Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

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| Name of healthcare service provider: | Mater Private Network Dublin |
| Centre ID: | OSV-0008820 |
| Address of healthcare service: | Eccles Street, Dublin 7, DO7 WKW8 |
| Type of Inspection: | Announced |
| Date of Inspection: | 08/04/2025 and 09/04/2025 |
| Inspection ID: | NS_0140 |

## About the healthcare service

### Model of hospital and profile

The Mater Private Hospital Dublin is part of the Mater Private Network (MPN). The MPN Dublin is an acute tertiary healthcare facility located adjacent to the Mater Misericordiae Hospital and brings together over 200 specialist expertise to treat an extensive range of conditions including: heart, cancer, eye, orthopaedic, spinal and vascular (veins) conditions. The hospital provides 24/7 access through its cardiac care unit, private cancer centres, and an emergency department offering patients a walk-in service for immediate access to consultant care. It is managed by the Mater Private Network Hospital Board. Services provided by the hospital include:

- acute
- medical
- in-patient services
- elective surgery
- emergency care
- high-dependency care
- diagnostic services
- outpatient care.

### The following information outlines some additional data on the hospital.

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|---|---|
| **Number of beds** | 214 inpatient beds<br>24 day case beds |

## How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare Version 2 2024* (National Standards) as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare. To prepare for this inspection, the inspectors* reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publicly available information. This was the first inspection of the Mater Private Hospital Dublin undertaken by HIQA.

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.

*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.

## About the inspection report

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

### 1. Capacity and capability of the service

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

### 2. Quality and safety of the service

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) |
|---|---|---|---|
| 08/04/2025 | *08:30 – 17:30* | Elaine Egan | Geraldine Ryan<br>Angela Moynihan<br>Bairbre Moynihan<br>Laura Byrne |
| 09/04/2025 | *08:25 – 14:30* | Elaine Egan | Geraldine Ryan<br>Angela Moynihan<br>Bairbre Moynihan |

## Information about this inspection

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

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

The inspection team visited five clinical areas:

- Emergency department and Urgent Cardiac Care (UCC)
- St Camillus' Ward (paediatric/urology and cardiology)
- Our Lady's Ward (orthopaedic and spine)
- St Benedict's Ward (unscheduled care)
- St Elizabeth's Ward (oncology).

The inspection team spoke with representatives from the hospital's Executive Management Team, Quality and Risk and, Human Resource departments and clinical staff.

**Acknowledgements**

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

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

Over the course of the inspection, the inspectors spoke with a number of patients in the emergency department who told inspectors "staff were very nice and good", "excellent service, I am here just three hours and had bloods, ECG, ECHO, seen by consultant and waiting for a bed". In clinical areas visited patients were very complimentary about the nursing and medical staff. "Call bells are answered

[†] 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.

immediately", "staff are fantastic", "room is clean", "staff lovely and kind, good rapport with consultants and doctors", "the ward is spotless" "food is good" and "it feels like staff really listen". Patients told inspectors if they had a complaint they would speak with nursing staff on the ward. Staff were observed to be actively engaged with patients in a kind, respectful and caring way. Overall, all patients who spoke with the inspectors were complimentary about the care received.

## Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service (national standards 5.2, 5.5 and 5.8) is being provided. It also includes the standards related to workforce, use of resources (national standard 6.1).

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

Inspectors found that the corporate and clinical governance arrangements for assuring the delivery of safe, high-quality healthcare services were integrated, clearly defined and formalised. Organisational charts viewed detailed the management reporting structures, and the reporting arrangements for governance and oversight committees. The governance arrangements outlined to inspectors were consistent with those detailed in the hospital's organisational charts. However, the committee organogram did not include the recently formed Medication Safety and Optimisation sub-group.

The Mater Private Network Hospital Board (the Board) was responsible for providing comprehensive leadership, governance and oversight of the hospital to ensure the Mater Private Network (MPN) Dublin operated efficiently to enable the MPN Group to strategically direct accountability. The Board held at least ten regularly scheduled meetings a year and were responsible for approving and monitoring the hospital's programme for quality and patient safety.

The Board appointed a Group Chief Executive Officer (GCEO) who was a member of the Board. The GCEO was also the chair of the Hospital Executive Committee (ExComm). It was evident from discussions with management and from a review of

minutes of meetings that the ExComm team met as an Executive Management Team (EMT) monthly or more frequently if required. They were the senior decision making committee with responsibility for ensuring appropriate governance and oversight of the quality and safety of services at the hospital. Inspectors were informed that the ExComm team managed the resources of the Hospital Group to achieve strategic and annual business goals. Membership comprised Hospital Group Chief representatives and two clinical directors. Minutes of meetings reviewed clearly indicated alignment with terms of reference. The committee had a structured agenda which included governance and patient experience, quality, safety and risk management, and weekly rounding plan updates. All actions were assigned to a responsible person and it was evident that actions were progressed from meeting to meeting. The ExComm were accountable to the MPN Hospital Board.

The Board had a Board Sub Committee, the Group Board Quality and Patient Safety Committee who had responsibility for providing assurance to the Board that the MPN Dublin had good systems and processes in place for meeting its responsibilities for the quality of patient care safety within the MPN. The Group Board Quality and Patient Safety Committee was supported by Hospital Executive Committees and the Medical Advisory Boards. Members of the Group Board Quality and Patient Safety Committee were appointed by the Board and included members of the Board, the EMT and representatives of the Medical Advisory Committee. It was evident from minutes of meetings reviewed that meetings were structured as per the terms of reference. The Group Board Quality and Patient Safety Committee met monthly and through the GCEO and the Chair of the Group Board Quality and Patient Safety Committee, reported to the Board every second month. Agenda items discussed included the quality and safety plan 2025 and matters escalated from the Quality Using Effective and Safe Treatments (QUEST). Attendance at meetings was tracked. Actions were assigned to responsible persons and were time bound.

