergency department operated as a walk-in service. Inspectors were provided with the unit's inclusion and exclusion criteria, which outlined the types of patients appropriate for assessment and treatment within the department. Hospital management indicated that formalised pathways were in place for situations where a required specialty or bed was unavailable. These pathways, which were shared with inspectors, outlined how patients could be appropriately managed or redirected to alternative services as necessary.

Management described a recent quality improvement initiative introduced; a consultant-led supportive medicine service. The initiative aimed to streamline care coordination and ensure safe, timely discharges for complex patients. This service adopted a multidisciplinary approach to enhance discharge planning for patients with multiple co-morbidities who were under the care of more than one consultant.

The hospital employed three social workers who played a key role in discharge planning. Their responsibilities included coordinating and organising community services to support patients following discharge, ensuring continuity of care and reducing the risk of readmission.

Overall, hospital management had effective arrangements in place to achieve planned objectives that involved all levels of the service provided particularly in the four areas of focus on this inspection. However:

- there was no documented evidence of a formal report from the DPC or the TOC Committee to the QIRM Committee.

Judgment: Substantially 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 a broad range of data related to the quality and safety of the healthcare services it provided. This included information on compliance with national performance metrics, hospital activity levels, patient-safety incidents, complaints, healthcare-associated infections, workforce capacity, staff training and identified risks that could potentially impact service quality and safety. It was evident that collated performance data was regularly reviewed at meetings of the QIRM Committee, Clinical Governance Committee, SMT, heads of department and the Board. In addition, the Board had developed a standardised set of KPIs to monitor clinical outcomes across the hospital Group. Examples of these indicators included cardiology, infection prevention and control and unplanned returns to theatre or intensive care.

The hospital had recently revised and updated their risk management framework enabling a structured and consistent approach to the identification and escalation of reported risks. Operational oversight was provided by the health and safety manager, with strategic oversight from the head of quality and patient safety. The SMT conducted formal quarterly reviews of the hospital's risk register. Inspectors were provided with minutes from review meetings which confirmed that risk management processes were actively monitored and embedded within the hospital's governance structures.

The hospital had adopted the National Incident Management Framework for the management of all incidents including serious reportable events. Hospital management stated, and this was corroborated by the policies and documentation provided, that a formal incident review process was in place. The process included the convening of a Senior Incident Management Team, with the hospital CEO acting as the senior accountable officer. It was evident that the outcomes of reviews, including recommendations and proposed actions, were discussed at SMT and Clinical Governance meetings and oversight of the implementation of recommendations was maintained by the relevant governance group, with progress and updates reported to the QIRM Committee.

Management outlined how five priority focus areas based on emerging trends identified in monitoring data, were set annually by the Clinical Governance

Committee. For example in 2025, focus areas included falls prevention, development of a procedure-specific paediatric emergency management pathway, increasing hand hygiene compliance to 95% and reducing the incidence of peripheral venous cannula infections.

An audit programme had been formally established under the oversight of the QIRM Committee. A clinical auditor was appointed to the quality team to lead the programme and coordinate the audit schedule in collaboration with the Audit Committee.

Management described the hospital's patient experience programme. Patients were offered multiple avenues to provide feedback, including anonymous submissions through a feedback platform. This is discussed further under national standards 1.7 and 1.8.

Overall, there were systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality and safety and reliability of healthcare services provided.

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.

The workforce arrangements in the hospital were planned, organised and managed to provide high-quality, safe and reliable services.

Inspectors reviewed the hospital's staffing plan 2025/2026, which was developed in alignment with the hospital's operational objectives and formulated based on the projected service demands and anticipated staffing requirements.

Hospital management confirmed that the hospital employed 4.76 Whole Time Equivalent (WTE) medical consultants. In addition, 350 WTE consultants, not directly employed by the hospital, had privileges granted to practice in the hospital. Oversight and responsibility for the credentialing process was managed through the office of the CEO and the clinical lead for the respective specialty, with final approval by the Medical Advisory Committee. Inspectors were informed that a formal review of the credentialing process was conducted annually for all consultants. All consultants were registered on the relevant specialist division of the Irish Medical Council's specialist register.

Medical consultants were supported by a total of 29.04 WTE non-consultant hospital doctors (NCHDs), with 23.82 WTE positions filled at the time of inspection. Hospital

management reported that these vacancies had no impact on patient care and outlined measures in place to manage the shortfall.

Patients' named consultants remained the primary point of contact for matters related to their care, both during and outside of core working hours. During out-of-hour periods (11pm to 8am), one NCHD was available onsite for medical reviews, supported by an off-site on-call registrar and an onsite intensive care unit registrar.

