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:	Beaumont Lodge Transitional Care Unit operated by Bartra Healthcare
Centre ID:	OSV-0008809
Address of healthcare service:	Kilmore Road Artane D05 X038
Type of Inspection:	Announced
Date of Inspection:	09/04/2025 and 10/04/2025
Inspection ID:	NS_0141

About the healthcare service

Model of hospital and profile

Beaumont Lodge Transitional Care Unit, referred to in this report as 'Beaumont Lodge', is a rehabilitation and transitional care facility for patients who require further care, rehabilitation or reablement following an acute hospital admission. It is a member of the Bartra Group trading as Bartra Opco (Beaumont NH) Ltd. At the time of inspection, the facility had a formal arrangement in place with the Health Service Executive (HSE) whereby all beds were in use for HSE patients.

The facility provided the following care and services:

- rehabilitation/reablement following surgery or illness
- complex dressing management
- IV antibiotics
- palliative care
- stepdown care for people awaiting long term care, home care packages, home adaptations or equipment
- respite care
- convalescent care.

Number of beds	221 inpatient beds

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare Version 2 2024* (National Standards) as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare.

To prepare for this inspection, the inspectors* reviewed information which included 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 facility
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors during the inspection
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during the inspection and information received after the inspection.

About the inspection report

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

*Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare.

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
09/04/2025	08:45 – 17:00	Aedeen Burns	Emma Cooke Sara McAvoy Danielle Bracken
10/04/2025	09:00 – 17:00	Aedeen Burns	Emma Cooke Sara McAvoy Danielle Bracken

Information about this inspection

This announced 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 four clinical areas:

- Hannan
- Coffey
- Crowley
- Dickson

During this inspection, the inspection team spoke with the following staff at the facility:

- Representatives of the facility's senior management team, risk and compliance team, human resources team, and medical team.
- A representative for
    - Infection Prevention and Control Committee
    - Drugs and Therapeutics Committee
    - Deteriorating Patient Improvement Committee
    - Bed Management Department

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.

[†] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.
[‡] Deteriorating patient programmes ensure there is a standardised, high quality systematic approach to the recognition, response and management of the deteriorating patient for example through the use of National Early Warning Score Systems.
[§] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[**] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

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

On the first day of inspection, 202 of the 221 beds were occupied. Inspectors visited all four clinical areas. All rooms were single occupancy with the exception of two two-bedded rooms. All rooms had en-suite toilet and shower facilities.

Over the course of the inspection inspectors spoke with 25 patients across all four clinical areas. Patients described staff as being 'very kind', 'considerate' and 'hardworking'. Staff were observed to be respectful and interacting kindly with patients. Patients' privacy and dignity were supported through the availability of single en-suite rooms for the majority of patients. However, some patients reported delays in response to call bells and noted that staff seemed 'very busy'. Not all patients were aware of their plan of care. Some patients reported that they were unaware that snacks were available after the last meal of the day. These points are further discussed under standard 1.6.

Information on the process for making complaints was displayed in all clinical areas visited. Although some patients who inspectors met with were unaware of the process for making complaints, they described various ways in which they would make a complaint if needed. Information on making a complaint was available in the patient information booklet, which some patients showed to inspectors, and on the service's website.

Capacity and Capability Dimension

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

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

In 2020, Bartra Healthcare entered into an agreement with the HSE for the use of 189 beds for a number of referring hospitals. The purpose of this was to provide interdisciplinary short stay transitional care services for patients requiring additional therapies, reablement or higher dependency care outside of the acute hospital. At the time of inspection, all occupied beds were in use by patients who had been referred through Health Service Executive (HSE) pathways.

The CEO of Beaumont Lodge was supported by a Senior Management Team (SMT) who was responsible for the oversight of operations, leadership and strategy at Beaumont Lodge, and had responsibility for delivery of safe high-quality care at the facility. The CEO was appointed by the board of directors of Bartra Opco (Beaumont NH) Ltd and was responsible for oversight and governance of healthcare services provided at the facility. The SMT met monthly. Terms of reference submitted did not outline to whom the committee reported, however, it was explained to inspectors and evidenced in organisational diagrams submitted, that the committee reported to the board of directors of Bartra Opco (Beaumont NH) Ltd. through the CEO.

The SMT attended monthly performance meetings with the HSE, they also had a performance meeting with one of the referring hospitals to discuss the performance activity. Performance data reviewed at this meeting included, but was not limited to, bed utilisation, unplanned transfers, incidents including medication errors, falls and pressure ulcers.

The Clinical Governance Committee, as per their terms of reference, was responsible for advising the SMT in relation to the clinical leadership and clinical management of Beaumont Lodge. Their function was to assist the SMT in ensuring that clinical management and leadership were aligned to provide patient care that met appropriate quality and safety standards. This included ensuring that clinical policies, procedures and guidelines were introduced and updated as appropriate and regularly reviewed.

The committee reported to the SMT, and membership comprised members of the SMT, the advisory consultant geriatrician with oversight responsibilities for the facility, and medical officers who cared for patients who were on a nurse-led pathway. HSE consultants and non-consultant hospital doctors responsible for patients under their care in Beaumont Lodge, were not members of this committee. There was no pharmacy or health and social care profession representation on the committee. Terms of reference were not dated and had did not assign a chairperson. Inspectors were informed that the consultant geriatrician providing advisory services to Beaumont Lodge chaired this committee. The committee met in line with its terms of reference and evidence reviewed demonstrated that outputs from both the Medication Safety and Quality and Safety Committees, and unscheduled transfers out of the facility were reviewed. However, meeting minutes were not action orientated and there was no evidence of allocated time bound actions.

Beaumont Lodge had a Quality and Safety Committee. This committee was interchangeably referred to as "Quality, Safety and IPC Committee" and "Quality Safety Risk Committee" in documentation submitted to HIQA. Terms of reference were not dated and membership of the committee did not identify staff roles or positions held. Medical representation on this committee was provided by medical officers who at the time of inspection were responsible for the care of patients in the nurse-led beds. Therefore, medical staff representation on the committee was not reflective of all patients cared for in Beaumont Lodge. This committee was meeting monthly as per their terms of reference. Minutes of meetings reviewed outlined that the committee reviewed falls, scheduled and unscheduled patient transfers back to acute services, pressure sores, and complaints. Meetings were action orientated with timelines and persons assigned to actions. This committee also had responsibility for management of the risk register which is discussed under national standard 3.1.

Beaumont Lodge admitted patients from six referring hospitals covering three HSE Integrated Health Areas. Patients were admitted to one of two models of care – nurse-led or consultant-led. Patients on the nurse-led model were under the care of medical officers employed by the facility. Patients on the consultant-led model were admitted under the care of consultants employed by either the referring hospital or the HSE directly.

Inspectors found that existing clinical governance arrangements did not enable the management at the facility to have clear lines of governance for all patients and had the potential to impact on the ability to effectively oversee the delivery of care to all patients. Formalised arrangements for the clinical governance of patients were in place with only one out of six referring hospitals. There were gaps in the clinical governance oversight arrangements in place relative to the size, scope and complexity of the service provided, for example, there was a lack of a single clear, overarching clinical governance structure to manage all patients at Beaumont Lodge.

Clinical oversight was not provided to all medical staff working in the facility. A consultant geriatrician was in place to provide an advisory service for the patients and residents of all Bartra Healthcare's facilities including Beaumont Lodge. However, this person was not contracted to provide clinical oversight to medical officers employed by the service. Inspectors also found that formalised arrangements were not in place to cover this consultant's leave.

These gaps in clinical governance arrangements had the potential to significantly impact on the quality and safety of care provided and was identified as a significant risk. This risk was discussed with senior management on the day and following this inspection, HIQA wrote to the CEO on 11 April 2025 to escalate these concerns and seek assurance on the overarching clinical governance structure to manage all patients at Beaumont Lodge. Additional information was also requested relative to staffing concerns inspectors identified on the day. This will discussed further under national standard 6.1. The service management's response submitted to HIQA provided assurances that management were either addressing or had addressed the issues identified on the days of inspection.