The hospital appointed a Group Chief Medical Officer (GCMO) for the management and oversight of medical professionals and clinical services at the hospital. The GCMO was accountable to the GCEO. The director of nursing was responsible for the organisation and management of nursing services at the hospital and reported to Chief Operations Officer (COO), who reported to the Group COO, to the Group Executive, GCEO and the Board.

The QUEST committee was the overarching structure for quality and safety in the hospital. This committee, chaired by the Group Director of Quality and Patient Experience, reported to the Group Board Quality and Patient Safety Committee and through it, to the Hospital Board. As outlined in its terms of reference, the committee meet monthly with a set agenda and, items discussed included the tracker, risk register, updates on electronic healthcare records, quality plans and key focus areas, and policy updates. Inspectors met members of the QUEST committee,

reviewed minutes of meetings and it was evident that actions were assigned to a responsible person and were monitored from meeting to meeting. There were 14 subcommittees reporting through the QUEST committee including infection control, drugs and therapeutics, management of information and electronic healthcare records (EHR). Subcommittees of the QUEST committee oversaw the effectiveness and the quality of practice in the four areas of focus of this inspection- infection prevention and control, medication safety and deteriorating patient (including sepsis). It was noted in the minutes of QUEST meetings that transitions of care were discussed.

Inspectors reviewed documentation provided for four committees which were a focus on this inspection; infection prevention and control, medication safety, deteriorating patient and transitions of care. It was clear that each committee functioned as per terms of reference, operated to a defined agenda and included relevant multidisciplinary members, each committee provided regular updates to the QUEST. Time-bound actions were assigned to responsible persons for three committees. However, it was noted that the Infection Prevention Control Committee (IPPC) assigned actions to a relevant team rather than a responsible person. Additionally, it was unclear whether these actions were reviewed from meeting to meeting.

In summary, inspectors found there were formalised governance arrangements for assuring the delivery of high-quality, safe reliable healthcare at the hospital. There was a formalised structure reporting process from each governance committee to the QUEST committee, the Group Board Quality and Patient Safety Committee, GCEO and the Board. From documentation reviewed and from meetings with relevant staff, it was evident that each governance committee discussed and monitored information on performance and quality of healthcare services, and of the hospital's compliance with defined metrics. However:

- the infection prevention and control committee did not assign actions to a responsible person and it was not clear if actions were reviewed meeting to meeting.

Judgment: Substantially Compliant

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

Effective management arrangements were in place to support and promote the delivery of high-quality, safe, reliable healthcare services. Hospital management had established several committees to achieve planned objectives and ensure effective

management arrangements for infection prevention and control, medication safety, the deteriorating patient and safe transitions of care of patients. Management systems were also established to oversee patient flow from the emergency department through the hospital and into the community.

**Infection Prevention and Control**

It was evident that the hospital's infection prevention and control team (IPCT) promoted and supported staff in implementing infection prevention and control practices. The IPCT was led by a consultant microbiologist and reported on the monitoring and surveillance of infection prevention and control practices to the IPCC. Two subcommittees reported into the IPCC; sepsis and antimicrobial stewardship. A representative from each subcommittee attended the IPCC quarterly meeting. Inspectors were informed that the IPCC devised and approved the hospital's annual infection prevention and control strategy that set out the priorities for the year. It was noted that progress made on implementing the strategy was formally reported to the QUEST, Group Board Quality and Patient Safety Committee and to the Board. The annual infection prevention and control summary report for 2024 detailed the work undertaken by IPCC in that year, and the hospital's performance in relation to infection prevention control practices, surveillance and monitoring, and appropriate key performance indicators (KPIs). The hospital's performance in these areas are discussed further in national standards 2.8 and 3.1.

The hospital's antimicrobial stewardship programme[††] was implemented and overseen by the consultant microbiologist and the pharmacy team. The antimicrobial stewardship team reported into the IPCC which was evident in minutes of meetings reviewed by inspectors. The Drugs and Therapeutics committee reviewed and responded to the annual antimicrobial stewardship report, as per terms of reference. An antimicrobial stewardship report 2024 detailed the work undertaken by the antimicrobial team in that year and included antimicrobial consumption data 2024, analysis of antibiotic use by class, meropenem[‡‡] usage 2024, national point prevalence survey of antimicrobial use October 2024, antimicrobial shortages, antimicrobial medication incidents and quality improvement initiatives 2024 and 2025. This is discussed further under national standard 2.8.

**Medication safety**

[††] Antimicrobial stewardship programme – refers to the structures, systems and processes that a service has in place for safe and effective antimicrobial use.
[‡‡] Meropenem is an ultra-broad-spectrum antimicrobial used for patient with life-threatening infection. Usage of this antimicrobial is restricted in Irish hospitals, in most instances this drug should only be prescribed on the advice of a consultant microbiologist.

The hospital's pharmacy service[§§], led by the chief pharmacist and the Drugs and Therapeutics committee (DTC), was the overarching committee overseeing the quality and safety of the pharmacy service and supported medication safety practices. The DTC had a dual reporting relationship to the QUEST and Medical Advisory Board and had defined and formalised reporting to both committees, and up to the Board. The DTC committee recently established a subcommittee, the Medication Safety and Optimisation sub-group. Measures to support medication safety practices were set out in the hospital's annual medication safety plan. Medication incidents and medication management priority risks were discussed at the weekly Incident Review committee meeting and at the QUEST committee meeting. Inspectors were told the medication safety annual report was due for completion in May 2025.

