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:	Beacon Hospital
Centre ID:	OSV-0008878
Address of healthcare service:	Beacon Court Sandyford D18 AK68
Type of Inspection:	Announced
Date of Inspection:	27/05/2025 and 28/05/2025
Inspection ID:	NS_0149

About the healthcare service

Model of hospital and profile

Beacon Hospital is a private hospital located in Sandyford, South Dublin. It is operated by Beacon Hospital, trading as Beacon Hospital Sandyford Limited. Services provided by the hospital include:

- in-patient services for acute medical and surgical patients
- elective surgery for adults and children from the age of 6 months to 16 years
- emergency care
- intensive care
- diagnostic services
- outpatient care.

The following information outlines some additional data on the hospital.

Number of beds	181 inpatient beds 70 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 submitted by the provider, unsolicited information and other publicly available information since the last inspection.

During the inspection, inspectors:

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

About the inspection report

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

1. Capacity and capability of the service

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

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

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector	Support Inspector(s)
27/05/2025	*09:00 – 17:30*	Bairbre Moynihan	Danielle Bracken Geraldine Ryan Laura Byrne Rosarie Lynch
28/05/2025	*08:45 – 16:00*	Bairbre Moynihan	Danielle Bracken Geraldine Ryan

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* and 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 the following clinical areas:

- Emergency department
- Theatre
- 6 North (Oncology)
- 3 North (Cardiology and Cardiothoracic)
- 4 South (Surgical, Medical and Paediatric).

The inspection team spoke with representatives of the hospital's Senior Management Team, Patient Safety and Quality and Innovation, Human Resources 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

Inspectors greeted and chatted to a number of patients throughout the two days of inspection and in more detail to ten patients to elicit their experiences of being a patient in Beacon Hospital. Overall patients were complimentary about the staff and

[†] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.
[‡] Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration.
[§] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[**] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

the care they received. Patients described their experience as "absolutely fabulous", "very good" and "very quick and efficient diagnosis".

Patients informed inspectors that they were aware of their plan of care and kept informed during their visit to the ED or ward areas.

Patients had access to call bells within reach in the ward areas and informed inspectors that bells were answered promptly.

Patients stated that they had no complaints to make and some patients were aware of how to make a complaint if required.

There was overall consistency between what inspectors observed in the clinical areas visited and what patients told inspectors about their experiences of 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 is being provided. It also includes the standards related to workforce. Beacon Hospital was substantially compliant with three national standards (5.2, 5.8 and 6.1) and compliant with one national standard (5.5).

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. The governance arrangements described were consistent with those illustrated in the hospital's organisational charts. However, inspectors identified that the sepsis committee did not have medical or surgical representation as outlined in the terms of reference (TOR). This along with other findings are outlined below.

The Board of Directors provided oversight of the governance of Beacon Hospital. The Board appointed a chief executive officer (CEO) who was delegated with overall responsibility and accountability for the governance and the quality of healthcare

services delivered. TOR reviewed indicated that the Board met nine times per year and more frequently if required.

The clinical governance committee (CGC) was a non-executive sub-committee of the board, chaired by a board director with membership including the CEO, medical director, and the director of patient safety quality and innovation (PSQI). This committee was responsible for informing the board of any identified gaps in the quality and safety and risk management arrangements in the hospital. Minutes of meetings and interviews reflected that meetings took place in line with the TOR.

The CEO chaired and was a member of the Executive Management Team (EMT) and reported to the CGC. Inspectors were informed that this was an operational meeting, held weekly and agenda items included for example, patient care, quality and safety, patient safety and experience, and a presentation on infection prevention and control.

The Internal Risk Management (RMC) reported to the CGC. The TOR of the Internal Risk Management committee were contained in the Internal Risk Management Plan. The plan indicated that the committee was a peer review body responsible for the oversight of reportable serious adverse events (SREs) and creation, implementation and analysis of actions from investigations. The committee was chaired by the medical director with representation from members of the Executive Management Team (EMT). A review of meeting minutes indicated that this committee had oversight of key performance indicators (KPIs), unanticipated mortalities, case reviews, medication events and complaints.

Inspectors were informed that the Quality Improvement Committee (QIC) was the overarching committee where the four areas of focus of this inspection were discussed. Chaired by a member of the medical staff, the committee met quarterly and reported to the RMC. Terms of reference indicated that the committee provided a framework underpinning the hospital's overall quality improvement (QI) efforts and helped to formulate the patient safety and quality programme. It was evident from meeting minutes reviewed that audits, annual reports and particular issues in relation to infection prevention and control (IPC), sepsis, code blue[††] and medication safety were agenda items at this meeting. However, no assigned actions were documented in three sets of meeting minutes provided.

