Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	Bon Secours Health System CLG trading as Bon Secours Hospital Dublin
Centre ID:	OSV-0008818
Address of healthcare service:	Glasnevin Hill Glasnevin Dublin9 D09 YN97
Type of Inspection:	Announced
Date of Inspection:	29/04/2025 to 30/04/2025
Inspection ID:	NS_0122

About the healthcare service

Model of hospital and profile

The Bon Secours Hospital, Dublin is part of the Bon Secours Health System Group*. Established in 1951, the hospital is an acute general hospital delivering services to elective adult only in-patient and outpatient care for low risk medical and surgical patients.

Services provided by the hospital include:

- elective general surgery
- ear, nose and throat (ENT)
- ophthalmology
- orthopaedics
- general medicine
- gastroenterology
- cardiac
- diagnostics

The hospital also accepts direct patient referrals for medical assessment, from a GP, a consultant or self-referral.

The hospital operates an out-patient satellite clinic in Cavan that offers consultations and limited non-invasive diagnostics tests.

The following information outlines some additional data on the hospital.

Number of beds	90 inpatient beds 70 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*

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

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 previous inspection findings (where available), information submitted by the provider, unsolicited information[‡] and other publically 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

[†]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.
[‡] Unsolicited information is information not requested by HIQA but is received by HIQA from people who use services, their relatives, staff in the service or any member of the public

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)
29/04/2025	08.30 – 17.00	Rosie O'Neill	Marguerite Dooley Mary Flavin Maeve McGarry
30/04/2025	08.30 – 13.30	Rosie O'Neill	Marguerite Dooley Mary Flavin Maeve McGarry

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.[§§]

The inspection team visited three clinical areas:

- Medical Assessment Unit (MAU)
- St Brigid's Ward (general medical and cardiology)
- Sacred Heart Ward (general surgical, orthopaedics and general medical)

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

- Infection Prevention and Control
- Drugs and Therapeutics
- Deteriorating Patient and Sepsis
- Bed Management

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

[§] . 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.

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 medical assessment unit (MAU) was a ten bay unit, which included two isolation rooms, was open five days a week, from Monday to Friday (07.30am to 7.15pm) and provided services to adults over 18 years of age. St Brigid's was a 18-bedded general medical and cardiology ward comprised of four single rooms, two two-bedded rooms, two three-bedded rooms and one four-bedded room. Sacred Heart was a 26-bedded general surgical, orthopaedic and medical ward comprised of five single rooms and seven three-bedded rooms.

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. All the patients were complimentary about the staff and the care they received commenting that "*everything was explained well*", "*a great stay so far*", and "*the staff were brilliant*". The patients inspectors spoke with were not aware of the hospitals complaints policy, but outlined that they would raise any concerns with the nursing staff. Any concerns patients raised with inspectors were brought to the attention of the Clinical Nurse Manager (CNM).

Experiences of receiving care, as recounted by patients to inspectors, were consistent with the findings from patient evaluation surveys that patients had the option to complete following discharge.

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 Dublin was found to be compliant with the three national standards (5.2, 5.5, 5.8) and substantially compliant with one national standard (6.1) assessed. Key inspection findings leading to the judgment of compliance with these four national standards are described in the following sections

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

The Bon Secours Hospital, Dublin 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 Group (BSHSG).

Board of Directors

The Board of Directors (Board) was the governing body responsible for strategic direction, accountability, and oversight of the BSHSG. The Board appointed a Group Chief Executive Officer (CEO), who was responsible for operational delivery, strategic alignment, and mission execution, and was accountable to the Board.

The Board appointed the hospital CEO who was delegated with overall responsibility and accountability for service delivery, financial targets, quality standards and mission effectiveness at the Bon Secours Hospital Dublin. The hospital CEO was a member of the BSHSG Executive Management Team (EMT). The EMT was accountable to the group CEO designate and the group CEO, who were accountable to the Board.