**Deteriorating patient**

The hospital's deteriorating patient programme[***] was overseen by two committees; a recently formed Sepsis Management committee and a Cardio Pulmonary Resuscitation committee. The Sepsis Management committee was chaired by a consultant in emergency medicine, met quarterly, and there were defined and formalised reporting structures to the QUEST committee. As outlined in the terms of reference, the Sepsis Management committee provided assurances to the QUEST committee with regard to the appropriate management of the deteriorating patient. It was evident from a review of minutes that actions were assigned to a responsible person and the status of actions were reviewed from meeting to meeting. It was also evident that sepsis was discussed at the QUEST committee meetings. Hospital management stated, and from a review of minutes of meetings it was evident a number of new initiatives were implemented or were in the process of being implemented including; uploading the sepsis form to the electronic healthcare record with links from the INEWS to a sepsis form and a new sepsis audit was recently implemented.

The Cardiopulmonary Resuscitation (CPR) committee was implemented under the leadership of a consultant cardiologist, a consultant anaesthetist, and membership was multidisciplinary. The CPR committee met three times a year and there were defined and formalised reporting structures to the QUEST committee. A terms of reference and a structured agenda was in place. Actions were assigned to responsible persons and actions were reviewed meeting to meeting. Hospital

[§§] Clinical pharmacy service - is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting

[***] The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the HSE. Early Warning Systems (EWS) improve recognition and response to signs of patient deterioration. A number of EWS designed to address individual patient needs are in place in acute hospitals.

management informed inspectors and it was evident from review of minutes, that deteriorating patient incidents were discussed with improvements and learnings noted and shared (for example, undertaking audits of CPR trolleys and cardiac arrest telephones protocols). From evidence provided during this inspection it was clear that there was management and oversight of the deteriorating patient in the hospital.

**Patient flow**

Admissions and patient flow staff reported to the head of clinical services and patient flow, who reported to reported to Chief Operating Officer. The hospital convened a Discharge Planning and Average Length of Stay Committee who were responsible for discharge planning processes. The committee was chaired by COO who was a member of the QUEST committee and Group Board Quality and Patient Safety Committee. The committee met monthly, had a terms of reference, operated off a defined agenda, and included relevant multidisciplinary members. It was evident from minutes of meetings that actions were assigned to a responsible person and status of actions were reviewed from meeting to meeting. Additionally, ED PET times, discharge lounge numbers, delayed discharges, medical public patients, consultant rounding and electronic healthcare record system were reviewed. Hospital management stated, and it was evident from a review of minutes of meetings that a number of recent improvements occurred, for example; updating admission and patient flow policy, St Anne's ward was recently opened (an additional 4 beds) and the emergency department hours extended to opening hours on Sundays since March 2025. It was evident that transitions of care were discussed at the QUEST committee meetings. From evidence provided during this inspection it was clear that there was management and oversight of transitions of care in the hospital.

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

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 for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

The hospital collected a range of different measurements related to the quality and safety of healthcare service provided. This included data relating to compliance against national metrics, hospital activity, patient-safety incidents, complaints, healthcare associated infections, workforce, training and risks that had the potential to impact on the quality and safety of services. It was evident that collated and performance data was reviewed at meetings of the relevant governance meetings (the QUEST committee meetings, Group Board Quality and Patient Safety Committee meetings and at meetings with the Board).

Risk management structures were established in alignment with the HSE's Risk Assessment Tool, which facilitated the proactive identification, assessment, evaluation, tracking and escalation of reported risks. The quality and safety manager was responsible for overseeing the effectiveness of the hospital's risk management processes. They reported to the Group Director of Quality and Patient Experience, who in turn updated the QUEST, Group Board Quality and Patient Safety Committee and the Board. Local risk registers with mitigating actions documented were observed in the clinical areas visited by inspectors. Inspectors noted that reported risks were managed by the clinical nurse managers (CNMs) and assistant directors of nursing (ADONs) with support from the quality department. All reported risks were discussed at the weekly Incident Review Committee meeting. It was evident that CNMs implemented actions to mitigate both actual and potential risks to patients. All departmental risks (medium-rated risks) were documented in the hospital-wide risk register. Management stated when necessary, risks that could not be addressed within clinical areas were escalated to the QUEST, on to the Group Board Quality and Patient Safety Committee and up to the Board for review. These escalated risks were reviewed and if accepted, were documented on the corporate priority risk register.

A Serious Incident Management Team was responsible for ensuring that all serious reportable events and serious incidents were managed in line with local and national policies. The implementation of all recommendations and actions following reviews was overseen by Group Director of Quality and Patient Experience and by the QUEST. The hospital had a Quality and Patient Safety Plan (2023-2026) overseen by the QUEST committee. Inspectors reviewed the draft Group Quality and Patient Safety Plan 2025 which outlined five priorities for the year: improving patient

experience, enhancing the electronic healthcare record, prioritising clinical support pharmacy support services, ensuring robust infection prevention control measures, and deteriorating patients with a focus on maximising adherence to INEWS. The hospital's audit plan was also included in the Quality and Safety Plan 2025 with oversight provided by the QUEST with reports submitted to the Group Board Quality and Patient Safety Committee and through it, up to the Board.

Findings from a recent patient experience survey were positive. Hospital management stated that quality improvement initiatives had been implemented including updating signage in the hospital reception area and enhancing the hospital website. Further discussion on this topic can be found under national standards 1.7 and 1.8.

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

Judgment: Compliant

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

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

Inspectors reviewed the MPN Dublin Staffing Plan 2025 which was aligned to the hospital's operational objectives, prepared and determined based on the anticipated needs of the hospital.

Hospital management confirmed that the hospital currently employed 46 WTEs medical consultant positions, and confirmed all were on the relevant specialist division of the specialist register with the Irish Medical Council (IMC). It was also confirmed that consultants not employed by the hospital were granted privileges to practice in the hospital, and this was underpinned by a formalised process supported by a hospital policy. Responsibility and oversight of this process was assigned to the GCEO with final approval of privileges by the Board. Medical consultants were supported by a total of 44 WTEs non hospital consultant doctors (NCHDs), with 42 WTEs positions filled, two NCHD WTEs posts were vacant. Hospital management stated that the deficit did not impact on patient care. Patients' named consultants were the primary source of contact during and outside core working hours for

matters related to their care. During out of hours, there was one medical officer (registrar grade) available on site for medical review of patients and an anaesthetist onsite 24/7.