At the time of inspection, the hospital was funded for 9.72 WTE pharmacist posts, with 8.22 WTE pharmacists in post. Hospital management stated a business case had been submitted for an additional two WTE pharmacy posts to further support the service. Inspectors were informed and staff confirmed that the antimicrobial stewardship pharmacist worked collaboratively with clinical staff across the hospital and prioritised high risk patients for review. In two of the three inpatient units visited, a dedicated clinical pharmacy service was available. In the third unit, Abraham Colles Unit, a clinical pharmacy service was available upon request, and paediatric patients on this unit were prioritised. A dedicated clinical pharmacy service was not in place for the emergency department however staff stated they had access to a pharmacist if required. This is discussed further under national standard 3.1.

The infection prevention and control team had a full complement of staff and inspectors were informed that an additional clinical nurse manager 3 (CNM) for the IPC team had been recruited and was due to commence employment in the coming weeks.

There was a total of 415.32 WTE (inclusive of management and other grades) approved nursing posts with 392.63 WTEs in place; a deficit of 22.69 WTEs. On the days of inspection, the inpatient units visited had their full complement of nursing staff. Hospital management reported that 1 WTE post at CNM 2 grade in the emergency department was being recruited for at the time of inspection. Inspectors were informed by management and noted that challenges in recruiting and retaining staff were recorded on the hospital risk register. Efforts to recruit additional nursing staff were actively underway and nurse management described interim measures in place in the hospital to support safe staffing levels.

The human resources (HR) department reported directly to the CEO and, subsequently, to the Board. The interim head of human resources was a member of the Senior Management Team (SMT). Hospital management emphasised that recruitment, staff turnover, compliance with mandatory training, and staff retention remained key priorities. It was apparent from a review of meeting minutes and speaking with management that these areas were routinely monitored and reviewed through KPI metrics at SMT and heads of department meetings. Management described and staff confirmed that a structured induction programme was in place

for all newly appointed nursing staff, and that an induction programme for NCHDs was under development at the time of inspection.

Management reported that the absenteeism rate in the hospital ranged between 2% and 4% and confirmed that this was being actively monitored. Clinical staff in two units reported an increase in absenteeism in the weeks preceding the inspection however no impact to patient care was noted or reported by patients who spoke with inspectors. Management outlined the controls implemented to address this issue and inspectors observed that these mitigating measures were documented on the hospital's corporate risk register.

Hospital management stated that each department manager was responsible for ensuring staff completed the mandatory training relevant to their roles. Training records were recorded in a centralised training repository system which all staff had access to. Department managers stated they had access to compliance reports and followed up with staff regarding any outstanding training. The HR department notified the NCHDs when their training required updating and this was confirmed by medical staff that inspectors spoke with.

At the time of the inspection, inspectors noted a high level of compliance with mandatory training requirements among nursing staff across the units and departments visited for most training competencies. Compliance with Paediatric Emergency Assessment, Recognition and Stabilisation (PEARS) training ranged between 80% and 85% in both units who cared for paediatric patients with additional training sessions booked in the following weeks. However, in the two units, compliance with the Irish Paediatric Early Warning Score (IPEWS) was low—23% in Abraham Colles unit and 37.5% in Patrick Fitzgerald unit. Hospital management stated that the low compliance with IPEWS had been identified and was being addressed through the development of an in-house training programme. An action plan provided during the inspection outlined that all required staff would complete training by December 2025.

Training records received following the inspection indicated high levels of compliance among NCHDs with Basic Life Support (BLS), PLS, and Advanced Paediatric Life Support (APLS) training. Compliance with the IPEWS training was 100% for NCHDs. However, while compliance with PEARS training stood at 53%, hospital management provided an action plan outlining steps to achieve 100% compliance in PEARS training by year end.

Training records for the emergency department indicated that 80% of staff had completed training in the Manchester Triage System[§§]. Inspectors were informed that training for the remaining staff was scheduled in the coming weeks. This training gap was recorded on the hospital's risk register, with additional controls implemented to mitigate associated risks.

Inspectors reviewed the mandatory training records of healthcare assistants and noted a high level of compliance in the units and departments inspected.

In summary hospital management demonstrated effective planning, organisation, and oversight of the workforce to support the delivery of high-quality, safe healthcare. Inspectors found a strong commitment within the hospital to ensuring staff completed mandatory training requirements. However:

- staff training in IPEWS, PEARS, PLS and Manchester Triage System requires review.

Judgment: Substantially Compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety (1.6, 1.7, 1.8, 2.7, 2.8, 3.1, and 3.3). 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 hospital were found to be compliant with six national standards (1.6, 1.7, 1.8, 2.7 3.1 and 3.3) and substantially compliant with one national standard (2.8). Key inspection findings informing judgements on compliance with these seven national standards are described in the following sections.

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

Inspectors observed that staff were actively aware of the importance of respecting and promoting patients' dignity, privacy, and autonomy. The hospital collected patient feedback through surveys and featured questions on privacy, dignity, and respect. Inspectors reviewed the patient satisfaction report and observed high levels of satisfaction in these areas. Closed-circuit television (CCTV) was active in public areas of the hospital with appropriate signage clearly displayed.

