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: | Charter Medical Private Hospital |
| Centre ID: | OSV-0008897 |
| Address of healthcare service: | Ballinderry<br>Mullingar<br>Co Westmeath |
| Type of Inspection: | Announced |
| Date of Inspection: | 10/12/2025 and 11/12/2025 |
| Inspection ID: | NS_0177 |

## About the healthcare service

### Model of hospital and profile

Charter Medical Private Hospital is part of the Charter Medical Group and provides:

- Elective intermediate care beds for stepdown and rehabilitation purposes, provided under service level agreement with the Health Service Executive (HSE).

Elective surgical procedures and ambulatory care including:

- General Surgery
- Dermatology
- Endoscopy
- Gastroenterology
- Orthopaedics
- Oral/Maxillofacial
- Sports and Exercise Medicine
- Ophthalmology
- Pain Management
- Ear, Nose and Throat
- Gynaecology
- Physiotherapy
- Rheumatology
- Urology
- Rapid Access Clinic - Medicine for the Elderly
- Minor Injury Unit provided onsite at Charter Medical Private Hospital on behalf of the HSE.

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

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| **Number of beds** | Total beds: 77, of which 36 are stepdown and rehabilitation 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 since last inspection.

During the inspection, inspectors:

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

*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) |
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| 10/12/2024 | 09:00 –17:30 | Cathy Sexton | Maeve McGarry<br>Sorcha Burns<br>Yvonne Young |
| 11/12/2025 | 09:00 – 14:30 | Cathy Sexton | Maeve McGarry<br>Sorcha Burns<br>Yvonne Young |

## 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 three clinical areas:

- The Stepdown Unit
- Surgical 1 Ward
- Theatre and the Endoscopy Unit recovery areas.

During this inspection, the inspection team spoke with representatives of the hospital's Senior Management Team, Quality and Risk Team, 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

Throughout the inspection, the inspectors spoke with patients and observed how staff actively engaged with patients in a respectful, kind manner and ensured patients' needs were promptly addressed. Patients receiving care in the clinical areas visited by inspectors and who spoke with inspectors described their experiences as "*good*" and the care "*was very good, staff were kind and caring*". Inspectors saw patients receiving timely assistance with their meals, if required.

[†] 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.

Patients who spoke with inspectors noted they had not received information on how to make a complaint, but noted if they wanted to raise an issue or make a complaint, they would speak with a staff member. The inspectors observed information available in the clinical areas about patient feedback surveys and leaflets on how to make a complaint.

## 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, use of resources.

Charter Medical Private Hospital was compliant with national standard 6.1, substantially compliant with national standard 5.8, and partially compliant with national standards 5.2 and 5.5 assessed under this dimension.

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

There were formalised governance arrangements in place to assure the quality and safety of healthcare services at Charter Medical Private Hospital. Organisational charts outlined the hospital's governance structure and detailed reporting arrangements. However, there were some gaps in the oversight arrangements necessary to provide assurance about the quality and safety healthcare services at the hospital.

The chief executive officer (CEO) was the accountable person with overall responsibility and accountability for the governance of healthcare services provided at the hospital. The CEO was a member of the hospital's board and reported to the interim group chief executive officer of Charter Medical. The hospital's board was chaired by an appointee. The terms of reference indicated that board meetings took place quarterly, although meeting minutes indicated that two meetings had taken place in 2025. Safety and risk was a standing agenda item at the board meetings and the board received a quality report in advance of meetings taking place.

The hospital's senior management team included; the pharmacy manager, director of nursing, quality and risk manager, operations manager, director of infection

prevention and control, and the human resources manager. All members of the senior management team reported to the hospital's CEO. Senior management team meetings took place monthly and were chaired by the hospital's CEO.

The Clinical Governance Committee was the hospital's principal committee with responsibility for quality and patient safety. This committee was chaired by the clinical director. Inspectors reviewed meeting minutes which demonstrated meetings were well attended and followed a set agenda which included updates from across the clinical areas of the hospital and a quality and risk update.

The hospital had a Quality and Risk Improvement Committee, which met every two weeks. The agenda alternated between clinical and non-clinical group meetings. Sub-committees such as Medication Management Committee and the newly formed Resuscitation and Deteriorating Patient Committee reported into the Quality and Risk Improvement Committee and upward to the Clinical Governance Committee. There was evidence that infection, prevention and control issues were discussed at the Clinical Governance Committee meetings. The hospital had also initiated a Drugs and Therapeutics committee, but this new committee had not yet met and was not reflected in organograms provided to inspectors.

The director of nursing was responsible for the organisation and management of the nursing services and had line management responsibility for nursing staff and health and social care professionals. The hospital's clinical director was responsible for the clinical services in the hospital and reported to the CEO of the hospital and to the medical director of the Charter Medical group. The clinical director was the chairperson of the hospital's Medical Advisory Committee (MAC) and was responsible for the management of credentialing and privileging of consultants. The medical director was the line manager for the resident medical officers who were employed by Charter Medical Private Hospital.

Patients in the Stepdown Unit were under the care of one of three named consultants, corresponding to the hospital from which the patient was referred. The consultants attended Charter Medical Private Hospital at a minimum once per week. The service was supported by a consultant on call 24/7 and a non-consultant hospital doctor on site 24/7. For surgical patients, inspectors were informed that the patient's surgical and anaesthesiology consultants were on call and in close proximity to the hospital post-surgery until patients are discharged. An anaesthetic registrar was on site in the hospital if there were admitted surgical patients. Charter Medical Private Hospital did not provide high dependency care at the hospital. In the case of a deteriorating patient, patients were transferred to a higher level of care typically via a protocol 37 ambulance transfer to the emergency department at the nearest acute hospital. The hospital tracked the number of unplanned patient

transfers, which were logged as an adverse occurrence.

Charter Medical Private Hospital had a scope of service document which outlined the services provided by the hospital. These included; elective surgical procedures, elective intermediate care beds provided under service level agreement with the Health Service Executive (HSE) and a Minor Injury Unit which was provided onsite at Charter Medical Private Hospital on behalf of the HSE. The hospital accepted patients which were defined by the American Society of Anaesthesiologists (ASA) Physical Status Classification System as ASA I (normal healthy patient) and ASA II (a patient with mild systemic disease).

Inspectors noted that inclusion and exclusion criteria for services at the hospital were defined across several policies. However, there were some inconsistencies identified across documentation reviewed and from discussions with staff. The age range accepted for paediatric surgery for example, was inconsistent in documentation seen by inspectors. In addition, exclusion criterion outlined to inspectors in relation to children with additional needs was not reflected in documentation. The hospital should ensure that the scope of service and inclusion and exclusion criteria for services provided are clearly and consistently defined.