The hospital was funded for a total of 27 WTEs pharmacy posts. At the time of the inspection pharmacy had a full complement of staff. Management stated and inspectors noted that a clinical pharmacist was assigned to each clinical area and an antimicrobial stewardship pharmacist worked closely with staff in the clinical areas visited. The infection prevention and control team had a full complement of staff.

At the time of the inspection, there was a total of 610.91 WTEs (inclusive of management and other grades) funded nursing posts with 638 WTEs in place (an excess of 27.09 WTEs nursing posts in the hospital). Hospital management informed inspectors that 30.60 WTEs nursing posts were on different types of leave and nursing had 3.75 WTE vacancies in April 2025. The delivery of nursing care was supported by healthcare assistants (HCAs) and the hospital employed its full complement of 72 WTEs. On the days of inspection, the clinical areas visited had their full complement of nursing staff. Hospital management reported that a number of nurses had paediatric experience, and the CNM 2 held a paediatric qualification. Additionally, one nurse was pursuing a postgraduate diploma in paediatrics and was expected to return in May 2025.

The human resource department, reported to the Group Chief Peoples Officer who reported up to the ExComm committee, GCEO and the Board. Management stated that succession, recruitment, attrition and retention planning were ongoing priorities for the department. An induction programme was provided to all staff and this was confirmed by staff who had attended the induction programme. Hospital management also stated an adaptation programme was in place for international nurses on commencement of employment and this was confirmed by staff. Inspectors were informed that the staff absenteeism rate was 2.8% at the time of the inspection and this was being tracked.

Management explained that each department was responsible for overseeing the mandatory training of their staff and had a policy in place to support this. Management also described an ongoing initiative to centralise training records in progress at time of inspection. Attendance of NCHDs at essential and mandatory training sessions was recorded in the National Employment Record (NER) system, with copies sent to the human resources department in the hospital. This was confirmed by the NCHDs who spoke with inspectors.

Staff training records reviewed for nursing staff reflected excellent attendance across all mandatory training areas, indicating strong adherence to training protocols in the emergency department , St Benedict's and St Camillus' wards. However, nursing

staff in St Elizabeth's ward did not achieve 100% of mandatory training in basic life support and infection prevention and control. Similarly, nursing staff in Our Lady's ward did not achieve 100% in basic life support training. Healthcare assistants in Our Lady's ward and St Camillus' ward did not achieve 100% training in hand hygiene and infection prevention and control.

In summary, hospital management were planning, organising and managing the workforce to support the provision of high-quality, safe healthcare. Inspectors found that there was a strong commitment in the hospital for staff to complete mandatory training. However the following requires review:

- nursing staff compliance in mandatory training in basic life support (St Elizabeth's and Our Lady's wards) and infection prevention and control (St Elizabeth's ward)
- healthcare staff compliance in hand hygiene (Our Lady's and St Camillus' ward).

Judgment: Substantially Compliant

## Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety (1.6, 1.7, 1.8, 2.7, 2.8, 3.1, and 3.3). It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred.

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

It was evident through observation and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients. Staff were observed communicating with and providing care to patients in a manner that respected their privacy and dignity. Staff in the clinical areas visited who spoke with inspectors outlined how they promoted dignity, respect and autonomy for patients in their care. All patients were provided with menu choices and patients in the emergency department received vouchers for the hospital restaurant. Staff informed inspectors, and patients confirmed, that they were consistently kept informed about their plan of care.

There were en-suites in all single rooms and all multi occupancy rooms had a shared toilet and shower. Disposable privacy curtains were in place around each bed space. Inspectors were informed and observed that a room was available in clinical areas for private discussions with patients and families when required, and patients requiring end-of-life care were accommodated in single rooms.

Patients' personal information was observed to be protected and stored appropriately in line with relevant legislation and standards.

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

Judgment: Compliant

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

There was evidence that staff promoted a culture of kindness, consideration and respect for patients receiving care. Inspectors observed staff to be respectful, kind and caring towards patients and were communicating in an open and sensitive manner. Patients were highly complementary about their interactions with staff. Patients told inspectors "staff were very nice and good", "staff are fantastic", "it feels like staff really listen" and "call bells are answered immediately".

There was a significant focus on providing a patient-centred approach to care in the clinical areas. Patients were invited to participate in patient feedback surveys. Feedback was provided through the Hospital Consumers Assessment of Hospital Providers Services and the Voice of the Patient Net Promoter Score Survey. Inspectors reviewed results of surveys conducted in the hospital from July – September 2024. These responses provided detailed responses on various themes

and achieved the target of 88%. Overall, the feedback was very positive. This is elaborated on under national standard 1.8. Information leaflets covering a range of health topics were available and easily accessible to patients.

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.**

Inspectors found that there were systems and processes in place in the hospital to respond to complaints and concerns. The group director of quality and patient experience was also the patient liaison officer assigned responsibility for reviewing and collating information in relation to complaints. The hospital's complaints policy guided staff on the management of complaints and set out processes and timelines for acknowledging and responding to complaints.

Hospital management told inspectors that complaints were tracked, trended and discussed weekly at the Patient Services Team Meeting and also at the Voice of Customer committee meetings. It was evident that complaints and feedback were discussed monthly at the QUEST and escalated every second month to Group Board Quality and Patient Safety committee. Hospital management gave an example of a recent formal complaint that was escalated to the GCEO for further action which was addressed to the satisfaction of the complainant. The group director of quality and patient experience monitored the effectiveness and timeliness of the hospital's complaints management processes, and at the time of the inspection, 100% of complaints were resolved within the allocated timeframe of 30 days. Management outlined examples of changes implemented in response to feedback and complaints. These changes included updating signage at reception, revising letters to explain the length of procedures, and updating the website to clarify the hospital's financial requirements.