All inpatient areas inspected featured single en-suite bedrooms. Inspectors observed that staff knocked before entering patient rooms, demonstrating respect for privacy. All patients were offered menu choices and patients who inspectors spoke with reported satisfaction with the meals provided.

[§§] The Manchester Triage System was designed to assist healthcare professionals to determine the clinical priority of patients attending urgent and emergency care facilities. The Tool consists of a series of charts that, when taken together and used by a trained professional, enable a safe and appropriate decision about clinical priority to be made.

In the emergency department, inspectors observed the use of privacy curtains alongside glass enclosures within patient bays to support patient privacy. Staff described an initiative aimed at enhancing privacy and dignity for a particular cohort of patients in the department, demonstrating a proactive approach to person-centred care.

Patient information was appropriately protected, with medical records stored within the nursing stations in the units and departments inspected. A child safety statement was visibly displayed at the entrance of the Abraham Colles unit and inspectors were informed that internet controls were in place to enhance online safety for paediatric patients.

In the theatre department, privacy curtains were in use in the recovery area. Staff were observed appropriately assessing and reassessing patients' pain levels and postoperative status.

In summary, service users' dignity, privacy and autonomy was respected and promoted.

Judgment: Compliant

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

Inspectors observed that a culture of kindness, consideration, and respect was actively promoted by staff across all units and departments visited. Patients reported being kept well-informed about their care plans, their call bells were answered promptly and praised staff for the care that they had received.

Inspectors noted the availability of an 'Essential Information' patient booklet, which outlined patients' and staff rights, the hospital's vision, mission and values, as well as general information about the patient journey through the hospital. In two units, staff confirmed access to a translator service when required.

Inspectors were informed by hospital management that ongoing patient feedback was actively collected to assess patient satisfaction with their hospital experience. Feedback was gathered through various channels, including anonymous submissions, suggestion boxes, and direct engagement with the SMT during leadership rounding and direct communication with the quality department. Management outlined that feedback was analysed and disseminated hospital wide with improvement plans developed where necessary. Management highlighted several quality improvement initiatives that were implemented in response to patient feedback including the expansion of inpatient menu options and improvements to hospital signage which inspectors observed.

Hospital management highlighted the 'Annual Blackrock Health – Better Together Awards', which recognised and celebrated staff contributions across the hospital.

Inspectors were informed that CNMs and Social Workers maintained a list of available advocacy services for patients to access when needed.

Overall, hospital management and staff were found to actively promote a culture of kindness, respect, and consideration.

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 implemented effective systems and procedures for managing complaints and concerns. Oversight of complaint data review and compilation was assigned to the head of quality and patient safety. Staff spoken with adhered to the hospital's complaints policy, which provided clear guidelines and timelines for acknowledging and responding to complaints.

Hospital management informed inspectors that complaints were systematically tracked, analysed, and reviewed every second week at a dedicated complaints forum, and at quarterly QIRM Committee meetings. Additionally, a summary of clinical complaints was shared with the chair of the Clinical Governance Committee every two months, a process verified by inspectors. Board meeting minutes confirmed that the complaints process was routinely assessed for effectiveness. At the time of inspection, 99% of complaints were resolved within the 30-day timeframe.

In response to patient feedback, the hospital implemented several service improvements, including the "red teapot" initiative to identify patients requiring additional assistance, expanded menu options, and increased management rounding in the emergency department. Inspectors observed evidence of these enhancements during the inspection.

The SMT members conducted monthly leadership rounds in various hospital locations, assessing cleanliness, staff knowledge, addressing concerns, and engaging with patients to gather feedback on their care experience. This was also confirmed by staff.

Information on how to make a complaint was readily available in the units and departments inspected, including signage at nursing stations, in the patient handbook, hospital website and on television screens in patients' rooms. Inspectors observed comment cards and suggestion boxes strategically placed in the inpatient

units. Staff reported that verbal complaints were typically resolved at the point of contact and logged on the complaints system to support organisational learning. Complaints training was provided to staff with high levels of compliance noted in the units and departments inspected.

Overall, inspectors found that systems were in place to respond effectively to complaints and feedback.

Judgment: Compliant

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

Inspectors observed that the physical environment in the units and departments inspected supported the delivery of high quality, safe, reliable care.

Units and departments inspected were observed to be clean, well-organised, and maintained to a high standard. Each of the three inpatient units visited featured single-occupancy rooms with en-suite facilities. Specifically, the medical side of the William Stokes unit comprised of 20 such rooms, the Abraham Colles unit contained 35 rooms, and the Patrick Fitzgerald unit consisted of 42 rooms. Inspectors found the en-suite areas to be clean and well-maintained with cleaning checklists completed as per protocol. In the emergency department inspectors observed 12 enclosed single cubicles with disposable curtains which were noted to be changed as per hospital policy.

