

Annual Report 2025

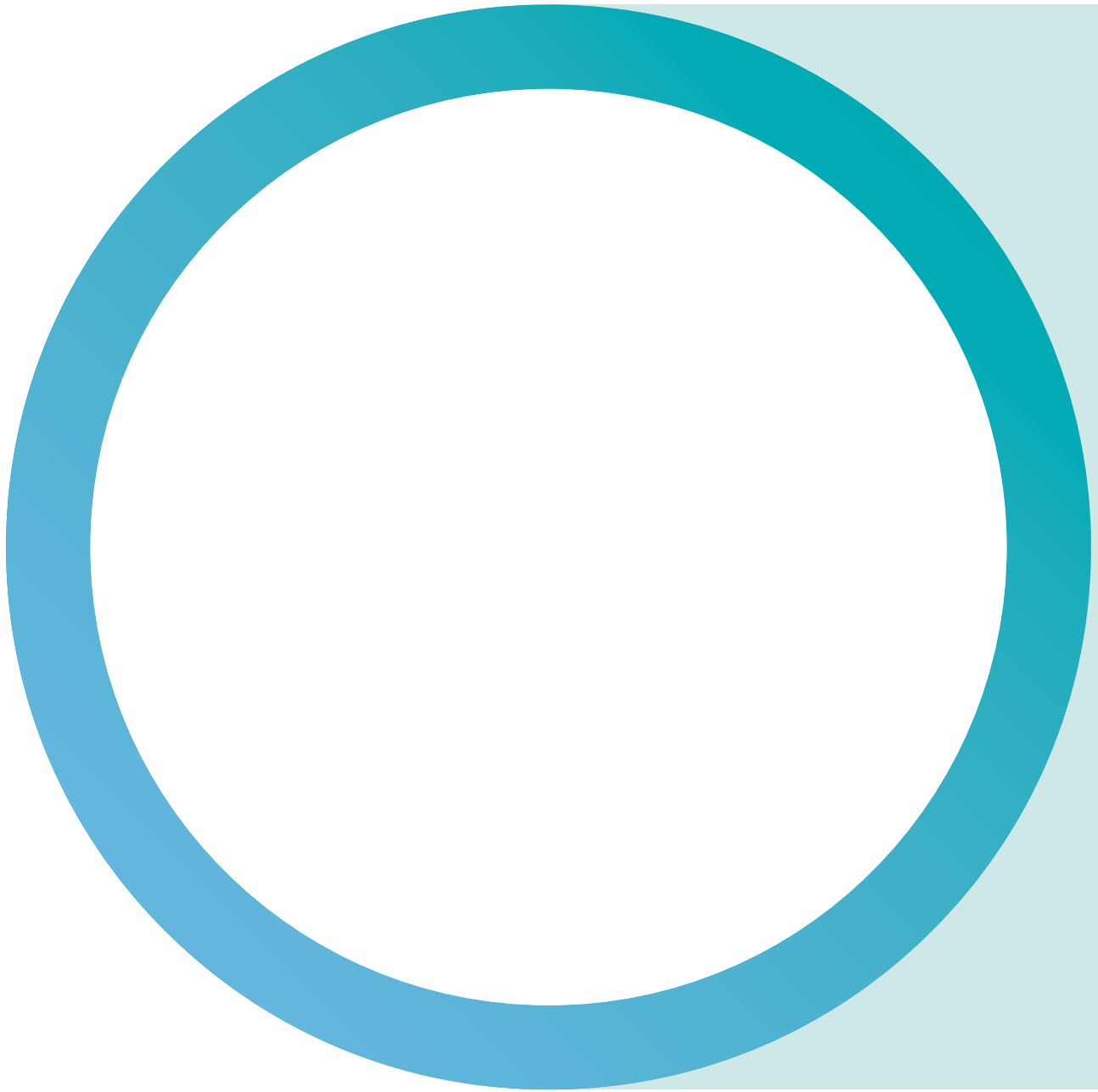


Health
Information
and Quality
Authority

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte



*Enabling the best
outcomes for all*



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Foreword from the Chairperson



Martin O'Halloran
Chairperson

This year's Annual Report outlines the work undertaken by HIQA in 2025 to achieve better outcomes in health and social care services for all. This report is our first under our Corporate Plan 2025-2027. The Annual Report is structured around the four longer-term Outcomes set out in our Corporate Plan and is designed to amplify how HIQA's work delivers measurable impact for the people of Ireland.

Our new Corporate Plan sets out a clear and ambitious strategic direction for the organisation over the next three years. In the Corporate Plan, we have moved towards real outcomes that we want achieved for the people of Ireland. By supporting evidence based policy, regulation and continuous improvement, the plan provides a strong framework to guide our work and ensure that HIQA continues to effectively meet emerging challenges and evolving public needs.

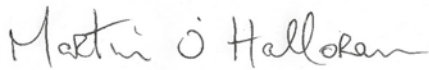
I was greatly saddened by the unexpected passing of my predecessor Professor Pat O'Mahony in 2025. I want to acknowledge Pat's outstanding leadership as he steered HIQA through significant change as it expanded and took on new functions. He was a trusted friend and colleague in the regulatory world.

I am honoured to lead HIQA as its fourth Chairperson at what is a critical time for the organisation, as we continue to take on new functions informed by emerging national and EU regulation, policy and priorities. New areas proposed for expansion include the regulation of home support providers, healthcare licensing and overseeing the health system's preparedness for external threats to critical health and social care delivery.

Furthermore, the Health Information Bill to further the use and availability of health information in Ireland and extended requirements in relation to health technology assessment will also impact HIQA's role. The expansion of our role in these areas reflects not only the trust placed in HIQA as an independent regulator but also the growing complexity of Ireland's health and social care system. At the same time, advances in eHealth, data governance and cyber security are reshaping how services operate and how people interact with the health system, creating both new opportunities and new risks. During 2025, we undertook significant preparatory work in each of these areas, ensuring that these innovations are supported by strong regulatory systems.

I want to express my sincere gratitude to the dedicated staff of HIQA for their professionalism, commitment, and resilience throughout the year. Their work continues to strengthen the safety, quality and trust that underpin our health and social care systems, and it is a privilege to support your efforts. I would also like to thank my fellow Board members for their guidance and steady support as I transitioned into the role of Chair. Their collective expertise and constructive collaboration have been invaluable, and I am deeply appreciative of the spirit of teamwork that defines our Board and the wider organisation.

I believe in this organisation, its people, its values and mission and the potential to continue to effect real change for those using health and social services. It is a privilege to have the opportunity to steer HIQA at this time of significant change and growth.



Martin O'Halloran
Chairperson

Message from the Chief Executive



Angela Fitzgerald
Chief Executive

Welcome to HIQA's Annual Report for 2025.

I warmly welcome the appointment of Martin O'Halloran as Chair of the Board in 2025 and wish him every success in his role. Martin brings deep experience and a strong commitment to public service, and I look forward to working with him as we continue to drive HIQA forward in fulfilling its mission.

I would also like to pay special tribute to Professor Pat O'Mahony who sadly passed away in August 2025. In his capacity as Chair of HIQA, Pat's leadership and strategic focus along with his calm, measured approach were critical to HIQA's success during his tenure against a backdrop of extensive expansion of our remit. His judgment, wisdom and unwavering support for HIQA were valued by both the Executive and the Board. On a personal level, Pat was a trusted friend, both a source of strength and a valued sounding board. Pat is deeply missed by all of us who had the privilege of knowing and working with him.

This year's Annual Report is aligned with our Corporate Plan 2025-2027 and is presented under the four Outcomes that we want to see achieved for the people of Ireland through standard setting, regulation and evidence to inform decision-making.

To enable safe, joined-up care and support, we use our regulatory lens to drive improvements in terms of safe and effective care and support. A key area of focus is governance, management, leadership and culture as these provide the cornerstone to safe and effective care. Our review of the governance of implantable medical devices at Children's Health Ireland (CHI) made important recommendations for both CHI and national healthcare services on corporate and clinical governance within hospitals to ensure effective clinical oversight when new interventions are introduced and overseen safely and effectively. This report was informed by the direct experiences of the families impacted by the use of non-CE marked springs in surgery, and we are grateful to them for engaging with our review.

During 2025, we initiated an intensive regulatory response to the RTÉ Investigates programme, which showed a series of failings in two nursing homes owned by one operator. At the heart of this issue is the requirement for all care providers to have the necessary arrangements in place to be assured about the quality and safety of care and basic human rights are upheld. The Minister of State with responsibility for Older People requested an independent review of the effectiveness of the regulatory and legislative framework for inspecting nursing homes. By agreement with the Minister, this independent review was progressed with our external auditors last year and we look forward to their recommendations. As a learning organisation, we are committed to looking continuously at how we can strengthen our regulatory process and approach to ensure that providers keep residents safe, well cared for and enjoy fulfilled lives in residential care.

The year marked a significant step forward in strengthening transparency, accountability and patient safety across the healthcare sector with the publication of our first inspection reports on the quality and safety of private hospitals. This follows the extension of our regulatory powers into private health services under the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023.

As part of HIQA's role to support evidence-informed decision-making, we provided advice to Government on the requirements for delivery of safe and effective services in the HSE Mid

West region on a sustainable basis. Our review highlighted a need for immediate action and investment to address current risks to patient safety in the shortest time frame and safest way possible, as well as longer term considerations for the region. Government has fully accepted our advice and is implementing a comprehensive plan for the region.

Our health technology assessment and evidence synthesis outputs reflect our commitment to ensuring that health policies and interventions in Ireland are grounded in rigorous, independent analysis of the clinical effectiveness and cost benefits at a population level. They also ensure that, in the context of competing resources for critical services, opportunity costs are also considered in investment decisions.

In March 2025, we welcomed the National Immunisation Advisory Committee (NIAC) as a core function of HIQA. NIAC's expertise and longstanding contribution to public health in Ireland are widely recognised, and this integration strengthens our shared commitment to evidence-based guidance in immunisation. During 2025, we also made significant progress in strengthening Ireland's health information system by working closely with the Department and with European partners to support the implementation of the European Health Data Space Regulation in Ireland. This marks an important step toward ensuring that Ireland is ready to fully benefit from a more connected, secure and patient-centred European data infrastructure.

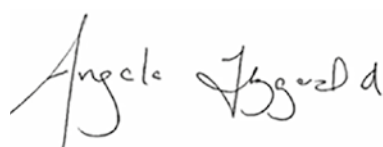
Throughout the report you will see how we seek to engage with people using services and draw on their voices to inform and shape our work. This includes the experiences of women in the National Maternity Experience Survey, which provided clear insight into the tangible improvements implemented in maternity care since the 2020 survey, as well as amplifying areas that need improvement. We have formal structures in place to enable effective patient and public engagement in our research work, and held a conference in November 2025 to bring policy-makers, regulators and healthcare providers together to discuss what really matters to patients and service users.

We aim to be a high-performing, effective organisation that drives positive outcomes for everyone. To support this, we have been driving a comprehensive a Digital and Data Transformation Strategy that seeks to optimise the use of technology and data analytics in our work. During 2025, we successfully implemented a financial management system and also went live with the first phase of our new regulatory system.

Last year, we launched our first ever People and Culture Strategy, which will guide how we enable our dedicated staff by fostering an inclusive, supportive and high-performing workplace. As an organisation, we are fully committed to sustaining a positive working environment that supports our people with the aim of continuing to work to make HIQA an employer of choice. We are focused on embedding a culture of sustainability and diversity, equality and inclusion, and meeting and exceeding our carbon reductions.

My sincere thanks to all our stakeholders, including service providers, advocacy organisations and people using services who worked with, and supported us throughout 2025. We have enjoyed strong and effective collaboration with the Department of Health, Department of Children, Disability and Equality, Department of Justice and other Government departments, the HSE, Tusla, and other State agencies. These engagements have been vital in progressing our shared vision of enabling the best possible outcomes for the people of Ireland.

Finally, I wish to thank HIQA's Board for its leadership, guidance and support and to our staff for their extraordinary commitment and passion in delivering on our mission.



Angela Fitzgerald
Chief Executive

Tribute to Professor Pat O'Mahony



Our esteemed Chairperson, Professor Pat O'Mahony, died suddenly in August 2025. Pat had served as Chairperson of HIQA's Board since 2018. Under his leadership, the organisation went through significant change as our legal remit and role expanded.

Pat advocated for the importance of HIQA remaining relevant, while never losing sight of what we were founded to do — ensure safer, better care for people. Putting people at the centre of our work is embodied in our values set out in our Corporate Plan, and Pat championed these values throughout his time with HIQA.

The COVID-19 pandemic was a challenging time for the country and for HIQA. As we adapted how we worked to meet these challenges, Pat supported us to ensure we continued to instil a positive and enabling organisational culture that promotes excellence.

Pat advocated strongly for close collaboration and strategic engagement with key stakeholders, whether with Government departments, colleagues in the health and regulatory sectors or service users to ensure that we were informed by best practice but also by the lived experiences of people using services. Pat's passion for keeping people at the centre of all that we do was central to his leadership approach, and he was always generous in sharing his time, wisdom and experience. He is greatly missed by all in HIQA.



2025 at a glance



Launch of
**Corporate
Plan 2025-2027**



Launch of
**People and
Culture Strategy
2025-2027**



2,116
inspections of
health, social care
and international
protection services



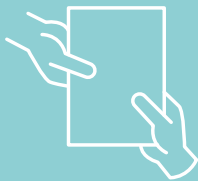
3,354
women responded to
the National Maternity
Experience Survey



56,908
pieces of requested
information and
notifications received
about health and
social care services



2,100
pieces of feedback
received about health
and social care services
from residents, families,
staff and the public



144
notifiable incidents
received under Patient
Safety (Notifiable
Incidents) Act 2023



1,121
respondents to
consultation to inform
independent review
on the design and
delivery of urgent and
emergency healthcare
services in the HSE
Mid West



19
recommendations
to improve governance
and oversight of
implantable medical
devices following
review of Children's
Health Ireland



31 March 2025
National Immunisation
Advisory Committee
(NIAC) becomes
function of HIQA



200

attendees at CICER-hosted conference 'Our Healthcare System, Our Voices: An Evidence-Based Approach for Healthcare'



24

health technology assessment and evidence synthesis publications



1,300+

attendees at events across the country for providers of nursing homes and residential disability services



280+

attendees at webinar on 'Secondary use of data under the European Health Data Space Regulation' in conjunction with European Commission and Department of Health



90,465

completions of online learning courses on national standards and guidance



132

roles recruited across HIQA



Retained

International Organization for Standardization (ISO) accreditation for quality management system, ISO 9001:2015



Retained

Platinum accreditation of Excellence Through People scheme by the National Standards Authority of Ireland



9

consultations held with the public to inform our work

Who We Are

The Health Information and Quality Authority (HIQA) is the independent body that promotes safety and quality in the provision of health and social care services in Ireland.

Through regulation, standard setting and evidence to inform decision-making functions, we support health and social care services to consistently deliver excellent standards of care and the best possible health and social care outcomes for all.