Inspectors observed that information on how to make a complaint was available to patients in the clinical areas visited. This information was provided in leaflets and on posters displayed throughout the hospital. Hospital management informed inspectors that patients and their families were informed that a member of Sage could attend complaints meetings at the hospital. Inspectors were provided with a recent example of this occurring.

Inspectors who spoke with patients in the clinical areas visited found that patients were not familiar with the hospital's complaints process and indicated that if they had a complaint they would speak to a member of staff. Staff in clinical areas stated

that verbal complaints were resolved at the point of contact and logged as incidents to share learning from all complaints received. Hospital management informed inspectors that complaints training was provided to staff during induction and this was confirmed by staff.

Staff in the clinical areas visited told inspectors they received feedback from patient surveys. Quality improvement plans following the recent survey included providing more food choices at meal times and offering snacks to patients. Overall, there was evidence that the hospital had systems and processes in place to respond effectively to complaints and concerns 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.**

Inspectors observed that the physical environment in the areas visited supported the delivery of high-quality, safe, reliable care.

In the clinical areas visited, all single rooms had en-suite bathroom facilities and in multi-occupancy rooms, patients shared en-suite bathroom in each bay. Inspectors observed that shared en-suites were clean on the day of inspection and cleaning checklists were completed.

Physical distancing of one metre was observed between beds in multi-occupancy rooms. The clinical areas visited had dedicated cleaners, with access to additional cleaning staff available out of hours if required. The CNM2 and cleaning supervisors had oversight of the standard of cleaning in their areas of responsibility. Staff articulated that there was sufficient cleaning staff in the clinical areas (day/night) and confirmed that bed curtains were changed regularly in line with hospital policy. The hospital employed an external cleaning company for environment and terminal cleaning[†††] and inspectors were told there was good access to the cleaning

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

supervisor and maintenance when required. The hygiene services for the MPN retained a gold cap award in 2024.

Inspectors were informed there was a system in place for the cleaning of equipment and patient equipment was observed to be clean. Inspectors noted that storage of equipment was an issue, for example,

- the assisted bathrooms in St Camillus' and Our Lady's wards were used to store equipment and staff belongings and not available for patient use
- patient equipment was stored on corridors and on the stairwell in St Elizabeth's ward
- the patient day room in Our Lady's ward was used to accommodate two fridges: one for ice packs for patient treatments and the other for staff use. The above were brought to the attention of management.

Patients requiring standard and transmission-based precautions were accommodated in single rooms. The single isolation room doors were mostly closed in the clinical areas visited with the exception of St Camillus' ward which was brought to the attention of the CNM for action. Personal protective equipment was available outside single rooms and all multi-occupancy rooms. The correct and appropriate use of infection prevention and control signage in relation to standard and transmission-based precautions was observed in the clinical areas visited.

Inspectors observed appropriate segregation of clean and used linen, and hazardous materials were safely and securely stored in the clinical areas visited. Wall–mounted alcohol hand sanitiser dispensers were strategically located and readily available to staff. Hand hygiene signage was prominently displayed in the clinical areas. Inspectors observed that not all hand hygiene sinks were compliant with national best practice.

In summary, inspectors found the physical environment supported the delivery of high-quality, safe, reliable care. However, the following was noted:

- not all hand hygiene sinks were compliant with HBN requirements
- patient equipment was inappropriately stored on corridors and a stairwell (St Elizabeth's ward), in a day room (Our Lady's ward). Patient equipment and staff belongings were inappropriately stored in assisted bathrooms (St Camillus' and Our Lady's wards).

Judgment: Substantially Compliant

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

Inspectors found that there were systems in place at the hospital to monitor, evaluate and continuously improve the healthcare services and care provided. Hospital management used information from a variety of sources (KPIs, findings from audit activity, risk assessments, patient-safety incident reviews, accreditation programmes, patient and family feedback) to compare and benchmark the quality of their healthcare services across the Mater Private Network, and to support the continual improvement of healthcare services. The Clinical Audit Steering Committee was established in 2024. The audit programme for 2025 was detailed in the Quality and Safety Plan (2025) draft report, which was reviewed by inspectors.

**Infection prevention and control**

Hospital management informed inspectors that the hospital reported four times a year to the Health Protection Surveillance Centre (HPSC) on rates of *Clostridioides difficile* * infection, *Carbapenemase-Producing Enterobacteriaceae* ‡‡‡(CPE), *Carbapenem-resistant Enterobacterales* §§§(CRE),*Vancomycin Resistant Enterococcus* ****(VRE), *Methicillin-resistant Staphylococcus aureus* †††† (MRSA). The Infection Prevention Control committee (IPCC) reported on these rates four times a year to the QUEST committee; however, it was not clear on minutes of the QUEST committee meetings reviewed if organism surveillance (*Clostridioides difficile, CPE, staphyloccus aureus, VRE,* central line associated infections, and catheter related blood stream infections) were discussed at the QUEST committee meeting. Hospital management stated that rates were low and this was also evident in the Infection Prevention and Control Committee Meeting Annual Report 2024 reviewed by inspectors.

Inspectors were informed that an Infection Prevention and Control Committee Meeting Annual report 2024 detailing the hospital's healthcare-associated infection

‡‡‡ Carbapenemase-Producing Enterobacteriales (CPE), are Gram-negative bacteria that have acquired resistance to nearly all of the antibiotics that would have historically worked against them. They are therefore much more difficult to treat.

§§§ Carbapenemase producing Enterobacteriaceae (CRE), are a family of bacteria which can cause infections that are difficult to treat because of high levels of resistance to antimicrobials.

**** Vancomycin Resistant Enterococci (VRE) are bacteria that live in the bowel. VRE can cause an infection if it gets into your bladder, kidneys or blood.