Inspectors reviewed documentation provided for the four areas of known harm which were a focus for this inspection; infection prevention and control, medication safety, deteriorating patient and transitions of care. It was evident from a review of

[††] Code blue is term used in Beacon Hospital to indicate a cardiac or respiratory arrest or a patient who is unconscious and requires immediate resuscitation.

TORs that the Infection Prevention and Control Committee (IPCC), Drugs and Therapeutics Committee (DTC) and Code Blue Committee functioned in line with the TOR, operated to a defined agenda and included relevant multi-disciplinary members. TOR indicated that the DTC reported to the Medical Board via the QIC. However, terms of reference for the IPCC and Code Blue committees did not indicate where they reported to. Notwithstanding this representatives from the committees provided clarity on the reporting relationships and it was evident from meeting minutes reviewed that members of the EMT were represented on each of the committees and could escalate issues to the QIC, RMC and or CGC as appropriate.

Inspectors reviewed the terms of reference of the Sepsis Committee which indicated that committee membership included medical or surgical representation, however, at the time of inspection there was no consultant on the committee. This was not in line with the TOR. Management informed inspectors that they were endeavouring to have a multi-disciplinary attendance at this committee. Notwithstanding this, inspectors were informed that a review was to take place with the aim of forming a deteriorating patient committee and this was confirmed in meeting minutes reviewed. Inspectors were informed that a consultant has been identified who will chair and lead on this programme.

No governance committee was in place to review and discuss issues in relation to transitions of care (TOC). Furthermore, transitions of care was not an agenda item at any meeting minutes reviewed. On review of meeting minutes, it was evident that incidents in relation to TOC were discussed at the RMC and the patient transfer process was discussed at an EMT meeting. At interview members of the EMT provided assurances and were assured that any issues in relation to transitions of care would be discussed and addressed.

Overall, inspectors found there were formalised governance arrangements for assuring the delivery of high-quality, safe reliable healthcare at the hospital. Senior management described the lines of accountability and responsibility for each of the four areas of focus. However:

- the sepsis committee did not have a medical or surgical consultant in place in line with the terms of reference
- transitions of care was not formally discussed at any forum described above
- terms of reference of the IPCC, Sepsis and Code Blue committee did not indicate the reporting relationships
- no assigned actions were identified from the QIC committee which is the overarching committee where committees of the four areas of focus report to.

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.

The hospital had effective management arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services in relation to the four areas of focus for this inspection.

The hospital had a clinical director and a deputy clinical director in place. Management stated that while consultants had no reporting relationship with the clinical directors, patient safety issues and concerns could be escalated to them by consultants and escalated to the Internal Risk Management Committee and the Clinical Governance Committee as applicable which the clinical director was a member of.

Nursing services in the hospital were managed and organised by the director of clinical services who was supported in the role by assistant directors of nursing (ADONs). Theatre, Emergency Department, 6 North, 4 South and 3 North had clinical nurse managers (CNMs) of different grades who were responsible for the management and oversight of the clinical areas and operationally accountable to a CNM 3 and upwards to the ADON.

The hospital's infection prevention and control team (IPCT) was led by two consultant microbiologists. Inspectors were informed that the hospital was in the process of recruiting two additional microbiologists. The current microbiologists provided 24 hours a day, seven day a week microbiology cover, accessed laboratory results off-site, and provided advice. In addition, the IPCT consisted of an ADON, clinical nurse specialist (CNS), and a CNM2 liaison nurse. The IPCT produced an annual report for 2024 which stated that all goals for 2024 were achieved.

Antimicrobial stewardship (AMS) was a sub-committee of the IPCC. The AMS programme was implemented and overseen by the consultant microbiologist and an AMS pharmacist. AMS was a standing agenda item at the IPCC and the DTC.

The hospital's pharmacy service was led by the head of pharmacy services and the DTC. This was the overarching committee overseeing the quality and safety of the pharmacy service and it supported medication safety practices. The DTC had two sub-committees: the Medication Safety Committee (MSC) and the AMS Group. The DTC had produced an annual report of medication events and related reporting for 2024. This report outlined the goals for 2025 along with the timeline for completion for example, developing a medication safety dashboard.

Inspectors were informed that the hospital had no lead for the deteriorating patient programme, however, senior management stated that a consultant intensivist was identified to lead this programme. A clinical facilitator was designated to lead on the education of the deteriorating patient. Two committees provided oversight: the Sepsis Committee and Code Blue Committee and both committees met quarterly. The Code Blue Committee was chaired by a consultant anaesthetist, with multidisciplinary attendance including members of the EMT, IPC, nursing and PSQI. However, as discussed under national standard 5.2 the Sepsis Committee did not have medical or surgical consultant representation as outlined in the TOR. Notwithstanding this there was good attendance with multi-disciplinary representation. While both committees were providing oversight of areas of sepsis and patient deterioration, they were working independently of each other with no evidence of communication between both committees. Inspectors were informed that an overarching committee for the deteriorating patient was being progressed and this will be an area for follow-up on the next inspection.