Hospital Management Team

The hospital CEO was supported by the Hospital Management Team (HMT) which was the senior executive forum of the hospital and met every two weeks and as required. The Terms of Reference (ToR) outlined the HMT was responsible for overseeing the strategic direction of the hospital, monitoring and managing service delivery, financial targets, quality standards and ensuring effective risk management and mission alignment. 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.

Medical Advisory Committee

In line with the ToR the purpose of the Medical Advisory Committee (MAC) 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 HMT on issues affecting the provision of healthcare including the recommendation on the awarding of privileges to consultants by the CEO. The MAC was chaired by a medical consultant, was accountable to the hospital CEO and met quarterly. Documents submitted to HIQA show a standard agenda, and minutes demonstrate actions arising from meetings were assigned to named individuals, were time-bound and followed up from meeting to meeting.

Clinical Governance Committee

In line with the ToR the purpose of the Clinical Governance Committee (CGC) was to provide the HMT with the assurance that excellence in care was delivered in the hospital, and in particular, that adequate and appropriate governance, measurements and controls were in place. The CGC was chaired by the hospitals' Clinical Director was accountable to the MAC and met twice yearly. Documents submitted to HIQA show 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 CGC also reported quarterly to the chairperson of the Board on quality and patient safety issues.

The hospitals' Clinical Director 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 Director of Nursing (DON) was responsible for the organisation, management and delivery of nursing services in the hospital and reported to the hospital CEO.

Quality, Risk and Patient Safety Committee

In line with the ToR the purpose of the hospitals Quality, Risk and Patient Safety Committee (QRPSC) was to provide senior leadership with the assurance that high quality and safe standards of care was provided by the hospital and, that adequate and appropriate structures, processes and controls were in place to support the delivery of care. The QRPSC was chaired by the hospital CEO, was accountable to the EMT and met quarterly. A number of other committees reported to the QRPSC, including Infection Prevention and Control, Drugs and Therapeutics and Deteriorating Patient and Sepsis. Sub-committees furnished reports to the QRPSC on a quarterly basis and provided updates at each meeting. Documents submitted to HIQA show a standard agenda, and minutes demonstrate actions were assigned to named individuals, were time-bound and followed up from meeting to meeting. Inspectors were satisfied that the committee had effective oversight of the quality and safety of healthcare services at the hospital.

Infection Prevention and Control Committee

In line with the ToR, the purpose of the Infection Prevention and Control Committee (IPCC) was to provide advice and to communicate to the HMT all aspects of infection prevention and control in the hospital and to provide assurance to the QRPSC and HMT that there was a clear accountability framework for infection prevention and control (IPC) within the hospital. The committee was chaired by the hospital CEO was accountable to the QRPSC and met quarterly. The day-to-day management of IPC was assigned to the IPC team. Documents submitted to HIQA show a standard agenda, and minutes demonstrate actions arising from meetings 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 purpose of the Drugs and Therapeutics Committee (DTC) was to make recommendations on and formulate hospital policy regarding the safe, effective and cost-effective prescribing and use of medicines in the treatment of hospital patients. The DTC had recently established a nurse prescribing working group to provide oversight, and support the introduction of nurse prescribing. The committee was chaired by a hospital consultant, was accountable to the QRPSC and met quarterly. Documentation 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 pharmacy service also met with other pharmacy services in the group through a monthly forum.

Deteriorating Patient and Sepsis Committee

In line with the ToR the purpose of the Deteriorating Patient and Sepsis Committee (DPSC) was to provide a local governance structure in relation to the areas of Irish

National Early Warning system (INEWS)***, the deteriorating patient and sepsis, with responsibility for the ongoing performance and service improvement of the above in the hospital. The DPSC was chaired by the hospitals' Clinical Director, was accountable to the QRPSC and met quarterly. The hospitals INEWS and sepsis working groups reported to, and furnished quarterly reports to the committee. Documentation 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.