There were no paediatric patients in the hospital on the day of inspection. Hospital management reported that there was no formalised access to a paediatric consultant and no appointed clinical lead for paediatric surgery or paediatric anaesthesiology. There was also no named clinical lead for each of the early warning systems in use by the service, as is indicated by best practice. The hospital should reflect on the structures and systems in place to support clinical services, particularly paediatric services, to ensure effective oversight arrangements are in place to support the quality and safety of the service.

Overall, the hospital had formalised governance arrangements to ensure the delivery of high quality and safe healthcare services. The following opportunities to strengthen these arrangements were identified:

- the hospital should clarify its acceptance criteria, particularly for paediatric patients, ensuring these are well defined and consistent across policies
- there was no formalised access to a paediatric consultant, no named clinical lead for paediatric surgery or paediatric anaesthesiology
- the service had no named clinical lead for each of the early warning systems in use.

Judgment: Partially 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 management arrangements in place in relation to the four areas of harm which were the focus of this inspection.

The hospital had recently employed a director of infection, prevention and control (IPC) who was the only dedicated IPC resource in the hospital. This position represented an uplift in resources from a previous part time IPC nurse role. There was evidence of outbreak management and IPC surveillance but the IPC programme was under development at the time of the inspection and there was no annual programme or objectives yet in place. There was no formal antimicrobial stewardship (AMS) programme and inspectors were informed that a consultant microbiologist could be contacted for advice if needed, although IPC staff indicated that they had not previously availed of this service. There was evidence that IPC issues were addressed at the Clinical Governance Team meetings and Quality and Risk Improvement Committee. While the hospital had a Hygiene and Infection Prevention Control Group, it was unclear how active this committee was and staff indicated that the committee was a work in progress. There was evidence that IPC issues were discussed at the Clinical Governance Team meetings and Quality and Risk Improvement Committee.

The hospital had a pharmacy service lead by the chief pharmacist. The Medication Management Committee was responsible for overseeing medication safety at the hospital. This committee was chaired by the pharmacy manager and attendees included nursing and a representative of the resident medical officers, but there was no consultant representation. Shortly prior to the inspection, the hospital developed terms of reference for a new Drugs and Therapeutics Committee which planned to meet in 2026. Given medication safety issues identified on this inspection discussed under national standard 3.1, the hospital should continue to progress and strengthen multidisciplinary oversight of medication management and safety practices at the hospital.

Admission and discharges for the stepdown and rehabilitation beds were managed by nurse management. A pre-assessment team managed surgical admissions, supported by the hospital's operations manager. The hospital had no specific transitions of care committee. Management of overall capacity planning and forecasting was discussed at cross-site Charter Medical group operations meetings. Activity levels formed part of the local weekly senior management team meetings. Updates on activity levels and metrics, including numbers of patients discharged to home or long-term care settings were discussed at the Clinical Governance Team meeting. Weekly multidisciplinary team meetings were held on the Stepdown Unit

with each of the relevant consultants that included discharge planning.

Patients at the hospital were monitored using the Irish National Early Warning Score (INEWS)[††] and the Irish Paediatric Early Warning Systems (PEWS). Oversight of the recognition, response and management of the deteriorating patient was the responsibility of the Resuscitation and Deteriorating Patient Committee, which was recently established and had previously operated as the Resuscitation Committee. The new committee had met once and planned to meet twice per year and was chaired by the clinical director. The committee planned to have oversight of simulations, education, training and audits related to the deteriorating patient.

The Clinical Governance Committee had responsibility for the development and oversight of policies, procedures, protocols and guidelines. During the inspection, inspectors observed multiple active versions of policies across topics, within which inconsistencies were identified, for example, inclusion/exclusion criteria and the process of escalation of care. In addition, some staff who spoke with inspectors' relayed information which was not in line with transitions of care and clinical risk management policies. The inspectors were informed that additional policies had been developed to support accreditation, which increased the numbers in circulation. The hospital would benefit from a comprehensive review of all available policies and procedures to ensure standardisation of approaches, with removal of duplicate or conflicting documents to strengthen oversight and governance at the hospital.

Overall, inspectors found that the hospital was in the process of developing management arrangements to support and oversee the service. The hospital had recently established and updated their committee structure to align oversight arrangements with the four key identified areas of harm. While this demonstrated a commitment to improving oversight, many of these committees were newly formed and will require time to embed to provide assurance of their effectiveness and to ensure compliance with this national standard. Areas for improvement include:

- policies, procedures, protocols and guidelines should be reviewed to ensure they are consistent, reflect local practice and support decision making
- the IPC programme was in development and should be progressed with formalised reporting arrangements
- the oversight arrangements for medication management should be progressed to provide adequate multidisciplinary oversight of medication management practices at the hospital.

[††] Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned ICU admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.

Judgment: Partially Compliant

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

Inspectors found that there were assurance systems in place to monitor, evaluate and improve the services in Charter Medical Private Hospital. Information on a data related to the quality and safety of healthcare services was monitored improve the quality, safety and reliability of healthcare services.

The hospital had an overarching annual plan audit in place for 2025 and evidence was provided of audit and monitoring in relation to medication safety, the deteriorating patient, infection, prevention control and transition of care. An annual report was compiled in 2025 based on audits carried out in 2024, with over 647 audits completed, which was commendable. The results of audits were publically on display in clinical areas. The Quality and Risk Improvement Committee monitored clinical audit and provided assurances to the Clinical Governance Team on audit activity.

The hospital had a Risk Management Strategy and Clinical Risk Management Policy, which referenced the national standards. Risks were recorded on a single hospital risk register, which was overseen by the chief executive officer and managed by the quality and risk manager. Risk ratings were applied and recorded along with controls and mitigating actions. Some risks did not have an assigned responsible person, a date for re-assessment or timeline for close out. It was unclear from documentation reviewed by inspectors when the hospital's risk register was last formally updated as there was a lack of evidence of sign-off or annotation of a review. The hospital's Risk Management Strategy referenced that high-level risks were reviewed monthly and inspectors were informed that the risk register was reviewed weekly at the senior management team meeting.

Incidents and near misses were reported as adverse occurrences. Overall, there was evidence indicating the proactive identification of patient-safety incidents with good reporting levels. However, the systematic monitoring of patient-safety incidents could be strengthened by clarifying the taxonomy used to categorise incidents and the system in place for analysis of such events to ensure a consistent approach. This is discussed further in national standard 3.3.