Inspectors were informed that matters relating to the deteriorating patient fell under the remit of the Clinical Governance Committee, however, there was no reference to this function in the committee's terms of reference. Terms of reference for a Deteriorating Patient Committee were in draft, and inspectors were informed this committee had not yet been convened.

The director of nursing (DON) was the lead for infection prevention and control (IPC) in the facility. Inspectors were informed that the Quality and Safety Committee held responsibility for assuring the senior management team in relation to infection prevention and control matters at the facility. Infection prevention and control was a standing item agenda at this committee. Inspectors were also informed that advice and guidance could be sought from the Integrated Healthcare Areas relating to outbreak management. There was no formal IPC representation or links to IPC committees in the hospitals or community. There was no formal IPC clinical oversight for the lead for IPC in the facility.

The Medication Safety Committee acted as an advisory group to the senior management team on specific medication safety issues. Terms of reference did not have an approval date, did not identify a chairperson and did not outline reporting relationships into and out of the committee. Membership indicated that medical representation on the committee was provided by the medical officers responsible for the small number of patients admitted under the nurse-led model. There was no medical representation from doctors providing care to the patients on the consultant-led pathway, who constituted the majority of patients at the facility. Pharmacy representation was provided by an external pharmacy provider which supplied medications to Beaumont Lodge. The committee met monthly in accordance with their terms of reference. Actions from the meetings were allocated to individuals or groups, and evidence was seen of actions being progressed.

Transitions of care were managed by the head of bed management, deputy director of nursing and director of clinical services. Inspectors were informed that a Bed Management Committee was under development but had not met yet. The head of bed management did not sit on any of the governance committees of Beaumont Lodge.

Overall, findings as outlined above evidenced that formalised governance arrangements for assuring the delivery of high quality safe care were not in place relative to the size and complexity of the service. Diverse referral pathways into the facility had resulted in complex clinical governance arrangements which had the potential to significantly impact on the quality and safety of care provided to patients. Action was required to address the following findings:

- there was a lack of clear, coherent, overarching clinical governance structures to manage all patients at Beaumont Lodge
- clinical oversight was not provided to all medical staff working in the facility
- terms of reference for Quality and Safety, Clinical Governance and Medication Safety Committees did not reflect the attending membership, objectives and functions of committees and did not have documented approval or review dates
- membership of the governance committees that were in place were not representative of the various clinical oversight arrangements in place for all patients at the facility
- formalised arrangements were not in place to cover consultant leave
- formalised governance arrangements were not in place for the oversight of the deteriorating patient and infection prevention and control.

Judgment: Not Compliant

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

The service provided at Beaumont Lodge had evolved since first opening resulting in the facility accepting more complex and acute patients. Inspectors found that appropriate management arrangements relative to the size and complexity of the facility had not been effectively implemented to plan and manage this service change and transition.

As previously outlined, patients were admitted under one of two distinct models of care: nurse-led or consultant-led. Clinical and medical arrangements were different for each model.

Medical cover for patients under the Nurse-led model of care consisted of:

- medical officers employed by Bartra, who provided medical cover for patients under the nurse-led model of care from 9am to 5pm seven days per week. Outside of these hours the service used the HSE out-of-hours GP service. Approximately 32 patients came under this arrangement at the time of inspection. These patients were from various hospital and Integrated Health Areas not included in the arrangements described below.

Consultant-led care was provided to the remaining patients and medical cover consisted of:

- two consultants, employed by one of the referring hospitals, who had responsibility for 80 patients referred from that hospital
- one consultant, employed by the HSE to provide 20 hours consultant cover for patients referred from two other referring hospitals, had responsibility for the remaining 109 patients.

Agency non-consultant hospital doctors, through an agency contract arrangement with the HSE, provided 24/7 cover, during and out of hours, for patients under the consultant-led model of care. The consultants reported to clinical directors in referring hospitals but were not represented on any committees within Beaumont Lodge. At the time of the inspection no arrangements were in place to provide cover in the event of absence or leave for the consultant employed directly by the HSE providing care to the patients from two of the referring hospitals.

Inspectors reviewed a sample of the rosters for the non-consultant hospital doctors and found instances where non-consultant hospital doctors' shifts were not filled, particularly in the out-of-hours setting; this will be discussed further under national standard 6.1. These issues were included in the risk letter issued to the facility following this inspection. The assurance report submitted to HIQA provided assurances that management were addressing the issues identified on the days of inspection.

The director of nursing (DON) was responsible for the organisation and management of nursing services at the facility and reported to the director of clinical services. The DON was supported by a deputy director of nursing and assistant directors of nursing (ADON) for each clinical area. Each ward had a Clinical Nurse Manager 2 (CNM2). At night a CNM2 deputised for the DON, a staff nurse, known as the "nurse in charge" who was supernumerary to the nurse patient ratios for the night, sometimes covered this role.

The Medication Safety Committee had responsibility for the effective management of medication safety at the facility. There was no medication strategy or priorities set out by the committee for the service. The facility did not directly employ a pharmacist but had a service level agreement with a community pharmacy for the supply of medications seven days per week. A separate company provided a software programme for the digital prescription and administration of medications. Acknowledging the change in service in recent years, the facility should review the arrangements for the provision of clinical pharmacy services to ensure they meet the needs of all patients.

The director of nursing was the lead for infection prevention and control in the facility. The facility had an approved position for a dedicated infection prevention and control nurse at the time of inspection, however this role was vacant since September 2023. Inspectors were informed that a 0.5 whole time equivalent (WTE) post for this role had recently been advertised. The facility had no formalised access to microbiology advice, or antimicrobial pharmacy advice appropriate to their needs, however inspectors were informed that advice could be accessed from the patient's referring hospital. This will be discussed further under national standard 3.1. The facility did not have an overarching infection prevention and control plan in place. The facility should develop strategic objectives and an associated operational plan for infection prevention and control and antimicrobial stewardship that reflect the needs and priorities of the facility in line with national standards.

The Clinical Governance Committee was responsible for monitoring the management of the care of the deteriorating patient in the facility. While unscheduled transfers of patients back to acute hospitals were discussed at this meeting, there was no evidence that a standardised approach to the recognition, response and management of the deteriorating patient was being monitored by this committee. Management told inspectors that they intended to convene a deteriorating patient committee in the coming weeks and implement Irish National Early Warning System (INEWS). In the interim, the facility would continue to apply their local deteriorating patient policy that was in place. On review of the policy, it did not indicate who was responsible for patients on the consultant-led pathway during out of hours in the absence of non-consultant hospital doctors.

Transitions of care for patients referred into Beaumont Lodge were coordinated by the bed management team. This team coordinated admissions to the service through bed management departments of referring hospitals. The head of bed management met with the director of nursing and director of clinical services daily to assess bed availability and to manage patient flow through the service. Referrals were received from consultants in referring hospitals. The team attended referring hospitals to assess the suitability of some patients for referral but also conducted telephone assessments for patients in more distant hospitals. Inclusion and exclusion criteria for acceptance to Beaumont Lodge had been established and formed part of the admissions policy for the facility, this will be discussed further under national standard 3.1.

Overall inspectors found that current management arrangements did not fully take into account the size, scope and complexity of the facility which had evolved in recent years and had the potential to impact on the quality and safety of care being provided. Areas for action included:

- management arrangements did not ensure that there was 24/7 medical cover arrangements consistently in place for all relevant patients
- an infection prevention and control and antimicrobial stewardship plan reflecting the needs and priorities of the facility was not in place
- the policy for care of the deteriorating patient did not indicate the escalation procedure for patients on the consultant-led pathway during out of hours in the absence of non-consultant hospital doctors.

Judgment: Partially 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.

Beaumont Lodge was monitoring a number of measurements relative to the four key areas of known harm which were the focus of this inspection - infection prevention and control, medication safety, deteriorating patient and transitions of care.

The facility reported monthly data to the HSE and to one of the referring hospitals with whom it had a service level agreement. However, targets and benchmarks relevant to the data collected, were not always defined to facilitate identification of opportunities to improve the quality and safety of the facility.

Beaumont Lodge had formalised risk management structures and processes to manage and minimise risks. There was a process in place for risks to be escalated through local governance structures. The QPS Committee was responsible for the management and oversight of the risk register. Risks identified on the risk register and the management of risks will be discussed further under national standard 3.1.