†††† Methicillin-resistant Staphylococcus aureus (MRSA) infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics used

surveillance was submitted annually to the QUEST, Group Board Quality and Patient Safety Committee and the Board.

Hand hygiene audits were carried out by the IPCT. A review of minutes of meetings indicated that audit findings were discussed at the IPCC, QUEST and Group Board Quality and Patient Safety Committee. Inspectors reviewed hand hygiene audits results submitted to HIQA for the clinical areas visited completed in January, February and March 2025. The results ranged from 83%-97%. The IPC representatives stated that when results fell below the expected standards additional hand hygiene training was provided and this practice was re-audited. Actions taken to improve compliance included, on-the-spot education, continuous in-service education, visual reminder in relation to bare-below elbow technique, feedback to CNMs and heads of departments in a timely manner, a training device deployed to all departments on a rotation basis to enhance staff knowledge and hand hygiene skills.

Clinical equipment audits were carried out by IPCT using adenosine triphosphate[‡‡‡‡] (ATP) swabbing to meet hygiene compliance. A review of minutes of meetings indicated that audit findings were discussed at the IPCC meetings and were included in the Infection Prevention and Control Committee Meeting Annual Report 2024. A sample of ATP audits completed in quarter 3 and quarter 4 2024 and quarter 1 2025 were reviewed. While the majority of results were below the goal of 25 in the clinical areas visited, it was noted that some ATP results above the goal of 25. Inspectors were told that actions were assigned to CNMs, however, it was not evident to inspectors that when the audit results were above normal levels if time-bound actions were assigned to a responsible person.

Environment and equipment audits were carried out using a computerised system. From a review of meeting minutes it was unclear to inspectors if audit findings were discussed at the IPCC meetings and noted that not all actions were assigned to a responsible person or were time-bound.

**Medication safety**

Medication audits were carried out and audit findings reported to the Drugs and Therapeutics committee and the recently formed (February 2025) Medication Management and Optimisation sub-group who will have a role in medication audit to underpin medication safety. A medication audit on the change of the management of controlled drugs was recently conducted. Recommendations included editing the register to include a date of birth, reorder levels and quantities for each ward based on usage, a new information poster for staff in clinical areas and a re-audit undertaken in three months. A spot audit looking at in-patient admissions over five days was completed and it was found that 18% of home medications were

prescribed correctly during admission. The actions generated following the audit included; greater clinical pharmacist surveillance and intervention on the wards and consistency in the work flow by prescribers for all admission pathways. However actions were not time-bound. The pharmacy department quarterly medication audit was completed in all clinical areas where medication was stored in the hospital. Each clinical area also conducted a Misuse of Drugs Act (MDA) audit checklist.

Antimicrobial stewardship practices were monitored and evaluated. Management stated that the hospital had participated in the European Centre for Disease Prevention and Control[§§§§] national point prevalence survey of the hospital-acquired infections and antimicrobial use. The findings in October 2024 found that antimicrobial prevalence in MPN Dublin was 43%, slightly higher than the national antimicrobial prevalence for all hospitals (40.2%). Inspectors reviewed the hospital's Antimicrobial Stewardship Report 2024 and noted the overall total annual antimicrobial consumption decreased in 2024 by 13% compared to 2023. The main areas of focus in 2025 is adherence to surgical prophylaxis, sepsis guidelines and more intravenous to oral switches when appropriate.

**Deteriorating patient**

Management stated that compliance with the early warning system escalation and response protocol was audited by the clinical facilitator monthly and results reported back to the CNM. Inspectors found that compliance rates in the months preceding the inspection ranged from 82% - 89% in four of the clinical areas visited. Actions following the audits were assigned to nurses and doctors but they were not time-bound. The emergency department recently commenced auditing the emergency medicine early warning score (EMEWS) with 66% compliance noted. There was no evidence provided to inspectors that time-bound actions were assigned for improvement. Sepsis audits conducted from January to March 2025 in St Elizabeth's ward revealed excellent compliance with the Sepsis 6 pathway. Actions included integrating the sepsis management form into the electronic healthcare record and initiating monthly audits across the hospital.

**Transition of care**

The clinical handover communication tool, Identify, Situation, Background, Assessment, Recommendation/ Read back/ Risk (ISBAR 3) audits had been carried

[‡‡‡‡] Adenosine triphosphate (ATP) is an energy molecule found in all living things. By testing for the presence of ATP on a surface, you're testing for the presence or growth of microorganisms, like bacteria.

[§§§§] The European Centre for Disease Prevention and Control (ECDC) is an agency of the European Union aimed at strengthening Europe's defences against infectious diseases. It provides scientific advice, data analysis, and support for disease prevention and control measures across EU member states

out in the hospital in January, February and March 2025 with low results noted in January and February (20% - 25%), with significant improvement in March (60%). Hospital management told inspectors that the low results were due to the recent implementation of the electronic healthcare records. Actions taken to improve audit results included providing additional information sessions for staff and re-auditing. Inspectors reviewed a transitions of care audit from the emergency department to the clinical areas, completed in January to March 2025. The results indicated that hand off sheets were completed for 53% of patients in January, 59% in February and 40% in March. Actions taken to improve audit results included training for nursing staff on completing the form and a change was required in the electronic healthcare record. Although actions were assigned to clinical nurse manager, they were not time-bound.

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

- actions from audits undertaken (IPC, medication safety, deteriorating patient and transitions of care) were not assigned to a responsible person and were not time-bound
- it was unclear if environmental and equipment audit results were discussed at infection prevention and control committee meetings
- hand hygiene audit results were not always reaching the target of 90%.