Staff described the cleaning process for patient equipment which included a tagging system and cleaning after each use which inspectors observed. Inspectors found equipment generally clean and all cleaning checklists were up-to-date in the units and departments inspected.

Patients requiring standard or transmission-based precautions were appropriately accommodated in single, en-suite rooms. Isolation room doors were closed in line with best practice and infection control signage was correctly displayed as observed by inspectors. Disposable or patient-specific blood pressure cuffs were available for isolated patients. Emergency department staff demonstrated protocols for managing suspected transmissible infections with personal protective equipment (PPE) readily available, appropriate signage in place, and staff observed performing hand hygiene at correct intervals.

Clean and used linen were properly segregated and hazardous substances were securely stored. Alcohol-based hand sanitiser dispensers were accessible throughout the units and departments supported by visible hand hygiene signage. Hand hygiene

sinks met national standards and two clean utility rooms had sinks removed following a risk assessment by the IPC team due to increased Carbapenemase producing *Enterobacterales* (CPE) risk. Additional hand sanitiser was provided in these areas.

Patient equipment was appropriately stored in designated areas. Waste and sharps bins were correctly segregated and safely stored. Negative pressure rooms were available in two inpatient areas and emergency department staff outlined the procedures in place for accessing them if the need arose.

In summary, inspectors found the physical environment supported the delivery of high quality, safe, reliable care.

Judgment: Compliant

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

Inspectors found that there were systems in place at the hospital to monitor, evaluate and continuously improve the healthcare services and care provided.

Hospital management drew on a range of sources including KPIs, audit findings, risk assessments, patient-safety incident reviews, medication error reports, patient outcome measures and feedback from patients and families, to benchmark the quality of healthcare services at hospital and Group level to drive continuous service evaluation and improvement.

The Quality Improvement and Risk Management Programme Annual Report, submitted to inspectors, provided an overview of the 2024 Quality Improvement and Patient Safety Programme. The report highlighted enhancements in the hospital's audit processes, oversight and monitoring mechanisms. Notable developments included the implementation of a digital auditing solution, the appointment of a dedicated clinical auditor and the creation of an audit plan and schedule in collaboration with the Audit Committee.

Infection prevention and control

The IPCC stated they reviewed the surveillance data and reported to the QIRM Committee four times a year, and surveillance data was compiled and reported to the Clinical Governance committee every second month.

Minutes from recent QIRM and IPC Committee meetings confirmed that organism surveillance was actively discussed and evaluated against established benchmarks, with data differentiated between hospital-acquired and non-hospital-acquired infections. Inspectors were informed that rates of *Clostridium difficile* and Methicillin-

Resistant *Staphylococcus aureus* (MRSA) bacteraemia were below the national benchmarks set for 2025. An overview of the actions taken to manage and reduce these infections was provided.

CPE rates were also reported to be below the 2025 benchmarks and inspectors were informed by management of a recent outbreak within the hospital, which is discussed further under national standard 3.1.

Surgical site infection surveillance was actively monitored and reported, with orthopaedic and spinal infection rates remaining below National Health Service (NHS) benchmark levels in 2025. Surveillance also identified an area requiring improvement, which prompted hospital management to initiate a review and implement a targeted quality improvement initiative (QIP). This intervention was reported to be having a positive impact.

The IPCT actively monitored compliance with care bundles as part of its ongoing surveillance and quality improvement programme. Inspectors were informed that monthly audits were conducted to assess adherence to evidence-based practices, with results reviewed at both IPC and QIRM Committee meetings. Between January and August 2025, monthly compliance with care bundles was consistently high: central venous catheter (92–100%), peripheral catheter (95–99%), and urinary catheter (93–99%).

Hand hygiene audits were conducted by the IPC team, supported by designated clinical hand hygiene auditors across units and departments. A review of meeting minutes confirmed that audit findings were regularly discussed at the IPCC, QIRM Committee, SMT and heads of department meetings. Inspectors were provided with a hospital-wide QIP, initiated in response to previously suboptimal compliance, aiming to achieve a target of 95%. Audit data showed that inpatient unit results in June were below target, followed by a steady improvement in compliance during July and August 2025. Patrick Fitzgerald unit reported compliance of 89.8% in the most recent audit completed. The emergency department maintained 100% compliance between June and August 2025. Feedback to staff in clinical areas was evident; for example, inspectors observed recent hand hygiene results displayed in the respective departments and units and these were discussed at staff meetings.

Environmental and equipment audits were conducted using a digital auditing tool. In recent months, the audit process was strengthened through the adoption of a multidisciplinary team approach, which included participation from a member of the SMT. This enhancement was outlined in an ongoing QIP shared with inspectors. Inspectors reviewed environmental and equipment audit results for three months preceding the inspection and inpatient units met or exceeded the target, with the exception of the emergency department, which recorded 88.7% compliance in

September 2025. An action plan was provided to address the identified issues, with 11 of the 12 actions completed at the time of inspection.