Rates of infections in the facility were reported at the QPS Committee, but this information was not trended or assessed against any national or other relevant performance standards in a way that could inform the quality, safety and reliability of infection prevention and control practices. Numbers of infections that developed within 72 hours of admission to the facility were also reported.

All medication safety incidents were reported at monthly performance meetings between Bartra Healthcare and the HSE and the referring hospital with which the facility had a service level agreement. Although inspectors were told that incidents were being reported as per HSE policy, medication safety incidents were not reported per bed day used. The classification of errors did not reflect the HSE NIMS (National Incident Management System)[††] reporting framework or other international method of classifying medication errors. Inspectors were informed that plans were in place to introduce an internationally recognised classification system.

Data on transitions of care was reported and reviewed at performance meetings. Data reported included numbers of referrals and assessments and reasons for acceptance or rejection of admission. Other data reported included average length of stay and age profile of patients admitted. This data was tracked and trended. Data was collected to compare planned destination of discharge with actual destination of discharge; however this data was not being evaluated to assess or inform service quality which represents a missed opportunity.

[††] The National Incident Management System is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation.

Numbers and summaries of unscheduled transfers to emergency departments were reported to the HSE and to the referring hospital with which the service had a service level agreement. There was limited analysis of this data to inform improvements in quality, safety and reliability of healthcare services.

Beaumont Lodge had a schedule of audits relating to hand hygiene compliance, environmental cleanliness, infection control and medication storage and administration which was overseen by the director of nursing.

Feedback on complaints and compliments from the people who used the service was shared with staff within the facility, the HSE and with one referring hospital. A patient satisfaction survey was completed in 2024. This will be discussed further under national standard 1.7.

In summary, while data was being collected, further opportunities were identified to ensure that the data collected was being used to inform and drive improvements in the quality, safety and reliability of the service. In the absence of clearly defined targets or benchmarks for the data collected, there is a risk that performance cannot be effectively evaluated and that trends are not identified early, potentially leading to undetected deficits in care quality or service delivery.

Judgment: Partially Compliant

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

Beaumont Lodge had established that a nurse to patient ratio of 1:15 day and night and a healthcare assistant (HCA) ratio of 1:8 during the day, and 1:10 at night was sufficient to provide care to their patient cohort. No evidence was provided to inspectors that this ratio was based on a needs or activity analysis or national or international evidence. Inspectors were informed by senior management that these were minimum ratios and that extra staff could be supplied in times of extra demand. These staffing ratios were established when the facility opened and had not been reviewed since the facility had evolved over time to reflect what was now a sub-acute facility.

Inspectors reviewed staffing activity documentation for the month of March 2025 and found that staffing numbers did not always meet the minimum ratio requirements established by the facility. Documentation showed that the number of patients to each staff member exceeded the ratios established by the facilities for 29 days in March. During this time period, inspectors noted shifts that reported a nurse to patient ratio of up to 1:18 and a healthcare assistant ratio of up to 1:11.

In the end of month audits for January and February preceding the inspection, 75% of patients in the facility were classified as being between medium and maximum dependency. This was defined by the facility as the need for two staff members to assist a patient at any time with activities of daily living. Inspectors found similar dependency levels in place on the day of inspection. The impact of low staff to patient ratios was evidenced in experiences recounted to inspectors by some patients who waited long times for call bells to be answered and reported medication rounds being prolonged. Patients also reported that staffing levels impacted on their experience of communication with staff.

There was an overall resourcing deficit of 14 healthcare assistants when assessed against the number defined by management as necessary to maintain staff to patient ratios. There was an ongoing programme of recruitment to address these vacancies and in the interim, deficits were filled using agency staff. Documentation reviewed outlined that 15% of healthcare assistant shifts were outsourced to agency to be filled for the first three months of 2025. The majority of these agency shifts were filled. At the time of the inspection three patients required 1:1 nursing supervision which was provided by agency HCAs and funded by the HSE.

Non-consultant hospital doctors (NCHD) provided care to patients under the consultant-led model 24/7. Inspectors identified unfilled shifts in the non-consultant hospital doctor roster particularly in the out-of-hours setting. Inspectors were informed that in the absence of these doctors, nurses would contact the out-of-hours general practice service or emergency services. This was not outlined in the policy for the deteriorating patient. The NCHDs were not employed by Beaumont Lodge and were employed by a referring hospital via an agency to cover these shifts. Inspectors were informed that these shifts were often not covered by the same doctors on a recurring basis, so doctors on duty were frequently unfamiliar with the setting. The ADON on duty was responsible for orientating doctors unfamiliar with the site to policies and procedures, including IT systems in use for medication prescription and administration. Inspectors were informed that in the weeks preceding the inspection a consultant at Beaumont Lodge had taken responsibility for the management of this roster and was endeavouring to ensure cover by staff familiar with the setting.

Deputising or cover arrangements were not in place for the consultant with responsibility for patients being referred from two of the referring hospitals when this consultant was unavailable or on leave. This was not a suitable or sustainable arrangement and had the potential to impact on patient safety and formed part of the risk letter that was issued to the hospital following this inspection. In response to this, management at the facility outlined actions that were in progress to ensure consistent medical oversight during periods of consultant leave.

The facility had a service level agreement with an agency for the provision of health and social care professionals and did not directly employ physiotherapists, occupational therapists, speech and language therapists or dietitians. The service level agreement with the agency was for the provision of five whole-time equivalent (WTE) physiotherapists and three WTE occupational therapists. At the time of inspection there were 24 patients waiting for occupational therapy, these referrals were triaged by an occupational therapist and patients were prioritised according to need and impact on discharge. Inspectors were informed that remote dietetic support was available through a company which manufactures and supplies nutritional products.

Training records for staff directly employed by Beaumont Lodge relating to the four areas of harm demonstrated good levels of compliance. Records reviewed showed that compliance with staff attendance at infection prevention and control training ranged from 92- 100% for all relevant staff. 81% of nurses and 100% of doctors were up to date with basic life support training. Medication safety training had been completed by 96% of nurses and 100% doctors. 92% of nurses had completed training on clinical handover, however clinical handover training was

not mandatory for doctors. Records provided showed that all staff were trained on INEWS in preparation for the introduction of early warning scores at the facility.

Overall, inspectors were not assured that the service provider adequately planned, organised, or managed their workforce to meet the objectives of delivering high-quality, safe, and reliable healthcare. Inspectors found that current staffing arrangements and levels did not consistently take account of the size, complexity and specialities being provided at the facility. Workforce arrangements had not been appropriately reviewed and evaluated since the service was first established and did not reflect the expansion in the range and scope of services being provided and the acuity of patients being accepted. These concerns were raised with management on the day and formed part of the high-risk letter issued to the facility following inspection and required continued engagement with the provider since the inspection. The service management's response and ongoing engagement with HIQA provided assurances that management were addressing the issues identified on the days of inspection. Areas for action included:

- the service had not reviewed workforce arrangements since it had evolved from its original intended purpose, to ensure that workforce arrangements could meet the size, complexity and specialities of the service provided
- nursing and healthcare staffing ratios were not sufficient to consistently meet the needs of patients at all times
- there were unfilled non-consultant hospital doctor shifts particularly in the out-of-hours setting.

Judgment: Not 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.

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

Staff who spoke with inspectors were aware of the need to promote and respect the dignity, privacy and autonomy of service users. On the day of inspection interactions between patients and staff were observed to be performed in a manner that promoted privacy and dignity.

Inspectors spoke with patients and relatives on the day of inspection. Inspectors were informed that the physical environment was not always managed in a way that reflected patient centred care and supported and promoted autonomy for patients with specific needs. For example, the layout and arrangement of furniture in patient bedrooms to ensure that call bells were always accessible. Some patients who inspectors spoke with reported delays in responding to call bells which impacted patients' autonomy and dignity in the performance of activities of daily living. These instances were brought to the attention of management on the day of inspection. Patients also spoke about the impact that staffing deficits was having on their autonomy. This will be discussed further under national standard 6.1.