An assistant director of nursing was the patient flow lead for the hospital. Supporting the ADON in the role was a discharge co-ordinator and nine CNM3s.

Hospital management had established a Patient Safety Committee, attended by senior and middle-level managers, front-line staff and medical personnel to ensure that patient safety risks were identified and addressed in a timely manner. Inspectors were informed that this committee met weekly.

Overall, hospital management had effective arrangements in place to achieve planned objectives that involved all levels of the service provided.

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 collated a range of patient-safety indicators, which were reviewed at senior management level. This information provided the Clinical Governance Committee and relevant governance committees with assurances about the quality

and safety of healthcare services provided in the hospital. These will be discussed under national standard 2.8.

There were formalised risk management structures and processes in place to proactively manage and minimise risks at the hospital. Hospital management had a master risk register which contained the risks that were escalated through the governance structures to the board as relevant. These contained existing controls and a time-bound action plan. The risk register was an agenda item at the clinical governance meeting and board meetings.

Patient-safety incidents were reported on the hospital's incident management system. From discussions with management, a review of meeting minutes and reports received it was evident that the patient safety and quality innovation department tracked and trended patient-safety incidents and these were discussed and presented at the QIC meeting and upwards to the board. The IPC annual activity report and evaluation report for 2024 indicated that incidents were discussed at the Patient Safety Committee meeting, however, a list of incidents for this meeting was provided to inspectors and there was no evidence of trending being completed. Furthermore, IPC incidents were not an agenda item nor were they discussed at the IPCC. Similarly there was no evidence that incidents on the deteriorating patient were discussed at the Sepsis Committee and the Code Blue Committee.

Sentinel events were discussed at the QIC and CGC. The hospital had an up-to-date policy "Root Cause Analysis and Sentinel Event Management" policy which outlined the reporting, the procedure and timelines for reviewing sentinel events. Inspectors were informed at interview that oversight of recommendations from root cause analysis reviews was provided by the board.

The hospital had arrangements in place to monitor the services' performance. Key Performance Indicators (KPIs) that were monitored included: healthcare associated infections, average length of stay, mortality, patient safety notification reporting culture, inpatient falls, patient satisfaction, complaints and medication events. Oversight of the KPIs was provided by the QIC, CGC and upwards to the board.

It was evident through a review of documentation that multiple audits were taking place in relation to the areas of focus for this inspection. However, time-bound action plans were not always devised.

While 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, a deficit in oversight of the following was identified:

- incidents were not discussed at the IPCC, Sepsis Committee or Code

Blue Committee

- action plans were not time-bound.

Judgment: Substantially 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 were planned, organised and managed to provide high-quality, safe and reliable services.

Hospital management confirmed that all medical and surgical consultants were on the relevant specialist division of the specialist register with the Irish Medical Council (IMC). It was also confirmed that consultants were granted privileges to practice in the hospital, and this was underpinned by a formalised process with final approval for privileging granted by the CEO. Consultants were supported by non-consultant hospital doctors (NCHDs). 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), a senior house officer (SHO) and an intensive care registrar available on site for review of patients.

Inspectors identified that there was minimal gaps in staffing in the five clinical areas visited on the days of inspection. Local management informed inspectors that vacant shifts were filled by ward staff and that the ratio of staff to patients was consistent. Staff did not identify any staffing issues to inspectors. Meeting minutes from the weekly forecasting meeting indicated that staffing requirements for the week in each area was discussed. No gaps in staffing were identified in relation to the four key areas of known harm that were the focus of this inspection. At interview human resource management confirmed this with inspectors.

The human resource department tracked the staff absenteeism rates. This was reported as 3% at the time of inspection which was in line with the hospital's target of 3%. Management stated that back-to-work interviews were conducted with staff on return from unplanned leave. Occupational Health supports were available to staff onsite, and staff and their families had access to an employee assistance programme (EAP) if required.

CNMs in their respective areas had oversight of training for nurses and healthcare assistants (HCAs). The education department monitored training for the hospital.

Inspectors were informed that staff could access individual records through the intranet.

Training compliance records were received pre and during inspection. A review of these indicated good compliance levels with nursing in standard and transmission based precautions, medication safety and hand hygiene. However, healthcare assistants' hand hygiene training results in 4 South and 6 North were between 80-86% which is below the benchmark of 90%. In addition, doctors achieved an overall compliance rate of 61%.

Good compliance levels were identified in Irish National Early Warning Score (INEWS) training in 3 North and 100% of nurses had completed training in the Paediatric Early Warning Score (PEWS) in 4 South. Notwithstanding this, poor training compliance rates were identified for the INEWS in 6 North and 4 South where 71% and 74% of staff nurses had completed this training respectively. 68% of staff nurses had completed training in the Manchester Triage System in the ED. Inspectors were informed that staff nurses did not work in triage unless they had completed the training.