Transitions in Care

The management of patient flow into, across and out of the hospital was managed by the scheduling and bed manager, (accountable to the CEO and DON), and the patient flow coordinator (accountable to the DON). The hospital had a service level agreement in place with one private hospital and an arrangement with another private hospital for the use of intensive care beds, bed to bed transfers only.

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 meeting minutes was articulated in meetings with lead representatives during inspection. An area for improvement includes formalising the current arrangement with one of the private hospitals for the use of intensive care beds, bed to bed transfers only.

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.

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

Medical Assessment Unit

The hospital operated a five day medical assessment unit (MAU) from Monday to Friday that offered a consultant led service and a range of diagnostic tests for medical patients requiring immediate care. There were three pathways for referral to the MAU; referral from a GP, referral from a hospital consultant or self-referral. The MAU had an inclusion

*** 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.

and exclusion criteria policy which set out the clinical conditions that could be assessed in the unit. This information was also publically available on the hospital website. All patients who were referred to the unit underwent a telephone pre-assessment prior to being given an appointment.

Inspectors were informed that approximately once a month a member of the public presented themselves at the main hospital reception, either requesting, or in need of medical assistance. In such cases a member of the MAU staff carried out an initial assessment, with the person either being transferred to the MAU for immediate treatment or given an MAU appointment. If the person's clinical presentation was outside the scope of the MAU, they were advised to attend their GP, attend an emergency department and when necessary the hospital organised an ambulance transfer to an emergency department.

The MAU was under the clinical leadership of a consultant in emergency medicine, with a consultant and NCHD on duty each day. The day to day operational management of the unit was the responsibility of the CNM II who reported to the site nurse manager. On the day of inspection the unit was noted to be operating well with effective medical and nursing management. The hospital measured a number of patient experience metrics, 2024 data demonstrated patients were reviewed and a care plan put in place within specified time frames. Overall inspectors were satisfied there was appropriate leadership, governance and oversight for the effective management of the MAU.

Infection Prevention and Control

The IPCC had oversight of the implementation of the hospitals IPC and antimicrobial stewardship (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[†††], audit, hand hygiene, AMS, clinical support and education. 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.

Medication Safety

The hospital had a clinical pharmacy service[‡‡‡] in place that was available from Monday to Friday (09.00am to 17.00pm) and Saturdays (09.00am to 11.00am). Outside of core hours the site nurse manager was the designated point of contact, and pharmacy staff could be contacted by telephone for advice and support. Pharmacist-led medication

[†††] 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.

[‡‡‡] 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

reconciliation was carried out on over 90% of inpatients. Antimicrobial medication management was supported with staff access to a dedicated pharmacist, consultant microbiologist and an on-call microbiology service. The pharmacy service had a 2025 work plan that set out objectives to be met, which included, compliance with key metrics, AMS in conjunction with the IPCC, and a focus on venous thromboembolism (VTE) management.

Deteriorating Patient and Sepsis

The DPSC was led by the hospital CD with membership from the wider hospital including microbiology, anaesthesiology, nursing, IPC, pharmacy and nurse practice development. The DPSC had a 2025 work plan that set out objectives to be met, which included, compliance with key metrics, sepsis management and escalations of care.

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 cardiac arrest, anaphylactic shock and sepsis management.

Inspectors reviewed the out-of-hours and on-call arrangements for medical staff, 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 scheduling-bed manager, and the patient flow coordinator were responsible for daily admissions and discharges of patients. The scheduling-bed manager was responsible for scheduled admissions and inter-hospital transfers during core hours, at all other times the site nurse manager was responsible. The patient flow coordinator was responsible for the discharge of complex patients to home or community settings. The hospital had guidance in place for the management of unscheduled presentations, admissions to, transfers within and transfers from the hospital. The patient flow coordinator described good links with another hospital in the area, which assisted in supporting patients being discharged from the hospital.

§§§ 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.

Hospital activity was reviewed four times a day at multidisciplinary safety huddle meetings, where patient flow, patient acuity and any risks were discussed and managed. The patient flow coordinator also attended a daily huddle with another hospital in the area.