The layout and design of the service which primarily comprised single rooms, supported patients' privacy and dignity. In the two-bedded rooms inspectors observed that screens were used to provide privacy. Respect for individuals' dignity and privacy was maintained during the provision of personal care. Inspectors observed patients out of their beds, appropriately dressed and some patients were engaging with activities in the dining room.

Patients' healthcare records and patients' personal information was observed to be stored appropriately, in line with relevant legislation and standards.

In summary, staff endeavoured to promote the privacy and dignity of patients. However, deficits in patient centred care and delays in responding to call bells impacted patients' autonomy and dignity in the performance of activities of daily living.

Judgment: Partially Compliant

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

There was evidence that the service provider promoted a culture of kindness, consideration and respect.

Intentional rounding[‡‡] by nurses and healthcare assistants had been introduced in some clinical areas to encourage the staff to monitor the patient under four key themes: pain, position, personal needs and possessions. The aim of this intervention was to ensure that all patients were in a comfortable safe position and that their needs attended to.

During the inspection, inspectors observed considerate and respectful interactions between staff and patients in the clinical areas visited. This was confirmed by the patients who spoke with the inspectors.

Feedback was sought from people using the service. A patient satisfaction survey conducted in 2024 demonstrated good levels of patient satisfaction at that time in the patients surveyed. Systems and processes were in place to support patients receiving care at the end of life.

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 facility had effective processes in place for the response and management of complaints.

The director of clinical services had been delegated responsibility as the designated complaints officer.

The facility's complaints policy was aligned to the HSE policy for management of complaints and the facility reported that all complaints were being resolved within the timeframe of 30 days allocated in HSE policy.

[‡‡] Intentional rounding is a timed, planned intervention that sets out to address fundamental elements of nursing care, typically by means of a regular bedside ward round.

Information on how to make a complaint was available in patient handbooks which patients received on admission and on the facility's website. Inspectors also observed that this information was displayed in the clinical areas inspected. Information on advocacy services was also displayed in the clinical areas inspected.

Complaints were discussed at Senior Management Team Meetings and at performance meetings with the HSE and the referring hospital with which the facility had a service level agreement.

There was evidence that quality improvement initiatives were implemented in response to complaints. For example, 'intentional rounding' and protected meal times was recently been implemented in response to patients' complaints regarding wait times for care and dissatisfaction with meals.

Overall, the facility had a complaints procedure in place that reflected national guidelines. The complaints procedure was clear, transparent, open and accessible to people using the service.

Judgment: Compliant

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

On the day of inspection inspectors visited four clinical areas. Coffey ward accommodated 32 beds, Hannan ward accommodated 61 beds, Dickson and Crowley wards accommodated 64 beds each. All these beds were in single en-suite rooms with the exception of two twin rooms in Crowley. All wards were found to be clean and well maintained on the day of inspection.

Opportunities for improvement were found in a number of areas in relation to infection prevention and control. Inspectors noted that not all sinks, which were designated as clinical hand-hygiene sinks, conformed to national requirements[§§]. Two compliant hand-hygiene sinks were available in the larger wards and one in the smaller ward. This required staff having to walk considerable distances to access an appropriate hand hygiene sink. Wall-mounted alcohol-based hand-sanitiser dispensers were strategically located throughout the clinical areas, however, inspectors noted that some of these did not function on the day of inspection. This was brought to the attention of staff to be addressed at the time. Sinks in the clinical medication preparation areas were not

[§§] Clinical hand wash basins should conform to HBN 00-10 part C Sanitary Assemblies or equivalent standards. National Clinical Effectiveness Committee. Infection Prevention and Control (IPC) National Clinical Guideline No. 30. May 2023. Available on line from: gov - Infection Prevention and Control (IPC) (www.gov.ie)

compliant with national requirements. Management should review the availability of hand-hygiene facilities to ensure they are appropriate to the setting and are provided in line with best practice and national guidelines.

Single rooms were sometimes used for isolation purposes but did not have anterooms or separate handwashing facilities. Inspectors observed that signage notifying staff as to the correct infection control precautions to be taken in single rooms, although present on some wards, was not consistently used. Personal protective equipment was available as required on the clinical areas visited.

Waste and used linen was correctly stored and segregated on the wards. However, inspectors found that supplies and equipment were not always stored appropriately. For example, large amounts of clean linen were inappropriately stored in a room where used mop heads were stored and laundered. Intravenous drip stands and mobility aids were stored in a bathroom. These issues were brought to the attention of management to be addressed on the day and were being addressed at the time of inspection.

Inspectors were informed that cleaning of equipment was the responsibility of the staff who used it. Inspectors observed the presence of a labelling system in place to indicate clean and ready-to-use equipment, however, use of these labels was not consistent across the areas inspected.

Environmental cleaning was carried out by the designated cleaning staff assigned to the wards. The clinical nurse manager and cleaning supervisor oversaw the cleaning activities on the wards. Cleaning staff were available onsite from 8am to 6pm. Environmental hygiene audits for inspected clinical areas were provided to inspectors, with overall compliance rates ranging from 92 -100%. Actions were implemented in response to areas that fell below acceptable targets.

Clean utility rooms were locked and medications, including controlled medications, were stored appropriately. Daily temperature checks for medication fridges were performed by nurses, however, while the room was locked not all fridges were locked on the day of inspection.

Overall, while the service appeared clean and well maintained. Opportunities for improvement were identified based on the following findings:

- isolation rooms with dedicated handwashing facilities for patients with multi drug resistant organisms were not available
- not all sinks designated as handwashing sinks were compliant with national requirements
- signage to inform staff on the correct infection prevention and control precautions was not consistently used

- the system of labelling to indicate that equipment was clean and ready for use was not consistently used
- patient equipment was inappropriately stored in patient bathrooms
- clean linen was being inappropriately stored with soiled mop heads.

Judgment: Partially Compliant

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

The management team were proactively and systematically monitoring information relative to the four key areas of known harm which were the focus of the inspection (infection prevention and control, medication safety, transitions of care and the deteriorating patient (including sepsis)). Opportunities for improvement were required in relation to evaluating the information the facility was gathering to identify areas for improvement and provide assurances on the quality and safety of the service provided.

The quality and safety of care relating to infection prevention and control was assessed using relevant indicators and benchmarks as follows:

- local hand hygiene audits
- performance of environmental and equipment audits
- infection prevention and control training compliance
- reporting of infections occurring in the facility to the referring hospitals and the HSE

Monthly audits of hand hygiene compliance, environmental hygiene and laundry, and quarterly infection control audits were conducted using a standardised approach. Environmental hygiene audit results were completed by household staff and scores of 92-93% were noted. Monthly observational hand hygiene audits were performed by CNMs in clinical areas. Compliance results seen by inspectors for the months preceding the inspection were between 97-98%. CNMs reported that non-compliance was addressed on the day and that results were discussed at daily staff huddles. Compliance with hand hygiene training for staff directly employed by Bartra was 92% for nurses, 93% for healthcare assistants, 100% for doctors and 90% for health and social care professionals. Inspectors were informed that the respective agencies and hospitals had oversight of training for agency staff or staff not employed by Bartra.

Testing for transmissible and multi-resistant organisms was in line with current national guidance and assessed as part of the acceptance for referral to the facility. Infection control audits performed by the director of nursing demonstrated compliance scores of 92-100%. Time-bound action plans, with identified responsible persons, were

developed in response to findings that fell below acceptable targets. Oversight of these action plans was the responsibility of the director of nursing. While the facility was reporting all infections occurring in the facility to the referring hospitals and the HSE there was no KPI associated with this data.

Medication safety at the facility was monitored through medication safety audits and the reporting of medication safety incidents. Medication safety audit results for the first quarter of 2025 showed compliance levels of 98-100% with the parameters measured. Medication safety incidents were recorded but there was no KPI associated with this data, rates were not reported and the classification of errors was not in line with the HSE incident policy which had been adopted by Beaumont Lodge.

The facility developed a policy for the management of the deteriorating patient that was effective from March 2025. The facility was not yet using the Irish National Early Warning System (INEWS) observation chart, although inspectors were informed that an adapted version was in draft. No audits of the monitoring of vital signs or escalation of care in the event of patient deterioration were provided. Transfers back to the acute setting, were reported, however, further opportunities for improvement were noted in relation to tracking and trending of this data to identify opportunities to improve the quality and safety of care provided.