Judgment: Substantially Compliant

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

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

**Risk management**

There were systems in place to proactively identify, assess and manage immediate and potential risks to patients. All risks were analysed using the HSE Risk Assessment Tool (adopted by the hospital). Risks, along with associated controls and assigned actions to mitigate these risks to patients, were recorded on local risk registers viewed by inspectors. For example, these risks included emergency department activity finishing late and admitted patients staying overnight due to unavailability of beds. In the clinical areas, risks such as electronic health care record system, medication errors, COVID-19, weather alerts, paediatrics placed on adult ward, low hand hygiene compliance, staff training deficiencies and equipment

left in corridors were noted and some of these risks were noted during this inspection. It was clear from meeting minutes and discussions with management and staff that all departmental risk registers were reviewed quarterly by CNM, ADON and supported by the quality and risk manager and the group director of quality and patient experience. CNMs stated they were responsible for implementing and overseeing the effectiveness of actions. It was evident that risks that could not be managed in clinical areas were escalated to the relevant department head and committee for review.

The Executive Committee (ExComm) member or the head of department reviewed and approved the departmental risk register prior to submission to the Quality Department. The quality and risk manager stated they collated and categorised all departmental risks and combined it into one hospital-wide risk register. The categorised risks were shared with the appropriate Head of Department/Committee. Inspectors were informed that the quality and safety manager together with the group director of quality and patient experience manager defined the top departmental safety risks, known as the Departmental Safety Risk Register (medium rated risks). Hospital management stated that this register was presented to the Quest committee, and the Group Board Quality and Patient Safety Committee for review twice a year; inspectors observed this in the minutes of meetings reviewed. Medium-rated risks associated with the three of the four areas of harm were documented on the departmental safety risk register and included infection prevention and control, medication safety and clinical handover. It was noted that all risk assessments had assigned time-bound actions and were regularly reviewed. Management stated and staff confirmed that risk management training was provided. All high-rated risks were documented on the Corporate Priority Risk Register. The deputy CEO was responsible for this register and it was reviewed by the Hospital Board. The top three categories of high risks were capacity, private health insurance reimbursement and recruitment and retention of staff. Risk was not a specific agenda item on all committee and board meetings, however, it was evident to inspectors that risk was discussed at each meeting.

**Emergency department**

On the day of inspection, inspectors observed unauthorised access to a restricted area via an unlocked side entrance, access to intravenous cannulas and syringes in phlebotomy trolleys and staff property in unlocked storage presses containing patient equipment in the emergency department. A risk assessment was submitted to HIQA post inspection with a number of actions to mitigate these risks. All actions were assigned to a responsible person and were time-bound due for completion by 30 April 2025. Furthermore, the hospital confirmed that all of the above had been addressed and completed. This will be followed up on the next inspection.

**Infection prevention and control**

In line with national guidelines patients admitted to the hospital were screened for multi-drug resistant organisms (MDROs) and there was an electronic alert system on the electronic healthcare records to alert staff to patients who were previously inpatients with confirmed MDROs. Management stated that compliance with MDRO screening was audited by the IPCT and this was evident in the annual report 2024 reviewed by inspectors. Staff stated that patients requiring transmission-based precautions were isolated within 24 hours of admission or diagnosis, in line with national guidance and this was evident on the clinical areas visited. No outbreak of infection was reported on the days of inspection. Staff confirmed they had access to a microbiologist for advice when required.

**Medication safety**

A clinical pharmacy service was provided in all clinical areas visited and staff stated they could contact the pharmacy department if needed. Medication reconciliation was undertaken on all patients on admission. The hospital supported the use of a patient's own drugs and nurses supervised administration which was supported by a policy on the use of patients' own drugs. In the clinical areas visited, there was an automatic drug dispensing unit. Medication stock replacement was undertaken by pharmacy staff and the hospital site manager had access to stock out of hours. Staff described how they applied risk reduction strategies with high risk medicines aligned with APINCH[*****]. There was a list of sound alike look alike drugs (SALADS) underpinned by a hospital policy available. The hospital's medication management policy, prescribing guidelines, including antimicrobial guidelines and medication information were in date, available and accessible to staff at the point of care. Inspectors also observed that medicines were stored securely and in line with national guidance for example, insulin, potassium and opioids. Medication fridge temperatures were monitored and recorded.

**Deteriorating patient**

Staff used the most recent version of the national early warning system for various cohorts of patients. The Irish National Early Warning System[†††††] (INEWS) and the sepsis 6 care bundle were used to support staff to recognise and respond to the

[*****] 'A PINCH' medications represented the acronym A PINCH include anti-infective agents, anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants

[†††††] INEWS is an early warning system to assist staff to recognise and respond to clinical deterioration.

deteriorating patient. The ISBAR $_3$[‡‡‡‡‡] communication tool was used for clinical handovers. The emergency department used the Emergency Medicine Early Warning System (EMEWS). The Paediatric Early Warning System (PEWS) was used on the paediatric unit on St Camillus' ward. All staff spoken with were knowledgeable about the INEWS, EMEWS and PEWS escalation and response protocol to ensure timely management of patients with a triggering early warning score. Inspectors conducted a thorough review of a number of patients' healthcare records. It was observed that, while the majority of INEWS entries were appropriately recorded and adhered to the required frequency, there were instances where three patients' observations were not documented in accordance with policy due to missing parameters. This was brought to the attention of staff. Emergency equipment was readily available, such as a resuscitation trolley, an automated external defibrillator (AED), and a Broselow pack for paediatrics complete with algorithms, which was checked daily. Oxygen points were at each bedside. Sepsis management guidelines were available to staff.