Medication safety

Medication safety audits carried out by clinical staff across inpatient units were conducted monthly as part of quality care metrics (QCM). Inspectors were provided with a recent QIP developed by the senior nursing management team in response to identified shortfalls in audit outcomes and trends in reported medication incidents. The QIP focused on strengthening medication safety through the development of competency booklets for nursing staff and the implementation of standardised mandatory medication training. The goal of the initiative was to ensure that 100% of clinical nursing staff completed the medication competency assessment by December 2025. Audit data from the three months prior to inspection showed consistently high compliance across inpatient units: William Stokes unit (94.83–99%), Abraham Colles unit (91.2–95.7%), and Patrick Fitzgerald unit (89–98.2%). However, inspectors were informed that the QCM audits had not been implemented in the emergency department at the time of inspection and so medication safety audits were not completed.

Hospital-wide audits on medication storage and labelling of high-alert medications and sound-alike look-alike drugs (SALADs) were conducted, with compliance rates ranging from 93% to 100% between January and May 2025. Inspectors noted that audits were not completed in the three months leading up to the inspection. Management were aware of this and informed inspectors of their plans to address, enhance and refine the audit process in the future. Audits submitted by the hospital following inspection identified newly introduced audits which included oversight of insulin storage, allergy status and management and a monthly audit of inpatient transfers between clinical areas. Monthly antimicrobial restriction audits were conducted by the antimicrobial pharmacist, and data from January to June 2025 confirmed that all restricted antimicrobials were authorised in accordance with hospital policy.

Findings from these audits were formally presented to both the DTC and the QIRM Committee. CNMs confirmed they received structured feedback on audit outcomes. Additionally, inspectors observed that recent audit results were prominently displayed on quality boards within the units and departments. Management indicated that QIPs would be initiated going forward for audits that did not reach the target set.

Deteriorating patient

Management confirmed that compliance with the Irish National Early Warning System (INEWS) and Paediatric Early Warning System (PEWS) escalation and response protocol for inpatients was audited through the QCM audit process.

Inspectors were provided with a recently developed hospital-wide QIP, created by the senior nursing team, aimed at strengthening the recognition, escalation, and management of deteriorating patients with an additional QIP developed on use of the ISBAR for escalations. This initiative was prompted by a hospital-wide audit result of 86.2%, (target of 95%). Key areas identified for improvement included:

- timely assessment and reassessment of physiological observations according to the required frequency
- documentation of care escalation using the ISBAR communication format.

To further support staff a competency booklet was introduced and targeted workshops on the management of deteriorating patients were scheduled over the coming months. Audit results shared with inspectors demonstrated generally high levels of compliance in the three months preceding the inspection for the units inspected.

Inspectors noted from the DPC meeting minutes that audit feedback was communicated to NCHDs via the committee's co-chair which was confirmed with medical staff interviewed. Audit results were also discussed at the quarterly QIRM committee meetings.

Inspectors reviewed sepsis audit results from the units inspected, including the emergency department and noted varying levels of compliance. Management stated that a Sepsis Committee was in the process of being established at the time of inspection and outlined plans to strengthen clinical practice in this area, including the appointment of sepsis champions, delivery of education and awareness sessions, rollout of the new National Sepsis Form, and the organisation of sepsis workshops to address the non-compliances identified in the sepsis audits.

Transitions of care

Inspectors reviewed hospital-wide monthly audit results on the use of the clinical handover communication tool, Identify, Situation, Background, Assessment, Recommendation/Read Back/Risk (ISBAR3). Results from June to August demonstrated consistently high levels of compliance: 93% in June, 97.4% in July, and 98.5% in August. The audit evaluated both the ISBAR process and the timing of handovers, covering nursing-to-nursing as well as nursing-to-medical handovers, including the quality of information shared.

Inspectors were also provided with a QIP specific to the emergency department, where the ISBAR format had recently been adopted for patient handovers to inpatient units. Auditing of this process was scheduled to commence in October 2025.

Management described a newly implemented QIP focused on enhancing staff knowledge and education around integrated discharge planning across the hospital. Led by the senior nursing team, the initiative included several key actions: the establishment of nursing grand rounds dedicated to discharge planning, delivery of targeted education sessions for staff and the integration of discharge planning into the nursing orientation programme. The effectiveness of this QIP was to be monitored through QCM audits conducted across the wards. A copy of the QIP was provided to inspectors.

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

- QCM for medication safety were not completed in the emergency department.

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 arrangements in place to ensure proactive identification, evaluation, analysis and management of risks in the delivery of safe care.