The bed management department had developed a standardised tool based on ISBAR3*** to support the safe transitions of care to Beaumont Lodge. The tool also ensured that patient selection was aligned with the facility's admission policy. Compliance with the tool was audited in March 2025 and showed an overall compliance level of 95%. ISBAR was also used to enhance safety during transitions of care at nursing handover, however, compliance with this tool was not audited.

Inspectors noted that some of the audit tools in use at the facility were designed for use in a residential setting. Management should review existing audit tools to ensure they reflect the current scope of service and are representative of the profile of patients admitted to the facility.

In summary, while there was evidence that information relative to the quality and safety of the service was collected and monitored, opportunities for improvement were noted in relation to evaluating the information gathered to identify areas for improvement. The following areas for action were identified:

*** The ISBAR (Introduction, Situation, Background, Assessment, Recommendation) framework, endorsed by the World Health Organisation, provides a standardised approach to communication which can be used in any situation it forms part of National Clinical Guideline No.1 INEWS and Communication (Clinical Handover) in Acute and Children's Hospital Services National Clinical Guideline No. 11

- systems in place for the monitoring of the deteriorating patient (including sepsis) were not audited
- medication safety incidents were not being reported in line with specified policies
- compliance with the use of ISBAR for clinical handovers was not audited
- examples of audit tools reviewed did not reflect the service provided and were not representative of the profile of patients admitted to the facility.
- KPIs were not developed relevant to all data collected. Without defined targets or benchmarks, there is a risk that performance is not effectively monitored and early trends are missed, potentially leading to undetected issues in care quality or service delivery.

Judgment: Partially Compliant

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

The facility had structures and systems in place for the identification and management of risks which was supported by a risk management policy. As discussed under national standard 5.8, a risk register was in place and reviewed regularly at the Quality and Safety Committee. However, inspectors found that the risks identified on the risk register did not have a detailed enough description to reflect specific risks identified on the day of inspection and in some cases the control measures in place were not sufficient to mitigate the risk.

On the first day of inspection inspectors found that the placement of emergency response equipment did not enable staff to effectively and immediately respond to an emergency situation. Emergency equipment was not centrally located and was stored in various locations across the clinical area with some supplies locked in rooms. This was identified as an immediate risk and escalated to senior management on the day of inspection to be addressed immediately. Inspectors received assurances and observed that this had been addressed by the end of the first day of inspection and communication had been issued to staff to inform them of this change.

Inspectors reviewed the risk registers related to the four key areas of harm, which were the focus of this inspection. The risk of a patient deterioration was entered on the risk register, however the risk description did not reflect the actual risk identified. A number of existing controls to minimise this risk were documented. However, it was unclear when these controls were reviewed, and what actions had been taken to ensure that they were effective. Beaumont Lodge had a policy in place for the management of the deteriorating patient, however, systems for escalation of care in the event of a deteriorating patient varied depending on the model of clinical oversight under which the patient was

admitted. At the time of inspection an early warning score system was not in use. Inspectors were informed that the service intended to introduce this in the near future and that all staff were trained on Irish National Early Warning System (INEWS). However, the admission pathways of nurse-led and consultant-led model meant that two systems for the escalation of care for a deteriorating patient will be in use which has the potential to impact on the quality and safety of care delivered.

Risks relating to IPC which were on the risk register included the risk of transmission of infections. Control measures for these risks, as described on the risk register, were seen to be in place during the inspection, supported by policy, and audits. Patients were screened for multi drug resistant organisms prior to admission from the referring hospital. Information on their infection status was also obtained from the referring hospital. Patients were tested for influenza and COVID-19 if they developed symptoms during their admission.

Beaumont Lodge reported two infection outbreaks in 2024, both of which were of COVID-19. Reports seen by inspectors demonstrated that outbreaks had been managed with the involvement of public health, outbreak reports were completed following outbreaks and learning from the outbreak was identified. The facility did not have formalised access to clinical microbiology advice as appropriate to their needs. Inspectors were informed that microbiologists in the referring hospital provided advice when needed, but this arrangement was not formal.

The risk of medication errors had been identified and was on the risk register. The absence of a clinical pharmacy service or access to antimicrobial advice was not on the risk register. The facility did not directly employ a pharmacist but had a service level agreement with a community pharmacy for the supply of medications seven days per week. In the absence of a clinical pharmacy service, a locally agreed policy of medicine reconciliation by the supplying pharmacist, medical officers and two registered nurses prior to administration of medications had been implemented. Staff were aware of some sound-alike look-alike drugs (SALAD) and high-risk medications however SALAD and high-risk medication lists displayed in medication preparation areas were generic and had not been adapted to address medications frequently used on the wards. There were no forcing functions[†††] to limit prescribing or ordering of medications inappropriate to the setting. Beaumont Lodge used digital medication administration software. Members of the Medication Safety Committee who spoke with inspectors on the day of inspection were not aware of any forcing functions designed in the electronic medication administration system to protect patients from the risk of medication error. Staff had received training on medication safety, and administration of medications was guided by policy. The ADON or CNM on duty had responsibility for providing training to agency doctors and nurses on the use of the electronic administration record.

There was no antimicrobial stewardship (AMS) programme in place for the facility. Inspectors were informed that AMS advice could be accessed from referring hospitals but this arrangement was not formalised. Inspectors were informed that the facility followed HSE antimicrobial resistance and infection control (AMRIC) guidelines, and that doctors could use the resources in the referring hospitals for guidance. Practices seen on the day were not in line with AMRIC guidelines, for example medication stock lists observed by inspectors included restricted antibiotics.

In the clinical areas visited, medications were noted to be stored securely with the exception of medication fridges which were not all locked. Medication fridges were used solely for the storage of medications and the temperature was monitored appropriately. Staff had access to approved, current medicines information at the point of preparation and administration. Local policies had been developed to support medication management.

[†††] Forcing functions in medication safety are design features that make it impossible to commit certain errors, or ensure that essential steps are completed before allowing a medication to be administered.

There was a policy in place to support safe transitions of care on admission to Beaumont Lodge with set inclusion and exclusion criteria. Acceptance criteria included patients with early warning scores (INEWS) greater than two on discharge from the acute hospital and those with unstable blood result parameters on discussion with medical staff. However, as discussed in national standard 5.5, admission criteria, and exceptions to same, did not take into account having appropriate medical oversight arrangements in place at the facility. Special arrangements for ongoing monitoring of patients with an already high early warning score were not described. A standardised transfer assessment was developed to capture essential information on transfer and the use of the document was audited. Beaumont Lodge had repatriation agreements with some referring hospitals for patients who were not critically unwell (planned transfers). Patients requiring emergency care (unplanned transfers) were transferred to the Beaumont Hospital emergency department. In 2024, there were 136 planned and 279 unplanned transfers back to acute hospitals. The facility completed a limited analysis of these transfers, there was no evidence of root cause analysis or improvement plans to inform change or reduce the risk of harm associated with this element of service delivery.

Nurses used the ISBAR communication tool to structure nursing handover and conducted daily safety huddles. Inspectors were informed that medical handover was verbal and did not follow a set structure or criteria.

In summary, while the facility had systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services, risks identified on the risk register did not reflect specific risks identified on the day of inspection and in some cases the control measures in place did not mitigate the risk. Areas for action relate to the following findings:

- formalised access to microbiology advice and antimicrobial stewardship advice appropriate to the facility was not in place
- practices were seen on the day which were not in line with antimicrobial resistance and infection control guidelines
- there was no formulary for the facility, or any list of medications which should not be administered or had restrictions on their access
- systems for medication ordering and administration did not include forcing functions to protect patients from the risk of medication error
- admission criteria, and exceptions to same, did not take into account having appropriate medical oversight arrangements in place at the facility
- medical handovers did not follow best practice for clinical handover.

Judgment: Partially Compliant

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

There was a system in place in the facility to identify, manage, respond to and report patient-safety incidents. Inspectors were informed that Beaumont Lodge followed HSE policy related to patient-safety incidents, however, quality improvement plans arising from patient-safety incidents were not consistently developed and actions in response to incidents were not always implemented. Inspectors also found that serious reportable events (SREs) were not consistently managed in line with the HSE Incident Management Framework.

The director of clinical services was the senior accountable officer for management of patient-safety incidents. The facility did not have a serious incident management team that met on a regular basis, however local policy dictated that the senior management team were responsible for the initiation and management of reviews into serious patient-safety incidents.

There was oversight of patient-safety incidents relative to the four key areas that were the focus of this inspection at the relevant governance committees. Incidents were reported at senior management team meetings and performance meetings with the HSE and referring hospitals. The service reported incidents on falls, medication errors, infections, complaints, general incidents and pressure ulcers.

Staff who spoke with inspectors were knowledgeable about how to report a patient-safety incident and were aware of the most common patient-safety incidents reported. Patient-safety incidents were reported electronically and staff received training in electronic incident reporting which enabled real time reporting of incidents.

Staff reported that learning from incidents was shared at daily ward huddles in clinical areas, however, the development and implementation of quality improvement plans in response to incidents was not always evident. For example, inspectors were informed that ease of access to emergency equipment in the event of a deteriorating patient, which was identified as an immediate risk on this inspection, had previously been identified as an action in response to an incident but this had not been addressed at the time of this inspection.

A total of 56 medication incidents were reported in 2024. While medication errors were discussed at governance meetings, inspectors were informed that pharmacy were not involved in the management of medication incidents that did not originate in pharmacy. Inspectors reviewed an example of a medication incident that occurred involving a high-risk medication and found that there was no evidence of root cause analysis or shared learning through the organisation regarding the management of this event.

Inspectors found examples whereby serious reportable events (SREs) were not consistently managed in line with the HSE Incident Management Framework. For example, incidents associated with falls resulting in serious injury and pressure ulcers above stage three.

In summary, while systems were in place to identify, manage, respond to and report on patient-safety incidents, areas for action were identified as follows:

- quality improvement plans arising from patient-safety incidents were not consistently developed
- an action arising from an incident involving a deteriorating patient had not been implemented
- pharmacy input into the management of medication errors was limited to those that occurred in the pharmacy only
- serious reportable events were not consistently managed in line with the HSE Incident Management Framework as per policy.

Judgment: Partially Compliant

Conclusion

HIQA carried out an announced inspection of Beaumont Lodge Transitional Unit to assess compliance with national standards from the National Standards for Safer Better Healthcare. This inspection focused on four areas of known harm-infection prevention and control, medication safety, deteriorating patient and transitions of care.

Capacity and Capability

Formalised governance arrangements for assuring the delivery of high quality safe care were not in place relative to the size and complexity of the facility. HIQA identified a number of concerns on inspection relating to the clinical governance arrangements in place. Diverse referral pathways into the facility had resulted in complex clinical governance arrangements. Multiple clinical oversight arrangements did not fully enable clear, accountable and easily understood governance arrangements to support delivery of care. Furthermore, gaps in clinical oversight arrangements as identified on this inspection had the potential to significantly impact on the quality and safety of care provided to patients. HIQA wrote to the CEO of Bartra Healthcare immediately after this inspection to escalate these concerns and seek assurances related to findings identified on the days of inspection. These assurances were provided.

The service provided at Beaumont Lodge had evolved since first opening in 2020 resulting in the facility accepting more complex and acute patients. Inspectors found that appropriate management arrangements relative to the size and complexity of the facility had not been effectively implemented to plan and manage this service change and transition.

Beaumont Lodge had formalised risk management structures and processes in place and were monitoring a number of measurements related to the quality and safety of healthcare services related to the four key areas of known harm which were the focus of the inspection (infection prevention and control, medication safety, transitions of care and the deteriorating patient (including sepsis). Notwithstanding this, targets and benchmarks relevant to the data collected were not defined to facilitate identification of opportunities to continually improve the quality, safety and reliability of the service.

Quality and Safety

Inspectors observed staff being kind and caring towards people using the service and staff endeavoured to promote the privacy and dignity of patients. However, deficits in patient centred care and delays in responding to call bells impacted patients' autonomy and dignity in the performance of activities of daily living. The clinical areas inspected were clean and well maintained however the storage of patient equipment in bathrooms and clean linen with cleaning mops required review.

The management team were proactively and systematically monitoring information relative to the service. Opportunities for improvement were noted in relation to evaluating the information gathered to identify areas for improvement and provide assurances on the quality and safety of care.

Management had systems in place for the identification, management, and response to patient-safety incidents. However, the review of patient safety incidents was not always aligned to policy and actions arising from incidents had not been effectively implemented.

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	Not Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Partially 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.	Partially 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	Not 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.	Partially 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.	Partially Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Partially Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Partially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Partially Compliant

Compliance plan provider's response:

Standard	Judgment
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Not Compliant

Outline how you are going to improve compliance with this national standard

1. Strengthening Governance Structures & Reporting Lines

Senior Management Team (SMT):
The Terms of Reference (ToR) for the SMT have been updated to explicitly outline that the SMT reports to the Board of Directors of Bartra Opco (Beaumont NH) Ltd.
This ensures clear organisational accountability and oversight.

2. Clinical Governance Committee Enhancement

HSE Consultant Involvement:
HSE-appointed consultants from the two hospitals now participate in the monthly Clinical Governance Committee, ensuring representation of consultant-led patient care pathways.

Expanded Multidisciplinary Membership:
The Clinical Governance Committee now includes representation from Health and Social Care Professionals (HSCPs) to reflect a full interdisciplinary approach to governance.

Updated Terms of Reference:

The ToR is now updated, with a clearly designated Chairperson. They have been updated to include the membership of both the Consultants from the two hospitals and representation from the Health and Social Care Professionals. They now also include a review of the functions, outputs and trends from the monthly Deteriorating Patient Committee.

3. Quality, Safety & Risk – IPC Committee Standardisation

The committee's name has been standardised as "Quality, Safety, Risk & IPC Committee" across all documentation.

The ToR is now dated, with membership clearly identifying staff roles and designations.

Additional medical representation, reflecting consultant-led patients, will be incorporated once consistent NCHD cover from acute hospitals is secured. Beaumont Lodge is also in the process of recruiting 3 Star MD candidates at registrar level, ensuring consistency and full clinical representation on this committee.

4. Formalising Clinical Governance Agreements

Memorandum of Understanding (MOU):
As mentioned in our assurance letter to HIQA dated 19 June 2025 an MOU with the second hospital has been secured, establishing clear clinical governance arrangements for admissions from this hospital.

Admissions ongoing review (other two hospitals):
There is ongoing engagement with other two hospitals to formalise governance structures, including clear lines of accountability. Admissions have been paused from these hospitals until formal agreements are in place.

5. Clinical Oversight for Medical Officers (Nurse-Led Beds)

Clinical Oversight Agreement:
Formal oversight arrangements for the medical officer covering nurse-led patients have been established through an addendum agreed with the consultant geriatrician, ensuring defined clinical supervision.

6. Deteriorating Patient Governance Structure

Separate Deteriorating Patient Committees have been established for both our consultant led beds and our Nurse led beds with ToR's agreed for both
These committees feed directly into the overarching Clinical Governance Committee, ensuring structured oversight and escalation of deteriorating patient issues.

Planned and unplanned patient transfers will be analysed and trended monthly at the deteriorating patient committees and Clinical Governance committee.

INEWs audit will be reviewed monthly at the deteriorating patient committees, Clinical Governance Committee and Quality, Safety, Risk- IPC committee meetings.

The committees will analyse any gaps in care escalation and review the escalation local protocols. They will also analyse trends on misses, near misses, adverse events, and incident reports and their correlation to deteriorating patient.

7. Consultant Leave Cover Arrangements

Formalised Consultant Leave Cover:
Agreements are now in place with the HSE General Manager Older Persons service to

ensure continuous clinical oversight during consultant leave, mitigating gaps in governance and ensuring patient safety.

In any circumstance where there is unprecedented NCHD absence, arrangements are in place to ensure that clinical cross cover is extended to all patients under the consultant led beds.

Timescale:

Actions	Timescale
Action 1	Completed April 2025
Action 2	December 31, 2025
Action 3	October 31,2025
Action 4	December 31, 2025
Action 5	Completed April 2025
Action 6	November 30, 2025
Action 7	Completed April 2025.

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

Outline how you are going to improve compliance with this national standard

1. Deteriorating Patient Escalation Procedures

The Deteriorating Patient Policy has been updated to explicitly outline the escalation procedure for consultant-led pathways during out-of-hours periods.

In the absence of Non-Consultant Hospital Doctors (NCHDs), nursing staff escalate deteriorating patient cases to DDOC (Doctor on Duty) services, ensuring continuous medical support.

Post-inspection, HSE-appointed consultants now participate in the Deteriorating Patient Committee for patients referred from their respective hospitals, ensuring direct clinical oversight and timely review of escalation pathways.

2. Strengthened Consultant Presence & Risk Mitigation

The contracted hours for the HSE-appointed community consultant have increased from 20 to 27 hours per week, enhancing clinical oversight capacity and ensuring availability for governance functions.

A structured daily escalation process has been introduced for NCHD absences, whereby:

Absence is escalated to HSE consultants daily and HSE Head of Older Persons service monthly

Consultants conduct a risk assessment of patient admissions.

Admissions are paused if deemed unsafe, prioritising patient safety and clinical capacity considerations.

3. Infection Prevention and Control (IPC) & Antimicrobial Stewardship

Active recruitment is underway for:

A dedicated Nurse IPC Lead.

A facility based clinical Pharmacist.

These roles will be tasked with developing and implementing a Strategic Operational Plan for IPC, Antimicrobial Stewardship, MERC tailored to Beaumont Lodge's service profile, ensuring alignment with HSE National Standards.

4. Implementation of INEWS

The Irish National Early Warning Score (INEWS) system has been successfully rolled out for consultant-led beds, facilitating early detection and management of clinical deterioration.

For patients on nurse-led beds, regular clinical observations are conducted as per clinical indications. The medical officer-led pathway continues to provide medical oversight for these patients.

The Nurse Practice Development Coordinator is in the process of developing locally adapted INEWS policy for Nurse Led Beds, to ensure patient safety by standardising the approach of escalation pathways. In addition, the development of this action strengthens governance and adherence to the National Standards for Safer Better Healthcare.

Timescale:

Actions	Timescale
Action 1	**September 30, 2025**
Action 2	**Completed April 2025**
Action 3	**February 28, 2026**
Action 4	**September 30,2025**

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.	Partially Compliant

1. Formalised Shared Clinical Governance with Acute Hospitals

The facility now operates under formalised shared clinical governance arrangements with two main referring hospitals.

These agreements outline joint oversight responsibilities, ensuring clear lines of accountability for the quality and safety of care provided to patients admitted from these hospitals.

Beaumont Lodge reports monthly Key Performance Indicator (KPI) data to both hospitals, providing continuous visibility over clinical outcomes and operational performance.

2. KPI Data Analysis & Trending

Post-inspection, Beaumont Lodge is working with our Electronic Patient Record (EPR) provider in restructuring the capturing and reporting of the KPI data adapted from RCSI hospital Group KPI Target (2025). Beaumont Lodge is also reaching out and actively engaging with similar facilities to gain insight on their benchmarking matrix and data collection of their KPI's. In the interim, we will measure KPI's as follows:

Falls – per 10,000 bed days; with a target of no patient falls associated with mortality or morbidity while being care for in Beaumont Lodge. Beaumont Lodge will set up a monthly falls committee which will conduct a detailed analysis of falls in Beaumont Lodge and ensure appropriate QIPs are in place.

Pressure Ulcers grade 2 and above- to be captured per 10,000 bed days with a target of no grade 3 and above developed during patient stay in Beaumont Lodge.

Medication error – per 1000 bed days. Target of 3.0 medication incidents per 1000 days as per the HSE National Service Plan 2022.

The NCC MERP Index classification will be reviewed by the clinical pharmacist once this post is filled, to support the medication incident categorisation.

Scheduled and unscheduled patient transfers. – Readmission rates of patients within 30 days of discharge from the acute hospitals will be captured for all beds. The targets will be set for surgical readmission rate to the same hospital within 30 days as ≤ 2% (NSP 2024) and medical readmission rate to the same hospital within 30 days as ≤ 11.1% (NSP 2024)

Complaint trends. - Beaumont Lodge adheres to the HSE *Your Service Your Say* policy, all complaints are acknowledged within 5 working days, and investigated promptly, and responded to within 30 working days. The current target against this performance indicator is 75% in line with *HSE Your Service Your Say.* Beaumont Lodge is 100% compliant with the Target and all complaints have been responded within 30 working days.

KPI reports are reviewed in monthly governance meetings with the SMT and the referring hospitals, ensuring data-driven discussions around performance improvement and risk mitigation.

Identified trends are used to inform quality improvement initiatives and targeted interventions.

3. Deteriorating Patient Committee – Data Tracking and Governance

The Deteriorating Patient Committees (separate for consultant-led and nurse-led pathways) now:

Review and analyse all scheduled and unscheduled transfers back to acute hospitals.

Track, trend, and evaluate escalation events and patient outcomes, ensuring lessons learned are integrated into clinical practice.

Escalation pathways are continually reviewed based on committee findings, ensuring the governance structure remains responsive and adaptive.

Outputs from these committees feed directly into the Clinical Governance Committee, ensuring a closed governance loop from incident to system-level learning.

Timescale:

Action 1	**December 31, 2025**
Action 2	**March, 2026**
Action 3	**December 31, 2025**

Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Not Compliant

Outline how you are going to improve compliance with this national standard.

1. Improved Nurse-to-Patient Staffing Ratio

Following a comprehensive workforce review, the nurse-to-patient ratio has been reduced from 1:15 to 1:13, as documented in the assurance report submitted to HIQA post-inspection.

This change ensures safer staffing levels, particularly considering the complexity of care needs within the facility.

2. Ongoing Workforce Review Aligned to Patient Acuity

A continuous workforce monitoring process has been established to ensure that staffing numbers are:

Regularly reviewed.

Adjusted based on patient acuity levels and clinical dependency.

Staffing ratios are now reviewed in conjunction with:

KPI data on incidents and adverse events.

Bed occupancy patterns and patient turnover.

Feedback from governance committees.

3. Administrative Resource Secured for NCHD Booking

Beaumont Lodge has appointed a dedicated administrative resource to manage and coordinate the booking of Non-Consultant Hospital Doctors (NCHDs) via agency services.

This has significantly improved the consistency and reliability of medical cover, reducing variability in shift fulfilment.

Daily monitoring of NCHD rosters ensures that any anticipated gaps are escalated early to the HSE consultants for risk assessment and operational decision-making.

Timescale:

Action 1	June 30, 2025
Action 2	December 31,2025
Action 3	April 30,2025

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

Outline how you are going to improve compliance with this national standard

1. Increased Frequency of Call Bell Response Audits

The call bell response time manual audit frequency has been increased from monthly to weekly.

This change ensures closer monitoring of staff responsiveness and enables real-time identification of delays or patterns of non-compliance.

Weekly audits are reviewed by the Quality, Safety, Risk & IPC Committee, with findings used to implement targeted improvement actions where required.

Beaumont Lodge has requested the SLS provider to incorporate the Beaumont Lodge Call Bell Threshold ≤5 minutes into their system.

2. Ongoing Staff Education & Awareness Campaign

A programme of regular staff education and awareness sessions has been established focusing on:

The importance of timely response to call bells.

Reinforcing that patient access to call bells must never be restricted.

Highlighting the link between call bell responsiveness and patient safety, dignity, and satisfaction.

These sessions are incorporated into routine staff meetings, induction for new staff, and ad-hoc refresher training following audit findings.

3. Continuous Monitoring and Governance Oversight

The results of weekly call bell audits, along with actions and improvement measures, are reviewed by:

The Director of Nursing (DON).

The Quality, Safety, Risk & IPC Committee.

Any repeated non-compliance will trigger focused supervision interventions and individual staff performance reviews.

Timescale:

Action 1	**September 30, 2025**
Action 2	**September 30, 2025**
Action 3	**September 30, 2025**

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.	Partially Compliant

Outline how you are going to improve compliance with this national standard

1. Close Monitoring of IPC Signage and Equipment Labelling Compliance

A structured process is now in place for close monitoring of staff compliance in:

Utilising appropriate IPC signage (e.g., isolation signage, hand hygiene prompts).

Ensuring all medical and care equipment is correctly labelled in line with IPC protocols.

Compliance is monitored through:

Weekly environmental walkabouts by IPC lead (DON), HOD's

Findings are escalated to the Quality, Safety, Risk & IPC Committee for oversight and corrective action.

2. Staff Education on Equipment Storage Practices

All clinical and support staff have been educated on correct storage protocols for patient equipment.

Dedicated equipment storage areas have been clearly identified on each floor, and staff have been instructed that equipment must be stored appropriately when not in use.

Random spot checks are being conducted to monitor adherence, with non-compliance addressed through supervision and re-education.

3. Environmental Hygiene Oversight by Housekeeping Manager

The Housekeeping Manager has been assigned responsibility for:

Ensuring all linen is appropriately stored, segregated, and handled in line with national IPC standards.

Conducting routine checks to ensure linen trolleys and storage areas remain compliant.

Linen storage compliance forms part of the environmental audit programme, with outcomes reported Quality, Safety, Risk & IPC committee for governance oversight.

Clinical Handwash Basins – There were no clinical handwash basins installed on the corridors of Beaumont Lodge when it opened in 2020. However, this risk was noted in early 2023 and following a review, eleven clinical handwash basins were installed on the corridors and surrounding areas in places that were accessible to suitable drainage outlets. The Director of Nursing and Head of Maintenance will undertake a further review of the provision of installing additional clinical handwash basins.

Timescale:

Action 1	**April 30, 2025**
Action 2	**October 31, 2025**

Action 3	**December 31, 2025,**

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

Outline how you are going to improve compliance with this national standard

1. Strengthened Infection Surveillance and Data Analysis

A robust infection surveillance system is now in place, whereby:

All infections are captured and categorised into specific groups (e.g., UTIs, RTIs, bloodstream infections).

This infection KPI data forms part of the monthly governance reports.

1 A - Trends and patterns are reviewed by the Deteriorating Patient Committee, Clinical Governance Committee, Quality, Safety, Risk & IPC Committee, with targeted action plans developed based on findings.

Infection data is also shared with referring hospitals during governance meetings, enabling collaborative review and improvement.

2. Appointment of Nurse Practice Development (NPD) ADON for Continuous Clinical Improvement

The NPD ADON post has been filled post-inspection, providing leadership for nursing education and clinical audit and has rolled out INEWS (Irish National Early Warning Score) training and escalation pathway education.

Regular INEWS documentation audits to monitor compliance with clinical deterioration protocols.

ISBAR clinical handover audits for nurses to ensure structured communication during patient care transitions.

Audit findings are formally presented to governance committees, ensuring that identified gaps are addressed through focused improvement plans.

3. Embedding Real-Time Monitoring Mechanisms for Early Detection of Deterioration

Beaumont Lodge has implemented measures to ensure early identification and timely response to patient deterioration, including:

Intentional rounding by nursing staff to proactively assess patient needs and detect changes in condition.

Daily huddles to facilitate team-based communication, identify at-risk patients, and allocate resources accordingly.

An end-of-shift daily escalation report is completed by nursing staff, capturing any incidents of patient deterioration.

This report is reviewed by the Senior Nursing Management Team to ensure timely oversight and provide clinical guidance or intervention where required.

Trends from escalation reports are tracked and discussed in governance meetings to identify systemic improvements.

Timescale:

Action 1	**April 30,2025**
Action 1 A	**March 31, 2026**
Action 2	**July 31, 2025**
Action 3	**April 30,2025**

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

Outline how you are going to improve compliance with this national standard

1. Formalised Access to Antimicrobial Stewardship Advice

Beaumont Lodge has secured formal access to antimicrobial stewardship (AMS) advice through an addendum to the Service Level Agreement (SLA) with the appointed Consultant Geriatrician for Bartra Healthcare, effective 21st April 2025. Beaumont Lodge is also actively recruiting for an IPC Nurse and a Pharmacist that will seek more active links with the acute hospitals for antimicrobial advice.

2. Reinforcement of Best Practice in Antimicrobial and Infection Control

Targeted education and training sessions have been conducted with all clinical staff, focusing on:

Adherence to antimicrobial resistance protocols.

Compliance with infection prevention and control (IPC) guidelines.

The Quality, Safety, Risk & IPC Committee is now tasked with auditing AMRIC and IPC practice compliance, with non-conformance addressed through focused supervision and re-education.

3. Development of a Facility-Specific Medication Formulary

A local formulary for Beaumont Lodge is under development in collaboration with the pharmacy provider and Consultant Geriatrician.

This formulary will include:

A list of medications approved for use within the facility.

A restricted medications list, detailing drugs requiring additional authorisation.

The medication safety committee will review and approve the formulary, ensuring it remains current and aligned with best practice.

4. Enhanced Medication Ordering & Administration Systems

The existing electronic medication management system has been reviewed to introduce additional forcing functions, including:

SALADS.

The pharmacy partner conducts accuracy audits prior to medication dispatch, ensuring a secondary validation layer.

5. Admission Criteria Review to Align with Medical Oversight Capacity

Admission criteria have been reviewed and updated to ensure that medical oversight arrangements are considered in all admissions, including:

The availability of NCHD and Consultant cover.

Risk assessments for exceptions outside standard admission pathways.

Admissions are paused when medical oversight is insufficient, ensuring patient safety is prioritised.

6. Standardisation of Medical Handover Process

ISBAR (Identify, Situation, Background, Assessment, Recommendation) has been adopted as the standardised framework for all nursing handovers. Nurses already use the ISBAR tool for handover and Consultants are working with the NCHDS to standardise the process of Medical Handover

The Nurse Practice Development (NPD) ADON conducts regular audits on ISBAR compliance for nursing handover

Training sessions have been provided to ensure staff competency in structured handovers.

Audit findings from the nursing handover are reviewed at governance committees and corrective actions taken as necessary.

Timescale:

Action 1	**March 31, 2026**
Action 2	**March 31, 2026**
Action 3	**March 31, 2026**
Action 4	**March 31, 2026**
Action 5	**July 31, 2025**
Action 6	**December 31,2025**

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

Outline how you are going to improve compliance with this national standard

1. Strengthened Incident Review Process and Governance Oversight

A revised incident review process has been implemented, ensuring that SRI's are managed according to the Incident Management Framework

Investigated in a timely and structured manner with a critical incident review if deemed necessary.

Linked directly to a Quality Improvement Plan (QIP) where corrective actions are required.

Monitored through a formal escalation pathway to ensure closure and learning.

The Senior Management Team (SMT) has reinforced its oversight role, receiving regular updates on SRI's and QIP progress to ensure strategic governance visibility.

2. Enhanced Quality Improvement Plan (QIP) Monitoring Framework

A strengthened quality process has been developed to:

Ensure QIPs are action-oriented with clear timelines and designated owners.

Establish an escalation protocol for any overdue actions, ensuring unresolved items are promptly escalated to the SMT for intervention.

The Quality, Safety, Risk & IPC Committee has been assigned direct responsibility for overseeing QIP adherence, ensuring:

Timely implementation of corrective actions.

Barriers to completion are identified and addressed proactively.

3. Governance Oversight via Quality, Safety, Risk & IPC Committee

A standing agenda item has been introduced in the Quality, Safety, Risk & IPC Committee meetings specifically for the review of all active QIPs.

The designated Chairperson of the Committee holds direct accountability for:

Overseeing the QIP tracking process.

Verifying the completion and closure of all QIPs.

Escalating any delays or systemic issues to the SMT.

Progress updates on QIPs are presented in monthly SMT governance meetings, ensuring organisational alignment and accountability for quality improvement initiatives.

Timescale:

Action 1	**April 30, 2025**
Action 2	**December 31, 2025**
Action 3	**December 31, 2025**