There was evidence that the services used patient feedback via surveys and complaints to improve the quality of healthcare services. Patient surveys were given to patients by the ward staff and collected by the administration staff. This feedback

was collated, was on display in the clinical areas and was shared with the staff. There were a number of examples of quality improvement plans generated by patient feedback evident in Endoscopy. These included implementation of a unidirectional patient flow through the unit and a dedicated set down area for collection of patients after their procedure.

There were quality boards located in the clinical areas, which displayed quality metrics organised by the four known identified areas of harm, audit results and patient feedback for that particularly area. This information board also publically displayed the most common occurring adverse occurrences in the previous month to highlight areas to focus on for quality improvement, which was a positive initiative.

Overall, while there was opportunity to strengthen oversight of the risk register, the hospital had systematic monitoring arrangements are in place to continually improve the quality, safety and reliability of healthcare services.

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.**

There were arrangements in place to plan organise and manage the workforce to support the delivery of services at Charter Medical Private Hospital. The workforce reflected the size, complexity and specialties of the service being provided at the hospital.

A human resource (HR) manager had overall responsibility for workforce planning, staff recruitment and key performance indicators related to workforce. The HR manager reported to the chief executive officer and was a member of the hospital's senior management team.

At the time of the inspection, Charter Medical Private Hospital had a total workforce of 232 staff and a vacancy rate of 4.96%. The absenteeism rate was 3.6% which was commendable.

The director of nursing was supported by 2.8 whole time equivalent (WTE) assistant directors of nursing (ADONs), 2.77 clinical nurse managers 2 and 16.65 clinical nurse managers 1. There was one vacant clinical nurse manager 3 post at the time of inspection. A total of 66.1 WTE staff nurse posts were approved, with 59.5 WTE of these posts filled at the time of inspection. There were 36.75 WTE approved healthcare assistants positions, with 34.75 in post. The hospital also employed housekeeping staff and two WTE multi-task attendants. Inspectors were advised of

new approved clinical roles above the current complement, which were yet to be filled including; one clinical nurse specialist post, two healthcare assistants, four WTE non-consultant hospital doctors, 2.15 WTE pharmacists and one occupational therapist.

The planned nurse-to-patient ratios in the Stepdown Unit was 1:6 ratio during day shifts and 1:8 during night shifts. In addition, health care assistant to patient ratio was 1:4 during day shifts and 1:8 during night shifts which were the staffing levels in place at the time of inspection. On each shift there were supernumerary clinical nurse managers rostered, including at night. Inspectors reviewed the rosters for the month preceding the inspection and noted a relatively high reliance on agency staff. For example, in one of the weeks preceding the inspection, there were nine day shifts and eight night shifts covered by agency staff. Inspectors were informed that agency staff were required to supplement staffing levels during periods of heightened demand during the year and agency staff familiar with Stepdown Unit were used.

Management reviewed the staffing requirements for theatre, depending on the scheduling of theatre lists. Bank staff and agency staff were used to fill vacancies on the rosters in theatre.

The hospital employed resident medical officers (RMO) who were non-consultant hospital doctors. In the Stepdown Unit, there were two RMOs on site during the day and one at night. There were 17 WTE approved RMO posts, 13 of which were filled at the time of inspection.

There were 3.15 WTE approved pharmacist posts, with 2.15 WTE in post and one pharmacy technician. A 0.8 WTE physiotherapy post was approved and filled, and an occupational therapist and a speech and language therapist were also available to patients at the time of inspection with a plan to recruit an occupational therapist as part of the planned additional clinical posts.

Human resources and clinical facilitators captured uptake of and attendance at mandatory and essential staff training on Excel spreadsheets. Inspector's were informed that there were plans to move to a centralised HR system to record staff training. Compliance with staff training was a standing agenda item at Clinical Governance Team meetings and was overseen by senior management team. All new employees attended the hospital's induction programme which took place monthly. This programme included training on medication management, the deteriorating patient and infection prevention and control. Children's first, adult safeguarding, INEWS and sepsis training was mandatory for all clinical staff. Updates on staff attendance at mandatory and essential training was displayed in the clinical areas on quality boards. Overall, from documentation reviewed by inspectors there was good

uptake of mandatory training from nurses, healthcare assistants and NCHDs. Of these staff groups for example, 91.7% were up to date with INEWS training, 93.8% with hand hygiene and 92.8 with standard and transmission based precautions.

Paediatric patients accounted for 2% of the surgical activity in the hospital. The hospital had four WTE paediatric nurses employed. While there were no paediatric patients in the hospital when inspection took place, management indicated that paediatric activity was scheduled and staffing was organised accordingly. The four paediatric trained nurses had Paediatric Life Support (PLS) and Paediatric Early Warning system (PEWS) training.

All surgical and theatre nurses had Patient Observation and Notable Deterioration Evaluation and Response (PONDER) training. This was a programme developed in-house by the clinical facilitator to provide essential skills and knowledge for early recognition and effective management of a patient deteriorating and was a positive initiative developed by the hospital.

Inspectors were informed that all consultants were on the specialist register of the Irish Medical Council, which was a prior condition to gain privileges. Reviews of clinical practice privileges were carried out and overseen by the Medical Advisory Committee.

Overall, the hospital had planned and managed the workforce to ensure it consistently responded in a timely manner to change. An induction programme was in place and there was oversight of mandatory training records, with good compliance with attendance overall.

Judgment: Compliant

## Quality and Safety Dimension

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

Charter Medical Private Hospital was found to be compliant with national standards 1.6 and 1.7, substantially compliant with national standards 1.8 and 2.8, and partially compliant with national standards 2.7, 3.1 and 3.3 assessed under this dimension.

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

Staff who spoke with inspectors were aware of the need to promote and respect patients' dignity and privacy. Patients were aware how to seek assistance and call bells were available within reach. Patients who spoke with inspectors indicated that staff were attentive and that call bells were responded to promptly.

In the clinical areas visited by inspectors, staff were seen to promote a person-centred approach to providing care by recognising patient's individual needs. For example, care plans were discussed with patients and patients were prepared for discharge with one patient noting, *"their opinion was taken into account when planning discharge".*

Surgical patients were supplied with dignity shorts as well as gowns, and inspectors were informed that there was positive feedback from patients on this initiative. Curtains were used in multi-occupancy rooms when patients were receiving personal care, and male and female patients were segregated. The Stepdown Unit had good availability of single rooms, which promoted patients' dignity. There were some infrastructural challenges in this clinical area, which did not support autonomy of patients such as lack of ensuite facilities and uneven floor surfaces and is discussed further under national standard 2.7.

Menu choices were provided and the majority of patients were complimentary of the food and commenting that the "*food was gorgeous"* and it was *"tasty and excellent"*.

During the inspection, patients' personal information was stored securely and privacy of patient information was maintained. A variety of information leaflets were available to inform patients on issues such as how to make a complaint, the feedback process and advocacy services.

Overall, there was evidence that hospital management and staff respected and promoted the dignity, privacy and autonomy of people receiving care at the hospital.

Judgment: Compliant

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

Inspectors observed staff engaging with patients with kindness, consideration and respect. Inspectors observed that patients were communicated with in an open and sensitive manner.

Patients who spoke with inspectors were in the main, very complimentary about staff. In the surgical and theatre recovery area patients noted that staff were *"excellent", "very efficient"* and *"nurses brilliant, always kept an eye on me".* Patients acknowledged the "*great care"* and "*support offered*" by the clinical staff, catering and cleaning staff.

There was evidence that patients' views, values and preferences were actively sought. Patients indicated that staff asked on a daily basis if they would like a shower or needed to be supported with personal hygiene needs.

There were mechanisms in place for patients to provide feedback on the service provided. Some of this feedback was displayed on the notice boards for patients and their families to view.

Overall, staff in the hospital promoted a culture of kindness, consideration and respect for people receiving care in the service.

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**.

There were effective systems in place to respond to feedback and complaints received from patients and their families. The hospital's complaints policy guided the management of complaints. Patients advised inspectors that if they wanted to raise an issue or concern they would discuss it with a member of staff or send an email to the hospital.

The hospital's chief executive officer (CEO) was the accountable person for the management of complaints and signed off on all formal complaints responses. The CEO was supported by the quality and risk manager in the management of complaints. Complaints were discussed weekly with the CEO and the director of nursing and feedback on complaints was reported upward to the hospital board as part of the quality and risk reports.

There was a system for logging and managing formal complaints on a complaints register seen by inspectors. The hospital aimed to acknowledge complaints within five working days and to close complaints within 30 days. There was evidence that most complaints met the 30-day timeline and rationale was provided for cases falling outside the timeframe. Hospital management advised that 39 complaints had been received in 2025 up to the time of inspection, of which 16 were open, 10 were on

hold and 12 were closed. Of these 39 complaints, five were considered as adverse occurrences and were also logged as such.

Complaints were collated and themes were identified such as cancellation and rescheduling of procedures, clinical issues and missing property, however the numbers of complaints received per theme were not quantified. Staff on the wards involved in the complaints process received online training on how to manage a complaint. Inspectors were advised that ward managers managed verbal complaints locally and that efforts were made to resolve such complaints at the point-of-care by staff. Verbal complaints were not formally captured in a way which allowed tracking or trend analysis, which may represent a missed opportunity for shared learning and quality improvement.

Information leaflets and posters were available in the clinical areas visited by inspectors on how to make a complaint. Advocacy services were promoted the hospital via posters on display in the clinical areas.

It was evident that the hospital had a strong focus on obtaining patient feedback. Patients had an opportunity to provide feedback on their experience at the hospital through a patient survey form, which was also available on the hospital's website. The feedback captured the overall rating of their experience, aspects that exceeded expectations and aspects that could be improved. Each clinical area had a response rate target of 28% and from August to September 2025, the average response rate from the survey was 27.3%. Inspectors observed feedback boards in the clinical areas displaying positive feedback messages from patients and families.

Overall, there were effective processes in place to respond promptly and openly to complaints and concerns made by patients and or their families. There may be opportunity to enhance learning and service improvement from trending of complaints received and analysis of verbal complaints.

Judgment: Substantially Compliant

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

Overall, the hospital was found to be clean and secure. At the time of the inspection, an Estates and Facilities Phased Works Project Plan was ongoing. Some areas of the hospital had been refurbished and there was a plan in place for further refurbishment of the facility in 2026. Inspectors noted that clinical areas which had already been upgraded were in good condition. However, in some clinical areas the

physical environment did not fully support infection control practices with limited hand hygiene sinks, inadequate facilities for waste disposal and outdated infrastructure that required upgrading.

Parts of the Stepdown Unit had been ungraded, however in areas yet to be refurbished some surfaces did not facilitate effective cleaning, and there was uneven flooring and evidence of wear and tear. Alcohol gel was available and strategically located in the clinical areas visited, but there were insufficient clinical hand wash sinks in parts of the Stepdown Unit. Inspectors were informed that installation of additional clinical hand washing facilities was part of the refurbishment plan that was in progress.

In the Stepdown Unit, the sluice room had a macerator for the disposal bedpans and urinals. There was a general domestic sink in this room but no clinical sink available for hand washing. In the Endoscopy sluice room, a commode with a disposable insert which had staining was observed by inspectors and as there was no macerator in this room, staff indicated that inserts were disposed of in the yellow bin. The hospital should ensure appropriate facilities are in place for the safe disposal of waste including potentially contaminated items.

Storage issues and challenges with adequate space were noted on the hospital's risk register. The Surgical 1 Ward had been recently refurbished and was clean and spacious with sufficient toilet facilities, but storage issues were identified. Wheelchairs were stored in a four-bedded room and while clean linen was kept in a storeroom, there were additional clean pillows and linen found stored in a wardrobe in an ensuite bathroom. A lack of storage was also an issue in the main theatre. The recovery area was noted to be small and challenging for staff when at full capacity.

Inspectors observed that a clean cloth system was in use for cleaning in the hospital. In general, linen was appropriately segregated and there was appropriate management of hazardous materials and chemicals for cleaning. The main household store for chemical storage in the hospital was on the ground floor and this room was locked. Household supervisors carried out audits of the cleaning schedule. The hospital used a green tagging system seen by inspector to indicate equipment was clean.

In the Stepdown Unit, there was evidence that patient placement was considerate of challenges posed by the physical environment. Such challenges included that some single rooms were not ensuite and one room was only available for patients at end of life, as the resuscitation trolley could not be accessed in the room due to space limitations. The accessibility and availability of toilet and shower facilities in the Stepdown Unit was cited as challenging by some patients. Risk assessments were carried out to support appropriate placement of patients. Although the hospital's

infection prevention and control policy did not reference prioritisation of patient placement, a map outlined the facilities that were available and unavailable across rooms in the Stepdown Unit. Inspectors were informed that this map was used to support patient placement along with the individual patient risk assessments.

Overall, inspectors were not assured that healthcare was consistently delivered in a physical environment that minimised the risk of healthcare-associated infection transmission. Some assurances were provided to inspectors as a facilities improvement project plan was underway. This plan must be progressed as a priority by hospital management to ensure healthcare is consistently provided in a suitable environment to meet patient needs, in line with national standards. Issues identified with the environment included;

- a lack of clinical hygiene sinks, uneven floor surfaces and surfaces which did not facilitate effective cleaning in the Stepdown Unit
- inadequate waste disposal facilities in Endoscopy
- storage issues were noted in some clinical areas.

Judgment: Partially Compliant

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

There were systematic monitoring arrangements in place at Charter Medical Private Hospital to identify and act on opportunities to continually improve the quality, safety and reliability of the service. The hospital used various sources of information such as audits, metrics and patient feedback to measure the quality and safety of care provided.

The Quality and Risk Improvement Committee monitored clinical audit and an audit plan was in place for 2025 and 2026. The plan included audits that related to infection prevention and control, medication safety, transition of care and the deteriorating patient. Inspectors were informed that audits were assigned to nurses and healthcare assistants and were overseen by the clinical nurse managers (CNMs). The CNMs were responsible for following up on non-compliances with team members and communicating findings to the wider team via the daily ward huddles. In the Stepdown Unit for example, a total of 14 audits were completed monthly including nursing metrics.

The hospital had a plan to introduce an electronic audit system to support audit activity in 2026. At the time of inspection, the hospital used a comprehensive, standardised audit form for all audits carried out. The audit forms for medication

safety audits were found to be fully completed and included the reason for non-compliances, corrective actions, responsible persons and date for close out of actions. However, the audit forms were incomplete for other topics, for example, sections on the rationale for non-compliances and the required corrective actions were not always populated.

The hospital had a quality improvement template tool and there was evidence of quality improvement plans put in place in some clinical areas such as Endoscopy, although it was unclear if the tools were consistently applied in response to non-compliant audit findings.

Staff in the clinical areas carried out monthly hand hygiene audits with a compliance target set at 100%. In the Surgical Day Ward, hand hygiene audits reviewed by inspectors showed compliance rates ranging from 71% to 94% between September and November 2025. In the Stepdown Unit, hand hygiene audit compliance ranged from 71% in September 2025 to 91% in November 2025. Bare below the elbow audits were completed at the safety huddles and results reviewed by inspectors indicated good compliance.

There was evidence of audit of clinical handover from theatre to the Surgical Ward. In addition, there were audits of transitions of care in the Stepdown Unit, which included a review of the information recorded on the handover form and compliance ranged from 83% to 97% in September and October 2025. However, audit questions did not capture aspects of the verbal handover, for example, there was no prompt regarding the patient's infection, prevention and control status and therefore this information was not captured.

Responsibility for the equipment cleaning checklists was with the cleaning supervisor. In theatre, inspectors saw examples of environmental audits carried out using a national auditing tool.

Audits of compliance with the hospital's medication management policy were carried out. There was evidence of action plans developed by the auditors to correct non-compliances, for example in relation recording of patient weight and direct oral anticoagulants charting. Compliance with the procedures set out in controlled drug policy was audited in the Surgical Day ward, demonstrating 100% compliance from September to November 2025. However, based on findings of this inspection in relation to the management of controlled drugs, as outlined in national standard 3.1, the hospital would benefit from reviewing medication audits to ensure they are comprehensive and capture all aspects of practice.

In relation to the deteriorating patient, there was evidence that INEWS audits were carried out in all clinical areas visited by inspectors, with good compliance rates

documented. There was a lack of evidence in relation to sepsis audits.

The hospital had a strong focus on gathering and using patient feedback. The percentage of patients who provided feedback was reported for each area. Inspectors found there were active efforts to increase feedback received for example, feedback increased from 11% in May to 27% in June 2025.

The hospital used a variety of outcome measures to evaluate the effectiveness of the service provided. There was opportunity to improve the comprehensiveness of audit questions to fully capture performance and provide assurance in relation to the four known areas of harm. The amount of audit activity carried out at the hospital was commendable and there was a strong focus on gaining patient feedback.

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

Overall, while the hospital had systems in place to protect patients from the risk of harm associated with the design and delivery of healthcare services, these systems were not fully effective to provide assurances to hospital management on the quality and safety of care.

The hospital had risk management structures in place and an overarching hospital risk register that was overseen by the chief executive officer. Clinical staff had access the risk register via the quality and risk manager. There were risks escalated to the hospital risk register related to the four areas of harm and key risks included infection prevention and control risks relating to the environment and adequacy of space. Inspectors were informed that risks identified at ward level were escalated to the hospital risk register via adverse occurrence reporting and risk assessments. Patient specific risk assessments were carried out in clinical areas and were discussed at the daily safety huddles, for example, falls risks.

Inspectors found that the systems in place for the management and oversight of controlled drugs were inadequate. For example, in one clinical area, the documentation of controlled drugs was in a notebook which was being used to log drugs in addition to the controlled drug register. Also, checks were not being performed at the beginning and end of each shift in some clinical areas visited, as per local policy and best practice. Inspectors identified these issues as an immediate risk and escalated to senior management for immediate address.

The hospital aimed that patients admitted to the Stepdown Unit had reconciliation of medication completed within 24 hours of admission by the pharmacy team.

Inspectors found that in the main, this target was achieved. All new staff completed medication management training at induction and agency staff received training on orientation to the drug kardexes. However, risks were identified in relation to the use of multiple drug kardexes in the hospital, including two versions of the same kardex due to a supply issue. HIQA wrote to the service following on from the inspection to highlight the identified issues and to seek assurance regarding these potential risks. In response, the hospital committed to removing a former version of the kardex from circulation and ensuring only the newer version is in use.

High-risk drug posters were on display in the clinical areas. An electronic system was used for theatre and pharmacy fridges that was monitored by the pharmacy team. Inspectors were informed that there was as process for accessing medication out of hours.

The pre-assessment screening for surgical patients attending the hospital included the potential risk of carrying a multi-drug resistant organism (MDRO). Staff in the Stepdown Unit received a handover from referring hospitals, which was documented locally and sometimes was received verbally. Inspectors noted healthcare-associated infection status of the patient this was not always flagged on the documentation used for this purpose. Outbreaks and hospital acquired MDROs were monitored but not reported locally as adverse occurrences. Outbreaks were discussed at the Clinical Governance Team meetings and inspectors saw an example of an outbreak report.

Infection prevention and control signage was appropriately displayed outlining contact based precautions to be observed in the areas visited. Adequate personal protective equipment was available in clinical areas. In the Stepdown Unit, inspectors observed two rooms in use for isolation purposes with appropriate signage and waste bins in place at the entrance of the rooms. Staff were knowledgeable on infection prevention and control practices and procedures to reduce the spread of infection. The Stepdown Unit had 12 single rooms, six of which were ensuite. Inspectors saw evidence that patient placement was considered supported by a map of rooms and facilities available. However, as discussed under national standard 2.7, there were IPC risks in the Stepdown Unit posed by aging infrastructure. This included surfaces that did not lend themselves to effective cleaning, as well as insufficient handwashing facilities in parts of the ward that have not yet been refurbished.

The hospital had systems and processes in place to support the recognition and management of deteriorating patients. A multidisciplinary safety huddle was attended by an inspector in the Stepdown Unit and noted that discussions included the patients' early warning scores and parameters in place. A sample of healthcare records reviewed by inspectors demonstrated that increased frequency of

observations was undertaken, as per the locally adapted INEWS‡‡ chart when a patient deteriorated. However, there were three different policies seen by inspectors which outlining the management of the deteriorating patient and these were not fully consistent with the process for escalation of care as outlined on the INEWS form seen in use. The service would benefit from a review of relevant policies to ensure the approach to recognise, respond and manage the deteriorating patient is clear, consistent and reflects local practice.

In general, patients who required a higher level of care were transferred from the hospital to the nearest emergency department via ambulance. The risks associated with transferring of patients to a higher level of care and challenges experienced with ambulance times were identified on the hospital risk register and were monitored. The hospital recorded and monitored these transfers via adverse occurrence reporting which were categorised locally as a protocol 37 transfer. In the six months prior to the inspection, there were 15 transfers to a higher level of care.

Hospital policy outlined that the Identify, Situation, Background, Assessment, Recommendation (ISBAR) tool was used to ensure critical information is communicated during transitions of care. The use of clinical handover in the ISBAR format was evident in patient records in the Stepdown Unit, Theatre and Recovery. A transit lounge was available in the Surgical 1 Ward for patients awaiting discharge following surgery.

Inspectors identified opportunity to improve the systems in place to protect patients from the risk of harm in relation to:

- the documentation to support safe custody of controlled drugs was not in line with best practice, the hospital provided assurance to HIQA that this has been rectified immediately following the inspection
- multiple kardexes and versions of kardexes were in use and should be rationalised to ensure consistency, reduce the risk of medication errors and to support safe prescribing
- the escalation of care for the deteriorating patient should be clearly outlined in policy, aligned with local clinical practices and relevant resources.

Judgment: Partially Compliant

‡‡ Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration. Early recognition of deterioration can prevent unanticipated cardiac arrest, unplanned ICU admission or readmission, delayed care resulting in prolonged length of stay, patient or family distress and a requirement for more complex intervention.

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

There were systems and processes were in place at Charter Medical Private Hospital to identify and manage patient safety incidents. However, there was opportunity to improve the systems in place to classify and respond to patient-safety incidents.

Clinical staff reported adverse occurrences in electronic form, which inspectors were informed included near misses and patient-safety incidents. The reported adverse occurrences were collated by the quality and risk manager. Trending was reported at the Quality and Risk Improvement Committee and an update was given at the Clinical Governance Team meeting, with onward reporting to the chief executive officer and the board.

Staff who spoke with inspectors were able to describe how a patient-safety incident was reported. There was evidence that feedback and the learning from adverse occurrences were shared with staff.

Overall, there were good levels of reporting of adverse occurrences and upward trending was evident. Feedback from staff and management was also indicative of a positive culture of reporting. Inspectors reviewed a report summarising adverse occurrences reported in 2025 up to the time of the inspection, which were trended into themes and organised to highlight the top themes reported per quarter. Categories included falls, documentation, tissue viability and protocol 37, under which transfers to higher levels of care were reported. Monthly reported numbers were compared for 2024 and 2025 and variations in reporting levels were discussed and rationalised at committee meetings.

The taxonomy used by the hospital to categorise incidents was unclear, as terminology and descriptors of incident severity were inconsistent across documents and in discussions with inspectors. While the trend data and documentation seen by inspectors demonstrated the surveillance of incident reporting, it did not categorise or trend adverse occurrences by severity as per the hospital policy. Therefore, it was unclear for example what proportion of adverse occurrences were near misses versus patient-safety incidents. Medication safety incidents at the hospital were not categorised using the NCC MERP system.

There was evidence of reviews carried out on foot of patient-safety incidents. However, it was unclear what type of review should be undertaken in response to incidents of different severities. While documentation and staff referenced various review tools used such as root-cause analysis and the London Protocol, there was a lack of clarity on the thresholds that triggered each review type or when they should be instigated.

Overall, there were systems in place for staff to report incidents and there were good levels of reporting, with upward trending of reporting which is a positive indicator of the patient safety culture at the hospital. However, inspectors identified opportunity to strengthen the systems in place to effectively identify, manage, respond to and report on patient-safety incidents including;

- the classification system should be strengthened to ensure a clear single taxonomy is used by the service
- this classification system should be supported by a clear policy framework that defines the appropriate level of response following a patient-safety incident.

Judgment: Partially Compliant

## Conclusion

An announced inspection was carried out at Charter Medical Private Hospital to assess compliance with national standards from the National Standards for Safer Better Healthcare. The focus of the inspection was on four areas of harm – infection prevention and control, medication safety, deteriorating patient and transitions of care.

### Capacity and Capability

Overall, the hospital had formalised governance arrangements in place to ensure the delivery of high quality and safe healthcare services. Opportunities to strengthen these arrangements were identified particularly around the definitions of the scope of services and exclusion criteria. In line with best practice, the hospital should consider having clinical leads for the early warning systems and paediatric services.

Inspectors acknowledged that much work has been done to align oversight arrangements with the four key identified areas of harm with a number of new committees formed. The newly established committees will need time to fully embed to ensure management arrangements are effective. Good practice was evident by the use of quality boards which displayed audit findings, patient feedback and adverse occurrence trends in clinical areas. There was evidence of quality improvement initiatives generated from patient feedback in some clinical areas.

The hospital planned and managed their workforce to ensure it consistently responded in a timely manner to change. There was good oversight and uptake of mandatory and essential training.

**Quality and Safety**

Staff were observed providing person-centred care and interacting with patients in a respectful, kind and caring manner. Patients praised the staff and spoke positively about their care at the hospital. There was evidence that dignity and privacy were considered in the care provided. There were systems in place to address and manage complaints and the hospital had a strong focus on gaining patient feedback. There was high levels of audit activity carried out and some opportunities to enhance oversight and monitoring of the service in relation to the four known areas of harm.

Inspectors identified some risks in relation to medication management practices and assurances were sought from the service. Opportunity was identified to improve clarity on the process of escalation of care across documentation and policies. Inspectors found that the physical environment did not reliably minimise the risk of healthcare-associated infection. Although certain clinical areas had been upgraded, other areas of the hospital had aging infrastructure. A facilities improvement plan was in progress which should be prioritised by hospital management to ensure healthcare services are delivered in an appropriate physical environment.

There were indicators of a positive patient safety culture at the hospital with good levels of reporting of patient-safety events. Inspectors identified opportunity to strengthen the systems in place in relation to management of patient-safety incidents by ensuring a single taxonomy is used to classify patient safety events, supported by a clear policy framework that defines the response following a patient-safety incident.

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

| 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 | Partially Compliant |
| Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services. | Partially Compliant |
| Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. | 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 | Compliant |
| **Dimension: Quality and Safety** | |
| **Theme 1: Person-centred Care and Support** | |
| Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted. | Compliant |
| Standard 1.7: Service providers promote a culture of kindness, consideration and respect. | Compliant |
| Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process. | Substantially Compliant |

| Theme 2: Effective Care and Support | |
|---|---|
| Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users. | Partially Compliant |
| Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved. | Substantially Compliant |
| **Theme 3: Safe Care and Support** | |
| Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services. | Partially Compliant |
| Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents. | Partially Compliant |

**Compliance Plan for Charter Medical Private Hospital**

**Inspection ID: NS_0177**

**Date of inspection: 10 and 11 December 2025**

**Compliance plan provider's response:**

| Standard | Judgment |
|---|---|
| Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare. | Partially Compliant |
| Outline how you are going to improve compliance with this national standard.<br>1) Acceptance criteria for paediatric patients should be clearly defined and consistent across policies.<br>Action: | |

• Communication disseminated to all relevant staff to ensure consistent understanding of paediatric inclusion and exclusion criteria and its application in practice in line with the hospital's scope of service.

• Currently undertaking review of all policies and clinical guidelines relating to the admission and treatment of paediatric patients to ensure clear and consistent acceptance criteria aligned with the hospital's scope of service.

• Planned digitalisation of risk management system to include document management module.

Lead Responsible: Quality and Risk team/ Heads of department

Timeline: Completion Q3 2026

Monitoring / Assurance: Compliance with Scope of Service monitored through clinical governance review and audit.

2) No formalised access to a paediatric consultant and no named clinical lead for paediatric surgery or paediatric anaesthesiology.

• Clinical lead for paediatric anaesthesiology has been identified and formal arrangements are underway. Clinical/Surgery leads are being progressed

Lead Responsible: Clinical /Medical Director/CEO

Timeline: Q2 2026

Monitoring / Assurance: Clinical Governance Committee.

3) No named clinical lead for each early warning system in use.

• Clinical lead for Resuscitation/Deteriorating patient has agreed to be named lead for early warning systems.

Lead Responsible: Clinical /Medical Director/CEO

Timeline: Q2 2026

Monitoring / Assurance: Clinical Governance Committee.

4) Governance committees should meet in line with their terms of reference and actions should include assigned leads and timelines.

• Updated and revised organisation and communication strategy issued 09/02/2026. This outlines terms of reference, meeting templates mandating documented time bound actions and responsible persons.

Lead Responsible: Committee lead/Chair

Timeline: Q2 2026

Monitoring / Assurance: Governance meeting cascade document, responsibility of Chair of individual meetings to update/monitor and report compliance. This reports into Senior Management Team and Clinical Governance Committee

**Timescale:**

1. Acceptance criteria for paediatric patients - Q3 2026

2. Formalised access to a paediatric consultant - Q2 2026

3. Named clinical lead for each early warning system - Q2 2026

4. Governance committees - meet in line with their terms of reference - Q2 2026

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

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

1) Policies, procedures, protocols and guidelines should be reviewed to ensure they are consistent, reflect local practice and support decision making.

Actions:

• The 2026 planned review of all hospital policies, procedures, protocols and guidelines has commenced.

• Review and update our policy governance framework, including version control and defined review cycles.

• Update our existing centralised policy register and review schedule

• Planned digitalisation of risk management system to include document management and policy control module

Lead Responsible: Quality & Risk Manager

Timeline: Q3 2026

Monitoring / Assurance: Progress monitored through the Quality & Safety Committee and reported to the Senior Management Team / Compliance monitored through policy register and governance committee oversight / Audit of policy review schedule reported to Quality & Risk Department.

2) IPC programme was in development and should be progressed with formalised reporting arrangements.

Actions:

- Finalise and implement the Infection Prevention and Control (IPC) Programme aligned with national guidance and standards.

- Establish formal IPC reporting arrangements, including defined reports to the Quality & Risk Lead and Senior Management Team.

- Monitor IPC indicators, audit findings and improvement initiatives through governance committees.

Lead Responsible: IP&C Lead / COO

Timeline: Q3 2026

Monitoring / Assurance: Oversight through Infection Prevention & Control Committee / Regular IPC reports including surveillance data, audits and improvement actions / Quarterly reporting through governance structures.

3) Oversight arrangements for medication management should be progressed to provide adequate multidisciplinary oversight of medication management practices.

Actions:

- The planned restructured D&T Committee, that was previously reporting through CGT formally met on 12/02/2026 with multidisciplinary representation as per Terms of Reference which included Clinical Director attendance.

Lead Responsible: Senior Pharmacist

Timeline: Q3 2026

Monitoring / Assurance: Committee reports submitted to the Clinical Governance Committee / DTC

**Timescale:**

- Policies, procedures, protocols and guidelines revision - Q3 2026 / Monitoring Ongoing
- IPC programme development and progression - Q2 2026 / Monitoring Ongoing

| |
|---|
| • Oversight arrangements for medication management - D&T held Feb 12th, 2026 / will be embedded Q3 2026 / Monitoring Ongoing |

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

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

1. Stepdown Unit - Lack of clinical hygiene sinks, uneven floor surface & surfaces that did not facilitate effective cleaning.

As per post inspection feedback, detailed submission was provided on December 31st, 2025, the following actions were taken to address:

• Undertaken an environmental review of the Stepdown Unit to assess the requirement for additional clinical hand hygiene sinks in line with infection prevention and control standards.

• Conducted a risk assessment of flooring and surfaces in the Stepdown Unit in collaboration with Estates and IPC teams

• Developed and progressed an implementation plan of programme of works including installation of additional clinical hand hygiene sinks where required and replacement or refurbishment of flooring and surfaces to ensure they support effective cleaning and infection prevention and control practices

Lead Responsible: Estates & Facilities Manager / IPC Lead

Timeline: Environmental Review & Risk Assessments - Complete.