Our Vision, Mission and Values

Vision

Health and social care services consistently deliver excellent standards of care and the best possible outcomes for the people of Ireland



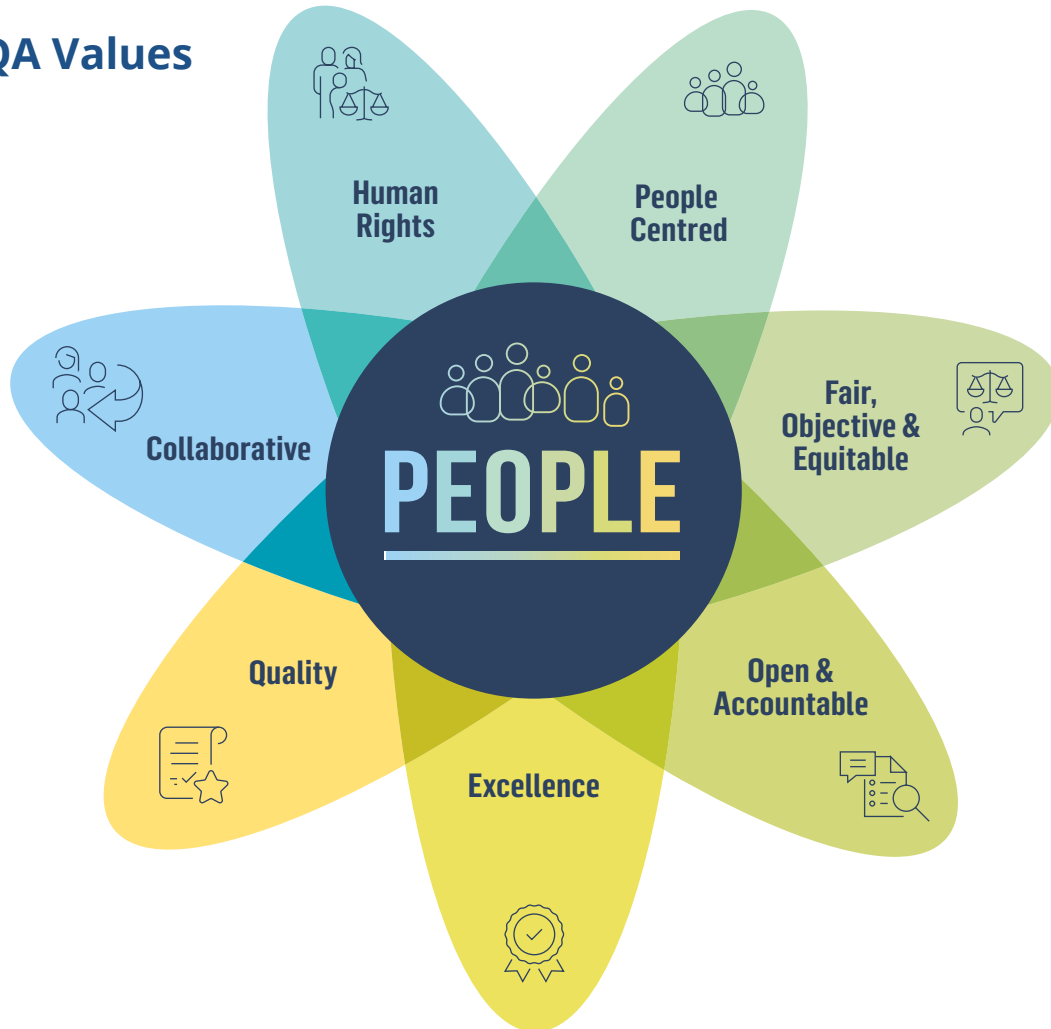
Mission

To enable the best possible health and social care outcomes for all, through evidence-informed decision-making, standard setting, and regulation



Our Values guide the organisation, embodying its identity and principles. They shape how we do our business and how we engage with all internal and external stakeholders.

HIQA Values



Human Rights

We promote and champion human rights

We believe in promoting and championing the rights and dignity of every individual interacting with the health and social care sectors. Practices should uphold human rights and create an environment where everyone feels valued and respected. This commitment reinforces HIQA's role in safeguarding these rights in all of our activities.



People Centred

We value and respect the needs of the people we work with and for

We value and respect the needs of both service users and staff. We support the delivery of services that meet the requirements of the people using them. Moreover, we foster an inclusive and supportive working environment that ensures that all voices are heard and considered.



Fair, Objective and Equitable

We are fair, objective and proportionate in our work

Our ways of working are objective, fair and proportionate, and decisions are informed by evidence. We believe in equitable treatment across the health and social care sectors and integrity in regulatory practice.



Open and Accountable

We communicate how we work and the outcomes of what we do

We are transparent in our work and clearly communicate our processes, methodologies, and outcomes. Through being open and transparent, we foster public trust and encourage engagement with stakeholders and demonstrate accountability in our operations.



Excellence

We strive to constantly innovate and seek to improve the quality of our work

We strive for the highest standards in all activities and continuously seek to innovate and improve our work. We believe that supporting excellence in our own work will ultimately benefit people using services.



Quality

We support continual quality improvement for people who use services

We focus on supporting ongoing quality improvement initiatives, thereby enhancing care delivery through a culture of learning and development. This commitment ensures that services evolve to meet the changing needs of individuals and communities.



Collaborative

We work in partnership with all colleagues and stakeholders

We work in partnership with our colleagues and stakeholders, including service providers, government bodies, people using services and the public. We value shared expertise and partnerships. This collaborative approach enhances the effectiveness of initiatives and promotes joined-up thinking across the health and social care landscape.



This Annual Report outlines the work of HIQA from 1 January to 31 December 2025, the first year of implementing our Corporate Plan 2025-2027.

Corporate Plan 2025-2027 Outcomes

Under our Corporate Plan 2025-2027, we have set out six clear deliverables for the next three years while keeping a clear view of our four long-term outcomes. By outlining 2025-2027 outcomes along with longer-term outcomes, we aim to demonstrate our commitment to clear progression over time with each phase building on the last and bringing us closer to realising our vision.

Our three-year Corporate Plan is implemented through our annual Business Plans. This report outlines the progress made in achieving each of the six Outcomes in our Corporate Plan. The Outcomes are:



Service Focus



HIQA's standard setting, monitoring and regulation of quality and safety are enabling improved outcomes for the people of Ireland



HIQA is influencing and enabling service providers to deliver improved service user experiences and better outcomes

Evidence-informed Impact



HIQA provides evidence to inform policy decisions and practice developments across health and social care services and at a population level

Governance and Organisational Effectiveness



HIQA is delivering value and impact for all stakeholders through agile and collaborative ways of working, efficient systems, fit-for-purpose structures, and appropriate governance



HIQA is a sustainable and inclusive organisation

People



HIQA is an employer of choice through its staff supports, opportunities and positive organisational culture

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Service Focus

Chapter 1:

Service Focus



HIQA's standard setting, monitoring and regulation of quality and safety are enabling improved outcomes for the people of Ireland

HIQA's work is centred on improving outcomes for the people of Ireland. By setting national standards and regulating services, we support providers to deliver safe, high-quality care that protects people's rights, promotes their wellbeing, and enables them to live with dignity and as much independence as possible.

Standard Setting

A key element in achieving this Outcome is the development of person-centred national standards for Ireland's health and social care services. In 2025, progress was made in relation to *National Standards for Home Support Services*, *National Standards for Residential Services for Children and Adults with Disabilities* and two sets of standards for health information.

National Standards for Home Support Services

In 2025, we developed Ireland's first *National Standards for Home Support Services* in preparation for the implementation of a regulatory framework and licensing system for home support providers, which is currently being developed by the Department of Health.

Following a policy decision to widen the scope to include children, additional work is ongoing to further develop the standards. We are also working on developing implementation support tools to support the sector. When finalised, the adoption and implementation of these standards nationally will benefit service providers by providing guidance and clarity, ensuring that children and adults in receipt of home support services receive high-quality, person-centred care.

The standards will support the previously unregulated home support sector to improve quality and provide safe, person-centred care, ensuring better outcomes for people accessing home support.

National Standards for Residential Services for Children and Adults with Disabilities

In 2025, we carried out an evidence review to inform an update of the *National Standards for Residential Services for Children and Adults with Disabilities*. The standards were first published in 2013, and our review aimed to identify what has changed in disability services and highlight important areas for inclusion in any updated standards.

This evidence review is contributing to knowledge of the sector while building a robust evidence base to inform updates to the national standards. The updated standards will support services to provide people with disabilities with safe, quality, person-centred care. The implementation of these standards by service providers will ensure the rights of people with disabilities are upheld in residential services and improve their health and wellbeing.

Setting National Standards for Health Information

The European Health Data Space (EHDS) sets out a phased approach for integrating six priority categories of electronic health data into national health information systems by between 2029 and 2031. To support this, last year we commenced the revision of two national standards to support key national digital infrastructure projects in line with the requirements of the EHDS Regulation.

- ▶ The National Standard for a Demographic Dataset for Health and Social Care aims to define the core set of data elements required to identify an individual uniquely. It is essential to provide core information about service users for the purpose of providing health and social care (primary use) and making data available for service planning, policy-making, research, and statistical analysis (secondary use). A demographic dataset will be a component of all other national health information standards and as such is a key building block for this programme of work.
- ▶ The National Standard for Hospital Discharge Information defines the core set of data elements required when a patient is discharged from an acute hospital to the care of their GP and other primary care practitioners to provide continued safe quality care and support.

To update these standards in 2025, we undertook extensive stakeholder engagement with patients and service users, health and social care professionals, administration staff, personnel working on IT projects for health and social care, researchers, policy-makers, and the public through a working group, focus groups interviews, and public consultations. Both standards are now being tested in the system to ensure that they are fit for purpose and can be implemented in practice before they are finalised.

These standards are the first in a suite of standards to support the system to ensure prioritised categories of data are integrated into national health information systems to meet the requirements of the EHDS Regulation and to support the provision of person-centred, joined-up, safe care and support.

Regulation of Social Care Services

Regulating and monitoring social care services provides independent oversight to promote safe, high-quality care and support for people who depend on these services. Through the work of the Chief Inspector of Social Services, we focus on improving outcomes for people living in residential disability services, nursing homes and children's services.

Service providers are legally responsible for the operation of their centres and for ensuring that residents receive safe, high-quality care every day. Our inspections assess whether these measures are in place and help ensure that corrective action is taken by providers where care does not meet the required standards.

We do this by:

- ▶ registering designated centres
- ▶ inspecting and reporting on the quality and safety of services
- ▶ ongoing monitoring of compliance in services
- ▶ meeting and engaging with people who avail of the service and their families to hear their experiences
- ▶ receiving, analysing and risk-assessing information from a range of sources to inform our regulation activity.

Where we find risks, we take enforcement action.

During 2025, we carried out 1,994 inspections of nursing homes, children's services and residential disability centres.

Regulation of residential disability services

In 2025, our regulatory oversight continued to support improvements in the quality and safety of residential services for people with disabilities.

Our inspections and monitoring found that improvements in compliance identified in 2024 were largely sustained across disability services in 2025. This indicates that many providers are delivering more consistent, good-quality care and support to residents that meets regulatory requirements, with a growing number of providers striving to exceed those standards.

For people living in these services, this means they are more likely to experience care and support that respects their rights, promotes their wellbeing and responds to their individual needs. Inspectors found that most residents were receiving good-quality care delivered in a human-rights-based way.

During 2025, there were over 9,480 residential places available to adults and children with disabilities across 1,745 residential services in Ireland.

To monitor the safety and quality of these services, inspectors carried out 1,191 inspections during the year, equating to 1,598 inspection days. This includes 196 inspections with a specific focus on adult safeguarding. Inspections may be announced, unannounced or take place at short notice and can occur at any time of the day or night.

Our independent inspection monitoring programme plays an important role in enabling sustained improvements in services, holding providers accountable for delivering safe, dignified and person-focused care.

What residents in disability services told us on inspection:

"I love it here... feel safe here"

"I like being out in the community meeting people"

"House is not for me... too noisy at night time"

"It can be hard to talk to people when there is too many people around"

"I am happy living here, this is our home"

"I have lived in many houses over the years and this is my favourite"

"I am very happy about where I live and the care I receive. I wouldn't like to live anywhere else"

How we use feedback from residents with disabilities to improve our work

Feedback from people living in designated centres is one of the most important ways we understand the quality and impact of services.

While we speak with residents as part of each inspection, in 2025, we also engaged directly with residents through 11 face-to-face forums across the country, attended by 115 residents from centres operated by 12 different disability service providers.

These forums gave residents the opportunity to share their experiences of living in residential disability services and to highlight what matters most to them

Communication and Accessibility Enhancements

Through this engagement, residents told us that good communication during inspections was important to them.

For example, they said it was important that inspectors showed their identification, greeted all residents in the centre and explained the inspection process, particularly during unannounced visits.

We took on board residents' feedback and in turn we enhanced our information and communication resources for residents in 2025.

These enhancements included:

- ▶ An [Irish Sign language video summary](#) and easy-to-read guide about our Residents' Forum 2025 Report.
- ▶ In 2025 we also launched '[Your guide to HIQA Inspections in Disability Services](#)'. This document helps to explain to residents the purpose of inspections and what happens during an inspection and is issued to all designated centres before an announced inspection occurs.
- ▶ In addition, the 'Your guide to HIQA Inspections in Disability Services' document is accompanied by an [Irish Sign Language \(ISL\) video](#) with subtitles also included.
- ▶ We also created a [Lámh \(manual sign system\) version](#).

By responding to residents' feedback, we are helping to ensure that inspections are conducted in a way that respects residents' wishes and reflects the feedback we have received. We will continue to look at ways we can improve our work to ensure people living in designated centres feel informed, that their voices and opinions are heard and, most importantly, that those opinions matter.

Responding to residents' feedback

Feedback received through the resident forums highlighted that many residents do not get to see inspection reports and may not hear about the findings of inspections that take place in their home or in services they use. Residents also told us that when they do access reports, they are often in a format that does not suit their communication or literacy needs, which can contribute to confusion or anxiety about inspections.

In response to this feedback, and to help improve residents' experience and understanding of inspections, we commenced a trial of easy-to-read summary reports with three large disability service providers during 2025. The easy-to-read summary report was developed to provide residents with a high-level summary of the key findings from an inspection in a more accessible format.



Pictured during the 2025 Resident Forums are HIQA staff with residents from a range of services including Sunbeam House Services; Stewarts Care Service Users Council; and residents from HSE Sligo & Donegal centres.

This helps to ensure that residents are informed about the outcomes of inspections in their homes and can better understand how findings relate to their care and support.

We plan to extend the issuing of an easy-to-read report for the majority of inspections during 2026. This will help ensure residents can learn about the findings from inspections of their homes in a more accessible format.

We would like to sincerely thank all of the residents who took part in the resident forums during the year and shared their valuable feedback with us.