Risk management

Management had effective systems in place to proactively identify, assess, and manage both immediate and potential risks to patient safety. Risks were systematically recorded on local, live digital risk registers, which were accessible to inspectors during the inspection. Each risk entry included associated controls and assigned mitigation actions with additional measures documented where necessary.

Hospital management stated that the CEO held ultimate responsibility for the corporate risk register, which was also subject to review by the hospital Board. Although risk was not a standing agenda item on all committee and board meeting minutes reviewed, it was evident from documentation and staff feedback that risk-related discussions occurred at the meetings. Meetings with senior management and minutes of meetings reviewed reflected that the hospital's corporate risk register was formally reviewed on a quarterly basis at dedicated senior management meetings.

The corporate risk register provided to inspectors, listed a total of 18 risks. These were categorised under clinical and patient safety, health and safety, human resources, information and communication technology and operations.

CNMs interviewed demonstrated how digital risk assessments were integrated into the live hospital risk register. These assessments outlined existing mitigation controls and were completed by CNMs with support from senior management and the health and safety manager. CNMs reported that they received risk management training to support their role in maintaining and overseeing risk registers, and confirmed their accountability for implementing and monitoring mitigation measures. Risks that could not be managed at the departmental level were escalated to the senior nursing team. Management reported that any risk entered into the register with a calculated score greater than 15 triggered an automatically generated alert to the SMT and placement onto the corporate risk register.

Infection prevention control

Risks relating to IPC recorded on the risk registers reviewed included, inadequate storage of equipment, device-associated infections, surgical site infections and insufficient skin preparation prior to procedures, all of which had controls in place to mitigate the associated risks.

Inspectors were informed at interview that all patients admitted to the hospital were screened for Carbapenemase producing *Enterobacterales* (CPE) in line with national guidelines and all patients were screened for Methicillin-Resistant *Staphylococcus aureus* (MRSA). The hospital had ceased screening of vancomycin resistant enterococcus (VRE) with the exception of the Intensive Care Unit and the Oncology ward. In addition, management stated and documentation confirmed that all patients who were inpatients for longer than five days were re-screened for the above multi-drug resistant organisms (MDROs). Inspectors noted that the hospital had introduced an audit for monitoring compliance with this process. An infection prevention and control risk assessment was completed at triage for adults in the emergency department and inspectors noted that this had been completed as appropriate. Additionally, questions relating to respiratory illness or recent overseas travel were asked at the point of registration to the emergency department. This was evidenced by inspectors and confirmed by staff.

In June 2025, the hospital experienced an outbreak of CPE. Inspectors were provided with a completed outbreak report, which included a time-bound action plan. This plan outlined specific responsibilities for each action, in addition, two supplementary QIPs were developed in response to the outbreak.

While AMS rounds were in place, high-risk patients were prioritised. Management stated that this was a priority area for the AMS committee. Staff informed inspectors they had timely access to advice if required, a member of the IPCT attended the wards daily and access to microbiology advice was on a 24/7 basis.

Medication safety

It was noted that risks relating to medication safety recorded on the risk register included, medication errors, the administration of concentrated electrolytes and the risk of bleeding whilst on anti-coagulation therapy; all of which had associated controls in place.

Clinical pharmacy services were in place for two of the three inpatient units inspected. In Abraham Colles unit, the service was prioritised for high-risk and paediatric patients. Staff confirmed that, while the service was not continuously present, they were able to contact the pharmacy department as needed for support with concerns or queries. Management informed inspectors that while there was no negative patient impact, this known risk was on the risk register with controls in place to mitigate the associated risks.

Pharmacy staff were responsible for managing medication stock replacement across inpatient units. Automated dispensing cabinets were in use, which enhanced stock management and provided improved oversight of medicines. Out-of-hours access to medications was managed by the site manager and no issues accessing medications out-of-hours were reported to inspectors.

In the emergency department, inspectors observed that an automated dispensing cabinet was not in place, and stock oversight responsibilities were not clearly defined. Some stock management issues identified were addressed during the inspection. These findings were discussed with hospital management who, following the inspection provided inspectors with an audit plan for medication safety oversight.

Staff were aware of risk-reduction strategies for high-risk medications implemented by the hospital and in accordance with hospital policy. A list of SALADs was available and supported by a specific policy and staff in the clinical areas described risk reduction strategies for these medicines. Medication management policies, including prescribing protocols and antimicrobial guidelines were current and readily accessible at the point of care. Inspectors observed secure storage of medications such as insulin, potassium, and opioids, consistent with national standards across the units and departments. Staff described and inspectors observed how medication refrigerator temperatures were monitored and recorded remotely via a centralised digital system which automatically alerted staff when temperatures deviated from the recommended range.