Further review of the Programme of works plan submitted in December 2025 - revision in January 2026 due to availability of healthcare specific external contractors and requirements to assist with bed capacity. This is under monthly review - Q4 2026

Monitoring / Assurance: Environmental review findings reported to the Quality & Safety & IP&C / Environmental improvement works tracked through maintenance and capital work programme.

2) Endoscopy Unit - Inadequate waste disposal facilities.

Action:

• Completed review and risk assessment of waste management facilities in the Endoscopy Unit. Determined waste disposal facilities are adequate and appropriate for both patient cohort and diagnostic procedures undertaken.

Lead Responsible: Endoscopy Unit Manager / IPC Lead

Timeline: Completed February 2026

Monitoring / Assurance: Outcomes reported to IP&C Lead and Quality & Risk Manager.

3) Clinical Areas - Storage issues

Action:

• Conduct a review of storage arrangements in identified clinical areas to ensure compliance with infection prevention and control and safety requirements.

• Implement measures to optimise storage, including removal of excess equipment, improved organisation of supplies and identification of appropriate storage areas.

Lead Responsible: Clinical Nurse Managers / Department Managers

Timeline: Q2-Q3 2026

Monitoring / Assurance: Storage practices monitored through environmental and IPC audits. Ongoing monitoring through local management checks and quality audit.

**Timescale:**

• Stepdown Unit - Lack of clinical hygiene sinks, uneven floor surface & surfaces that did not facilitate effective cleaning. Environmental Review & Risk Assessments - Complete. Programme of works for the Unit - revised to be completed Q4 2026

• Endoscopy Unit - Inadequate waste disposal facilities - Risk Assessment Complete February 2026

• Clinical Areas - Storage issues - Conduct a review of storage arrangements in identified clinical areas to ensure compliance with IPC and safety requirements - Q2 2026. Implement measures to optimise storage, including removal of excess equipment, improved organisation of supplies and identification of appropriate storage areas - Q3 2026

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

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

1) Controlled Drugs Documentation

As per post inspection feedback submission and risk assessment provided on December 22nd, 2025, immediate actions were taken to address the single incident in one clinical area as follows:

- Re-circulation of Medication Management Policy to highlight requirement for frequency of CD checks - Completed by Dec 22nd, 2025

- Amalgamation of standalone Management of Controlled Drugs audit tools into one overarching audit template - Completed by Dec 22nd, 2025

- Communication cascaded out to all clinical department's/Clinical Director and CGT - Completed Dec 22nd, 2025

- Implemented into Nursing Staff Orientation Programme - Completed by Dec 22nd, 2025

Lead Responsible: Senior Pharmacist / Director of Nursing / ADONs / CNMs

Timeline: Audit of above actions completed Jan 2026.

Monitoring / Assurance: Compliance monitored through D&T through medication management audits.

2) Multiple medication Kardex's used across the hospital.

As per post inspection feedback submission and risk assessment provided on December 22nd, 2025, immediate actions were taken to address this as follows

- Review and risk assessment of all medication kardex formats in use across the hospital - Completed by Dec 22nd, 2025

- Removal of old stock of Adult Medication Prescription & Administration Record v1.2 and ensuring only version 1.3 in use. Completed by Dec 22nd, 2025

- Implemented into Nursing Staff Orientation Programme (Agency and Bank) to include awareness of the specific Kardex in use within the department to which the nurse is assigned. Completed by Dec 22nd, 2025

- Implemented into the Staff Induction Medication Management Programme to explicitly reference the Kardex used in each department. Completed by Dec 22nd, 2025

Lead Responsible: Senior Pharmacist / Department CNMs

Timeline: Audit of above actions completed Jan 2026

Monitoring / Assurance: Implementation monitored through medication safety audits / Compliance monitored through local audits and medication safety reporting.

3) Escalation of care for the deteriorating patient.

• The planned Resuscitation and deteriorating patient meeting on 23/02/2026 commenced documentation and policy review to confirm alignment of procedure and practice across clinical departments.

• Continued monitoring of compliance to escalation procedures through clinical audit and incident review processes.

Lead Responsible: Deteriorating Patient Committee Lead / Director of Nursing/Quality & Risk Team

Timeline: Q3 2026

Monitoring / Assurance: Policy approval through Clinical Governance structures / Compliance monitored through clinical audit and staff education programmes / Findings reported to the Clinical Governance Committee.

**Timescale:**

• Controlled Drugs Documentation - Actions completed by Dec 22nd, 2026 / Audit completed Jan 2026 / Monitoring - Ongoing

• Multiple medication kardexes and versions of kardexes in use across the hospital - Actions completed by Dec 22nd, 2026 / Audit completed Jan 2026 / Monitoring - Ongoing

• Escalation of care for the deteriorating patient - Policy Review to be completed Q2 2026. Monitoring - ongoing

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

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

1) Incident classification system should be strengthened to ensure a clear single taxonomy is used by the service.

Action:

• Commenced review of the current patient-safety incident classification system to ensure the use of a single, clearly defined taxonomy across all departments within the service. We have moved from a heavily paper based system to digital - now reviewing

further options/modules and improvements to ensure alignment with national guidance and best practice to support consistent categorisation and reporting of incidents.

• Once defined, communication of the revised classification system will be cascaded to relevant staff to provide guidance where required to support consistent use.

Lead Responsible: Quality & Risk Manager

Timeline: Q3 2026

Monitoring / Assurance: Compliance monitored through incident management reporting and audit of incident reporting.

2) Classification system should be supported by a clear policy framework defining the appropriate level of response following a patient-safety incident.

Action:

• Review commenced of the Incident Management Policy to clearly outline processes for reporting, classification, review and escalation of patient-safety incidents. This is to ensure that clarity on the appropriate level of response, review and escalation depending on incident classification and severity.

• Communication of the updated incident management processes and reporting requirements to be cascaded to relevant staff.

• Monitor incident trends, learning and improvement actions through governance structures to support organisational learning and patient safety improvement

Lead Responsible: Quality & Risk Manager / Education & Training Lead

Timeline: Q3 2026

Monitoring & Assurance: Policy approval through Clinical Governance Committee / Implementation monitored through governance reporting / Compliance monitored through incident reporting audits and governance oversight.

**Timescale:**

• Incident classification system should be strengthened to ensure a clear single taxonomy is used by the service - Q3 2026

• Classification system should be supported by a clear policy framework defining the appropriate level of response following a patient-safety incident - Q3 2026