There was an agreed pathway with a hospital in the area to provide specialised critical care support for patients who became critically unwell.
The 2025 work plan included a review of all incidents of clinical handover, laboratory tests turnaround times, all transfers out of the hospital, unexpected returns to theatre, unexpected readmissions, unexpected deaths, ambulance response times and documentation.

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 QRPSC and was a standing item on the quarterly BSHSG performance meetings. Escalation of hospital risks was to the risk forum, which was a subcommittee of the 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.

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 national guidelines, hospital activity, incident management, service user feedback, workforce management and training.

The data results were reviewed at the relevant committees, the QRPSC and at the quarterly CGC and BSHSG performance meetings. Inspectors reviewed a range of metrics, audits and key performance indictors (KPI's) with evidence of quality improvements plans to address compliance. Results were shared with staff through line management structures, local education and the monthly QRPSC safety bulletin.

Management of patient-safety incidents

The hospital proactively identified, documented and monitored patient-safety incidents. The QRPSC provided oversight and management of all patient-safety incidents which occurred within the hospital and were tracked and trended by the QRPS department. Incidents were discussed at local governance committees, the QRPSC, the HMT, and reports were provided quarterly to the CGC and BSHSG performance 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, local education and the monthly QRPSC safety bulletin.

Feedback from people using the service

The hospital collected data from patients following discharge through a patient evaluation survey. Feedback from people using the service was shared with staff to promote awareness and learning. Inspector reviewed evidence of QIP's that had arisen from patient feedback.

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 BSHSG Chief People Officer and the hospital CEO and was a member of the HMT. 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 HMT and the BSHSG performance meetings.

Workforce

At the time of inspection the hospital whole time equivalent[****] (WTE) was 670.66. The absenteeism rate was 3.48% and the vacancy rate was 5.93%.

Employees were supported by their line managers and HR, with systems in place to support 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 a quick response (QR) code system and had an established equality, diversity and inclusion programme in the hospital.

Consultants working at the hospital were not employed directly by the hospital but were granted privileges[††††] to practice medicine at the hospital with a consultant complement of 227. The types of privileges ranged across a number of categories, from full admission privileges (admit or refer inpatients and day cases), visiting privileges (diagnostic reporting, anaesthesiology procedures, pathology procedures) and consultation services only privileges. The Medical Advisory Committee oversaw recommendations to the hospital CEO on the granting of privileges, with final approval granted by the BSHSG. A formalised process, supported by a BSHSG 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 which was a mandatory condition to gain privileges.

At the time of inspection the NCHD WTE was 16.62. 70% where employed by the hospital with the remaining 30% filled through agency. Inspectors were informed that permanent NCHD staff were currently being recruited to address the vacancy rate, with all positions being filled for the next intake of NCHD's in July 2025. This risk was recorded on the hospital risk register.

Each patient's named consultant were the primary source of contact during and outside core working hours for matters relating to their clinical care. At all times there were NCHDs at specialist registrar and registrar grade available on-site for the clinical review of patients. 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.

[****] 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 287.04 with a vacancy rate of 5.39%. Staffing levels from the clinical areas visited on the day of inspection were reviewed. Staff did inform inspectors that with the increased acuity of patients admitted to the hospital, patient care would benefit from additional ward staff.

The hospital had an IPC team in place compromising of 1 WTE, consultant microbiologist, 1 WTE CNM 111, 1 WTE hygiene and decontamination manager and 0.5 WTE administrative support. There was an out of hour's on-call microbiology service also available.

The hospital had 4.7 WTE pharmacists and 3 WTE pharmacy technicians with no vacancies. A 0.5 WTE post was a dedicated antimicrobial pharmacist.

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 and the nurse practice development unit with the hospital currently moving to an online management platform.

Training records from the three clinical areas visited on the day of inspection showed close to full compliance rates for the mandatory training related to IPC, INEWS, 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 confirmed 50 (17%) nurses were also trained in advanced cardiac life support (ACLS)[§§§§], with plans to train additional nurses in the future.