Deteriorating patient

Inspectors reviewed risk registers and noted risks associated with the management of deteriorating patients were included. For example, risks relating to the monitoring of patients on telemetry without assigned staffing and failure to escalate clinical deterioration appropriately. Following the inspection, additional risk assessments were provided for review. These documented risk assessments, including the

adequacy of NCHD medical cover for paediatric patients, the level of consultant cover for paediatric inpatients, and a risk related to staff unfamiliarity with escalation procedures for deteriorating patients. All identified risks had both existing and additional control measures in place to mitigate potential harm and ensure patient safety**.**

Staff stated they used the most recent versions of national early warning systems tailored to different patient cohorts. The Sepsis 6 care bundle was observed in use in the units for appropriate patients. In the emergency department, the Emergency Medicine Early Warning System (EMEWS) was implemented, while wards caring for paediatric patients utilised the age-appropriate Paediatric Early Warning System (PEWS). The ISBAR communication tool was noted to be used appropriately in charts reviewed for care escalations to the clinical teams. Staff interviewed demonstrated strong knowledge of INEWS, EMEWS and PEWS as well as the associated escalation and response protocols ensuring timely and appropriate management of patients triggering early warning scores.

Management stated and staff confirmed that several initiatives had been introduced to improve the care of deteriorating patients such as case reviews and shared learning sessions with CNMs, a workshop on deteriorating patient care for clinical staff, scenario and simulation based training, and ongoing training focused on INEWS, EMEWS, PEWS and the use of the ISBAR communication tool.

Inspectors conducted a review of patient healthcare records in the units and departments inspected and found that EWS entries were appropriately documented and generally adhered to the required monitoring frequency. Following the inspection, the escalation of care policy provided to inspectors clearly outlined a comprehensive escalation process for paediatric patients experiencing clinical deterioration. A discrepancy was noted where the escalation guide outlined in the paediatric observation chart did not align with the escalation protocol described in the policy. This was raised with hospital management who reported that the observation charts were in the process of being updated to align with the outlined protocol.

Emergency equipment, including both adult and paediatric resuscitation trolleys was available with age-appropriate equipment in the units and departments inspected as necessary. Anaphylaxis and hypoglycaemia kits were also in place and readily accessible. Monthly safety checks were consistently completed and inspectors observed that daily checks of emergency equipment were generally carried out as expected.

Oxygen points were present at each bedside and inspectors observed that sepsis management guidelines were accessible to staff in the units and departments inspected.

Transitions of care

Inspectors reviewed the risk registers and identified a number of risks related to transitions of care each with associated existing and additional controls. For example, the risk of patients presenting to the emergency department during periods when the department was closed and non-availability of telemetry or monitored beds.

Systems and policies supported safe patient discharge and transfer during and outside core hours. Admission criteria was defined, and each patient had a planned discharge date documented. Hospital management reported and staff confirmed that each morning, a discharge coordinator visited all inpatient areas to gather updates on anticipated discharges, identify any delayed transfers of care and explore the underlying reasons for any discharge delays. In addition to this daily process a weekly multidisciplinary team (MDT) meeting was held to review and take action on cases involving delayed discharges. At the time of inspection, hospital management reported six cases of delayed transfers of care, representing 3.6% of total inpatient beds available in the hospital.

The hospital implemented tiered huddles at various intervals throughout the day involving staff across multiple levels. Management stated that the aim of huddles was to proactively identify and resolve issues related to patient flow, bed availability, and operational pressures, with the capacity to escalate concerns swiftly and effectively. On the second day of inspection, inspectors attended one of these huddles, where hospital management from a range of departments discussed scheduled elective procedures, outpatient and pre-assessment clinic activity, current bed capacity, staffing challenges, and the availability of diagnostic services such as radiology and laboratory testing.

In the operating theatre department, an inspector observed and discussed with staff the patient pathway, from pre-operative preparation through to post-operative recovery. The use of the ISBAR communication format was consistently applied at each transition of care observed by the inspector. Patient flow within the department followed a standardised and well-coordinated process, beginning with pre-operative assessment, continuing through the surgical procedure, and concluding in the post-operative recovery area. At each stage of the patient journey, staff demonstrated adherence to key safety protocols using hospital-approved safety checklists. These included critical steps such as patient identification, site verification and consent.

A newly introduced intra-hospital transfer form and a recently implemented emergency department handover format were in use, both employing the ISBAR communication framework. Inspectors observed that staff in the units inspected consistently utilised the ISBAR format for shift handovers, thus supporting structured and effective communication across teams. Patient-safety huddles were conducted at intervals throughout the day in the units and departments inspected, contributing

to proactive risk identification and team coordination. Inspectors were also provided with a newly developed MDT discharge checklist for patients following thoracic surgery, aimed at enhancing discharge planning and continuity of care.

Discharge letters reviewed during the inspection demonstrated that appropriate follow-up plans were in place where required. While a sample of documentation reviewed did not include a dedicated section for recording IPC risks, such as MDRO status staff informed inspectors that this would be documented as a comment on the summary. Inspectors reviewed patient transfer data for 2024 and 2025, which showed low numbers, three transfers in 2024 and two in 2025.