**Transitions of care**

There was a system and a policy in place to support discharge and safe transfer of patients within and from the hospital during and outside of core working hours. The hospital had a defined criteria for admission. Each patient had a planned date for discharge, early consultant rounding and a discharge lounge was used to improve patient flow in the hospital. A Discharge Planning and Average Length of Stay committee meeting was held monthly and attended by senior hospital representatives (COO, DON, ADONs, medical workforce planner, head of scheduled and unscheduled care and commercial manager). Inspectors reviewed minutes of meetings which captured emergency department patient experience times (ED PETS, average length of stay (ALOS) and hospital readmissions. Hospital management stated that there were 12 delayed transfers of care (DTOC) of patients attributed to a delay with homecare packages. Hospital management also stated the average length of stay for patients had recently reduced by 45% due to an increase in patient discharges at the weekends. The rate of unscheduled re admissions per 100 discharges was monitored with a target of less than 7% with figures for July 2024= 4.08%, August 2024 = 4.94% and September 2024 = 4.99%. Inspectors were informed that the hospital had access to community beds and to Outpatient Parenteral Antibiotic Therapy[§§§§§] (OPAT) services for patients through their private health insurance. The hospital had a policy in place for transferring a patient to another facility. Inspectors reviewed a number of patients' discharge letters, with no issues identified.

**Policies procedures and guidelines**

Inspectors reviewed a range of policies procedures and guidelines and noted all were up to date. Staff had access to a range of up-to-date infection prevention and

control, medication safety, transitions of care and deteriorating patient policies procedures and guidelines via a document management system.

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

- INEWS observations in three patient records were not documented in accordance with policy.

Judgment: Substantially Compliant

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

The hospital had systems in place to identify, report, manage and respond to patient-safety incidents. The process was supported by an Incident Reporting and Management Policy, which aligned with the HSE's risk assessment tool for grading incidents. All incidents were reported using the local electronic system and were graded as low, medium, or high. Staff interviewed by inspectors were knowledgeable about reporting patient-safety incidents and were aware of the most common types reported. The quality department provided training on incident management and reported findings to hospital staff. This was confirmed by staff.

Hospital management informed inspectors that a risk analyst tracked and trended incidents. Patient-safety incidents were reviewed at the weekly Incident Review Committee meeting, chaired by the group director of quality and patient experience. Progress on incidents, local investigations and root cause analysis reports were escalated to both committees and this was as discussed by management with inspectors and noted in meeting records. Inspectors noted that the minutes of the Incident Review committee meetings did not specify time-bound actions. However, hospital management informed inspectors that all incidents were closed out within the target of 30 working days as per policy.

It was clear from discussions with management and noted in meeting minutes that the group director of quality and patient experience manager monitored the implementation of recommendations and quality improvement plans from patient-

‡‡‡‡‡ ISBAR communication tool stands for Identify, Situation, Background, Assessment and Recommendation. The tool is a structured framework which outlines the information to be transferred. ISBAR is a versatile and effective tool which can be used in a variety of situations, such as bedside handover, internal or external transfers (e.g. from nursing home to hospital, from ward to theatre) communicating with other members of the multidisciplinary team, and upon discharge/transfer to another health facility

§§§§§ Outpatient Parenteral Antibiotic Therapy (OPAT) is a treatment option in patients who require parenteral antibiotic administration, and are clinically well enough not to require inpatient hospital care.

safety incident reviews, and the Group Board Quality and Patient Safety Committee monitored the progress on actions from root cause analysis and system analysis.

There was oversight of patient–safety incidents related to the four key areas that were the focus of this inspection. It was evident in the minutes of meetings reviewed that incidents related to medication safety, transitions of care and the deteriorating patient were tracked, trended and discussed at the Incident Review committee meeting. Incidents were also discussed at the relevant governance committee meetings. Inspectors observed that infection prevention and control incidents were not recorded in the minutes of the Incident Review committee meetings provided to them. However, hospital management informed inspectors that these incidents were reviewed at the Incident Review Committee meetings when reported. It was evident that incidents related to infection prevention and control were discussed at Infection Prevention Control committee meetings and were included in the 2024 annual report reviewed by inspectors.

Medication incidents were further categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention****** (NCC MERP) medication error categorisation. Documentation reviewed indicated all medication incidents were reviewed at the Incident Review committee meeting, drugs and therapeutics committee and the QUEST.

Hospital management informed inspectors that serious incidents were reviewed by Serious Incident Management Team. Reviews including, root cause analysis, concise and comprehensive system analysis were completed within the target of 45 working days as per policy. Learning from incidents was shared with staff through various channels including huddles, clinical handovers, at the weekly incident review committee meeting, medication memos, CNM meetings, departmental meetings and formal training sessions and this was confirmed by staff.

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

Judgment: Compliant

****** The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) is an independent body composed of 27 national organizations. In 1995, the United States Pharmacopeial Convention (USP) spearheaded the formation of the National Coordinating Council for Medication Error Reporting and Prevention: Leading national health care organizations are meeting, collaborating, and cooperating to address the interdisciplinary causes of errors and to promote the safe use of medications

## Conclusion

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

### Capacity and capability

Inspectors found that the corporate and clinical governance arrangements for assuring the delivery of safe, high-quality healthcare services were integrated, clearly defined and formalised. The hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe, reliable healthcare services. There were systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. The workforce arrangements were managed to ensure the delivery of high-quality, safe and reliable healthcare.

### Quality and safety

There was evidence that staff promoted a culture of kindness, consideration and respect for patients receiving care. Inspectors found that there were processes in place to respond to complaints and concerns. The physical environment in the clinical areas visited supported the delivery of high-quality, safe, reliable care. Storage capacity in clinical areas visited required review. Inspectors found that there were systems in place to monitor, evaluate and continuously improve the healthcare services and care provided. The hospital had arrangements in place to ensure proactive identification, evaluation, analysis and management of risks to the delivery of safe care. The hospital had patient-safety incident management systems in place to identify, report, manage and respond to patient-safety incidents. It was evident through observation and discussions with staff members that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients.

## 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:

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| **Compliant:** A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard. |
| **Substantially compliant:** A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant. |
| **Partially compliant:** A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed. |
| **Non-compliant:** A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service. |

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

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|---|---|
| quality, safe, reliable care and protects the health and welfare of service users. | |
| 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 |