Minimal gaps were identified in medication safety training in the five areas inspected with results of between 87% and 100%.

Overall, the workforce arrangements were organised and managed to provide high-quality, safe and reliable services, however,

- deficits were identified in INEWS training for staff nurses, hand hygiene training for healthcare assistants and doctors.

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.

The hospital was partially compliant with one standard (3.1), substantially compliant with three standards (1.7, 2.7 and 2.8) and compliant with three standards (1.6, 1.8 and 3.3).

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. Inspectors spoke to a number of patients regarding the dignity and privacy in the clinical areas and patients did not highlight any concerns to inspectors.

The hospital contained a mixture of single en-suite rooms and multi-occupancy en-suite rooms. Sofa beds were available if family members requested to stay overnight. Privacy curtains were in place around each bed space and in the cubicles in the ED. The ED used an area called Block 0 if medical or nursing staff wanted to review patients or have a private conversation. This will be discussed under national standards 2.7 and 3.1.

Patients' personal information was observed to be stored appropriately.

Overall, on the days of inspection, 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 at the hospital. Inspectors observed considerate and respectful interactions between staff and patients in the clinical areas visited.

The hospital had recently devised a new survey for capturing patients' satisfaction and loyalty. Inspectors were informed that patients were contacted within 24 hours of discharge. The new survey was created at the request of the board and commenced in March 2025. Results guided the board with the top five priorities. For example, the opinion of bathroom facilities and the friendliness, sensitivity and courtesy of staff. Documentation received evidenced that the satisfaction survey was discussed at the Quality Improvement Committee and the Clinical Governance Committee.

Inspectors were informed that patients did not have access to advocacy services onsite. Management stated that if required they would contact an independent advocacy service. However, posters and leaflets were not evident in the hospital offering this service.

Overall, staff and management of the hospital promoted a culture of kindness consideration and respect. Patients' views were sought on discharge with areas for action identified. However:

- information on independent advocacy services was not available or accessible to patients.

Judgment: Substantially 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 systems in place to respond effectively to complaints. A data analyst was the designated complaints officer assigned with responsibility for managing complaints. It was evident from a review of meeting minutes that complaints was an agenda item at the Quality Improvement Committee, Internal Risk Management Committee and the Clinical Governance Committee meetings and that the trending of these was discussed.

The hospital had an up-to-date policy in place for the "management of complaints and positive feedback". Inspectors observed patient feedback forms and comment boxes in clinical areas. There was a culture of local complaints resolution in clinical areas. The policy outlined the timelines for the acknowledgement and response to complaints. Overall, this was consistent with what inspectors were told at interview.

Inspectors were provided with evidence of tracking and trending of complaints from quarter one 2025 and the Complaints and Patient Satisfaction Annual Report for 2024. Complaints were trended by theme with Safe and Effective Care representing 44% of complaints in 2024.

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. However, inspectors observed storage of linen in the medication room in the ED and an area known as Block 0 was in use as an overflow from the ED after 3pm.

The ward areas visited comprised a mixture of single en-suite rooms, two, three and four bedded multi-occupancy rooms which were all en-suite. Each of the ward areas contained a negative pressure room. The ED contained six bays and a procedure room. Inspectors were informed that the procedure room was used to facilitate a patient's isolation if required.

On the days of inspection the hospital was in the process of building a new reception area. Management stated and documentation confirmed that air filters were pre-purchased in anticipation of the building works. As a result windows were closed and air filters were in place in 6 North, 3 North and 4 South. Meeting minutes evidenced that building works were discussed at IPCC and board meetings.

In total seven patients between all ward areas inspected required isolation during the days of inspection. Doors to isolation rooms were closed with one exception. This was brought to the attention of management. Signage on the use of personal protective equipment (PPE) was displayed with PPE readily available.

Inspectors were informed that the hospital had replaced the clinical hand wash sinks in the ward areas and PACU in 2024. Observations by inspectors confirmed that these conformed to the required specifications.[‡‡] However, inspectors observed the sink in the sluice room in the ED did not and there was no clinical hand wash sink in the triage room. Notwithstanding this, staff had access to wall-mounted alcohol based hand sanitiser dispensers throughout the ED and ward areas.

Clinical areas were clean with few exceptions. The CNM2 and cleaning supervisors had oversight of the standard of cleaning in their areas of responsibility. Clinical areas had an assigned cleaner who worked from 8am to 4pm. Outside of these hours staff contacted a cleaner via a bleep system. Staff reported that they received a prompt response. HCAs were responsible for cleaning equipment. The IPCT had introduced a "HCA list of duties and cleaning records". An inspector was shown an example of this. This detailed the daily duties for HCAs for example, cleaning the

[‡‡] National Clinical Guidance No. 30-Infection Prevention and Control (IPC). Available online from https://www.gov.ie/en/publication/a057e-infection-prevention-and-control-ipc/#national-clinical-guideline-no-30-infection-prevention-and-control-ipc-full-report-volume-1.

medication room and a weekly schedule for a deep clean of a patient hoist. The ward manager signed the book weekly which was confirmed by an inspector and the IPCT reviewed it quarterly.

There was appropriate waste management processes observed in clinical areas visited. Clean and used linen was observed appropriately segregated and stored appropriately in ward areas, however, inspectors noted inappropriate storage of clean linen in the medication room in the ED. While the linen trolley was covered in plastic lining with a zip, it posed an infection control risk due to the small size of the room, the number of staff accessing the room and the preparation and disposal of medication and used sharps. In addition, it impeded access to the restricted drugs press. A risk assessment was completed while inspectors were onsite in relation to "the risk of transmission of infection from sharps container to clean linen". This was a yellow-rated risk and actions included that staff would use the Endoscopy Department linen store in the interim of another solution being identified.

Inspectors were informed that an area known as Block 0, was a pre-operative assessment area during the day until 3pm. After this, the ED could use Block 0 as an overflow from the ED to review patients. Inspectors attended this area and noted the following:

- Block 0 was located a floor below ED and this area was not secured
- all examination room doors were unsecured resulting in easy access to needles and syringes
- no emergency bell was available to alert staff in the ED if a patient deteriorated.

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

- Block 0 was unsecured with unrestricted access to needles and syringes
- no emergency call bell system was available in Block 0
- clean linen was inappropriately stored in a medication room in the ED.

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.

The hospital collected a range of different measurements related to the quality and safety of healthcare service provided. This included data relating to hospital activity, patient-safety incidents, complaints, hospital acquired infections, workforce, training and risks that had the potential to impact on the quality and safety of services. Collated performance data was reviewed at meetings of the relevant governance committee such as the QIC, RMC and CGC.

The hospital's infection prevention and control team reported quarterly on hospital-acquired healthcare associated infections (HCAI) to the Health Protection Surveillance Centre (HPSC). A 2024 IPC Surveillance Report was provided to inspectors which detailed rates of *Clostridioides difficile* infection, *Carbapenemase-Producing Enterobacterales* (CPE), *Vancomycin Resistant Enterococcus* §§(VRE), *Methicillin-resistant Staphylococcus aureus* *** (MRSA), Catheter Related Blood Stream Infections and Surgical Site Infections. IPC Surveillance was a standing agenda item at the IPCC and meeting minutes received evidenced that the IPC annual report and Q4 report were an agenda item at the QIC in March 2025.

Hand hygiene audits were carried out monthly by the IPC champions and reported bi-annually to the HPSC. The Q1 2025 report was provided to inspectors. This indicated an overall compliance rate of 96% which exceeds the HPSC benchmark of 90%. The report detailed how they compared to the HSE and other private hospitals.

Environmental hygiene audits††† were completed annually. Results from clinical areas inspected were provided to inspectors. Compliance rates with these areas ranged from 93% to 94% in 2024. The theatre scored 86%. There was evidence that theatre was re-audited with subsequent results of 78%, 97%, 95% respectively. Through the review of meeting minutes, inspectors identified that audit results were discussed at relevant governance meetings.

It was evident through a review of meeting minutes that antimicrobial stewardship (AMS) audits were taking place. A sample of antimicrobial stewardship audits were requested following inspection and one was provided from quarter 3 2024 in relation

§§ 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
††† Environmental hygiene audits included — the general environment, safe handling and disposal of sharps handling of disposal of linen and patient equipment.

to meropenem prescriptions. This indicated that 14% of all prescriptions for meropenem were not appropriate.

Medication safety was monitored through key performance indicators and audits. For example, the percentage of admissions where pharmacy-led medication reconciliation was completed. This ranged from 34% to 39%. Inspectors were informed that medication reconciliation was completed on a prioritised basis. This will be discussed under national standard 3.1. Additional KPIs monitored in relation to medication safety will be discussed under national standard 3.3. Audits were completed in ward areas on high alert medication. Results from Q1 2025 indicated that all of the clinical areas inspected scored 90-100% between January and March 2025. Medication unit inspections were completed quarterly in all clinical areas. The audit included for example, the cleanliness of the medication preparation area, the correct storage of medicines, medication labelling and high risk medication storage. Issues identified included the date of first opening of a medication not being completed and expired medications were observed. The audit indicated that results were emailed to CNMs in the relevant areas. Notwithstanding this, it was identified that audits were not a standing agenda item at the drugs and therapeutics committee or the medication safety committee.

Audits on compliance with the early warning system escalation and response protocol were completed quarterly. Good compliance was identified in INEWS scoring, calculating it correctly and completing each physiological parameter for example blood pressure, respiratory rate. However, overall hospital results indicated that consistently poor results were identified in the frequency of observations when an INEWS score was 4-6 and upwards with compliance rate ranging from 9% in 4 South to 50% in the ED. This was also a finding in the ward areas inspected. No time-bound action plan accompanied these audits. At interview the audit findings were discussed with senior management who stated that the hospital had ongoing ALERT[‡‡‡] training in place and focused training sessions were facilitated by the clinical facilitator. Sepsis audits were completed quarterly on for example, the Sepsis 6 pathway. The hospital was auditing the number of Code Blue and ALERT calls quarterly. Code Blue indicated 100% compliance with Advanced Cardiac Life Support (ACLS) response times in less than five minutes.

The clinical handover communication tool, Identify, Situation, Background, Assessment, Recommendation/Read back/Risk (ISBAR 3) audits were carried out quarterly. Good compliance levels (100%) were identified in all areas inspected. An audit of compliance with the pre-operative checklist was completed monthly in theatre with excellent compliance between January and March 2025. A chart audit

[‡‡‡] The role of the ALERT in Beacon Hospital is to provide nurse to nurse assistance in the assessment of at-risk patients outside the Intensive Care Unit (ICU)

completed in quarter 1 2025 indicated that in 38% of cases handover did not take place correctly. Audit results provided to HIQA did not include a time-bound action plan.

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:

- there was no evidence provided to indicate that action plans were devised following poor compliance rates in audits
- audits were not a standing agenda item at the drugs and therapeutics committee meetings.

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 systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services. Arrangements were in place to ensure the proactive identification, evaluation, analysis and management of significant information and risks to the delivery of safe healthcare services however, Block 0 was being used by the ED after 3pm. This had not been risk assessed or this practice supported by a policy. This will be discussed later in the standard.

As discussed under national standard 5.8, the hospital had a master risk register which contained orange rated risks nine or above which could not be managed at local level. Examples of risks relating to the four areas of harm included the risk of incomplete handover, medication shortages, surgical site infection, and clinical alarm fatigue in the theatre setting. An additional risk will be discussed later in 3.1. Controls and time-bound recommendations were in place for each risk. Staff in the clinical areas had access to the risk assessments relevant to their area on an information technology system. Access to this was demonstrated to inspectors.

Inspectors observed quality boards in the clinical areas visited. These contained information on for example, audit results, management of sepsis, medication management and audits.

Inspectors were informed that all patients admitted to the hospital were screened for *Methicillin-Resistant Staphylococcus Aureus (MRSA).* Management confirmed at

interview that patients were screened for CPE in line with national guidance. In addition, patients who are admitted from another hospital were also screened for *Vancomycin Resistant Enterococcus (VRE).* An electronic alert system on the electronic healthcare records was available to alert staff to patients who were previously inpatients with confirmed multi-drug resistant organisms (MDROs). There was evidence from review of healthcare records that staff had assessed patients on admission for MDROs. No outbreak of infection was reported on the days of inspection and inspectors were informed that the last outbreak of infection was in 2022. Each clinical area had an infection prevention and control champion who attended monthly meetings.

A clinical pharmacy service[§§§] was provided to all wards and staff in the three wards visited confirmed this. Pharmacy-led medication reconciliation was completed on a prioritisation basis using a Red Amber and Green (RAG) system. The pharmacy department had undertaken a quality improvement initiative in 2024 to prioritise patients in the ED for pharmacy-led medication reconciliation resulting in an increase from 19% to 83% pre and post the intervention. A sample of records reviewed from three wards indicated that medication reconciliation had been completed in all cases. Through a review of documentation and from discussions with management it was evident that a risk in relation to a "24 hour kardex" resulted in some patients transitioning in a peri-operative setting and up to 24 hours afterwards, could have a medication prescribed and administered in two separate places. Controls in place included a policy to cover the transfer of medications and a pre-printed 24 hour kardex. A long-term recommendation included a single system of prescribing with a date of review for 31 May 2025. Incidents in relation to this risk were trended and staff in relevant clinical areas informed inspectors about the risk.

Clinical areas had access to a list of high-risk medications, and look-alike sound-alike medications (LASA) on display. Up-to-date polices were available to support practice. Prescribing guidelines, antimicrobial guidelines and medicines information were available and accessible to staff online, however, it was observed in 4 South that the paediatric prescribing guidelines were dated 2022. Staff had access to a medication fridge with remote monitoring of temperatures.

The hospital had introduced the Irish National Early Warning System[****] (INEWS) throughout the inpatient areas and the ED and Paediatric Early Warning Score (PEWS) in 4 South where paediatric patients were admitted on occasion. INEWS and PEWS scores were digitally recorded. The ED had not implemented the Emergency

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

Medicine Early Warning System (EMEWS) but used the INEWS. Management stated there was no plans to implement it due to the short length of stay of patients in the ED.

Inspectors were informed that the hospital was following national guidelines for INEWS and PEWS. All staff spoken with were knowledgeable about the INEWS and response protocol to ensure timely management of patients with a triggering early warning score. At the time of inspection no paediatric patients were admitted in the hospital. Inspectors reviewed a sample of patients' INEWS charts. It was observed that, while the majority of INEWS entries were appropriately recorded and adhered to the required frequency, there was an instance where a patient's observations was not documented in accordance with policy. Inspectors were informed that the patient was routinely on oxygen, however, the INEWS score was not modified or observations completed in line with national policy. Furthermore, inspectors were informed that the digital INEWS did not support the modification of parameters and that modification was documented in the patient's healthcare record, however, in this instance it was not completed. This was discussed with local management. Notwithstanding this, inspectors observed evidence of two instances where the ALERT team were contacted and responded to patients when their observations triggered high INEWS scores.

Emergency equipment was available in the three ward areas inspected, Theatre and the ED. A paediatric resuscitation trolley was available in the ED and 4 South. Oxygen was available at each bedside. Inspectors were informed by staff in clinical areas that scenario-based training was done on Code Blue. As discussed under national standard 2.7, inspectors identified that patients were being reviewed in Block 0. Management stated that only patients who met a defined criteria, for example stable, ambulatory patients attended Block 0, however, no policy was in place to support this. A policy was devised while inspectors were onsite detailing the inclusion and exclusion criteria for patients attending the area. In addition, inspectors identified that there was no suction or cardiac arrest trolley available in Block 0 and management stated that emergency equipment from the ED was used if required. Furthermore, an emergency box had not been checked since February 2025 and contained oxygen masks and suction catheters that were out of date. This was brought to managements' attention. At the end of the inspection, inspectors were provided with a risk assessment which was a red-rated risk on the use of Block 0. Actions to mitigate the risk were included which were for action by 29 May 2025.

Inspectors were informed that no formal pathways were in place for patients who were unwell with specific conditions to access the acute or children's hospitals but if a patient required transfer this was arranged from consultant to consultant.

The ISBAR 3 communication tool was used for the escalation of the care of the deteriorating patient, at handover and on transfer of patients. Inspectors observed multiple instances of this in use. Inspectors were provided with an example of a transfer form used from clinical areas to radiology called "Ticket to Ride", designed using the ISBAR tool and included information such as how the patient would be transferred to and from radiology. It was evident through discussions with staff that the use of the ISBAR tool was embedded in the hospital.

A policy was in place to support the transfer of patients both internally and externally. Hospital management attended and facilitated a number of meetings to aid the timely and safe transfer of patients:

- a huddle took place daily at 11am attended by senior nursing management. An electronic board guided management at this meeting on the current bed status, length of stay, ED activity, the daily bed status and the projected date of discharge for patients. A Red, Amber and Green (RAG) system was used to analyse patient flow and identify challenges
- a discharge multi-disciplinary team meeting was held weekly where patients' plan of care and requirements for discharge were discussed. Each patient had an expected date of discharge
- a weekly forecasting meeting, chaired by the ADON for patient flow, took place every Thursday. Meeting minutes of this meeting evidenced that staffing challenges, elective admissions for the week and patient flow issues were discussed.

A discharge co-ordinator visited the wards daily to identify patients for discharge whose discharge was delayed.

The hospital did not have access to rehabilitation beds in the community and hospital management stated that a pack outlining details on convalescence was provided to patients and their families prior to admission if required.

6 North recently piloted an integrated discharge plan with the aim of improving information for patients on discharge. Prior to its development a survey was completed of both patients and staff to identify their views on the process in place at the time. At the time of inspection, inspectors were informed that the integrated discharge plan would be rolled out in the hospital.

Staff had access to policies, procedures, protocols and guidelines (PPPGs) which were observed as being up to date. These were accessed via a document management system.

While the hospital had some systems in place to identify and manage potential risk of harm associated with the four areas of harm. The following was identified:

- the risks associated with the use of Block 0 had not been identified, risk assessed and supported by a policy
- the emergency box in Block 0 was not checked since February 2025 and contained out-of-date emergency equipment
- the online INEWS observation chart did not facilitate the modification of parameters where required
- paediatric prescribing guidelines were dated 2022.

Judgment: Partially 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. This process was supported by the Patient Incident and Near Miss Policy. This policy outlined the process for incident reporting for staff. Further support for the process was provided through the Root Cause Analysis and Sentinel Event Policy.

Patient-safety incidents were reported directly onto an Information Technology (IT) system and graded according to levels from one to nine with a level one incident a near miss and a level 9 incident resulting in death. Tracking, trending and analysis of incidents was completed by the PSQI department and presented in a quarterly report to the QIC. Incidents were trended by type and location.

Inspectors were informed by multiple staff that CNMs attended a weekly Patient Safety Committee meeting, co-ordinated by the director of PQSI, where all incidents that occurred on the preceding week were discussed. Incidents were an agenda item at the Medication Safety Committee and the DTC. A quarterly medication event report was presented at the DTC. This detailed trending of KPIs, for example, the reporting culture and medication event rate per 100 patient bed days, types of medication incidents and the level of harm. Incidents were tracked in relation to high alert and LASA medications.

Staff who spoke with inspectors were knowledgeable about the systems in place and their role in reporting and managing patient-safety incidents. Additional findings were discussed under national standard 5.8.

Overall, the hospital effectively identified, managed, responded to and reported on patient-safety incidents.

Judgment: Compliant

Conclusion

An announced inspection of Beacon Hospital was carried out to assess compliance with *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 and safe transitions of care.

Overall, the hospital was found to be compliant in four national standards (5.5, 1.6, 1.8 and 3.3), substantially compliant in six national standards (5.2, 5.8, 6.1, 1.7, 2.7 and 2.8) and partially compliant in one standard (3.1).

Capacity and capability

Formalised governance arrangements for assuring the delivery of high-quality, safe reliable healthcare were in place. Senior management described the lines of accountability and responsibility for each of the four areas of focus. Hospital management had identified a deficit in the governance of the deteriorating patient and it was evident through a review of documentation and discussions with management that this was being addressed. The management arrangements supported the operational functioning of the hospital and promoted the delivery of safe, high-quality healthcare services. Monitoring arrangements in place in the hospital enabled the identification of opportunities to continually improve the quality, safety and reliability of healthcare services and were systematic, however, deficits were identified in the oversight of trended incidents at committees in relation to the deteriorating patient and infection prevention and control. The workforce arrangements in the hospital were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare. However, gaps were identified in the uptake of training which are discussed under national standard 6.1.

Quality and Safety

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 and management of the hospital promoted a culture of kindness consideration and respect. Notwithstanding this, information on access to advocacy services was not available or accessible in the hospital. Patient's views were sought on discharge with areas for action identified.

The hospital had systems and processes in place to respond openly and effectively to complaints and concerns raised by people using the service. The physical environment supported the delivery of high-quality, safe, reliable care. However, an area called Block 0 in use by the ED was observed by inspectors which was unsecured and contained no emergency call bell. Assurance systems were in place to monitor, evaluate and continuously improve the healthcare services. However, time-bound action plans were not always developed when standards fell below expected targets. The hospital protected service users from the risk of harm associated with the design and delivery of healthcare services in the four areas of focus of the inspection. However, hospital management had not identified the risk of using Block 0, risk assessed it and no policy was in place to support the practice. Systems were in place to identify, manage, respond to and report patient-safety incidents.

HIQA will, through the compliance plan submitted by hospital management as part of this monitoring activity, continue to monitor the progress in implementing actions to address compliance with areas identified under national standard 3.1.

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	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.	Substantially 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.	Substantially 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

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

Compliance Plan for Beacon Hospital

Inspection ID: NS_0149

Date of inspection: 27 and 28 May 2025

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

1. The Risks associated with the use of Block O had not been identified, risk assessed and supported by a policy.

Compliance plan:

Risk assessment completed 28/5/2025 and due for review 28/08/2025. Risk assessment includes minimum staffing required for area, access controls, assessment of response to emergency situation, access to emergency equipment.

Policy completed which includes criteria for use of Block O, minimum staffing requirements, access controls, emergency procedures and equipment management.

2. The emergency box in Block 0 was not checked since February 2025 and contained out-of-date emergency equipment

Compliance plan:

The emergency box in Block 0 was checked and updated in May 2025. A weekly audit of compliance with checks has been in place since May 2025. Compliance is also checked by PSQI tracer teams.

3. The online INEWS observation chart did not facilitate the modification of parameters where required.

Compliance plan: Deteriorating patient committee working with Information Technology regarding potential redesign of online capture of modification of parameters. Currently any required modification is documented via freetext in the medical record by the Registrar / Consultant. Patient care is not compromised due to lack of modification – without modification the RN is likely to escalate sooner rather than later. As per the national INEWs guidelines, Healthcare provider concerns can always be escalated using clinical judgement.

4. paediatric prescribing guidelines were dated 2022. These out of date printed guidelines have now been removed and replaced with in date guideline document.
Timescale: 1. Risk assessment completed May 2025 and for review 28/8/2025. 2. Emergency box in Block O was not checked since February 2025 - checks completed and updated in May 2025 - closed 3. The online INEWS observation chart did not facilitate the modification of parameters where required: Q4 2025 for redesign options, Q2 2026 for implementation. 4. Paediatric prescribing guidelines were dated 2022. Closed.