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: 81% to 100% for IPC training, 65% to 94% for hand hygiene training, 98% for INEWS and ISBAR training and 70% to 92% for BLS training. Inspectors were informed that the move to the online management platform will assist in identifying staff not in compliance with training.

[§§§§] For healthcare professionals who either direct or participate in the management of cardiopulmonary arrest or other cardiovascular emergencies and for personnel in emergency response

Overall, inspectors found that hospital management were planning, organising and managing their healthcare workers to support the provision of high-quality, safe healthcare. The hospital are currently addressing the 30% vacancy rate in the NCHD roster. An area for improvement includes:

- progressing compliance with mandatory and essential training in the hospital.

Judgment: Substantially Compliant

Quality and Safety Dimension

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

Bon Secours Hospital Dublin was found to be compliant with five national standard (1.6, 1.7, 2.8, 3.1, 3.3) and substantially compliant with two standards (1.8, 2.7) 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' beds when delivering care and speaking to patients' in a respectful manner. Information was communicated in a clear and easily understood way and supported with relevant written information. Inspectors were informed that offices were available to patients' for private 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 to inspectors that staff were "*very courteous*", "*staff were brilliant*" and "*the cleaning staff were very friendly*". Inspectors observed call bells at each bed and patient's inspectors spoke with knew how to use the call bells.

Staff communication white boards were in place in the nurses stations. Patients' healthcare records (HCRs) were stored appropriately and information was observed to be protected on the day of the inspection.

In quarter one 2025 the hospital's own patient evaluation survey scored 9.9 when patients were asked; "*were you treated with dignity and respect ?".*

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. Mission statements were observed in ward areas.

Staff were observed actively listening to patients and responding in a considered and caring manner. This was confirmed by patients who expressed their satisfaction with the care and kindness they received. For example patients' stated that *"staff come and talk with you "* and *'everything is explained very well'.*

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 quality, risk and patient safety manager (QRPS) manager and was assigned responsibility for managing complaints in line with the BSHSG 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 hospitals response. The QRPS manager provided quarterly reports and a yearly report on patient feedback to the QRPSC and the BSHSG performance meetings.

For verbal complaints, local resolution at the point of care was encouraged in the first instance. Verbal complaints were recorded and the complaints manager was informed. 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, 116 complaints were recorded which included 40 verbal complaints and 76 written complaints. The hospital also offered inpatients the opportunity to participate in a patient evaluation survey following discharge.

Inspectors were informed that posters outlining the complaints process were currently on display in patient registration areas only, with a plan in place to extend these posters across the hospital. Inspectors noted a link to a feedback and complaints page on the hospitals website. Inspectors did not observe any information on how to access independent advocacy services in the clinical areas inspected.
Patient feedback was shared with staff individually, through line management structures, departmental staff meetings, and the monthly QRPSC safety bulletin.

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. Areas for improvement include:

- ensure patients have access to information on how to make a complaint, provide feedback and access to independent advocacy services.

Judgment: Substantially 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 MAU, St Brigid's ward and Sacred Heart ward, and overall observed that the physical infrastructure was clean and well maintained with some minor exceptions. The MAU was a 10-bedded unit, that included two isolation rooms, one of which was en-suite. Patients' had access to two toilets in the unit. The inpatient wards visited comprised of single rooms and two, three or four-bedded multi-occupancy rooms. All rooms had en-suite toilet and shower facilities.

In the clinical areas visited physical distancing of greater than one metre was observed between beds in the multi-occupancy rooms and in the MAU. 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 were informed that hygiene services were available from 07.00am to 10.00pm. Inspectors observed a green tagging system to indicate equipment had been cleaned in the clinical areas and were informed that nursing staff and HCA's carried out all of the equipment cleaning. Terminal cleaning[*****] and environmental cleaning was carried out by the hygiene services staff. Oversight of cleaning was by the hygiene services manager, the hygiene and decontamination manager (member of IPCC) and ward managers.

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 83% to 100%, with QIPs in place to address non-compliance.

Inspectors observed appropriate waste management in the clinical areas visited with clinical and non-clinical waste bins. There were dedicated medication preparation areas in the clinical areas visited with evidence of appropriate and secure medication storage. Sharp bins were partially closed, signed and dated. There was appropriate segregation of clean and used linen.

Inspectors observed that that not all the hand hygiene sinks for use in clinical areas conformed to recommended standards[†††††]. Inspectors observed some surfaces in bathrooms that did not facilitate effective cleaning. Inspectors were informed that sinks not in compliance with recommended standards, and bathrooms that required upgrading had been identified with a plan to carry out the upgrading works during 2025.

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 40 en-suite isolation rooms, staff were satisfied that this was sufficient to meet current demand.

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. Areas for improvement include:

- progressing the upgrade works to bring hand hygiene sinks for use in clinical areas and bathrooms in compliance with current standards.

Judgment: Substantially Compliant

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

[†††††] Health Protection Surveillance Centre, 2024. Infection Control Guiding Principles for Building.pdf

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, and national performance indicators and also service user feedback to measure the quality and safety of care provided. The hospital had a 2025 quality improvement and patient safety programme in place. The programme outlined KPIs and benchmarks that were measured against set targets and reported monthly through relevant governance committees and at BSHSG level.

Infection prevention and control monitoring
The IPCC had oversight of the IPC practices in the hospital. The IPC team reported quarterly to the QRPSC on monthly rates of *clostridium difficile infection*, *methicillin-resistant Staphylococcus aureus* , *methicillin-susceptible Staphylococcus aureus*, and joint replacement surgical site infection (SSI) rates. Inspectors reviewed the data and noted prevalence was lower or equal to the hospital KPIs, with the exception of knee replacements, where two superficial infections were reported during 2024, which brought it above the hospital KPI. Inspectors were informed that currently all inpatient admissions are screened for *Carbapenemase-producing Enterobacterales* with the rates under constant review with no recorded infections since quarter two 2024.

The hospital has a surveillance programme in place though the use of care bundles for peripheral vascular catheters, central venous catheters, urethral catheters. In 2024 the compliance rates were greater than 95%. There were also care bundles for surgical site infection rates, with compliance at 82.5%, inspectors were advised, for this measure there were a reduced number of audits due to the transition to online data collection. Across all measurements in IPC there was evidence of QIP's to address non-compliance, with improvement plans and reaudit agreed with an assigned owner. Inspectors confirmed that all notifiable diseases were reported to the Health Protection Surveillance Centre.

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

Results were shared with staff through line management structures, quality boards in the clinical areas, education and the monthly QRPSC safety bulletin. Inspectors were satisfied that the IPCC had oversight of monitoring of infection prevention and control practices in the hospital.

Antimicrobial stewardship monitoring

There was evidence of monitoring and evaluation of AMS practices in the hospital. These included collating data and reported quarterly to the IPCC on compliance with national KPIs for antibiotic prescribing, antibiotic prophylaxis and antibiotic consumption. Inspectors reviewed the 2025 work plan which demonstrated ongoing monitoring and evaluation of antibiotic consumption, antibiotic prophylaxis and antibiotic prescribing.

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, labelling, and observational audits of practices. 2024 audits reviewed showed compliance ranged between 80% and 100%, with the exception of the observational audits were compliance ranged from 50% to 100%. Documentation reviewed showed audits were discussed, improvement plans to address compliance and re-audit agreed with an assigned owner. 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, and the clinical communication tool, ISBAR to monitor compliance. The overall compliance rates for both metrics for 2024 and quarter one 2025 was above 93%. In areas were compliance was below the hospital KPI there was evidence of improvement plans to address compliance and re-audit agreed with an assigned owner.

The hospital collated data on sepsis management. Inspectors reviewed the annual sepsis report for 2024, and minutes from meetings which showed a comprehensive approach to sepsis management in the hospital. The hospital tracked and trended patient's with a confirmed diagnosis of sepsis and screened using the clinical decision support tool (sepsis 6). Non-compliance was reported via the incident management structures and followed up accordingly. The hospital had recently introduced a sepsis management pack to support clinicians in the diagnosis of sepsis. The pack contained the sepsis 6 algorithm, fluid resuscitation algorithm and AMS prescribing guidelines. The 2024 report shows that compliance with the administration of antibiotics as per local guidelines scored 86% compliance. It is evident the hospital were proactive in highlighting the importance of sepsis management with a plan of work for 2025.

Transitions in care monitoring

The hospital audited and reported on metrics related to patients transitioning into, across and out of the hospital. These included, unplanned, urgent and critical transfers from the hospital, readmissions of surgical patients, returns to theatre, unexpected deaths, transfer documentation, ambulance times and MAU triage and patient experience times.

The hospital also collated data on all transfers of patients who attended the MAU. In 2024, 1544 patients were reviewed in the MAU, with 479 admissions (31%), and 32 (3.0%) patients transferred, either directly from MAU or following admission. These patients required higher levels of care that could not be provided at the hospital.

The QRPS department had oversight and was the central repository for all quality and safety data in the hospital. In summary, inspectors were satisfied that the hospital systematically monitored and evaluated healthcare services.

Judgment: 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

Risk management in the hospital was supported with the BSHSG risk management policy. The QRPSC 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 all risks were in the low to moderate risk categories. Inspectors confirmed there were no risks related to the four areas of harm escalated to the corporate risk register. Inspectors reviewed risk assessments and risk registers in the clinical areas visited and were informed these were updated annually with the assistance of the risk officer. Staff whom inspectors spoke with were not aware of the hospitals ongoing risk management processes outside of their own areas. Inspectors were informed that this will be addressed with the introduction of an online risk management platform in late 2025.

Infection, Prevention and Control

The IPC team reviewed the IPC risk register, incidents and reported to the QRPSC quarterly. The highest rated risk was related to the non-conformance of a number of hand hygiene sinks for use in clinical areas to recommended standards, with a plan of work in place for 2025 to address these.

Inspectors were satisfied that the hospital screened all patients for multi-drug resistant organisms (MDROs) on admission in line with national guidance. Screening included MRSA, CPE, VRE and *extended spectrum beta-lactamase* (ESBL). Patients were isolated as per national guidance. This was in keeping with what staff told inspectors about the pre-admission screening process and patient isolation management. It was evident from talking to staff that IPC was a daily and ongoing focus in the hospital.

In 2024 the hospital had outbreaks of influenza A and COVID-19. Inspectors reviewed outbreak reports, which showed a multidisciplinary team was convened to oversee the management of the outbreak. The hospital had an outbreak of CPE in late 2024, with QIPs in place including ongoing screening of admitted patients.

Legionella testing was conducted every six weeks and measures were implemented to address report findings and was recorded on the IPC risk register.

At the time of inspection there were building works underway in a closed section of the hospital. The hospital had in place a construction permit and infection control approval form. These laid out the type of works to be undertaken, risk management, IPC measures and patient risk reduction strategies with agreed approval from the IPC team.

Medication Safety

The DTC reviewed the medication safety risk register, medication incidents and reported to the QRPSC quarterly. The hospital had a list of high-risk medications, inspectors observed high-risk medications were stored separately in individual red boxes in clinical areas visited. The hospital had developed a list of sound-alike-look-alike drugs (SALADs), with these drugs also stored separately from the main ward stock. Both lists were on display in medication preparation areas. Patient medications were stored in individual boxes in the drug trolley. Hospital staff had access to a medicines formulary via hospital desk-top computers and antimicrobial management via a telephone application (app).

Deteriorating Patient and Sepsis

The DPSC reviewed the deteriorating patient risk register and patient safety incidents and reported to the QRPSC quarterly. The hospital had systems in place to manage the deteriorating patient, these included the use of INEWS, sepsis 6 and ISBAR to support communication between staff in relation to patient care. Staff were knowledgeable about escalation and response protocols.

Inspectors reviewed the out-of-hours and on-call arrangements for medical staff, which demonstrated effective cover across all specialities. Escalation of care was to the NCHD in the first instance in line with the escalation and response policy and thereafter to the primary consultant as required. In the event that the primary consultant could not be contacted there was a named alternative consultant.

Transitions of Care

The QRPS department reviewed the transitions of care risk register and patient safety incidents and reported to the QRPSC 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 templates to facilitate safe transitions of care. Inspectors were informed all transfers to and from the hospital was a consultant to consultant decision only.

All scheduled patients underwent pre-assessment prior to admission. The hospitals IPC guidelines supported scheduled admissions and alerts were also recorded on the electronic patient management system.

The average length of stay (ALoS) for medical patients was 5.4 days and for surgical patients 1.6 days. The hospital had in place a 'home by 11' initiative, with approximately 50% of inpatients discharged before 11am.

The hospital had a range of patient information leaflets which were given to patients prior to discharge. Following patient feedback the hospital had recently introduced a new initiative with a 'Danger Signs' information leaflet which outlined particular signs a patient needed to be aware of and actions to take following discharge.

Policies, Procedures, Protocols and Guidelines (PPPG's)
Staff had access to a range of up-to-date PPPG's through the hospital's document management system. All polices reviewed on the day of inspection were either hospital or BSHSG policies and were all up to date.

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. The hospital should ensure staff are updated on the ongoing risk management processes in the hospital.

Judgment: 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 BSHSG incident management framework. The hospital had patient safety incident management 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. Incident reporting had increased year on year from 226 reports in 2021 to 1072 reports in 2024. High levels of incident reporting correlate with a strong patient safety culture.

All patient safety incidents were reviewed and categorised according to policy. 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. Incidents were tracked and trended, reviewed at relevant committees, at the QRPSC quarterly and a report provided quarterly to the CGC and for the quarterly BSHSG performance meetings.

Inspectors reviewed examples of reviews carried out in response to patient-safety incidents which were in line with the BSHSG policy.

During the inspection, inspectors were aware of a critical patient incident that occurred in the morning, with a staff debrief initiated and completed the same afternoon.

Results were shared with staff through line management structures, local education and the monthly QRPSC safety bulletin.

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 Dublin 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 eight national standards (5.2, 5.5, 5.8, 1.6, 1.7, 2.8, 3.1, 3.3) and substantially compliant with three national standards (6.1, 1.8, 2.7).

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. An area for improvement includes formalising the current arrangement with one of the private hospitals for the use of intensive care beds, bed to bed transfers only.

The hospital was clear as to the function of the MAU with effective leadership, governance, and oversight in place to support patients' using the service.

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, with a plan in place to address the 30% vacancy rate in the NCHD roster. The hospital should progress compliance with mandatory and essential training in the hospital.

Quality and Safety

The inspection at Bon Secours Hospital Dublin 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. An opportunity for improvement is ensuring patients have access to information on how to make a complaint, provide feedback and access to independent advocacy services.

The three clinical areas visited were very clean and tidy, and free from clutter with some minor wear and tear. There was a plan in place to upgrade hand hygiene sinks for use in clinical areas and bathrooms to ensure compliance with current standards.

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 effective risk management structures and processes, with evidence of ongoing monitoring and review, an area for improvement is keeping all departments updated on the ongoing risk management processes in the hospital.

Finally, the hospital had effective systems in place to identify, report, manage, and respond to patient-safety incidents, with oversight from the QRPSC, the HMT, the CGC and BSHSG performance meetings. A year on year increase in incident reporting demonstrates a strong patient safety culture.

Overall, Bon Secours Hospital Dublin demonstrates effective oversight in quality and safety, with 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	Substantially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Compliant
Standard 1.7: Service providers promote a culture of kindness, consideration and respect.	Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Substantially Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Substantially Compliant
Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.	Compliant
Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Compliant

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