Inspectors were provided with a QIP which aimed to address delays in the registration-to-triage process in the emergency department. On the day of inspection, the average wait time from registration to triage was 27 minutes, with an improved average of 21 minutes from triage to medical assessment. Management identified contributing factors such as data collection and documentation methods, which were actively being refined to improve accuracy and efficiency.

Policies procedures and guidelines

Inspectors reviewed a range of policies procedures and guidelines and noted all were up to date. Staff had access to a range of up-to-date infection prevention and control, medication safety, transitions of care and deteriorating patient policies procedures and guidelines via a document management system.

Overall, the hospital had systems in place to identify and manage potential risk of harm associated with the four areas of harm.

Judgment: Compliant

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

The hospital had established systems to identify, report, manage, and respond to patient-safety incidents. The hospital's incident management policy was developed in alignment with the HSE's Incident Management Framework. All incidents were reported through a local electronic reporting system, with oversight provided by the quality department. Inspectors were informed that incidents raised were discussed daily during morning safety huddles.

Staff interviewed demonstrated strong awareness of incident reporting procedures, were knowledgeable about the most commonly reported incident types and provided examples of QIPs implemented in response to increased incident reporting. For instance, the Abraham Colles unit implemented the SSKIN care bundle to address reported skin injuries. These initiatives were led by CNMs and overseen by

the senior nursing team. Learnings from reported incidents were documented within the hospital's digital incident reporting system.

Inspectors were informed that training on incident management, including incident investigations had been completed with staff, which was confirmed by staff in the units and departments visited. CNMs spoken with confirmed they received monthly and quarterly reports on incident trends from both the quality department and the medication safety pharmacist. Patient-safety incidents were regularly reviewed at the quarterly QIRM Committee meetings and every two months at the Clinical Governance Committee. The Board monitored group-wide KPIs, examples included inpatient falls and associated injury severity and rates and categories of medication safety events.

Hospital management outlined the process in place for managing serious reportable events and provided examples of incidents that had been handled in accordance with this process. Oversight of progress on recommendations arising from root cause analyses or comprehensive reviews was maintained by the quality department and discussed at the QIRM Committee and with the Senior Incident Management Team. It was evident that learning from incidents was shared with staff through various channels including huddles, clinical handovers, CNM meetings, a weekly culture of safety message, departmental meetings and formal training sessions and this was confirmed by staff.

Inspectors found evidence of the oversight of patient-safety incidents across the four areas of harm: infection prevention and control, medication safety, transitions of care, and the deteriorating patient. Meeting minutes reviewed confirmed that incidents in these areas were routinely monitored, discussed, and addressed through relevant committee structures.

Management stated that medication-related incidents were classified based on the severity of their outcomes, in accordance with the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) categorisation framework. The MSC formally reported on incidents to the DTC on a quarterly basis and minutes reviewed by inspectors confirmed that medication incidents were discussed at various committee meetings (Medication Safety, Drugs and Therapeutics and the QIRM).

Overall, the hospital had a system in place to identify, manage, respond to and report patient-safety incidents using an agreed taxonomy in line with national legislation, standards, policy and guidelines.

Judgment: Compliant

Conclusion

An announced inspection of the Blackrock Clinic was carried out to assess compliance with National Standards for Safer Better Healthcare. Overall, the hospital was found to be complaint in eight national standards (5.2, 5.8, 1.6, 1.7, 1.8, 2.7, 3.1 and 3.3) and substantially compliant in three national standards (5.5, 6.1 and 2.8).

Capacity and capability

Inspectors found that the hospital's corporate and clinical governance arrangements for delivering safe, high-quality healthcare were well-integrated, clearly defined and formalised. Effective management structures were in place to support and promote the consistent delivery of safe, reliable care. The establishment of the AMS and Sepsis Committees will strengthen these governance arrangements. Systematic monitoring processes were in place to identify and act on opportunities for continuous improvement in quality, safety, and reliability. Workforce arrangements were effectively managed to ensure the provision of high-quality care.

Quality and safety

Through observation and staff engagement, it was evident that staff were committed to upholding the dignity, privacy and autonomy of patients. The hospital had processes in place to respond appropriately to complaints and concerns. The physical environment in the units and departments visited supported the delivery of high-quality, safe and reliable care. Systems were established to monitor, evaluate, and continuously improve healthcare services. The hospital had effective arrangements for the proactive identification, evaluation and management of risks to patient safety. Patient-safety incident management systems were in place to ensure incidents were identified, reported, and addressed effectively. Patients who spoke with inspectors conveyed positive experiences of care and expressed appreciation for the professionalism and dedication of both staff and the management team in the hospital.

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

Compliance Classifications
As there were no findings of non or partially compliant standards a compliance plan is not required to be submitted with this report.

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Substantially Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	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.	Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant