



Report of an inspection against the *National Standards for Safer Better Healthcare.*

Name of healthcare service provider:	Bon Secours Health System CLG trading as Bon Secours Hospital Cork
Centre ID:	OSV-0008814
Address of healthcare service:	College Road Cork T12DV56
Type of Inspection:	Announced
Date of Inspection:	04/06/2025 and 05/06/2025
Inspection ID:	NS_0146

About the healthcare service

Model of hospital and profile

The Bon Secours Hospital, Cork is part of the Bon Secours Health System*. Established in 1915, the hospital is an acute general hospital delivering elective and unscheduled medical and surgical services to adults and children.

Services provided by the hospital include:

- general medicine
- general surgery
- orthopaedics
- cardiothoracic surgery
- cardiology
- ear, nose and throat (ENT)
- endoscopy
- oncology

The following information outlines some additional data on the hospital.

Number of beds

252 inpatient beds
93 day care beds

How we inspect

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

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

To prepare for this inspection, the inspectors[†] reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publicly available information since last inspection.

During the inspection, inspectors:

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

About the inspection report

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

1. Capacity and capability of the service

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

[†]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.

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)
04/06/2025	08:35 – 16:45	Rosie O'Neill	Mary Flavin Marguerite Dooley
05/06/2025	08:30 – 13:00	Rosie O'Neill	Mary Flavin Marguerite Dooley

Information about this inspection

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

This inspection focused on 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.^{‡‡}

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

[§] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.

^{**} Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration.

^{††} Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.

^{‡‡} Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

The inspection team visited three clinical areas:

- Medical Assessment Unit and Paediatric Assessment Unit
- St Patricks Ward
- Critical Care Unit

During this inspection, the inspection team spoke with representatives of the hospital management team, quality and risk, human resources, and medical staff. Inspectors also spoke with representatives from

- Infection Prevention Control and Antimicrobial Stewardship Committee
- Drugs and Therapeutics Committee
- Deteriorating Patient Committee
- Bed Management

Inspectors spoke to hospital staff from a variety of disciplines in the clinical areas visited during the inspection.

Acknowledgements

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

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

Inspectors visited three clinical areas during the inspection. The combined medical assessment unit (MAU) and paediatric assessment unit (PAU), was a 14 bay unit, with a dedicated four bedded paediatric unit, a seven bay adult unit and three single rooms (adult or paediatric use) which was open from Monday to Friday (08:00am to 6:00pm). The MAU assessed patients 16 years and over while the PAU assessed patients between the ages of 28 days to 16 years.

St Patricks was a 27-bedded adult surgical ward comprised of single rooms with en-suite facilities. The critical care unit (CCU) was a 10-bedded unit, with six bays and four single rooms (two negative pressure rooms) with en-suite bathroom and shower facilities.

Inspectors observed staff speaking and interacting with patients and their families in a respectful and kind manner. It was evident that staff took time to listen to and talk with patients. On the day of inspection, inspectors spoke with a number of patients and family members. All were complimentary about the staff and the care they

received commenting that “*cannot say enough about the level of care and*”, “*the staff are exceptional*”, and “*it’s like a home from home* “. Not all of the patients inspectors spoke with were aware of the hospitals complaints policy, but outlined that they would raise any concerns with the nursing staff.

Capacity and Capability Dimension

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

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

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

The Bon Secours Hospital, Cork (BSHC) had formalised corporate and clinical governance arrangements in place for assuring the delivery of high quality, safe and reliable healthcare. The hospital was managed by the Bon Secours Hospital System (BSHS).

Board of Directors

The Board of Directors (Board) was the governing body responsible for strategic direction, accountability, and oversight of BSHS. The Board appointed a Group Chief Executive Officer (CEO) responsible for operational delivery, strategic alignment, and mission execution, and was accountable to the Board. The Board appointed the hospital CEO who was also a member of the BSHS Executive Management Team (EMT). The EMT was accountable to the group CEO.

Senior Management Committee

The hospital CEO was supported by the Senior Management Committee (SMC), who met 10 times per year. Membership of the SMC was multidisciplinary and included the hospitals’ clinical director (CD), director of nursing (DON), quality and risk manager (QRM), business manager, finance officer, head of mission and head of human resources. The Terms of Reference (ToR) outlined the SMC was responsible for overseeing the strategic direction, operational performance, and cross-departmental coordination, while supporting collaborative planning, performance improvement, and the delivery of high-quality, patient-centred care in line with the mission and values of BSHS. Minutes of the

most recent meetings submitted to HIQA demonstrated actions arising from meetings were assigned to named individuals, were time-bound and followed up from meeting to meeting.

The hospital CEO also attended quarterly performance review meetings with the group CEO. The ToR outlined the purpose of the meetings was to discuss progress against key operational issues, budgets, quality metrics, staffing and mission alignment. Inspectors reviewed minutes from the most recent performance meetings, which demonstrated that the group CEO had comprehensive oversight of services in the hospital, actions arising from meetings were assigned to named individuals, were time-bound and followed up from meeting to meeting.

Clinical Management Committee

The Clinical Management Committee (CMC), also known as the Serious Incident Management Team was a standing committee of the SMC. In line with the ToR, the purpose of the committee was to oversee the delivery of safe, high-quality, and effective clinical care in the hospital. The committee also provided leadership and strategic direction in matters related to clinical governance, quality improvement, patient safety, risk management, infection control, and consultant affairs. The committee was chaired by the hospital CEO was accountable to the group CEO and met monthly. Membership of the CMC was multidisciplinary and included the hospitals' CD, DON, QRM, business manager, finance officer, head of mission and head of human resources. Documents submitted to HIQA showed a standard agenda, and minutes demonstrated actions were assigned to named individuals, were time-bound and followed up from meeting to meeting.

Medical Advisory Committee

In line with the ToR the purpose of the Medical Advisory Committee was to act as a forum by which consultants could participate in the hospitals policy making, strategic, and operational planning processes. In addition, the MAC provided a formal communication mechanism between consultants and the SMC in issues affecting the provision of healthcare including the recommendation on the awarding of privileges to consultants by the CEO with final approval granted by the BSHS. The committee was chaired by a medical consultant, was accountable to the hospital CEO and met quarterly. Documents submitted to HIQA showed a standard agenda, and minutes demonstrated actions arising from meetings were not always assigned to named individuals, with no evidence they were time bound and followed up from meeting to meeting. This should be followed up by hospital management.

Clinical Performance Committee

In line with the ToR the Clinical Performance Committee (CPC) was a sub-committee of the Board, chaired by a member of the Board with the purpose of providing the Board

with the assurance that excellence in care is delivered in all hospitals across the BSHS, in particular, that adequate and appropriate clinical governance, measurements and controls are in place. Membership included the group CEO, group head of quality and patient safety, and senior leadership from each of the BSHS hospitals. Each hospitals' CD provided a report to, and represented the hospital at the quarterly meetings. Documents submitted to HIQA showed a standard agenda, and minutes demonstrated actions arising from meetings were assigned to named individuals, were time-bound and followed up from meeting to meeting.

The hospitals' CD provided clinical governance and oversight to consultant colleagues, non-consultant hospital doctors (NCHDs) and clinical services at the hospital and reported to the hospital CEO. The hospitals' DON was responsible for the organisation, management and delivery of nursing services in the hospital and reported to the hospital CEO.

Quality and Safety Committee

The Quality and Safety Committee (QSC) was a standing committee of the SMC. In line with the ToR the committee provided oversight, leadership, and strategic direction in the areas of clinical quality, patient safety, risk management, and continuous improvement. The QSC was chaired by the hospitals CEO, and met quarterly. Membership of the QSC was multidisciplinary and included the hospitals' CD, DON, QRM, nurse practice development, quality improvement co-ordinator, chair of the MAC, consultant surgeon representative, consultant physician representative, chief pharmacist, laboratory manager and medical manpower manager. A number of sub-committees reported to the QSC, including Infection Prevention and Control, Drugs and Therapeutics and the Deteriorating Patient. Inspectors confirmed sub-committees furnished reports quarterly and provided updates at each meeting. These committees were not outlined in the ToR and this should be followed up by hospital management. Items discussed included accreditation, clinical metrics, patient safety incidents, patient experience, infection, prevention and control and medication safety. Documents submitted to HIQA showed a standard agenda, and minutes demonstrated actions were assigned to named individuals, were time-bound and followed up from meeting to meeting.

Inspectors were satisfied that the hospital through the CMC and QSC had effective oversight of the quality and safety of healthcare services at the hospital.

Infection Prevention and Control, Antimicrobial Stewardship Committee

In line with the ToR the Infection Prevention and Control, Antimicrobial Stewardship Committee (referred to as the IPCC) was responsible for developing, running, and continually improving the hospital's IPC and Antimicrobial Stewardship (AMS) programme. The committee was chaired by a consultant microbiologist, and reported to the QSC and met quarterly. Membership of the IPCC was multidisciplinary and included,

IPC nurses, antimicrobial pharmacist, hospital management representative, consultant surgeon representative, consultant physician representative, MAU and PAU consultant, nurse practice development, chief scientist in microbiology, QRM, theatre manager and an NCHD representative. The chairperson also attended the monthly hospital CMC meeting, and the committee provided a quarterly AMS report to the drugs and therapeutics committee. The day-to-day management of IPC was assigned to the IPC team. Documents submitted to HIQA showed a standard agenda, and minutes demonstrated actions were assigned to named individuals, were time-bound and followed up from meeting to meeting.

Drugs and Therapeutics Committee

In line with the ToR, the Drugs and Therapeutics Committee (DTC) was responsible for leading the development of systems and processes for safe and effective medication management within the hospital, while also acting in an evaluative, educational and advisory capacity to all hospital staff and hospital management in all matters pertaining to medications and their use. The committee was chaired by a medical consultant, and reported to the QSC, and met quarterly. Membership of the DTC was multidisciplinary and included the hospitals' chief pharmacists I and II, medication safety pharmacist, other pharmacists as required, consultant anaesthesiologist representative, consultant surgeon representative, Consultant microbiologist representative, QRM, nurse practice development, NCHD representative, nurse manager representative and head of finance. The hospitals' medication safety committee reported to the DTC. Documents submitted to HIQA showed a standard agenda, and minutes demonstrated actions were assigned to named individuals, were time-bound and followed up from meeting to meeting.

Deteriorating Patient Committee

In line with the ToR the Deteriorating Patient Committee (DPC) was responsible for providing oversight and guidance in relation to the areas of cardiac arrest, resuscitation, EWS^{§§}, (Irish National Early Warning System NEWS^{***}, Paediatric Early Warning

^{§§} Early Warning System (EWS) is an early warning system to assist staff to recognise and respond to clinical deterioration. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned Intensive Care Unit admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.

^{***} Irish National Early Warning System (INEWS) - is an early warning system to assist staff to recognise and respond to clinical deterioration. INEWS should be used for non-pregnant individuals, age 16 years or older. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned ICU admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.

System⁺⁺⁺, Irish Maternity Early Warning System⁺⁺⁺) deteriorating patient and sepsis. The committee was chaired by a consultant physician, was responsible to the QSC and met quarterly. Membership was multidisciplinary and included senior medical and nursing personnel, health and social care professionals who had a commitment to cardio pulmonary resuscitation, resuscitation and resuscitation training, EWS and sepsis. The hospitals sepsis, resuscitation and EWS working groups reported to, and furnished quarterly reports to the committee. Documents submitted to HIQA showed a standard agenda, and minutes demonstrated actions were assigned to named individuals, were time-bound and followed up from meeting to meeting.

Transitions of Care

While there was no transitions of care committee in place, the management of patient flow into, across and out of the hospital was managed by the bed manager Assistant Director of Nursing (ADON), (accountable to the DON), and two patient flow coordinator's (accountable to an ADON). Outside of core hours responsibility was with the operational ADON.

In summary, it was clear to inspectors that the hospital had formalised governance arrangements in place for the delivery of high quality, safe and reliable healthcare. Details outlined in organisational charts, terms of reference, agendas and minutes from minutes was articulated in meetings with lead representatives during inspection.

Judgment: Compliant

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

Medical Assessment Unit and Paediatric Assessment Unit

The hospital operated a combined medical assessment unit (MAU) and paediatric assessment unit (PAU) from Monday to Friday (08:00am to 6:00pm) that offered a consultant-led service and a range of diagnostic tests for adults and children requiring clinical assessment. Referral to the MAU and PAU was by consultant or GP only. Both units had an inclusion and exclusion criteria policy which set out the clinical conditions that could be assessed in the unit.

⁺⁺⁺ Paediatric Early Warning system (PEWS) is an early warning system to assist staff in the detection and/or timely identification of, and response to, deterioration in improving clinical outcomes for children aged 0-16 years in inpatient hospital settings. It is not for use within neonatal and maternity units, paediatric intensive care units or perioperative settings. PEWS is not an emergency triage system and should not be used for this purpose.

⁺⁺⁺ Irish Maternity Early Warning System (IMEWS) is a nationally agreed scoring system developed for early detection of life threatening illness in pregnancy and the postnatal period.

The MAU and PAU were under the clinical leadership of two consultants in emergency medicine, with a consultant and three NCHDs on duty each day, with one of the NCHDs trained in paediatric medicine. The day to day operational management of the unit was the responsibility of the Clinical Nurse Manager (CNM) II who reported to the operational CNM III. On the day of inspection the unit was noted to be operating well with effective medical and nursing management. Inspectors were advised that there was same day access to a wide range of diagnostics tests in the radiology and cardiology services. The hospital measured a patient experience metric, of six hours from review to decision to admit to an inpatient bed or discharge. Inspectors were informed that compliance with the metric ranged from 90%-95%.

Cardiothoracic Service

The hospital opened a cardiothoracic surgical service (CT) in September 2024 offering surgical care for a range of heart and lung conditions. Hospital management outlined to inspectors the detailed work undertaken in establishing and commissioning the service. The types of procedures carried out were based on the clinical presentation of the patient, which also determined if the procedure would be carried out at the hospital, or the patient required transferring to another hospital for a higher level of care. The hospital had a standard operating procedure for pre-assessment for cardiothoracic patients undergoing surgery. The service was led by the consultant CT surgeon supported by a full team of medical, nursing and perfusion staff.

Paediatric service

The hospital offered a clinical assessment and paediatric inpatient service for children aged from 28 days to 16 years. The hospital had guidelines in place that outlined the care pathway for the paediatric admissions via the PAU, elective admissions and for paediatric surgical admissions to the in-patient paediatric ward. The hospital had a consultant paediatrician clinical lead and a child protection and welfare policy in place.

Infection Prevention and Control

The IPCC had oversight of the implementation of the hospitals IPC and AMS programme. The IPC team had an annual work plan in place that set out the objectives to be achieved in 2025. The plan included infection control, surveillance, care bundles^{§§§}, surgical site infections (SSI), ventilator acquired pneumonia, hand hygiene and AMS. It was clear from the review of data and in communications with staff that the IPC team were highly visible, available to staff and were meeting their objectives and reporting through the hospitals governance structures.

^{§§§} A care bundle is a structured way of improving the processes of care and patient outcomes through the use of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes.

Medication Safety

The hospital operated a clinical pharmacy^{****} service from Monday to Friday (08.00am to 17.00pm) and Saturdays (09.00am to 4.30pm). Outside of core hours the operational ADON was the designated point of contact, and pharmacy staff were available by telephone for advice and support. Pharmacist-led medication reconciliation was carried out on over 96% of inpatients. Antimicrobial medication management was supported with staff access to a dedicated pharmacist, consultant microbiologist and an on-call consultant microbiology service. The pharmacy service had a 2025 work plan that set out objectives to be met, which included, compliance with key metrics and AMS in conjunction with the IPCC.

Deteriorating Patient

The DTC had an annual work plan in place that set out the objectives to be achieved in 2025. The plan included key metrics related to the EWS, escalations of care, sepsis management, cardiac arrest and critical transfers.

To support the clinical staffs' skills, knowledge and confidence in managing an acutely deteriorating patient, multidisciplinary training was offered that provided practical case-based scenario sessions and simulation training for the clinical management of the deteriorating patient.

Inspectors reviewed the out-of-hours and on-call arrangements for doctors, which demonstrated effective NCHD clinical cover across all specialities with escalation to the patients' primary consultant in the first instance.

The hospital had access to the National Ambulance Service (NAS) and Protocol 37⁺⁺⁺⁺ which ensures that patients with urgent medical needs outside the scope of the hospital are transported directly to other hospitals in the region, to provide specialised clinical care.

Transitions of Care

The bed manager, and patient flow coordinators were responsible for daily admissions and discharges of patients. The ADON was responsible for scheduled admissions, referrals to the MAU, PAU and inter-hospital transfers during core hours, at all other times the operational ADON was responsible. The patient flow coordinators were responsible for the discharge of complex patients to home or community settings. The hospital had guidance in place for the management of unscheduled presentations,

^{****} Clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting

⁺⁺⁺⁺ The Emergency Inter-Hospital Transfer Policy Protocol 37 has been developed for emergency inter-hospital transfers for patients who require a clinically time critical intervention which is not available within their current facility.

admissions to, transfers within and transfers from the hospital. The patient flow coordinators described good links with another hospital and community services in the area, which assisted in supporting patients being discharged from the hospital.

Hospital activity was reviewed three times a day at multidisciplinary safety huddle meetings, where patient flow, patient acuity and any risks were discussed and managed. In the clinical areas there were also scheduled staff huddles throughout the day.

The hospital had an annual work plan in place that set out the objectives to be achieved in 2025. The plan included, the clinical communication tool using Identify, Situation, Background, Assessment and Recommendation (ISBAR³)^{****}, transfers to the CCU, reviews of non-critical transfers and documentation audits.

In summary the hospital had effective management arrangements in place to support the delivery of high quality, safe reliable healthcare.

Judgment: Compliant

Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

The hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of the healthcare services provided, relevant to the size and scope of the hospital.

Risk Management

There were risk management structures in place to proactively identify, manage and minimise risks. The hospital maintained a risk register of identified hospital risks. The existing controls in place and the additional controls required to minimise these risks were outlined in the risk registers viewed by inspectors. The risk register was reviewed at relevant committees, quarterly at the QSC and was a standing item on the quarterly BSHS performance review meetings. Escalation of hospital risks was to the risk forum, which was a subcommittee of the group EMT who reviewed risks recommended for inclusion on the corporate risk register. The hospital risks related the four areas of harm are outlined further in national standard 3.1.

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

Monitoring service performance

The hospital collected data on a wide range of clinical measurements related to the quality and safety of healthcare services. Collated data was measured against international and national guidelines, hospital activity, incident management, service user feedback, workforce management and training. The data results were reviewed at the relevant committees, at the monthly CMC, at the quarterly QSC and a report provided quarterly to the BSHS performance review meetings and clinical performance committee meetings.

Inspectors reviewed a range of metrics, audits and key performance indicators (KPI's) with evidence of quality improvements plans to address compliance. Results were shared with staff through line management structures, quality boards in clinical areas and local education.

Management of patient-safety incidents

The hospital proactively identified, documented and monitored patient-safety incidents. The QSC provided oversight and management of all patient-safety incidents which occurred within the hospital and were tracked and trended by the quality and risk department. Incidents were discussed at local governance committees, at the monthly CMC, at the quarterly QSC and a report provided quarterly to the BSHS performance review meetings and clinical performance committee meetings.

Inspectors were satisfied there were processes in place to share learning from patient-safety incidents through communication from the various hospital committees, line management structures, quality boards and local education.

To summarise, the hospital had monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services in the four areas of known harm relevant to this inspection.

Judgment: Compliant

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

The hospital had structures and processes in place that ensured the workforce was planned, and managed to ensure the safe delivery of high quality, safe and reliable healthcare.

The Human Resources (HR) manager reported to the BSHS Chief People Officer and the hospital CEO, and was a member of the SMC. The hospital also had a dedicated medical manpower manager with responsibility for the medical workforce in conjunction with the

HR manager. The hospital had a number of KPIs in place related to workforce that included, recruitment and retention, talent management, learning and compliance. These were discussed at the hospital SMC and the BSHS performance review meetings.

Workforce

At the time of inspection the hospital whole time equivalent^{§§§§} (WTE) was 1280. The absenteeism rate was 3.55% and the vacancy rate was 0.78%. Employees were supported by their line managers and HR, with systems in place for staff to access occupational health services and the employee assistance programmes. In addition the hospital could initiate a critical incident protocol to support staff in the aftermath of a critical incident occurring in the hospital. The hospital sought staff feedback, through surveys and focus groups, with initiatives identified, such as enhanced communication between hospital management and staff.

The hospital had a consultant complement of 121. Consultants were not directly employed were granted privileges^{*****} to practice medicine at the hospital. The Medical Advisory Committee oversaw recommendations on the awarding of privileges to consultants by the hospital CEO, with final approval granted by the BSHS. A formalised process, supported by a BSHS policy, was in place to support the credentialing⁺⁺⁺⁺⁺, privileging and re-credentialing of consultants. All consultants practicing in the hospital were on the specialist register of the Irish Medical Council, this was a mandatory condition to gain employment and privileges at the hospital.

At the time of inspection the NCHD WTE was 57 across all grades, employed directly by the hospital and with no reported vacancies at the time of inspection. The hospital worked with the local university in the employment and training of new graduate medical doctors. Each patient's named admitting consultant was the primary source of contact during and outside core working hours for matters relating to their clinical care. NCHDs were available on-site 24 hours a day seven days a week.

Medical staff spoken with during the inspection were satisfied with these arrangements and outlined that they were sufficient to meet the current bed capacity numbers at the hospital. NCHDs felt supported by consultants stating good supervision, oversight and the availability of educational opportunities.

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

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

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

At the time of inspection the nursing WTE was 527.89 with no reported vacancies. Staffing levels from the clinical areas visited on the day of inspection were reviewed. It was evident that there were sufficient staffing numbers in these areas to ensure the delivery of high quality, safe care.

The hospital had an IPC team in place comprised of 2.5 WTE, consultant microbiologists, 1 WTE CNM 3, 2 WTE Clinical Nurse Specialists, 0.5 WTE clerical officer and a 0.6 WTE surveillance scientist. There was an out- of-hour's on-call consultant microbiology service also available.

The hospital had 17.31 WTE pharmacists, 16.68 WTE pharmacy technicians and a dedicated portering service. A 1.1 WTE post was a dedicated antimicrobial pharmacist. The service also supported the training of pharmacy students from the local university.

Training

It was evident from staff training records reviewed by inspectors that staff in the hospital undertook multidisciplinary team training appropriate to their scope of practice. The hospital had a system in place to monitor and record staff attendance at mandatory and essential training. Monitoring of attendance at training was overseen by the departmental manager, nurse practice development unit and medical manpower.

Training records from the clinical areas visited on the day of inspection showed close to full compliance rates for the mandatory training related to IPC, INEWS, PEWS, the clinical communication tool using Identify, Situation, Background, Assessment and Recommendation (ISBAR), and basic life support (BLS) for the nursing and healthcare assistant staff as relevant.

Inspectors reviewed overall records for mandatory and essential training for the hospital. Compliance with required training for hospital staff varied across specialities, with the following ranges observed: 85% to 100% for IPC training, 100% for INEWS, PEWS and ISBAR training, 100% for BLS training, and 95% to 100% for hand hygiene training. All paediatric doctors were trained in paediatric advanced life support. 20 of the 22 paediatric nurses were also trained, with plans to train the remaining two in the next three months. Advanced cardiac life support training was targeted at staff working in acute areas with 87% of CCU staff and 85% of MAU staff trained. 74% of nurses working in CCU had undertaken post graduate training in intensive care nursing.

In addition 99% of staff had undertaken 'Children First'^{*****} training and over 90% had undertaken complaints management training.

***** Children first is a national policy document which assists people in identifying and reporting child abuse

Overall, inspectors found that hospital management were planning, organising and managing their healthcare workers to support the provision of high-quality, safe healthcare.

Judgment: Compliant

Quality and Safety Dimension

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

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

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

It was evident to inspectors during visits to three clinical areas that the patients' dignity, privacy and confidentiality was promoted.

Staff were observed drawing curtains around patients' in the MAU and PAU when delivering care and speaking to patients' and families in a respectful manner. Information was communicated in a clear and easily understood way and supported with relevant written information. Inspectors were informed that private rooms were available to patients' and families for conversations relating to their care. Access to translation services were available to support communication with patients' in their native language.

Patients who spoke with inspectors described that "*everything is great, would change nothing*" and "*there was no waiting when you telephoned the hospital, staff knew what to do*".

Staff communication white boards were in place. Patients' healthcare records were stored appropriately and information was observed to be protected on the day of the inspection. Inspectors observed call bells at each bed with patients confirmed knowledge of activating same.

In the clinical areas visited the physical environment was clean, neat and free from clutter.

Experiences of receiving care, as recounted by patients to inspectors, were consistent with the findings from patient experience and feedback evaluation survey that patients had the option to complete following discharge. In quarter one 2025 the survey recorded that 96% of patients felt they were fully involved in all decisions about their care.

In summary, it was evident that hospital management and staff were committed to ensuring that patients' dignity, respect and autonomy was respected and promoted.

Judgment: Compliant

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

Inspectors observed that a culture of kindness consideration and respect was actively promoted by all staff in the clinical areas visited. Inspectors observed nursing philosophy and hospital mission statements on display.

Staff were observed actively listening to patients' and responding in a considered and caring manner. This was validated by patients' who expressed their satisfaction with the care and kindness they received. For example patients' stated that "*transition through the hospital is very good*" "*communication with the surgeon and ward staff was very good*".

In quarter one 2025 the hospital's own patient experience and feedback evaluation survey recorded 98% when patients were asked; "*were you treated with dignity and respect?*".

In summary, it was evident hospital management and staff promoted a culture of kindness, consideration and respect for people accessing and receiving care at the hospital

Judgment: Compliant

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

The hospital had a designated complaints officer who was under the remit of the QRM and was assigned responsibility for managing complaints in line with the BSHS complaint handling policy. The policy outlined the process and timelines for acknowledging and responding to complaints. The policy also outlined the process for an independent review of complaints in the event the complainant was not satisfied with the hospital's response. The QRM manager provided quarterly reports on patient feedback to the QSC and the BSHS performance review meetings and hospital clinical performance committee meetings.

For verbal complaints, local resolution at the point of care was encouraged in the first instance. Verbal complaints that could not be resolved locally were escalated to the complaints officer. Written complaints were managed by the complaints officer with input from key stakeholders. In 2024, 165 complaints were recorded which included 35 verbal complaints and 130 written complaints. In quarter one 2025 there were three verbal complaints and 35 written complaints. The hospital also offered inpatients the opportunity to participate in a patient evaluation survey following discharge. In 2024 and quarter one 2025, 94% of complaints were being addressed within the hospital's target of 30 days. Complaints were tracked and trended and categorised into themes such as communication, accommodation, delivery of care, discharge planning, referrals and admissions and billing.

Inspectors observed posters in areas visited outlining the complaints process, with a number of options, including a link to a feedback and complaints page on the hospital's website. Inspectors also observed a quick response code (QR) on how to access independent advocacy services in clinical areas inspected. Hospital management confirmed that if a patient wished to engage with the hospital, with, or through a third party, this would be fully supported by the hospital.

Feedback from people using the service

The hospital collected data from patients following discharge through a patient experience and feedback evaluation survey. Feedback from people using the service was shared with staff to promote awareness and learning. Inspectors reviewed evidence of quality improvement plans (QIP's) that had arisen from patient feedback. Patient feedback was shared with staff individually, through line management structures, departmental staff meetings, and quarterly reports.

In summary, inspectors found that the hospital had systems and processes in place to respond to and manage complaints raised by people using the service.

Judgment: Compliant

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

During this inspection, inspectors visited the combined MAU and PAU, St Patricks ward and the CCU, and overall observed that the physical infrastructure was clean and well maintained. The combined MAU and PAU, was a 14 bay unit, with a dedicated four-bedded paediatric unit, a seven bay adult unit and three single rooms (adult or paediatric use), one which was en-suite. Patients' had access to two toilets in the unit. St Patrick's ward comprised 27 single rooms with en-suite bathroom and shower facilities. The CCU was a 10-bedded unit, with six bays and four single rooms (two negative pressure rooms) with en-suite bathroom and shower facilities. Patients had access to two bathrooms with showers in the unit.

The facility management service had a 2025 infrastructure inspection and audit plan in place supported by a hospital policy. The purpose was to assess the overall condition, safety and compliance of the hospitals infrastructure, physical environment, and equipment to ensure the provision of high quality care and maintain a safe environment. Inspectors reviewed the 2025 report, which identified areas that required upgrading and improvements, with improvement plans and follow up. There were no building works underway at the time of inspection. Inspectors viewed the hospital policy and risk assessments in place for works undertaken in 2023. These outlined the type of works undertaken, risk management, IPC measures and patient risk reduction strategies. Legionella testing was conducted every four weeks and measures were implemented to address report findings as required.

In the MAU and PAU the physical distancing of greater than one metre was observed between beds in the multi-occupancy room. Alcohol hand gel dispensers were strategically located and readily available with hand hygiene signage outlining the World Health Organisation (WHO) 5 moments of hand hygiene clearly displayed throughout the three clinical areas. Inspectors noted hand-hygiene sinks for clinical use in clinical areas visited conformed to national standards. Personal protective equipment was available as required in the clinical areas visited.

Inspectors were informed that hygiene services were available twenty four hours a day, seven days per week. Inspectors observed a green tagging system to indicate equipment had been cleaned in the clinical areas and were informed that primarily HCA's carried out

equipment cleaning with oversight from the CNM. Terminal cleaning^{§§§§§} and environmental cleaning was carried out by the hygiene services staff, with additional cleaning available during outbreaks of infections. Oversight of cleaning was by the hygiene services manager and CNM's. Staff completed an online request to maintenance if equipment required repair and there was a timely response to requests.

Inspectors observed appropriate waste management in the clinical areas visited with clinical and non-clinical waste bins. There were dedicated medication preparation areas with evidence of appropriate and secure medication storage. Medication fridges were remotely monitored, which included temperature control and malfunction. Inspectors observed posters on high-risk medications, APINCH^{*****}, Sound-Alike-Look-Alike Drugs (SALADs), as well as a range of flow charts and medication safety information on medication management. Sharp bins were partially closed, signed and dated. There was appropriate segregation of clean and used linen.

In summary, inspectors found that the physical environment in the clinical areas visited was clean and well maintained and supported the delivery of high quality, safe, reliable care and protects the health and welfare of people using the services.

Judgment: Compliant

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

Inspectors were satisfied that the hospital had effective systems and processes to systematically monitor, evaluate and improve the healthcare services provided.

The hospital collated data aligned with local, group, national and international performance indicators and benchmarks and also service user feedback to measure the quality and safety of care provided. The KPI's and benchmarks outlined in the hospitals' 2025 quality improvement and audit schedule were measured against set targets and reported monthly through relevant governance committees and at BSHS level.

Infection prevention and control monitoring

The IPCC had oversight of the IPC practices in the hospital. The IPC team reported quarterly to the QSC and CMC on rates of *methicillin-resistant Staphylococcus aureus* (MRSA), *clostridium difficile* infection (C-Difficile), *vancomycin-resistant enterococci*

^{§§§§§} Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment

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

(VRE), *extended spectrum beta-lactamase* (ESBL), *Carbapenemase-producing Enterobacterales* (CPE) and Covid 19.

Inspectors reviewed the 2024 IPC report which showed MRSA, C-difficile and VRE rates were tracked, trended and were lower than the hospitals KPIs. Hospital management clarified that in 2024 there was a 17% increase in MRSA cases managed compared to 2023. The majority of these were patients with a previous history of MRSA. Of the new cases diagnosed on admission following screening, hospital management informed inspectors that 98% of these were mainly associated with other healthcare institutions or nursing homes. ESBL figures were reported separately. All patients were risk assessed on admission with new cases (either MDRO or ESBLs), noted and patients followed up accordingly. In 2024 universal screening for CPE was introduced for all in-patients with weekly screening for patients who remained in-patients for seven days or longer.

The hospital has a surveillance programme in place though the use of care bundles for peripheral vascular catheters, central venous catheters, urethral catheters and ventilator acquired pneumonia. In 2024 compliance with the four care bundles ranged from 83% to 100%. In February 2025 in CCU the compliance rate with the central venous catheter care bundle was 60%, increasing to 100% in March following the implementation of a QIP.

The hospital saw an increase in ventilator acquired pneumonia in 2024. Forty five patients were ventilated (similar utilisation as 2023) with three patients developing ventilator acquired pneumonia. This represents 13.8 per 1000 bed days which was above the benchmark of 10.0 per 1000 bed days. The CCU has established a working group to address these issues.

The hospital had in place a surgical site infection surveillance programme that reported on orthopaedic joint replacement surgery (hip, knee, shoulder, elbow), breast surgery, trans rectal prostate biopsies and colorectal surgery. The 2024 report shows all metrics recorded where lower than the hospitals set targets.

In the three months prior to inspection the three clinical areas were compliant with the hospitals target of 90% for hand hygiene practices.

Inspectors reviewed documentation for environmental hygiene and patient equipment sign off sheets and audits. The compliance rates for the three clinical areas visited ranged from 90% to 100%, with QIPs in place to address non-compliance.

Antimicrobial stewardship monitoring

There was evidence of monitoring and evaluation of AMS practices in the hospital. Inspectors reviewed the quarter one 2025 AMS and medication safety report. This

included information on antibiotic prescribing, antibiotic prophylaxis and antibiotic consumption. Inspectors noted poor compliance with surgical antimicrobial prophylaxis that the hospital were addressing. Inspectors reviewed the 2025 work plan which demonstrated ongoing monitoring and evaluation of AMS in the hospital. Inspectors were informed by staff that education and training initiatives were in place to support and improve antimicrobial stewardship practices within the hospital.

Management confirmed to inspectors confirmed that notifiable diseases were reported to public health in line with national policy and the hospital also reported into the national antimicrobial point prevalence survey.

Results were shared with staff through line management structures, quality boards, education and quarterly reports. Inspectors were satisfied that the IPCC had oversight of monitoring of infection prevention and control practices in the hospital.

Medication safety monitoring

There was evidence of monitoring and evaluation of medication safety practices at the hospital, audits were carried out on, medication storage and custody, prescription records, labelling and high risk medications. The 2024 results for medicines storages and labelling in 23 clinical areas was 94%. Inspectors reviewed the quarter one 2025 prescription records audit and action plan. Compliance ranged from 69% to 100%. Follow up actions included bringing incomplete, unclear and illegible prescriptions to the attention of the prescriber, education of medical staff on best practice in prescribing and ongoing monthly audits. Audit results were also brought to the attention of the ward CNM. The hospital is currently introducing an electronic healthcare records system including prescription charts, which should improve medication prescribing.

Inspectors reviewed the 2025 work plan which demonstrated ongoing audits and a focus on increasing clinician's knowledge on anticoagulation. In 2024 the hospital noted a number of medication errors related to the prescribing of insulin. The hospital initiated an awareness campaign around companion prescribing of glucagon with insulin for the management of hypoglycaemia and have also recently appointed two diabetic clinical nurse prescribers.

Risk reduction strategies in relation to medication safety are discussed further under national standard 3.1.

Deteriorating patient monitoring

The hospital collated performance data through monthly audits of INEWS, PEWS and the clinical communication tool, ISBAR to monitor compliance. For INEWS the previous five quarters showed average compliance with observation, escalation and response audits

greater than 80%. For PEWS the February, March and April 2025 average compliance with observation, escalation and response audits was greater than 80%. In areas where compliance was below the 100% KPI, there was evidence of improvement plans to address compliance and re-audit agreed with an assigned owner.

In January 2025 the hospital undertook a review of the clinical handover process to optimise the early recognition and escalation of the deteriorating patient. A number of potential initiatives were identified, these included a proforma for handover and identifying a dedicated time for handover. This will remain an agenda item on the DPC for 2025.

The hospital collated data on sepsis management. Inspectors reviewed the 2024 annual report, quarter one 2025 data, and minutes from meetings which showed a comprehensive approach to sepsis management in the hospital. The hospital tracked and trended patients screened using the clinical decision support tool with non-compliances followed up accordingly. In 2023 the hospital redesigned the sepsis form to outline two colour coded escalation care pathways. Clinicians were clearly directed to an amber or red pathway based on a number of physiological metrics. Inspectors discussed this tiered approach with hospital management.

The 2024 report showed, and hospital management clarified that compliance with the administration of antibiotics at one hour was 67%. In addition the hospital also measured compliance with completing the sepsis form and initiating all treatment within three hours, and achieved 63%. In quarter one 2025, the one hour compliance with the sepsis six bundle had increased to 44% (up from 36% 2024) and three hour compliance to 66% (up from 49% 2024).

In March 2024 the hospital introduced a sepsis trolley and a sepsis response team to support clinicians in the diagnosis and management of sepsis. There was a sepsis trolley in clinical areas that contained all relevant information and equipment to initiate sepsis treatment. The sepsis response team was comprised of senior doctors and nurses, who were contactable via a dedicated bleep system 24 hours a day, seven days a week to attend a deteriorating patient requiring urgent evaluation and treatment for sepsis.

It is evident the hospital were proactive in highlighting the importance of the INEWS and sepsis management with a plan of work for 2025. The hospital had also developed a number of innovative initiatives to increase staff awareness.

Transitions of care monitoring

The hospital audited and reported on metrics related to patients transitioning into, across and out of the hospital. These included, non-critical and critical transfers from the hospital, escalations of care using ISBAR, clinical handover and discharge summary audits.

In 2024 the MAU reviewed 4477 patients, admitted 3,176 (71%) and directly transferred 12 (0.37%) to higher levels of care. The PAU reviewed 1089 children, admitted 586 (49%) and directly transferred 2 children (0.18%) to higher levels of care. The hospitals focus for 2025 was on the transfer times of patients on wards requiring a higher level of care to the CCU. Inspectors were told currently 66% of patients are transferred within 30 minutes and 100% transfers completed within one hour.

Cardiothoracic Service

Since commencement of the surgical service in September 2024, the hospital have developed a suite of metrics and were in the process of developing and refining KPI's. Hospital management advised inspectors that as the service matures and the dataset grows these metrics and KPI's will remain under review. Currently data is collated on SSI, mortality, unplanned returns to theatre and average length of stay. At the time of inspection the service have undertaken 86 procedures, and inspectors reviewed outcome data. There were four (4.65%) transfers to a model four hospital, three for the management of pre-existing medical conditions and one for specialty clinical care not offered at the hospital.

The quality and risk department had oversight and was the central repository for all quality and safety data in the hospital. The hospital had identified a number of issues through their reporting structures and were addressing these at the time of inspection.

In summary, inspectors were satisfied that the hospital systematically monitored and evaluated healthcare services. Areas for improvement include:

- continued focus on IPC audit results
- compliance with antibiotic prescribing, particularly surgical antimicrobial prophylaxis
- continued focus on medication prescribing
- compliance with sepsis form

Judgment: Substantially Compliant

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

Risk management in the hospital was supported with the BSHS risk management policy. The QSC was responsible for the management of the hospital risk register which was reviewed quarterly. Inspectors reviewed the risk register related to the four areas of harm and noted that the majority were in the low to moderate risk categories. The software system that supported the chemotherapy manufacturing and review functions within the hospital was approaching end-of-life. At the time of inspection the hospital were reviewing other replacement software solutions. The hospital confirmed there was one risk, (related to the national availability of some drugs) escalated to the group risk register.

Inspectors reviewed risk assessments and risk registers in the clinical areas visited. The CNMs managed their local risks and risks that could not be managed locally were escalated accordingly. Inspectors were informed these were updated once or twice a year with the assistance of the QRM, and as part of the facility service infrastructure audits for that area.

Infection, Prevention and Control

The IPCC reviewed the IPC risk register and incidents and reported to the QSC quarterly. The highest rated risk were related to the management of patients with MDROs. Inspectors were satisfied the hospital carried out universal screening on all admitted patients for CPE. Risk assessments for other MDRO's were carried out and further screening initiated in line with national guidance, with patients isolated as required as per national guidance. It was evident from talking to staff that IPC was a daily and ongoing focus in the hospital.

In 2024 the hospital had one outbreak Covid 19 and one outbreak of CPE. Inspectors reviewed outbreak reports, which showed outbreak control meetings were convened with relevant stakeholders to include attendance from public health to oversee the management of the outbreaks. The reports outlined meetings, issues identified, corrective actions and outcomes.

Medication Safety

The DTC reviewed the medication safety risk register, medication incidents and reported to the QSC quarterly. The hospital had a list of high-risk medications, and sound-alike-look-alike drugs, stored separately from the main ward stock. These medications had red and yellow stickers respectively affixed to the boxes to further highlight risks with their

administration. Inspectors noted in one clinical area boxes of one type of high risk medication of various doses were all stored together, as a potential patient safety risk this was brought to the attention of management.

Staff in the clinical areas visited had access to medicines information on posters, desk top computer applications and phone applications. Up-to-date prescribing guidelines, antimicrobial guidelines, medicines formularies and other medication information were available at the point of preparation.

Deteriorating Patient

The DPC reviewed the deteriorating patient risk register, including sepsis and patient safety incidents and reported to the QSC quarterly. The hospital had systems in place to manage the deteriorating patient, these included the use of INEWS, PEWS, sepsis 6 and ISBAR3 to support communication between staff in relation to patient care. Staff were knowledgeable about escalation and response protocols. As referenced in standard 5.5, simulation training was provided and drills were conducted.

Inspectors reviewed the out-of-hours and on-call arrangements for clinical staff, which demonstrated effective cover across all specialities. Escalation of care was to the NCHD in the first instance in line with the INEWS escalation and response policy and thereafter to the primary consultant or nominated consultant as required.

In the event a woman was confirmed to be pregnant or within 42 days post-partum while attending at the hospital, there was a process of on the spot training in place to record her physiological observations utilising the IMEWS.

On the surgical ward to support the management of cardiothoracic patients there were six single rooms with cardiac monitoring, monitored by the CCU. This was supported with a dedicated telephone between the ward and CCU and held by a member of nursing staff at all times. There was also a cardiothoracic emergency trolley, in the event of a patient deterioration. The service was further supported by a full an on-call cardiothoracic theatre team.

Transitions of Care

The quality and risk department reviewed the transitions of care risk register and patient safety incidents and reported to the QSC quarterly. The hospital had systems in place to reduce the risk of harm associated with the process of patient transfer in and between healthcare services. The hospital had a number of transfer and discharge policies and templates to facilitate safe transitions of care. Inspectors were informed all transfers to and from the hospital was a consultant to consultant decision only.

Patients (16 years upwards) being admitted for elective procedures underwent pre-assessment. The hospital had systems and processes in place to support the bed allocation of patients. The IPC team worked closely with bed management for scheduled admissions and liaised with staff daily to prioritise patients for single-room isolation as required. The hospital had 80 en-suite single rooms, staff were satisfied that this was sufficient to meet current demand.

The average length of stay (ALoS) for medical patients was five days and for surgical patients 2.9 days. For patients undergoing cardiac surgery the ALoS was 6.8 days and 3.7 days for thoracic patients.

The hospital had a range of patient information leaflets which were given to patients during and prior to discharge. Examples included the care of an intravenous cannula and sepsis management

Following patient feedback the hospital had recently introduced a number of initiatives, these included the availability of patient information on the hospital website and an infographic outlining the patient journey across the hospital for one cohort of patients.

Policies, Procedures, Protocols and Guidelines

Staff had access to a range of PPPG's through the hospital's document management system. All policies reviewed on the day of inspection were either hospital or BSHS policies. Inspectors noted a number of key clinical management policies, procedures, protocols and guidelines (PPPG's) for the management of deteriorating patient in CCU required review and updating. These included PPPG's on the use of and care of a patient requiring non-invasive ventilation and the management of an intra-aortic balloon pump.

In summary, the hospital had systems in place to identify and manage potential risk of harm to people associated with the four areas of harm. Other areas for improvement include:

- review and updating of key PPPG's in use in the CCU.

Judgment: Substantially Compliant

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

The management of patient-safety incidents in the hospital was supported by the BSHS incident management framework. The hospital had systems in place to identify, report, manage and respond to patient safety incidents in line with legislation, and guidelines. Staff who spoke with inspectors were knowledgeable about escalation, management and reporting systems in place for patient safety incidents.

All patient safety incidents were reviewed and categorised according to policy. Inspectors viewed the 2024 incident management report. The report provided details on the number of incidents reported, categorised by incident, location and outcomes. In addition quality improvements were also outlined in the report. Medication safety incidents were further categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention medication error categorisation. Inspectors noted on review of incident management data an incident related to a radiology report and a non-adherence to theatre protocols. Hospital management informed inspectors that processes were being reviewed and updated with ongoing education of staff. The completion of actions will be reviewed as part of future monitoring.

All incidents were tracked and trended, reviewed at relevant committees, at the monthly CMC, at the QSC quarterly and a report provided quarterly to the BSHS performance review meetings and clinical performance committee meetings. Inspectors reviewed examples of reviews carried out in response to patient-safety incidents which were in line with the BSHS policy. Results were shared with staff through line management structures, quality boards and education.

In summary, inspectors were satisfied that the hospital had a system in place to identify, report, manage and respond to patient-safety incidents in relation to the four key areas of harm which were the focus of this inspection.

Judgment: Compliant

Conclusion

HIQA carried out an announced inspection of Bon Secours Hospital Cork to assess compliance with 11 national standards from the National Standards for Safer Better Healthcare. The inspection focused on four areas of known, infection prevention and control, medication safety, deteriorating patient and transitions of care.

Overall, the hospital was judged to be compliant with nine national standards (5.2, 5.5, 5.8, 6.1, 1.6, 1.7, 1.8, 2.7, 3.3) and substantially compliant with two national standards (2.8, 3.1).

Capacity and Capability

The hospital had formalised corporate and clinical governance arrangements in place for assuring the delivery of high-quality, safe and reliable healthcare appropriate to the size and scope of the hospital. The hospitals formalised governance structures were documented and effectively communicated through senior management structures, reflecting a strong commitment to oversight and accountability.

The hospital opened a cardiothoracic surgical service in September 2024 offering surgical care for a range of heart and lung conditions. Hospital management outlined to inspectors the detailed work undertaken in establishing and commissioning the service. The service had clear structures and processes to support patients and staff.

The hospital had effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services in relation to the four areas of known harm. The hospital had systematic monitoring arrangements to identify and act on opportunities to continually improve the quality, safety and reliability of the healthcare services provided.

The workforce arrangements in the hospital were planned, organised and managed to provide high-quality, safe and reliable services. The very low vacancy rate is commendable.

Quality and Safety

The inspection at Bon Secours Hospital Cork demonstrated a strong commitment by all staff in respecting and promoting the dignity, privacy, and autonomy of patients. Hospital management and staff were dedicated to fostering a culture of kindness, consideration, and respect. This correlated with feedback from the patient evaluation surveys.

The hospital had effective structures and processes in place to receive and respond to feedback from patients and families, with evidence of QIPs in place.

Overall the physical infrastructure was clean and well maintained. The hospitals' facility management service carried out regular infrastructure audits and identified areas requiring upgrading and improvements.

The hospital had systems in place to monitor, evaluate and continuously improve services. There was evidence of extensive and systematic data collection with effective assurance systems in place to monitor and support the continual improvement in the delivery of healthcare services. The hospital had identified a number of issues through their reporting structures and were addressing these at the time of inspection. The hospital had effective risk management structures and processes, with evidence of ongoing monitoring and review. A number of key clinical management PPPG's for the deteriorating patient in CCU required review and updating.

Overall, the Bon Secours Hospital Cork demonstrated effective oversight in quality and safety, with a number of areas for improvement to ensure the highest standards of patient care.

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

Compliance Classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the national standards is identified, a compliance plan was issued by HIQA to the service provider. In the compliance plan, management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the progress in implementing the action(s) set out in any compliance plan submitted. HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.

Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.

Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.

Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Substantially Compliant

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