Taking action to ensure providers protect residents and improve services

Good levels of compliance were found across many services in 2025. The Chief Inspector was also required to take escalation and enforcement actions during the year where providers had not made the necessary improvements to the quality and safety of support for residents. These actions are an important part of our regulatory responsibilities and are used to ensure providers take timely action to address risks and improve the care and support people living in designated centres receive.

Following inspection findings in 2025, we issued 47 warning letters to providers outlining improvements which were required. These warning letters advised the providers that failure to achieve compliance and positive changes for residents could result in further regulatory action, including the cancelling of registration or the attachment of additional conditions to the registration of a designated centre.

Where improvements in compliance to the benefit of residents were not found, the Chief Inspector took action. In 2025, the Chief Inspector issued 12 notices of proposed decision to cancel and or refuse renewal of registration of designated centres if required improvements were not achieved. In two centres, the providers did not implement sufficient improvements to ensure the safety and wellbeing of residents. As a result, the Chief Inspector took the decision to cancel the registration of these centres. The HSE assumed operation of one centre under Section 64 of the Health Act 2007 (as amended), ensuring continuity of service and care for residents. In the second case, the provider exercised their right of appeal against the cancellation, which initiated further legal proceedings.

Where risks are identified across a number of designated centres operated by a provider, the Chief Inspector undertakes a focused regulatory escalation programme aimed at strengthening the provider's own governance and oversight, in turn driving improvements across the provider's service.

Improving the quality of resident care through regulation

In February 2025, we published a report on a regulatory programme focused on governance and safeguarding in designated centres operated by Sunbeam House Services CLG. This programme was initiated following consistently poor inspection findings and potential risks to residents as a result of high levels of non-compliance across a number of the provider's designated centres.

The regulatory escalation programme included 34 inspections across 28 designated centres operated by the provider. Following completion of the programme, the Chief Inspector required the provider to submit a compliance improvement plan outlining how it would strengthen governance and oversight to ensure residents are safe and receive care and support that meets their needs and, in turn, improves compliance with the regulations.

During 2025, we observed that the provider had begun implementing significant organisational and governance changes, with progress in a number of areas extending beyond the actions outlined in their initial compliance improvement plan response. These changes continued to be monitored by the Chief Inspector throughout the regulatory programme, which concluded in February 2026, to ensure sustained improvements in the provider's governance and oversight of their designated centres.

Overview Report on the Regulation of Disability Services in 2024

Last year, we published an overview of our findings in residential disability services in 2024. Our inspections found that there was a growing emphasis on a human rights-based approach to care. Most staff had received training in human rights and were increasingly able to demonstrate how this informed everyday practice and supported residents to exercise choice, autonomy and participation in their communities.

Regulation of nursing homes

In 2025, our regulatory oversight continued to support the provision of safe, appropriate and dignified care for nursing home residents.

In 2025, we conducted 757 inspections of nursing homes throughout the country. This equated to 1,325 inspection days, as some inspections were carried out by more than one inspector or may have been carried out over a number of days. 95% of inspections were unannounced, meaning residents, staff and the providers of the nursing homes were not aware of the date or time that the inspection would take place. Unannounced inspections provide an important opportunity to assess the real-life day-to-day experience of residents and the quality of care and support being provided.

It is the responsibility of each registered provider to ensure that residents are safe and are receiving a high standard of care at all times. While unannounced inspections play an important role in checking that residents are receiving appropriate care, it is the registered provider's governance and management arrangements that ensure residents receive this standard of care every day, not only when inspectors are present in their home.

During each inspection, inspectors speak with residents, visitors, staff and the management team to build a picture of what it is like to live in the nursing home. Inspectors also observe practice and review documentation to check if the systems and processes in place meet the requirements of the regulations and are effective in ensuring residents' care and quality of life is of good quality and meets the needs of all residents in the nursing home.

This approach ensures that there is a clear focus on the experiences of residents living in the nursing home, as well as on the governance, management and oversight arrangements that are in place to ensure that they receive safe and effective care.

Where inspectors identify areas where residents' care or safety is not as good as it should be, the Chief Inspector may use a range of regulatory and enforcement actions to require providers to address identified issues and ensure that residents receive the care and support they need.

What residents in nursing homes told us on inspection:



Protecting residents and strengthening safeguarding

Safeguarding older people, particularly those who may be more vulnerable or dependent on others for daily care, is a fundamental responsibility of providers that operate nursing homes and is essential to the provision of high-quality care.

2025 saw the commencement of regulatory compliance inspections focused on safeguarding. The purpose of these inspections was to assess how effectively providers of nursing homes were safeguarding residents. This approach aimed to not only identify examples of good practice but also to highlight areas for improvement and to encourage a culture of awareness around the importance of safeguarding.

During these inspections, all regulations inspected were assessed through the lens of safeguarding, with a particular focus on whether providers had appropriate safeguarding policies and procedures in place and whether staff were skilled and knowledgeable in how to implement these safeguarding procedures into their daily practice.

Findings from these inspections highlighted areas where further work was needed, including ensuring all staff received safeguarding training and strengthening provider's safeguarding surveillance systems in their nursing homes to identify and respond consistently to safeguarding incidents should they occur.

Early feedback indicates that this targeted inspection approach has prompted many registered providers to reflect on their safeguarding practices and begin implementing meaningful improvements, helping to ensure that residents remain safe, respected and supported in their daily lives.

Taking action to ensure providers protect residents and improve services

In line with our responsive approach to regulation, our enforcement work in 2025 played a central role in safeguarding people living in nursing homes. Guided by a risk-based escalation approach, the Chief Inspector intervened wherever ongoing risks or persistent non-compliance threatened residents' health, safety and quality of life. This approach ensured that regulatory action taken was proportionate, targeted and focused on protecting residents' rights, dignity and wellbeing.

Where necessary, the Chief Inspector attached restrictive conditions to nursing home registrations, applying these measures only when evidence showed that residents' safety could not otherwise be assured. At the end of 2025 there were 100 such conditions applied to the registration of 85 nursing homes. These conditions are in place so that nursing homes take action to meet required standards of care.

On one occasion, the seriousness of a situation required a high level of enforcement action, with the Chief Inspector applying to the District Court to cancel a provider's registration. This is the ultimate power available to the Chief Inspector and is only used where there is a risk to the life or a serious risk to the health or welfare of residents living in a nursing home.

Providers also used existing regulatory mechanisms to adjust their nursing homes' conditions of registration, reflecting changes in capacity, improvements to premises or progress in addressing non-compliance identified by the Chief Inspector during inspections. Over 2025, 217 applications to vary or remove conditions were granted, while 10 were refused by the Chief Inspector where critical safety and care standards in those nursing homes had not yet been met.

In 2025, enforcement by the Chief Inspector was used not only to regulate but to also strengthen compliance in nursing homes, enhance standards of care and safeguard the wellbeing, safety and quality of life for people living in nursing homes.



Pictured are HIQA Chief Executive Angela Fitzgerald, Minister of State with responsibility for Older People Kieran O'Donnell TD and Nursing Homes Ireland CEO Tadhg Daly at the Nursing Homes Ireland annual conference.

Improving the quality of resident care through regulation

Service providers are legally responsible for the operation of their centres and for ensuring that residents receive safe, high-quality care every day. Our inspections assess whether these measures are in place and help ensure that corrective action is taken by providers where care does not meet the required standards.

In 2025, following the receipt of information raising concerns about the care of residents in a nursing home, inspectors carried out an inspection.

Inspectors found that residents' care was being affected by a deterioration in governance and management arrangements, which had contributed to issues with staffing, food and nutrition and cleanliness. This represented a decline in the quality of service in comparison with the previous inspection of the nursing home in 2024.

After the inspection, we met with the provider to discuss the findings and the impact the deterioration in governance and management arrangements were having on residents. The provider responded by submitting a comprehensive compliance plan response with a time-bound action plan aimed at improving care, strengthening governance arrangements and bringing the centre back into regulatory compliance.

A follow-up inspection 12 weeks later found that management systems had been strengthened, resulting in measurable improvements in residents' care and support.

A third inspection, carried out four months later, showed further enhancements in governance and management, leading to even further improved outcomes for residents and higher compliance with the regulations. The centre now had sufficient staff to meet residents' assessed needs, care planning was of a good standard, the premises were safe and clean, fire precautions had improved and food provided to residents was prepared, cooked and served safely.

These strengthened governance and management arrangements directly contributed to improved quality of life outcomes for residents, with their rights promoted and effective systems in place to safeguard them from harm and abuse.

This demonstrates how targeted regulatory oversight can drive meaningful improvements in care and ensure that residents receive the support and protection they deserve.

In 2025, the RTÉ Investigates programme on nursing homes highlighted care provided in two nursing homes, depicting treatment of residents that was wholly unacceptable and a violation of their rights and dignity. The programme included footage that was deeply upsetting to watch, particularly for residents and family members of residents.

Following the broadcast, the Chief Inspector engaged directly with the registered providers responsible for each of the nursing homes and initiated escalated regulatory actions to ensure residents were safe and receiving good-quality care. As these two nursing homes were part of a larger group¹ of nursing homes, we also undertook a full review of all other nursing homes within the same group, carrying out inspections at various times of the day and night.

These inspections assessed whether residents' care and support needs were being met consistently and whether the provider was taking appropriate action in response to the matters identified in the television broadcast. Inspectors met with residents and their families and friends to hear their views, which are reflected in each inspection report.

Findings from those inspections showed mixed levels of compliance. Some of the nursing homes operated by the provider delivered good-quality care and support, while others had ineffective governance and management arrangements in place. In some nursing homes, staffing levels were insufficient to meet residents' assessed needs or systems were not in place to ensure consistent delivery of care.

Where necessary to protect residents, a series of regulatory action was taken, including:

- ▶ **Restricted admissions:** Some of the providers within the group were restricted from admitting new residents to their nursing home(s). These restrictions were for varying periods of time and admissions only recommenced when the Chief Inspector was assured that the provider had taken the necessary action to improve the care of residents in those nursing homes.
- ▶ **Varying conditions of registration:** Conditions of registration were varied to ensure staffing levels were increased and, in one case, to ensure that residents with specific care needs were not admitted to that nursing home.
- ▶ **Reduction in the total number of residents who may be accommodated.** The number of residents in some nursing was reduced to ensure suitable staffing arrangements were in place to meet the number of residents living in the centre.

We engaged closely with the Minister of State with responsibility for Older People on this issue, meeting with him regularly and providing him reports on the Chief Inspector's Regulatory Oversight of Emeis Ireland's Designated Centres for Older People.

Review of Regulatory Effectiveness

Following the serious concerns about the unacceptable treatment of residents depicted in the RTÉ television programme in June 2025, the Minister of State with responsibility for Older People asked that an independent review is progressed to examine the effectiveness of the regulatory and legislative framework for inspecting nursing homes. The Minister requested HIQA's external, independent auditors to undertake the review which commenced in November 2025. The outcomes of the review, along with recommendations, will be submitted to HIQA in the first quarter of 2026, and will be shared with the Minister. During 2026, HIQA will develop and implement action plans in response to any recommendations made by the independent reviewers.

¹ There are 19 separate registered provider companies who are the legal entities responsible for the operation of the 25 designated centres (nursing homes).

Regulation and monitoring of children's services

We regulate and monitor children's social services to ensure they support improvements in the safety and quality of these services. We inspect and monitor residential care, special care, foster care and child protection and welfare services provided by the Child and Family Agency (Tusla), providers of non-statutory foster care services and Oberstown Children Detention Centre. We also regulate all special care units in Ireland, which means we have legal powers to drive improvements where needed. We meet with children and young people in these services on inspection to hear about their experiences, which are captured in our inspection reports.

During 2025, we carried out 46 inspections, comprising 346 inspection days, of the five different types of children's services under our remit.

Inspections of child protection and welfare services and foster care services in 2025

"Foster Mum is always here for us"

"I would love to stick with one social worker, but I don't get the chance"

The majority of inspections of child protection and welfare and foster care services in 2025 found that improvements had been made in the oversight of waiting lists and an increase in the number of children allocated to a social worker or other professional. This followed a targeted inspection programme in 2023 and 2024.

As a result, referrals relating to children in care were being responded to more effectively, with further improvements in foster care services being implemented during 2025. Initial screening of referrals was occurring in a timely way in the majority of child protection and welfare services. There were fewer children on waiting lists and improved oversight of children receiving services.

An example of a positive outcome for children in one child protection and welfare service inspected was that a safety plan was put in place for children, where required, before they were placed on a waiting list. This meant that those closest to the children, together with relevant professionals, had agreed actions to monitor and support the safety of these children.

In relation to statutory foster care services, Tusla further strengthened its governance through improved tracking of unallocated children and their foster carers. This resulted in better oversight and meant that children and foster carers benefited from a more consistent service.

Inspections of children's residential centres

"I feel safe in the centre"

In 2025, we started a new programme of inspections to promote improvements in safeguarding in children's residential centres. Safeguarding is essential to protect children from harm, uphold their rights and ensure they grow and develop in safe, supportive and nurturing environments.

Inspections of children's residential centres found that Tusla's internal assurance system in relation to the vetting of agency staff was not working effectively. As a result of our findings, Tusla implemented a national register of all agency staff working in children's residential services. Tusla also put additional systems in place to ensure that all agency staff are appropriately vetted and reference checked.

Subsequent inspections found that these measures had strengthened oversight of agency staff and contributed to safer services for children. This demonstrated how the safeguarding inspection programme supported improvements in practice, with learning shared across the sector. Additional training in areas such as exploitation was also provided to staff, supporting improved management and response to incidents.

Inspections of special care units

"I feel like I'm learning for the future here"

In 2025, we commenced a targeted programme of inspections focusing on the use of restrictive practices in special care units. These inspections were carried out to promote international best practice and support improvements in how restrictive practices are used to enhance children's experiences in special care settings. We carried out inspections in two special care units to review this.

Overall, both services demonstrated examples of good practice that supported positive experiences for children, such as enabling a child to go trick-or-treating outside of the unit. There was an opportunity for the provider to strengthen practice further by replicating the way in which learning in relation to the use of restrictive practices was shared with staff in one unit across the other units.

Inspection of Oberstown Children Detention Campus

"We're kept busy, there's loads to do here"

"Staff explain it easier, instead of in a more difficult way"

Engagement with young people during inspections is a key part of our approach and helps us understand their experiences of living in Oberstown Children Detention Campus. The majority of young people engage with HIQA either in person during inspections or through a survey.

Overall, young people told us they were positive about the care and support they received. Most young people who took part in the survey said that they were supported when they first arrived at Oberstown, and they also spoke positively about staff. Inspectors observed interactions between staff and young people that were respectful and supportive. Staff were skilled and knowledgeable practitioners who guided and supported young people, demonstrating a strong understanding of their individual needs, including their triggers and coping strategies.

Parents of young people were also consulted during inspection and spoke positively about their experience of the service, reflecting confidence in the care and support being provided.

Overview Report on the Regulation and Monitoring of Children's Services in 2024

In 2025, we published an overview of our findings from regulating and monitoring children's services in 2024. We found that where children were allocated a social worker or other care professional, the quality of service provided to them was strong. Areas requiring improvement included the availability of suitable placements for children in care and the need for adequate resourcing of services to ensure children consistently receive the support they need. We also published a children's summary of our findings so that children and young people in care could read about our findings.

Regulation and Monitoring of Healthcare Services

We promote safety and quality in healthcare services in Ireland. We monitor public and private hospitals and rehabilitation and community healthcare services to support the safety and quality of services provided to patients. We also regulate medical exposure to ionising radiation to ensure that every radiological procedure people receive is delivered as safely as possible.

In addition to routine monitoring of healthcare services, we also conduct reviews and investigations. In 2025, this included the completion and publication of the [independent statutory review](#) on governance of implantable medical devices at CHI, and advice to the Minister for Health on the delivery of urgent and emergency care in the HSE Mid West region. These are discussed later in this report.

Monitoring of healthcare services

In 2025, we monitored public acute hospitals, including emergency departments, private hospitals and community healthcare services throughout the country against the *National Standards for Safer Better Healthcare*.

The Patient Safety Act 2023 commenced in September 2024, enabling us to monitor private hospitals. HIQA standards were extended to private hospitals. This ensures that people accessing private healthcare receive the same protections of independent monitoring and oversight as those accessing public healthcare services. This new role allows us to provide greater transparency across the healthcare sector, aligned with our goal of enabling improved healthcare outcomes for the people of Ireland.

Monitoring of healthcare services is an ongoing process. As well as conducting inspections of services, it also involves receiving, analysing and risk-assessing information about a service.

During inspections, we review information we have about a service and speak with staff and with patients to learn from their lived experience of the healthcare service. Following this, inspectors make an assessment of the safety and quality of the services. Where we find risks and issues of persistent non-compliance, we escalate these to the appropriate healthcare service management.

Over the course of 2025, we conducted 60 inspections of healthcare services against national standards. This comprised 360 on-site inspection days.

Our inspections found good practice across the majority of healthcare services inspected. Overall, healthcare services continue to be challenged by capacity, staffing and infrastructural issues in order to meet the current and future needs of the population. Challenges related to overcrowding in emergency departments continue, though we found this was not the case in all services inspected, with a number of services performing notably well in managing patient flow for the majority of the year.

In October 2025, we published the first inspection reports of our findings in private hospitals. The ability to monitor these services and publish our findings acts as an important assurance to the public on service quality and safety. Overall, findings from inspections in private hospitals have been generally positive, with some exceptions. In the minority of services that have been found to perform less well on initial assessment, service providers have identified a clear plan for improvement.

Regulation of medical exposure to ionising radiation

HIQA is the competent authority in Ireland for medical exposure to ionising radiation. Our regulatory work in this area plays a vital role in ensuring safe radiological services are provided that contribute directly to improving outcomes for people who use them.

As of 31 December 2025, we were responsible for regulating 1,422 medical radiological facilities in Ireland which conduct medical exposure to ionising radiation. We use a risk-based approach to regulation, which means we prioritise our activities based on an assessment of the level of risk in undertakings.

A major project in 2025 included preparations for the International Atomic Energy Agency Integrated Regulatory Review Service Mission of Ireland in 2026, as outlined in the Governance and Organisational Effectiveness section of this report. As a result of preparing for the Mission, we conducted 25 inspections in 2025, comprising 50 on-site inspector days, prioritised as part of a risk-based approach to regulation.

Together, these activities supported facilities providing medical radiological services in Ireland to operate to the highest standards of safety and quality and demonstrated that regulation of medical exposure to ionising radiation led to improved outcomes for people across Ireland.

Overview Report of the Monitoring and Regulation of Healthcare Services in 2024

In November 2025, we published an overview report of the Monitoring and Regulation of Healthcare Services from 2024. The report outlined how HIQA inspections have been key driving factors in delivering sustained improvement in healthcare services for the benefit of people using services.

While good standards of care were observed by inspectors, healthcare remains a challenging environment and a number of key areas require ongoing improvement. The overview report found that hospitals continue to be challenged with suitable infrastructure to support demand, bed capacity and sufficient workforce among other issues.

We have seen a continued effort from many service providers to use the findings from inspections to drive improvements and positive outcomes for patients. Over 86% of the national standards assessed in 2024 had improved or maintained compliance levels on re-inspection. In addition, in facilities that provide medical exposure to ionising radiation, the number of regulations assessed as not compliant was 5%, which is significantly lower than the 12% identified between 2021 and 2023. This demonstrates both the value of ongoing monitoring of healthcare services and the commitment from health services to improve services and deliver high-quality care that keeps patients safe.

Monitoring of International Protection Accommodation Service centres

HIQA began monitoring and inspecting accommodation centres for people seeking international protection in Ireland against the *National Standards for accommodation offered to people in the protection process* (2019) at the beginning of 2024.

At the start of 2025, we had responsibility for inspecting 45 designated international protection accommodation service (IPAS) centres. By the end of 2025, the number of centres designated under our remit had reduced to 30 centres.

2025 was our second year of monitoring and inspecting accommodation centres, and we focused on driving improvement in key areas identified in our 2024 inspections.

Findings from inspections in 2025

Our inspection programme for accommodation centres plays a vital role in assuring the public of the safety, quality and oversight of accommodation provided to people seeking international protection in Ireland. In 2025, we conducted 37 inspections, comprising 172 on-site inspector days, of 32 accommodation centres across the country to assess them against the national standards. Our findings continued to highlight meaningful improvements across the sector, including significant progress in staff vetting, governance, risk management and safeguarding practices. These findings demonstrate that compliance with national standards is achievable and that independent monitoring does drive positive change which results in better services provided to those who need them, stronger accountability for providers and safer living conditions for residents – particularly those who are most vulnerable. While challenges such as sustained demand, overcrowding and the continued use of tented accommodation persist, the commitment of service providers to enhancing the quality of life of residents was clear throughout our work.

Our 2025 inspections saw improvements from the 2024 inspections in a number of areas. Importantly, we found that service providers benefited from their first year of being independently monitored and inspected and had made many positive changes one year on.

Overview Report on the Monitoring of International Protection Accommodation Service Centres in 2024

Last year we published a report on our key findings from the first year of monitoring designated IPAS centres.

IPAS residents reported generally positive experiences living in accommodation centres. Areas identified requiring improvement included governance and management, risk management and safeguarding and protection.

Speaking Up: How HIQA Amplifies the Voices of Residents of Accommodation Centres

Since taking on responsibility for monitoring IPAS centres, we have put residents at the centre of our work. To support this, we have a resident engagement strategy which outlines how and why we engage with residents. It outlines the different groups of residents we wish to meet and talk with while on inspections, such as adults, children, young adults and vulnerable residents.

We engage with residents through meeting them one-on-one or in groups, joining residents' meetings, or through questionnaires.

Meeting with residents

We met with 725 residents over the course of our 2025 inspections in accommodation centres: 487 adults and 238 children and young people. We met with residents while they were going about their daily activities in their home and met with others on a one-to-one basis. In addition, three focus group discussions were arranged during the inspection of a large accommodation centre.

Engagement through questionnaires

To supplement the information received from meeting with residents in person, we also distributed questionnaires in seven different languages and collected these before the inspections finished. Residents also had the option of completing the questionnaire electronically if they so wished. Adults were invited to provide feedback on a number of areas, such as safeguarding and protection; feedback and complaints; how the centre is managed; food, catering and cooking facilities; residents' rights; staff support; and accommodation. Children and young people were asked for feedback on: children's rights; education and play; making a complaint and providing feedback; accommodation; food and catering; and safeguarding and protection. In total, 289 questionnaires were returned from residents with 254 being completed by adults and 35 completed by children and young people.

"So much better than where we were before"

"The rooms are cramped and I've nowhere to study or complete college work"

"I feel at home"

"Before it was hectic, feels peaceful now"

What we learned

Overcrowding and lack of space remained significant issues for children and young people. Some explained that they had to share a bedroom or in some instances a bed with other siblings and they were not happy about this.

Adult residents shared a wide range of experiences about life in accommodation centres. Overall, they said that they felt safe, were supported by centre staff and felt connected to their local communities. Many valued the security, continuity and stability that accommodation centres provided, particularly for families. While many expressed satisfaction with the support they received and felt respected, others highlighted areas they would like to see improved, particularly in relation to their privacy, provision of food, the handling of complaints, consultation, cooking facilities, sleeping arrangements and safeguarding awareness.

Impact

Our approach to resident engagement means that we have been invited into hundreds of residents' homes and observed firsthand the quality of their accommodation. We have been in a privileged position to hear directly from them and what it is like to live in an accommodation centre. In return, we have dedicated a large section of our reports to highlighting what residents tell us, which ensures that their voices have prominence within our monitoring processes.



HIQA is influencing and enabling service providers to deliver improved service user experiences and better outcomes

Sharing learning to improve outcomes for people

Through our registration processes, guidance, service user experience data and ongoing support, we enable service providers to enhance their practices and improve the experiences and outcomes for the people of Ireland.

Independent review of governance at Children's Health Ireland

Following a request by the Minister of Health, we conducted an [independent statutory review](#) on governance of implantable medical devices at CHI, including use of non-CE marked springs in surgery at CHI at Temple Street. The review covered the period from November 2018, when the use of the springs was first considered as a possible treatment option for a small cohort of children attending CHI at Temple Street, to July 2023, when it was confirmed internally by CHI that the springs implanted into a number of children during spinal surgery, between 2020 and 2022, were not CE marked.

In April 2025, following completion of the review and engagement with stakeholders, including the families of children who had springs implanted, we published our findings and recommendations.

We identified that the controls in place within CHI for the management of the end-to-end processes did not provide the necessary adequate safeguards at each stage of the process, including those required for the procurement, introduction, decontamination and use of the springs in surgeries. As a result, children were not protected from the risk of harm. The experience of these children and their families was at the core of this review, and we thank the families who engaged with us and provided valuable insights into their experiences of the service.

Based on the findings of this review, we made nine recommendations specifically for implementation by CHI, nine recommendations to be implemented nationally in all healthcare services provided or funded by the HSE, and one recommendation for HSE-provided and funded health services and private hospitals. These recommendations focused on improvement in the arrangements to support leadership and management within the medical profession in hospitals and governance of the introduction and use of medical devices at individual and national level within the HSE.



Director of Healthcare Regulation Sean Egan being interviewed about our independent statutory review into governance and oversight of the use of surgical implants and implantable medical devices in Children's Health Ireland.

We continue to follow up on the recommendations for CHI, the HSE, and private hospitals on the governance and assurance structures which have been put in place, as well as ongoing status updates on implementation of the recommendations.

It is clear that our work in this important area has resulted in tangible improvements for both children using these services and their families, and the recommendations made also have wider relevance to health service delivery nationally.

Guidance and implementation tools

Guidance and implementation tools support health and social care providers to implement the national standards and deliver improved service user experience and better outcomes.

Approach to setting standards

We develop person-centred standards that are focused on improving outcomes. Standards are written from the perspective of the person receiving care, through the use of 'I' statements, and outline what a person should expect when receiving care and support.

In January 2025, we presented Ireland's approach to developing and implementing national standards to the WHO Consultative Forum to inform Global Standards for Long Term Care and, following that, to the Icelandic Quality and Supervisory Agency of Welfare.

Our work has been influential on the development of the *European Framework for Quality in Social Services*. The European Framework was launched in the European Parliament by the European Social Network in November.

These international invitations to share best practice reflected the impact of Ireland's evidence-based, outcomes-based standards model and position as a thought-leader in the space of health and social care standards.



Dr Niamh O'Rourke, Deputy Director of Health and Social Care Standards, speaking at the European Parliament Roundtable on Quality in Social Services in Brussels.

Supporting providers and staff to implement standards into their everyday practice

We have five online learning courses to support health and social care staff to put national standards into practice available on the Learning Hub on our website or through HSELand, the HSE's online learning portal. The courses cover the topics of infection prevention and control, adult safeguarding, applying a human rights-based approach to care, the fundamentals of advocacy and how to improve data quality for health and social care services. They are key tools in facilitating improved practice and support implementation of national standards and guidance in health and social care services, ultimately benefiting patients and people using services across the country.

In 2025, 90,465 people completed one of our five online learning courses, bringing the total number of course completions to 453,393 since 2020.

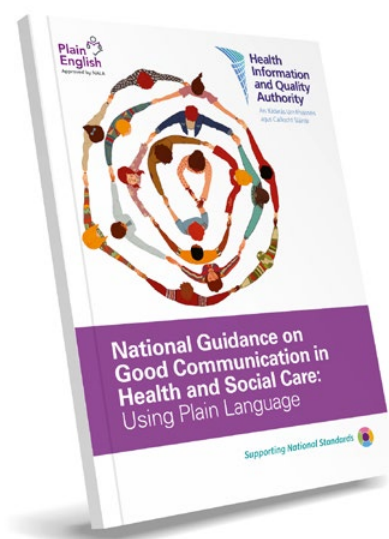
National Guidance on Good Communication in Health and Social Care: Using Plain Language

Studies show that one in five adults in Ireland have a low level of literacy and one in four people have low health literacy. While research undertaken by HIQA through its *National Engagement on Digital Health and Social Care* found that 75% people said that they would access their health information online, almost 50% people still struggle with basic digital literacy.

In response to these issues, we have developed *National Guidance on Good Communication in Health and Social Care: Using Plain Language*. The guidance was informed by a review of over 70 national and international communication guides, tools and resources engagement with plain language experts in the National Adult Literacy Agency (NALA) and SOLAS (the State agency responsible for Further Education and Training), the National Disability Authority, Tusla, the HSE and service user representatives.

The guidance supports health and social care staff to address diverse communication needs and preferences, recognising that anyone can have difficulty understanding information in a health or social care setting, regardless of age, ability, education or their first language. It also addresses each stage of communication of a person's journey through health and social care, from before they use the service, to when they are actively using it, up until they leave the service.

This national guidance assists in the implementation of national standards and aims to improve how information is shared and understood in every health and social care setting. By supporting staff to use plain language consistently, it helps ensure that everyone, regardless of their background, literacy level or communication needs, can access clear, accurate and meaningful information about their care.



Engagement with service providers

During 2025, we held a number of learning events across the country for providers and persons in charge of nursing homes and disability services. More than 1,300 delegates attended the events in autumn 2025. These events provided an opportunity to share learning from inspections, highlight areas for improvement, and support providers to strengthen governance, safeguarding and the quality of care delivered to residents and people using services.

We would like to thank everyone who took the time to attend and contribute to constructive discussions focused on improving services and achieving better outcomes for people living across the social care sector.



Pictures from our events for providers of nursing homes and residential disability services.

2

Evidence-informed Impact

Chapter 2: Evidence-informed Impact



HIQA provides evidence to inform policy decisions and practice developments across health and social care services and at a population level

Evidence has the power to inform policy. When you have good information, you can make good decisions, particularly in a system where there are so many competing demands. Supporting evidence-informed approaches helps ensure that decisions across health and social care are grounded in the best available evidence and practice. This supports the adoption of more effective interventions, better planning of services and, ultimately, improved outcomes and experiences for people using health and social care services.

Towards Safer Care: Our review of urgent and emergency care in the Mid West

In May 2024, the Minister for Health requested that HIQA conduct an independent statutory review to inform decision-making around the design and delivery of urgent and emergency healthcare services in HSE Mid West. As part of this request, we were asked to consider the case for a second emergency department in the region. We published terms of reference for the review in August 2024, and the review was published in September 2025.

We used our evidence synthesis experience to examine the best available evidence on addressing patient safety and capacity issues. Our regulatory lens allowed us to provide an independent and objective view on the advice, as we understand what is required to ensure services consistently deliver excellent standards of care and the best possible outcomes for the people in the Mid West region.

The review included:

- ▶ international evidence reviews to identify measures to alleviate emergency department overcrowding and the requirements for the provision of an emergency department service
- ▶ a review of policy developments between 2000 and 2024 that have impacted current service configuration, design and delivery in the Mid West
- ▶ regulatory inspection of the healthcare services in the Mid West, building on the ongoing programme of monitoring of services in the region against the *National Standards for Safer Better Healthcare* (2012)
- ▶ a review of data relating to capacity and service activity performance to understand the situation in the Mid West and how it compares with other health regions
- ▶ a stakeholder engagement exercise, including a public consultation, to seek the views of both people in the Mid West, and other interested parties regionally and nationally. This engagement resulted in 1,121 submissions via an online survey and 17 in-person meetings

We worked with the Economic and Social Research Institute (ESRI) to understand projected changes in the demand for urgent and emergency care and inpatient capacity in the region up to 2040. An expert advisory group was established to support our work.

Our advice highlighted an immediate need for action and investment to address current risks to patient safety in the shortest time frame and safest way possible and described the deficiency in inpatient bed capacity as the core issue impacting urgent and emergency healthcare delivery in HSE Mid West. The advice outlined what is required to address the current risks to patient safety and three potential options for how this might be achieved in the short and longer term.

How do we achieve safer healthcare in the Mid West Region?

We presented three potential options to the Minister for Health on how to achieve this in the short and long term.

Option A:

Expand

Expand capacity at University Hospital Limerick (UHL) on the Dooradoyle site.

Option B:

Extend

Extend the UHL hospital campus to comprise a new second site in close proximity under a shared governance and resourcing model.

Option C:

Develop

Develop a Model 3 hospital in HSE Mid West, providing a second emergency department (ED) for the region.

In December 2025, the Minister for Health announced that the Government had committed to implementing a combination of all three options presented in our report, demonstrating how HIQA's work of providing evidence through rigorous and unbiased analysis enabled a policy decision towards improving outcomes across Ireland's health and social care services.

Health Technology Assessment and Evidence Synthesis

Health technology assessment (HTA), evidence synthesis and evidence-based advice provide a solid basis for policy-making and transparency for the public with regard to the evidence informing decisions. We evaluate the clinical and cost effectiveness of health technologies to inform national investment decisions and we conduct evidence syntheses to support policy and service improvement in Ireland. HTA and evidence synthesis provide rigorous, independent analysis that ensures policy and practice decisions are effective, safe, and offer value. We provide high-quality evidence that supports improvement at population-level in areas such as:

National health decision-making, immunisation, screening programmes and public health advice



National decision-making

We inform national investment decisions by the Minister for Health and the HSE on a broad range of health technologies at population-level. These technologies are wide-ranging and may include medical devices, digital health technologies, diagnostic tests and health service reconfiguration, among other interventions.

Our advice issued in 2025 included:

- ▶ **Providing a telephone service for acute, non-urgent medical care needs in the pre-hospital setting:** We investigated international models and evaluated the budget impact and organisational implications of different models, before finalising our advice to inform a decision on whether to introduce a new telephone service in Ireland.

We also worked on a number of other projects during 2025 which will provide advice when published. These included:

- ▶ **Teledermatology to support management of primary care referrals:** We are examining the clinical effectiveness, safety, economic implications, and any organisational issues of using teledermatology to triage patients referred by GP to specialist dermatology services. Our advice will be published in 2026.
- ▶ **Transition to, and organisation of, adult healthcare services for individuals with severe neurological impairment:** We have commenced work to examine the clinical effectiveness and economic implications in this area and when published our advice will inform decision-making by the Minister for Health and the HSE.
- ▶ **Cochlear implants for adults in need of a unilateral implant:** Once published, our advice will be used to inform decision-making by the Minister for Health and the HSE with the potential to improve people's hearing.
- ▶ **Vesicostomy buttons in children:** We commenced work on this rapid HTA in late 2025, and our advice will be submitted to the Minister for Health following the completion of our research.

Immunisation

We conduct HTAs and evidence syntheses to inform national immunisation policies as prioritised by the Chief Medical Officer of the Department of Health. In 2025, this work involved two projects:

- ▶ **Immunisation against respiratory syncytial virus (RSV) in Ireland:** To support a policy decision on immunisation of infants and older adults (aged 65 years and older) against RSV for the 2026-2027 RSV season, we are examining the clinical and cost effectiveness, safety, and budget impact of alternate immunisation strategies, as well as the organisation, resource, ethical, patient and social implications associated with immunisation. In December, we launched a public consultation asking for feedback on our draft report.
- ▶ **COVID-19 vaccination in Ireland:** Following a request from the Chief Medical Officer, we have commenced an assessment of various COVID-19 vaccination strategies to provide advice to the Minister for Health to inform COVID-19 vaccination policy in Ireland.

Screening programmes

The National Screening Advisory Committee (NSAC) is an independent advisory committee that advises the Minister for Health and Department of Health on all new proposals for population-based screening programmes and revisions to existing programmes. Our Screening HTA function provides evidence-informed advice to inform the work of NSAC. To date, this has involved assessments of new population-based screening programmes and modifications to existing programmes, and reviews of processes used to inform screening policy (such as prioritisation and decision-making approaches, and the development of an ethical framework).

We provided the following advice to NSAC in 2025:

- ▶ **Population-based screening for abdominal aortic aneurysm in men:** An abdominal aortic aneurysm (AAA) is a swelling of the aorta and rupture of a large aneurysm can cause huge internal bleeding which is usually fatal. There is currently no screening programme in Ireland for AAA. Our advice to NSAC informed its recommendation to the Minister for Health regarding whether or not a population-based screening for AAA for men should be introduced in Ireland, with the recommendation being accepted by the Minister.
- ▶ **Extending BowelScreen to those aged 50 to 54 years:** Screening for bowel cancer (also known as colorectal cancer) aims to detect signs of cancer at an early stage where there are no symptoms. Work on a HTA to consider expansion of the programme to those aged 50 to 54 was completed in 2025, and our HTA was provided as advice to NSAC.

We also worked on a number of other screenings HTAs during 2025 at the request of NSAC. Once these projects are completed, they will be provided as advice to NSAC to inform its recommendations to the Minister for Health:

- ▶ **Screening for familial hypercholesterolaemia (FH) in children:** We commenced work on a HTA to support decision-making regarding screening for familial hypercholesterolaemia (FH) in children, which will be undertaken using a two-phase approach.
- ▶ **Addition of screening for congenital adrenal hyperplasia to the National Newborn Bloodspot Screening Programme:** We began work on this project during 2025 and are examining the clinical and cost effectiveness of newborn screening for congenital adrenal hyperplasia, as well as assessing the budget impact, organisational implications and ethical issues associated with its potential addition to the National Newborn Bloodspot Screening Programme.
- ▶ **Modifications to the BreastCheck programme:** We have commenced a HTA of extending the age of eligibility for the BreastCheck programme to those aged 45 to 49 and 70 to 74 years, with consideration of screening breast density.

Public health policy

We provide evidence-based advice to inform national public health policy in areas prioritised by the Chief Medical Officer of the Department of Health. In 2025, this included work on two projects requested by the Chief Medical Officer:

- ▶ **An update to the Irish low-risk alcohol guidelines:** We are working on informing the planned update of the low-risk alcohol guidelines by the Department of Health, which were last revised in 2015. This includes modelling the risk of alcohol-attributable mortality and hospital admission in Ireland and undertaking a systematic review on the association between alcohol consumption and mental health outcomes. When complete, our work will inform public health decision-making by the Minister for Health.
- ▶ **A summary of publicly-funded services for donor-assisted human reproduction in selected countries:** We are undertaking work to support the Department of Health in considering and developing a policy in relation to future provision of publicly-funded services for donor-assisted human reproduction in Ireland.

The Centre in Ireland for Clinical guideline support and Evidence Reviews (CICER)

The Centre in Ireland for Clinical guideline support and Evidence Reviews (CICER) at HIQA is funded by the Health Research Board (HRB) to deliver high-quality evidence to support the development of National Clinical Guidelines. National Clinical Guidelines are quality assured by the National Clinical Effectiveness Committee and mandated by the Minister for Health for implementation in Ireland.

CICER comprises a dedicated multidisciplinary research team supported by staff from HIQA, and the Discipline of Public Health and Primary Care in the School of Medicine in Trinity College Dublin.

In 2025, this work included:

- ▶ Supporting an update of the National Clinical Guideline to support the management of acute asthma attacks in adults (for those aged 16 years and older).
- ▶ Supporting the development of a new National Clinical Guideline which will support the management of obesity in adults.
- ▶ Supporting the development of a National Clinical Guideline on a Children's Emergency Medicine Early Warning System.
- ▶ Supporting the implementation of Ireland's second One Health National Action Plan on Antimicrobial Resistance strategic objective 5-07 by developing and piloting a costing tool for infectious disease outbreaks in public acute hospitals.
- ▶ Working on describing criteria and processes internationally for retiring clinical guidelines to inform updates to the current National Clinical Effectiveness Committee.



National Immunisation Advisory Committee

The National Immunisation Advisory Committee (NIAC) is Ireland's National Immunisation Technical Advisory Group, providing independent evidence-based recommendations and advice to the Minister for Health on immunisation and related health matters and developing Immunisation Guidelines for Ireland. First established in 1998, NIAC moved from the Royal College of Physicians of Ireland to HIQA on 31 March 2025.

The NIAC Secretariat within HIQA provides clinical, evidence synthesis and administrative support to NIAC.

During 2025, NIAC issued a number of recommendations, with some of these recommendations developed by NIAC while it was under the governance of the Royal College of Physicians of Ireland.

Two recommendations to the Chief Medical Officer of the Department of Health

- ▶ **Letter on 4 in 1 minimum interval rationale.** These recommendations have been implemented and incorporated into guidelines.
- ▶ **Updated recommendations for vaccination against COVID-19.** These updated recommendations have been implemented and incorporated into guidelines.

Three recommendations to the Minister for Health

- ▶ **Recommendations regarding the off-label use of meningococcal B vaccine (4CMenB) for the prevention of gonorrhoea.** These recommendations not to implement the vaccine have been accepted.
- ▶ **Updated recommendations for vaccination against RSV in older adults.** These have been incorporated into NIAC's guidelines. The decision of the Minister for Health on RSV for adults will be informed by our ongoing HTA into this topic.
- ▶ **Updated recommendations for post-exposure prophylaxis against rabies.** The Minister for Health accepted NIAC's recommendations and they have been implemented.

Updates to the Immunisation Guidelines for Ireland

In 2025, NIAC updated six chapters of the Immunisation Guidelines for Ireland:

- ▶ Chapter 11 (Influenza)
- ▶ Chapter 18 (Rabies)
- ▶ Chapter 5a (COVID-19)
- ▶ Chapter 2 (General Immunisation Procedures)
- ▶ Chapter 18a (RSV) – 2 updates
- ▶ Chapter 23 (Varicella-Zoster)

Health Information

We work to develop a consistent and standardised approach to the collection, use and sharing of health and social care information across services. This helps to drive improvements in the quality of health information and digital health in Ireland. We do this through developing national standards for health information and digital health and monitoring compliance against those standards. We also develop guidance and tools to improve information management and data quality. To support evidence-informed decision-making, we also analyse national health and social care data, advise Government on policy, and work with stakeholders to ensure evidence-based, high-quality information supports safer, better care. This work is critical to ensure good outcomes for people using services in light of the move towards a European Health Data Space, and the progress of the Health Information Bill 2024.

As such, a key focus for us in 2025 was supporting the health and social care sector to prepare for the European Health Data Space.

How HIQA is supporting preparedness for implementing the European Health Data Space in Ireland



HealthData@IE – setting up health data access body services in Ireland

The European Health Data Space Regulation (EHDS) is a European Union law that creates a framework for the access, use and sharing of electronic health data across EU Member States. It aims to give individuals greater control over their health data, enable secure cross-border healthcare, and support the reuse of health data for research, policy-making and regulatory purposes.

The implementation of the EHDS in Ireland will empower individuals to take control of their own health data and make it easier to access and exchange health data across EU Member States, both to support healthcare delivery and to facilitate secondary use of the data, including research and policy-making.

We are collaborating with the Department of Health and the Health Research Board on the HealthData@IE project to support the implementation of the EHDS. Our role is to support Ireland's preparedness for the EHDS, including engagement and education, enhancing data quality and establishing a national health dataset catalogue. In 2025, this work involved:

Supporting sector readiness

In 2025, as part of the HealthData@IE project, we conducted a readiness assessment to examine Ireland's health data holders' levels of preparedness for the implementation of the EHDS.

The assessment found that data holders face significant challenges and that a clear roadmap to guide progress through the HealthData@IE project and beyond is required, particularly considering the strategic approach to the secondary use of information in Ireland.

In 2026, we will continue to work to address these gaps and support data holders to prepare for the EHDS.

Development of a National Health Dataset Catalogue for Ireland

The EHDS aims to facilitate the use of anonymised and pseudonymised health data to help create a more efficient, innovative and responsive healthcare system that benefits everyone.

To support this, we have developed requirements and specifications for a National Health Dataset Catalogue for Ireland. A National Health Dataset Catalogue is a centralised digital registry designed to support the discovery of health and related datasets that are held by organisations within EU Member States. The catalogue will be one of the first key digital business capabilities developed as part of Ireland's national EHDS infrastructure and will be piloted in 2026.

It will play a vital role in enabling both data users and data holders to participate in a unified, transparent, and standardised metadata environment. It will make datasets findable and understandable, as well as supporting the use of health data for secondary purposes such as research, innovation, service planning, and policy development.

Stakeholder engagement and knowledge sharing

Throughout 2025, we proactively engaged with a wide range of stakeholders, including our Public and Patient Involvement (PPI) panel on the EHDS. Our [HealthData@IE Training and Education Resources Portfolio](#) signposts to information and training materials that can be used to learn more about the EHDS and help the sector to prepare for implementation.

In November 2025, we held a webinar with speakers from the European Commission and Department of Health to support health data holders understand their new legal obligations and identify the steps they need to take to prepare. These stakeholder engagement and knowledge-sharing activities help to inform and strengthen our work, while also supporting preparedness for the effective and successful implementation of the EHDS.



Members of the EHDS Competent Authorities Community of Practice for Secondary Use from across Europe collaborating to support the implementation of the EHDS Regulation.

Other key health information projects

Evidence for policy on registries in health and social care

In 2025, we continued a programme of work to inform national policy for registries in health and social care in Ireland. Following a request from the Department of Health, we conducted and published an *International review of approaches to registries in health and social care in six countries in the context of the European Health Data Space*. It explores how other countries approach registries in health and social care with a particular focus on governance arrangements, the maturity of systems, approaches to prioritisation and plans for the future.

We also undertook extensive engagement with national stakeholders to describe the current registry landscape in Ireland. The findings from this engagement will be published in 2026 and will inform the development of a roadmap and prioritisation criteria for policy and decision-makers and support development and investment in these vital sources of health and social care data in Ireland.

National Guidance for the Responsible and Safe use of Artificial Intelligence in Health and Social Care Services

Artificial Intelligence (AI) is already being used across health and social care in Ireland, has the potential to positively impact on the delivery of care, including streamlining administrative tasks and supporting diagnostics, but appropriate safeguards are needed. The use of AI tools must be guided by appropriate safeguards and be in compliance with legal obligations, including those set out in the EU Artificial Intelligence Act 2024.

Commissioned by the Department of Health, in 2025 we started to develop *National Guidance for the Responsible and Safe Use of Artificial Intelligence in Health and Social Care Services*. During the year, we completed an international evidence review and conducted extensive stakeholder engagement to inform the Guidance.

The Guidance will promote awareness and build good practice among services and staff about the responsible and safe use of AI in their services, and help the sector to prepare for the significant changes that are coming in this area. The Guidance will also educate and empower people using services on how AI can be used safely and responsibly during their care. The Draft Guidance was published in early 2026 for public consultation.

Use of Information for Monitoring and Regulation

We strive to promote safety and quality in the provision of health and social care services in Ireland. As a regulator, we receive different types of information from a variety of sources which we use to inform our work.

We receive feedback from people using services, their relatives, friends and employees, as well as the general public, about their experiences of using and interacting with services. We also receive information from providers of services who are legally required to submit information to us.

We actively engage with all stakeholders by reviewing all information and feedback received and assessing whether or not it indicates risk to safety, quality or regulatory compliance and each piece of information is acknowledged.

If we feel that the information provided requires action, we can take a number of steps, including: seeking further details from providers; requesting corrective plans; using the information to inform our inspections or carrying out unannounced inspections. Where immediate risk to the safety of people using a service is indicated, we use our full legal powers and report the incident, where appropriate, to the relevant authorities such as An Garda Síochána, Tusla or the HSE's Adult Safeguarding Team.

The breakdown of all information received during 2025 is included in Appendix B.

Feedback from people about services

Between 1 January and 31 December 2025, we received

2,100 pieces of feedback from people using services, their families, or members of the public



All of this information was acknowledged and logged and referred for assessment, risk rating and appropriate follow up.

When people provide feedback to us about services under our remit, it allows us to:

- ▶ Require providers to ensure services continue to meet high standards of care for patients and residents
- ▶ Consider how well providers handle complaints and use them as opportunities to improve care for patients and residents
- ▶ Identify any trends or patterns that could indicate that something unacceptable is happening in a service
- ▶ Make decisions when registering and or renewing the registration of designated centres.

Feedback helps inform how we regulated and monitored services during the year, and allowed us to better understand the real, lived experience of people using services.

How to submit your feedback on a service

If you would like to submit feedback on a service you can contact us at:

Phone: 021 240 9646

Email: concerns@hiqa.ie

Post: Information Handling Centre, HIQA, George's Court, George's Lane, Smithfield, Dublin 7, Ireland

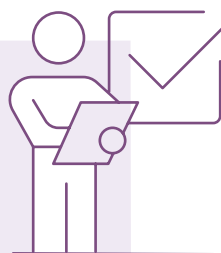
Find more information on our website: <https://www.hiqa.ie/get-touch/report-concern-or-give-feedback>

Information submitted by services

Between 1 January and 31 December, we received a total of

56,908

pieces of information from providers of services or persons in charge



This information is legally required for providers to submit to us, such as notifications of particular incidents.

All of this information was used to further inform and support our monitoring, inspection and regulations activities during 2025.

Following receipt of the information, if we consider that the service provider may not be compliant with the regulations and or national standards, we can respond by:

- ▶ Asking the service provider to submit additional information on the issue
- ▶ Requesting a plan from the service provider outlining how the issue will be investigated and addressed
- ▶ Using the information on inspection
- ▶ Carrying out an unannounced inspection to assess the quality and safety of the care being provided in the service.

Using evidence from the public and people using services

Feedback from patients, people using services and the public is valuable to shaping our evidence to inform decision-making.

How HIQA is involving patients and clinicians in National Clinical Guidelines development

In 2024, CICER was awarded the Knowledge Translation Award for “Scalable Training And Knowledge Exchange on guideline development for patients, public, and healthcare professionals: The STAKEholder project”, funded by the Health Research Board.

This project aims to:

- ▶ Increase awareness and transparency about what National Clinical Guidelines are and how they are developed
- ▶ Prepare patients, the public and healthcare professionals to take active roles in National Clinical Guideline development groups
- ▶ Better understand patients’ and healthcare professionals’ views on how National Clinical Guidelines are developed and implemented

Conference

A key deliverable of this project was the hosting of an in-person conference focused on the ecosystem of health decision-making in Ireland and the role of stakeholders, with a special emphasis on patients, the public and healthcare professionals.

The organisation and planning of the conference was done with input from advisory group members and stakeholder panels. This approach ensured that patients, the public, health professionals, and experts in health decision-making shaped the content and delivery of the conference.

The “Our Healthcare System, Our Voices: An Evidence-Based Approach for Healthcare” conference was held in October 2025 in Dublin in collaboration with the Royal College of Surgeons in Ireland (RCSI) University of Medicine and Health Sciences. The conference brought together patients, members of the public, clinicians, researchers and policy-makers, both online and in person, to explore how stakeholder involvement can be strengthened in the development of clinical guidelines and health technology assessments. The full-day event consisted of a series of keynote speeches, panel and roundtable discussions, drawing on themes of education, engagement and inclusion.

Our Deputy Chief Executive and Director of Health Technology Assessment Dr Máirín Ryan opened the event. Keynote speakers at the event included Professor Mary Horgan, Chief Medical Officer for the Department of Health and Dr Colm Henry, Chief Clinical Officer at the HSE. They discussed a variety of topics relevant to those in attendance, including: fostering open dialogue on patient collaboration; embedding patient and public involvement (PPI) within national policy; strengthening patient partnerships; advancing the concept of “living guidelines” to ensure adaptability and relevance over time; and supporting evidence-based decision-making informed by lived experience as well as scientific research. Our Chief Executive Angela Fitzgerald summarised the day and provided the closing remarks.



Pictured are: Dr Colm Henry and HIQA CEO Angela Fitzgerald; Angela Fitzgerald, Prof Mary Horgan and Dr Máirín Ryan; and the CICER conference team.

Feedback from the 200 people that attended either in person or virtually was overwhelmingly positive with a total of 89% of respondents indicating they were 'satisfied' or 'very satisfied' with the event.

"Understanding how to include patient input at the formulation stage and the role of research in shaping practice"

"Really good variety of speakers and topics"

"Learning strategies for applying patient involvement in real-world healthcare settings"



Interactive roundtable group sessions encouraged collaboration and knowledge exchange among participants during the conference.

Impact

The conference allowed us strengthen networks, raise awareness of the project's upcoming learning resources, and reinforce a shared commitment to transparent and inclusive decision-making. It demonstrated that stakeholder engagement is essential to informing trustworthy, people-centred health decision-making. This conference is a key part of a programme of work to inform the development of our approach to stakeholder engagement and will inform our update to the National Guidelines for Stakeholder Engagement in HTA.

National Care Experience Programme

The National Care Experience Programme is a joint initiative from HIQA, the HSE and the Department of Health. The Programme runs a suite of surveys that ask people about their experiences of care in order to improve the quality of health and social care services in Ireland.

In 2025, we continued to develop the model and methodology for a National Cancer Care Experience Survey, including engaging with stakeholders, such as cancer patients, to develop the survey questionnaire.

A pilot data extraction was undertaken in three hospitals to inform the eventual implementation of the survey.

We are also developing a National Mental Health Experience Survey in collaboration with the Mental Health Commission and people with lived experience of inpatient mental health care.

By expanding our suite of service user experience surveys, the programme is ensuring the people's voices are central to quality improvement initiatives across multiple and varied care contexts in Ireland.

National Maternity Experience Survey

In 2025, the second National Maternity Experience Survey took place, capturing women's experiences of maternity care in maternity hospitals, units and home births across Ireland. Through the survey, women highlighted areas of good experience and areas requiring improvements across services.



Areas of good experience

Most survey participants reported that:

- ▶ they were treated with respect and dignity during their pregnancy
- ▶ they had confidence and trust in the healthcare professionals caring for them during labour and birth
- ▶ their decisions about their maternity care were respected by healthcare staff.

Areas for improvement

People using maternity services need:

- ▶ better communication between the maternity service and their general practitioner (GP)
- ▶ opportunities to ask questions about their labour and birth to healthcare professionals
- ▶ a healthcare professional to talk to about worries and fears after the birth.

Four areas identified as priorities for improvement in 2020 – decision-making after birth, opportunities to ask questions after birth, emotional support in neonatal units, and feeding support in hospital – showed more positive results this year. This reflects that maternity services listened to women’s feedback and implemented targeted, effective changes to improve care.

Areas for improvement highlighted included professionals having adequate time to discuss women’s concerns or questions and enabling appropriate sharing of patient information within and across healthcare settings. This is an important objective within the Health Information Bill, which is at advanced stage. Areas that declined from the 2020 survey included postnatal care, such as feeding support at home, and engagement with GPs and or public health nurses.

The findings were published in December 2025 across a national report, 19 hospital reports and a report on experiences of home birth.

In response to the survey findings, the HSE has published a [‘Listening, Responding and Improving’](#) report, which highlights the improvement initiatives it is taking to address women’s feedback, many of which are already underway. We are also using the findings to inform our monitoring and inspections of Ireland’s maternity services.

Extension of the National Inpatient Experience Survey to private hospitals

After extensive and positive engagement with private providers, recommendations for the extension of the National Inpatient Experience Survey to private hospitals were developed in 2025, in line with HIQA’s expanded remit into private hospitals under the Patient Safety Act 2023. This work will continue in 2026 to ensure the voices and experiences of people using private hospitals is captured alongside those using public hospitals. Ultimately, this will benefit those using private healthcare by providing service providers with data that can be used to develop and implement quality improvement programmes and monitor progress over time.

Redevelopment of online results dashboards

In 2025, we redesigned dashboards to show the survey results for inpatient and maternity care experience on www.yourexperience.ie. These dashboards provide access to both the public as well as to over 260 users working in care provision, policy-making and standards development. The dashboards facilitate easier access and are a key resource in ensuring that stakeholders have the data they need to respond to the survey findings.

Patient and Public Involvement Panels

The voice of people who use and have experience of using services is essential to ensuring our work is based on real-life impact.

During the year, we established a patient and public involvement (PPI) panel as part of CICER to ensure their voices are heard in our work. Twelve panel members were selected from more than 110 applicants, and the panel met four times during 2025 following its establishment. During the year, the panel provided 58 suggestions on how patients and the public can be more meaningfully involved in the National Clinical Effectiveness Committee's National Clinical Guideline development process. These suggestions are currently being prioritised before moving to implementation.

We also continued to engage our HealthData@IE PPI panel as we work to support preparedness for the EHDS. This was established in 2024 to ensure the perspectives of the public and patients are central in the project. They continue to support the project by providing the public perspective to inform the development and dissemination of information resources aimed at the general public.



Members of the HealthData@IE PPI panel at an in-person workshop, September 2025.

Regulatory research and quality improvement

Regulatory research plays an important role in strengthening the quality and safety of health and social care services. By generating and sharing evidence, we support improvements in practice, strengthen regulatory approaches and contribute to better outcomes for people using services.

In 2025, we strengthened learning and collaboration across the sector through a range of research and knowledge-sharing activities. These included publishing academic papers in peer-reviewed journals, participating in national and international conferences to disseminate findings and engage with stakeholders, and collaborating with peer regulators internationally. We presented at the SINC (International Innovation Network for Health and Care Regulators) Congress in Porto and hosted a knowledge-sharing visit from the Icelandic Quality and Supervisory Agency of Welfare.

During the year, we also collaborated with other organisations to use the database of statutory notifications in social care, supporting researchers to undertake studies that extend learning across the sector. One example of this work was research collaboration with South East Technological University on a project exploring the use of restrictive practices in services. This project uses our data on notifications received from services about the use of restrictive practices to generate evidence that can support efforts to reduce their use and ensure they are applied only when necessary.

Our research also informs the development of inspection methodologies used by the Chief Inspector. This included contributions to the development of a thematic inspection programme for special care settings and strengthening approaches to engaging with children during inspections. Ensuring that inspection methodologies are grounded in current evidence helps strengthen regulatory oversight and supports improvements in the quality and safety of care.

Generic Justification of Ionising Radiation Practices

Since 2023, we have had responsibility to justify practices that involve exposing patients to ionising radiation. We worked on two projects during 2025 in this area:

- ▶ **Guidelines for the justification of medical radiological procedures on asymptomatic individuals:** We developed guidelines on the use of medical radiological procedures in asymptomatic individuals for the early detection of disease, but outside of a screening programme. The guidelines were published in November 2025 and apply to any person or organisation conducting medical radiological procedures.
- ▶ **Magnetic resonance-guided radiotherapy (MRgRT) evidence synthesis to support a generic justification decision:** We completed an evidence review in this area and published a generic justification decision relating to the use of MRgRT in June 2025. We were satisfied that, on consideration of the balance between the benefits and harms, this practice should be generically justified.



Pictured above are Chief Inspector Designate Finbarr Colfer, Chief Executive Angela Fitzgerald and Head of Programme Regulatory Practice Development Aileen Keane with the CEO of the Icelandic Quality and Supervisory Agency of Welfare (Gæða - og eftirlitsstofnun velferðarmála) at our Dublin office as part of their knowledge-sharing visit to Ireland.



Pictured are Deputy Director of Health Technology Assessment Dr Kieran Walsh and Director of Health Technology Assessment and Deputy Chief Executive Dr Máirín Ryan at the Heads of HTA Agencies Group (HAG) meeting in Copenhagen, Denmark with former HAG Chair Dr Rui Santos Ivo at the HAG meeting in Copenhagen in November 2025.



Pictured is Deputy Director of Health and Social Care Standards Dr Niamh O'Rourke at European Social Network event on The Future of Long-Term Care.



Pictured are members of the National Care Experience Programme team at the National Office of Clinical Audit Annual Conference 2025.



Pictured is Standards Development Lead Judy Gannon presenting at the European Social Services Conference 2025.



Above is Regional Manager Dr Agnella Craig chairing a session on education, training and competence formation as an international expert in the fields of higher education and the regulation of ionising radiation at the International Atomic Energy Agency conference in Vienna.



Pictured are HTA Analyst Barrie Tyner, Senior HTA Analyst and CICER Programme Manager Dr Celine Larkin, Patient Partner with The Centre for Arthritis Research in UCD Stacey Grealis, Deputy Director of HTA Shelley O'Neill and Marion Cullinane of the Clinical Effectiveness Unit in the Department of Health at the Guideline International Network (GIN) Annual Conference 2025 in Geneva, Switzerland.



Pictured above is Director of Healthcare Regulation Sean Egan speaking at the International Innovation Network for Health and Care Regulators (SINC) Congress 2025 in Portugal.



Pictured are our Chief Scientist Dr Conor Teljeur, Postdoctoral Fellow Dr Rasha Alshaikh, Health Services Researcher Laura Rouncivell and Senior Health Economist Dr Susan Ahern at the ISPOR - The Professional Society for Health Economics and Outcomes Research conference in Glasgow, Scotland.



Pictured are Deputy Chief Executive and Director of HTA Dr Máirín Ryan and Head of Assessment Joan Quigley at the HTAi Annual Meeting 2025 in Buenos Aires, Argentina.

3

Governance and Organisational Effectiveness

Chapter 3:

Governance and Organisational Effectiveness



HIQA is delivering value and impact for all stakeholders through agile and collaborative ways of working, efficient systems, fit-for-purpose structures, and appropriate governance

By working collaboratively with stakeholders, we aim to enhance communication, trust and the effectiveness of our activities. Strengthening governance and organisational effectiveness ensures that the health and social care sector can deliver meaningful value and impact, improved service delivery, and better outcomes for people using services.

Preparations for new functions

As the trusted regulator for the sector, our remit is expanding into further areas. During 2025, we engaged closely with the Department of Health and other Government departments to ensure these new functions are implemented in a way that supports service providers, strengthens regulatory oversight, and promotes safe, high-quality care for residents.

The legislation and regulations that we engaged on in 2025 include:

► **The Patient Safety (Licensing) Bill**

The Department of Health has prepared legislative proposals for a mandatory licensing system for public and private hospitals and other providers of high-risk healthcare activities. We will be the licensing authority, processing applications for licences, and monitoring the performance of licence holders.

► **Health (Amendment) (Home Support Providers) Bill 2025**

The Health (Amendment) (Home Support Providers) Bill 2025 intends to introduce the regulation of home support providers, under our Chief Inspector. This will provide independent monitoring and inspections and assure the public of the quality and safety of home support for the first time.

► **Health Information Bill 2024**

The Health Information Bill provides a clear legal basis for the establishment of electronic health records across public, private and voluntary settings to enhance patient access to and control over their data, and provide health professionals with a more complete, holistic view of patients they are treating. The Bill provides for the HSE to consult with HIQA on the preparation of guidelines in respect of health information referred to in the Bill. This acknowledges our central role in developing health information standards within health and social care settings, as well as the importance and necessity of drawing from and building on national expertise to ensure effective implementation of the legislation.

▶ **The Critical Entities Resilience Directive**

We are a Competent Authority for aspects of the health service as required by the EU Critical Entities Resilience Directive. This Directive aims to promote resilience and good business continuity practice across a number of key areas of the European economy and society to ensure that each EU Member State is well prepared to manage disruption and potential external threats.

▶ **Health Technology Assessment Regulation**

We are working with the Department of Health to support implementation of the EU Regulation on Health Technology Assessment (HTAR) in Ireland, which became applicable on 12 January 2025. We represent Ireland on the Coordination Group and its Joint Clinical Assessment and Methodology Subgroups.

▶ **European Health Data Space (EHDS) Regulation 2025**

We are working with the European Commission, the Department of Health, the Health Research Board, the HSE and other stakeholders to support implementation of the EHDS Regulation. Under the Regulation, each Member State will be required to establish a Health Data Access Body to support access to secondary health data. We are working to support key aspects of the Healthdata@IE grant funded project, to establish these services in Ireland by 2027.

▶ **Network and Information Security Directive (NIS-2)**

This EU directive, when fully implemented, will give HIQA a role on supporting and enhancing cyber security across the health sector in line with the National Cyber Security Bill 2024.

▶ **Amendments to the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013**

During the year, significant amendments to the Health Act 2007 came into effect, following recommendations from the COVID-19 Nursing Homes Expert Panel, to modernise and enhance the legislative framework for nursing homes. The changes strengthened requirements for providers and gave new powers to the Chief Inspector, improving oversight and ensuring that residents receive care that is safe, dignified, and high quality. From 31 March 2025, we began monitoring compliance with these measures to ensure that the changes in legislation translated into improved experiences and outcomes for residents.

▶ **Human Tissue (Transplantation, Post-Mortem, Anatomical Examination and Public Display) Act 2024**

We are awaiting the development of regulations on this Act which will give us regulatory and enforcement powers in certain elements of post-mortem activities.

Digital and Data Transformation

Key 2025 achievements:

- ▶ Implemented Digital and Data Transformation Strategy:
 - Delivered significant go-live milestone in our new regulatory IT system
 - Delivered new finance management system
 - Successfully transitioned the National Immunisation Advisory Committee to HIQA
 - Delivered enhanced cyber security infrastructure.
- ▶ Developed a new five-year Digital and Data Transformation Strategy 2026-2030
 - Which will deliver under the pillars of Data and AI, Digital Transformation and Technology Enablement.

In line with Government policy, we have committed to move to digital platforms to support efficient and effective management of key business processes and drive value and impact for all stakeholders. Given our remit, it is essential that we have the digital and data capabilities to enable us to take on new functions, optimise our research capabilities and have real-time access to data and analytics to inform our regulatory approach and response. For example, this includes automating the collation and visualisation of data to support staff in the more proactive identification of issues for further enquiry relating to health service quality and safety. The approach to automation will enhance productivity for inspectors to enable other regulatory work to be conducted.

As a regulator, ensuring that our data and systems are secure and have adequate protections from external cyber threat is a critical priority and is essential in terms of maintaining trust in our role. As a result, we continue to invest in our Digital and Data Transformation Strategy to support the development of information systems that are fit for purpose, agile and secure to support our existing and expanding regulatory and business functions. To deliver this Strategy, we have ensured robust governance structures and processes are in place to provide relevant oversight and steer critical initiatives.

During 2025, we delivered on 24 core projects, as well as progressing a number of other projects to enhance the IT systems across the organisation. We completed a number of projects to enhance and sustain our critical systems.

One key project was the significant go-live milestone in the development of our regulatory IT system in November 2025. Since then, feedback or concerns we receive about healthcare services is now being tracked using our new regulatory system. The receipt and triangulation of information from people using services, families, staff, and other sources is an essential part of our regulatory surveillance function. It also informs our inspection process and focus. The system will continue to expand into all areas of our regulatory functions over the coming years.

Other information management improvements included progress on migration of all staff to SharePoint Online, and the build out of additional capabilities on our IT service desk and logging system. We also completed ICT planning for the transition of the National Immunisation Advisory Committee into HIQA and supported organisation-wide systems development. We continued to strengthen our cyber security infrastructure to enhance our capabilities, with work undertaken on penetration test-remediation, improvements to role-based access controls, and supporting compliance with upcoming legislative requirements and the international standard for information security management systems.

Our Information Division is closely aligned to the business to provide proactive support on the growth of the organisation. Operational efficiency, resilience and business continuity were further supported through the rollout of cloud data backup, the initiation of the laptop refresh programme, the migration of mobile device management, and procurement for modern information and communications technology (ICT) managed services. Work also advanced on the Business Continuity Management Framework and the implementation of a managed print service.

These combined efforts ensured more efficient processes, stronger security, and improved organisational readiness, enabling us to deliver greater value and impact in our work.

Communications and Stakeholder Engagement Strategy

Our Communications and Stakeholder Engagement Strategy 2025-2027 supports engagement with stakeholders during the lifetime of the Corporate Plan. We are committed to increasing awareness and support for HIQA's role and programme of work among its stakeholders, enhancing opportunities for stakeholder engagement and involvement in our work, increasing the accessibility of the information we communicate and developing sustainable and future-proofed tools and channels to enhance our engagement. The strategy supports our public affairs, public relations, publications, digital media and internal communications functions.

During the year, we supported the publication and dissemination of all reports and publications, including: our recommendations and advice to the Minister on statutory reviews and health technology assessments; liaising with media, politicians and other key stakeholder groups about our work; developing infographics, videos and social media campaigns to highlight our work; supporting effective and engaging internal communications within the organisation; and coordinating and supporting internal and external events.

We also assisted in the preparations for attending three Oireachtas Committees. In 2025, we attended the Oireachtas Joint Committee on Health twice to discuss both our review and advice of urgent and emergency healthcare services in the HSE Mid West area as well as our regulatory powers and the regulatory action we took into a number of nursing homes. We also attended the Oireachtas Committee of Public Accounts to discuss our financial statements for 2023 and answer questions about our role and remit.



Pictured above: Angela Fitzgerald with members of our senior leadership answering questions at the Oireachtas Committee of Public Accounts.

In 2025, this included:



30

press releases
issued promoting
our work



89

publication statements issued
alongside the publication of
inspection reports



3

Oireachtas
Committees
attended



193

media queries
responded to



6

editions of external newsletter,
HIQA News, issued to over
4,000 subscribers



75

parliamentary
questions received
for input



20

external public
consultations
participated in



2,526,076

page views at
www.hiqa.ie



7,600+

emails received
into info@hiqa.ie

We continue to review our approach to communications and stakeholder engagement to ensure that we are meeting the needs of the people we engage with.

Internal Communications

Effective internal communication is central to delivering on our commitment to being an employer of choice and our goal throughout the year was to nurture a positive staff culture and promote connection and engagement across the organisation. During 2025, a range of internal communication and engagement initiatives helped nurture this inclusive culture and support staff wellbeing and connection to the organisation.

To engage with staff during the year, we ran a number of virtual, hybrid and in-person events.

As part of our commitment to a positive organisational culture and supporting staff, we run a series called HIQA Talks. These are online sessions that staff can attend to learn about a specific external organisation or relevant topic. In 2025, four HIQA Talks sessions were held, with 427 staff attending cross the four events.

These talks, which ranged from a session on our role in children's services to mark World Children's Day to a talk on neurodiversity at work, promoted shared learning and increased knowledge for staff.

We planned, organised and hosted three Year in Review events, one across each of our three offices, at the end of 2025. These events brought staff together and created an opportunity for meaningful engagement with senior leadership on the year's achievements and future plan, while further contributing to a culture of openness and inclusivity. In line with this, we also organised staff events for the launches of the Annual Report 2024, Corporate Plan and People and Culture Strategy to make sure our people were informed on and engaged with the strategic direction of the organisation as it continues to grow and expand.

During the year, we also held activities and events such as a Pride Bake off in June, a coffee morning in February to mark 10th International Care Day, Seachtain na Gaeilge, and International Day of Persons with Disabilities.

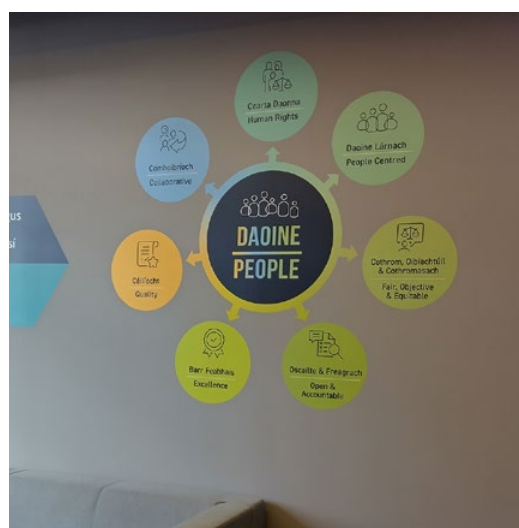
Keeping staff informed of what the organisation is doing, both internally and externally is critically important to us as we operate across a number of locations. To do this, we regularly issue 'All Staff' emails and memos, update our Intranet and deliver an internal staff e-zine. We published 11 issues of our staff e-zine which highlighted staff achievements, organisational updates and helped all colleagues stay up to date, connected and recognised for their work.

The visibility of and access to our senior leadership is a key part of our organisational culture of openness and transparency. We published videos from members of our Executive Management Team speaking about their areas of work and how all teams within HIQA work towards the same shared goal of improving the outcomes for people using health and social care services in Ireland. These videos helped strengthened transparency and trust by ensuring colleagues hear directly from leadership in a clear and accessible way.

Staff engagement is key to our culture and internal communications has a significant role to play in this. Promoting a sense of connection among colleagues to the organisation's Mission, Vision and Values is central to enabling us to achieve our objectives as an organisation. We designed, commissioned and organised the rollout of artwork displaying our Mission, Vision and Values across each of our three offices, reinforcing a values-led environment where people feel valued and have a shared sense of purpose.



Angela Fitzgerald speaking at a staff event in our Cork office.



Values artwork on display in our Galway office.

Maintaining operational effectiveness

At HIQA, we are committed to ensuring we remain agile and fit for purpose. With that in mind, we regularly conduct internal and external audits and reviews of how we do our work.

Excellence Through People

The Excellence Through People Certification is Ireland's national standard for human resource development. Following an audit conducted by the National Standards Authority of Ireland in November 2025, we maintained Platinum accreditation under the Excellence Through People Scheme. This continued accreditation provided independent validation of the employee experience in the organisation during a period of continued growth and reflects a culture where people feel informed, involved and supported.

Quality management system

During the year, we continued to implement our Quality and Risk Strategy and commenced development of our next Strategy. We reviewed and developed an updated Quality Service Charter, informing people on the level of service they can expect from HIQA. The Charter sets out our commitment to engaging with our stakeholders in line with the Principles of Quality Customer Service for Customers and Clients of the Public Service. This will be published in 2026.

Following a successful two-day audit, we retained the International Organization for Standardization (ISO) accreditation for our quality management system, ISO 9001:2015. This recognises the importance of ensuring the establishment, implementation, maintenance, and continual improvement of a quality management system for organisational effectiveness.

Integrated Regulatory Review Service Mission

In 2026, we will welcome the International Atomic Energy Agency in its Integrated Regulatory Review Service Mission to Ireland. The review aims to help countries to improve their radiation safety and regulatory systems. During 2025, significant work was undertaken to prepare for the review, including completion of a number of self-assessments. The review is being coordinated by the Department of Climate, Energy and the Environment, and will also examine the Environmental Protection Agency, our partner agency for radiation protection. Initial feedback received from the review has been very positive and we look forward to the final report.

Academic and international collaborations

Development of research partnerships for the National Care Experience Programme

In March 2025, we hosted an international call with 15 attendees from 10 organisations involved in care experience surveys across the world, cementing existing relationships and building new ones. Discussion centred on how to make our survey programmes as accessible as possible to people from marginalised groups. Organisations represented on the call included Scotland's Ministry of Health, the French Authority for Health, Austrian Federal Ministry for Social Affairs, and other organisations that conduct national survey programmes. Progress was also made in relation to working with the Picker Institute to establish an international grouping of organisations involved in care experience surveys. The purpose of this grouping is to share ideas and best practice on survey development and analysis.

Work continued with the University of Galway on an HRB-funded project exploring how the National Inpatient Experience Survey can be enhanced to ensure it sufficiently includes the perspectives of people from marginalised communities. A key output from this project was a paper called 'Exploring how health inequalities are conceptualised and measured in patient experience surveys in acute care: a protocol for a scoping review', published in 2025 in HRB Open.

We also concluded a separate HRB-funded project with Maynooth University that used advanced text analytics methods to identify actionable insights from the free text comments in response to inpatient and maternity surveys. Two interactive dashboards were developed to allow stakeholders interact with project findings. In addition, a report on the findings was published on www.yourexperience.ie.

We continued to provide access to survey data and encourage its use for additional insights, receiving 23 data access requests from researchers, care providers and students. Survey data has further been uploaded to the Irish Social Sciences Data Archive, an online data repository hosted by University College Dublin. This will provide valuable access to data for research and quality improvement initiatives in line with FAIR (Findable, Accessible, Interoperable, and Reusable) principles.



HIQA is a sustainable and inclusive organisation

Our focus on sustainability and inclusivity allows us to reflect the diverse needs of the communities we serve, ensuring we remain effective in how we operate.

Environment and sustainability

- ▶ Our energy performance has improved by 74.4% since 2009.
- ▶ We have reduced total CO₂ emissions by 48% compared to 2016-2018.
- ▶ We have reduced direct fossil fuel-related CO₂ emissions by 30.2% compared to 2016-2018.

We have worked to ensure our compliance with the Government's Public Sector Climate Action Mandate. We have reported on our implementation of the mandated requirements to the Sustainable Energy Authority of Ireland (SEAI). We developed and published a Climate Action Roadmap 2025 that sets out our overall objectives and restates our commitment to meeting or exceeding all targets set out by Government.

Through this roadmap, we will continually improve our facilities, services and resource management operations in respect of our climate-related and energy-saving goals, while also engaging with behavioural changes among our staff and other stakeholders.

Public bodies are required to meet both a 51% reduction in direct fossil fuel-related CO₂ emissions and overall total CO₂ emissions. Our only direct fossil fuel emissions result from the use of natural gas in our Dublin office. We have reduced direct fossil fuel-related CO₂ emissions by 30.2% compared to our baseline emissions, which are the average data from 2016 to 2018 as identified by the SEAI. We have also reduced total CO₂ emissions by 48% when compared to our baseline data of usage from 2016 to 2018. These reductions are on a trajectory towards meeting the mandated 2030 targets.

We have processes in place for offsetting the emissions associated with official air travel. During the year, payments to offset these emissions were paid into the Climate Action Fund at the Department of Climate, Energy and the Environment.

We are committed to ensuring sustainability in all aspects of its operations and to support this has established a Green Team, which is a group of staff members committed to sustainability that advises on, supports and promotes environmental initiatives across the organisation.

Diversity, Equality and Inclusion

We are proud of our diverse workforce, who deliver high-quality work across the organisation. We continue to work to create an inclusive, diverse and equitable organisation by identifying and acting on ongoing feedback and harnessing opportunities that enable meaningful change. We remain committed to encouraging and supporting cultural diversity and inclusion across the organisation through the activities of the staff-led Diversity and Inclusion Working Group. During 2025, staff took part in three Pride parades across the country. We also held an inaugural Diversity and Inclusion in Practice event for staff, where staff members showcased projects that they were working on which addressed diversity, equality and inclusivity.

In December 2025, our Diversity and Inclusion Working Group won the Outstanding Ally in the Public or State Agency category of the Out and Outstanding in Cork Awards. We were also nominated for Outstanding Employee Resource Group Awards as part of the 2026 National Diversity and Inclusion Awards.

In line with its People and Culture Strategy, HIQA is developing a Diversity, Equity and Inclusion (DE&I) Roadmap which will embed DE&I into how we work, lead, and support each other — making it part of our everyday culture.

4

People



Chapter 4:

People



HIQA is an employer of choice through its staff supports, opportunities and positive organisational culture

In our Corporate Plan 2025-2027, we set out our commitment to investing in staff development, creating a supportive work environment and fostering a motivated workforce that contributes to our mission and the overall improvement of health and social care. We want HIQA to be an employer of choice.

In 2025, we achieved this through:

- ▶ Launch of the People and Culture Strategy 2025–2027, providing a clear, organisation-wide roadmap to strengthen capability, culture and workforce sustainability.
- ▶ Enhanced organisational capability through a redesigned Corporate Learning and Development model, increasing engagement and fostering a culture of continuous professional growth.
- ▶ Sustained strong workforce growth and talent attraction, recruiting for 132 roles with increased candidate interest and demand and significant internal mobility, supporting both organisational expansion and career progression.
- ▶ Strengthened leadership capability and workforce integration through a dedicated manager development programme.

People and Culture Strategy 2025-2027



In 2025, we launched a new People and Culture Strategy for 2025 to 2027, aligned to support our Corporate Plan. Our people are at the heart of everything that we do as an organisation, and this strategy recognises and highlights this ethos.

The strategy focuses on how we will support and empower our people, and how we will continue to nurture a culture of collaboration and shared purpose within HIQA. The strategy aims to help us meet the opportunities and challenges of the future, so that we can work together to shape and achieve the culture and work environment that we are striving towards. The strategy is set out under three core pillars.



The strategy was launched through a series of in-person workshops across all three of our offices, allowing for staff discussion and engagement, supported by the development of an online hub with resources and further information for staff.

A key project within the strategy is to turn our values inwards — developing our values into lived, everyday critical behaviours by all within the organisation. This approach provides a clear, shared behavioural framework that strengthens organisational culture and reinforces accountability for values-led decision-making and ways of working. This work directly supports the Corporate Plan objective of embedding a strong, consistent organisational culture aligned to our mission and regulatory role.

Learning and Development

We are committed to fostering a high-performance learning culture that equips our people to deliver on our mandate in an increasingly complex and evolving environment.

In 2025, we implemented a redesigned Corporate Learning and Development operating model, informed by a comprehensive internal capability analysis and aligned to the People and Culture Strategy 2025–2027. This shift marked a move from ad hoc training provision to a structured, capability-led approach focused on building the skills required for organisational growth, regulatory excellence and operational resilience.

A structured, organisation-wide training calendar was introduced, improving visibility, forward planning and equitable access to development opportunities. As a result, learning engagement significantly increased, with participation expanding to 433 employees and overall delivery increasing from 400 to 1,500 hours. Importantly, almost half of participants engaged in more than one learning intervention, demonstrating a growing culture of continuous professional development rather than one-off attendance.

Beyond participation metrics, impact was evidenced in learner feedback and application. Staff reported that learning was directly relevant to their roles, immediately transferable to practice, and strengthened their confidence and capability in supporting a growing and increasingly complex organisation. This enhanced capability contributes to improved decision-making, regulatory consistency, cross-functional collaboration and service quality.

In parallel, we strengthened the broader development ecosystem to support both immediate performance and long-term capability building. An extensive mentoring programme was embedded to enhance the new hire experience, accelerate integration, and support knowledge transfer across the organisation. We also launched a dedicated manager development programme focused on building the skills required to lead and support teams in a blended working environment, strengthening management capability, consistency and employee engagement.

We continue to invest in academic education supports and access to external development opportunities, ensuring our workforce remains future-ready, professionally credible and aligned with evolving regulatory and sectoral demands.

Health and Wellbeing

The health and wellbeing of our staff continued to be a key strategic priority throughout the year. Our Wellbeing Programme, which is shaped by regular staff feedback and guided by our Wellbeing Ambassadors, continues to grow and mature, with strong engagement across all areas, reflecting a supportive and responsive approach to staff wellbeing. All activities are built around three core pillars: Mind, Body, and Spirit, supporting mental, physical, and emotional wellbeing. High engagement with supports on offer showed that employees felt safe and encouraged to prioritise their health and wellbeing.

During 2025, 40% of staff availed of on-site health consultations, while 30% of staff took part in our summer activity challenge, which encouraged movement, teamwork, and connection across teams and locations.

Overall, the continued strong participation in our Wellbeing Programme reflects a positive wellbeing culture and our commitment to supporting staff in a practical, inclusive, and meaningful way.

In addition, we offer an Employee Assistance Programme to provide support to our people. Approximately 13% of staff availed of the Employee Assistance Programme with utilisation right across the range of services offered, namely, career advice, relationship advice, legal, financial advice, life coaching and mental health support.

Recruitment

As our role and remit continues to expand, record levels of recruitment activity demonstrated a strong talent pipeline which reflects our strong employer brand. During the year, we recruited for a total of 132 roles across the organisation. We also updated our suite of recruitment information and resources for candidates.

Health and Safety

During 2025, we remained committed to ensuring that health and safety of everyone working in the organisation was protected. We continued to monitor our health and safety framework, which provides for the necessary policies, standards, materials and tools that support and assist the organisation. Fundamental to our commitment to continuous improvement in this area was promoting, providing training on, managing and improving health and safety matters across the whole organisation to ensure that staff feel comfortable and safe at all times while at work.

A full range of supports were provided to staff who work both in the office and from home under HIQA's blended working model to ensure they can work effectively and comfortably from these locations. This included furniture, equipment and all additional health and safety requirements, including training and health and safety-related risk assessments. We are dedicated to always supporting our current staff while continuing to position ourselves as an employer of choice for people that want to work in an organisation with a clear mission while also enjoying flexibility and a work-life balance.

5

Financial Statements

HIQA's Annual Financial Statements will be published in full in a Part 2 to this document upon receipt of the audited financial statements from the Office of the Comptroller and Auditor General.

6

Appendices



Appendices

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A. HIQA Board and Executive Management Team

Our Board

Our Board is at the centre of HIQA's governance, providing strategic direction to the organisation, and ensuring strong internal controls and statutory and operational compliance at all times. The Board comprises a Chairperson and 11 non-executive members, who bring expertise across the health and social care sector in addition to valuable experience and perspectives from related areas and industries. This mix of knowledge and skills ensures that HIQA's work is guided by informed and independent insight.

In August 2025, HIQA's Chairperson, Professor Pat O'Mahony, passed away having served as Board Chair for seven years.

In 2025, HIQA's Board met 10 times to progress various significant matters. The members of the Board during 2025 included:



Dr Pat O'Mahony (*Chairperson 3 October 2018 - 26 August 2025*)

Former Chief Executive of Clinical Research Development Ireland. Former Chairman of the Management Board of the European Medicines Agency. Former Deputy Secretary General and Head of Governance and Performance at the Department of Health. Former Chief Executive of the Health Products Regulatory Authority.



Martin O'Halloran (*Current Chairperson*)

Former CEO of the Health and Safety Authority. Former Chairman of the Board of the Institute for Public Administration and the Association of Chief Executives.



Bernadette Costello

Chartered Director and Chartered Accountant. Member of Board and Chair of the Audit and Risk Committee of Oberstown Children Detention Campus, Board and Finance Committee of Galway and Roscommon Education and Training, and Galway Harbour Audit & Risk Committee. Chairs HIQA's Audit, Risk and Governance Committee.



Dr Jim Kiely

Former Vice Chair of the Board of Tallaght University Hospital. Former Health Policy Adviser with the Irish Aid Health Programme. Chaired the Standing Committee of the WHO Regional Office in Copenhagen. Spent 11 years as Chief Medical Officer in the Department of Health. Chairs HIQA's Standards, Information, Research and Technology Committee.



Dr Paula Kilbane

Former CEO of Eastern Health and Social Services Board in Northern Ireland and Director of Public Health of the Southern Health Board Northern Ireland. Currently serving on the Board of the Health Products Regulatory Authority, Paula has wide experience as a director in the public, charitable and private sectors.



Dr Clíodhna Foley-Nolan

Consultant in Public Health Medicine. Former Director of Human Health and Nutrition at Safefood and Specialist in Public Health Medicine in the HSE.



Lynsey Perdisatt

HR Director, Retail & Corporate at An Post. Has worked at senior HR level in both the private and public sector, with significant experience in employee relations, industrial relations and change management. Chairs HIQA's Resource Oversight Committee.



Caroline Spillane

CEO of Institute of Directors Ireland. Former CEO of the Medical Council of Ireland. Former Director General of Engineers Ireland. Former Assistant National Director of the Health Services Executive.



Martin Higgins

Former CEO of Safefood. Currently serving as Deputy Chair of All Island Institute of Public Health, council member of the Pharmaceutical Society of Ireland, and Chair of the Audit and Risk Committees of both the National Disability Authority and the Competition and Consumer Protection Authority. Previously served on boards of Irish Medicines Board, health and social care professionals' regulator CORU, and Nursing and Midwifery Board of Ireland and as Board Chair of Food Safety Authority.



Marion Meany

30 years' experience working in health services. Former HSE Assistant National Director for Disability Strategy and Planning.



Danny McConnell

Fellow of the Chartered Institute of Public Finance & Accountancy. Board member of the South Eastern Regional College. Former Technology Consulting Partner in Deloitte in Northern Ireland.



Leonie Clarke

Chief Executive of the Irish Medicines Verification Organisation. Elected observer on Board of the European Medicines Verification Organisation. Former President and Council member of the Pharmaceutical Society of Ireland, and former Board member of the Health Research Board.



Dr Frank O'Donnell

Held national leadership roles in Microsoft, KPMG and PA Consulting. Member of the Strategic Advisory Committee for the National Screening Service focused on the adoption of AI. Previously a member of the Strategic Advisory Board of Genuity Science.

Board Committees

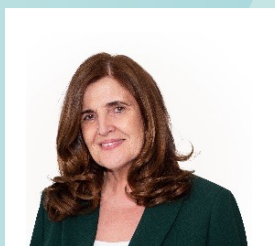
Four Board committees support the activities of the Board in governing HIQA:

- ▶ **Regulation Committee** oversees the effectiveness, governance, compliance and controls around the delivery of HIQA's regulatory functions.
- ▶ **Audit, Risk and Governance Committee** supports the Board in relation to its responsibilities for issues of risk, control and governance and associated assurance. The Audit, Risk and Governance Committee is independent from the financial management of the organisation. In particular, the committee ensures that the internal control systems, including audit activities, are monitored actively and independently. The committee reports to the Board after each meeting, and formally in writing annually.
- ▶ **Standards, Information, Research and Technology Committee** oversees the governance arrangements, including compliance and controls, for the functions of standards development, health information and health technology assessment functions.
- ▶ **Resources Oversight Committee** monitors the resource requirements of HIQA to ensure that they are aligned with HIQA's corporate strategy, including oversight of resource related risks. In addition, it oversees organisational needs and managerial performance.

Our Executive Management Team

The organisation is led by the Executive Management Team, which is supported by other senior managers who are responsible for our business functions.

The membership of HIQA's Executive Management Team in 2025 comprised:



Angela Fitzgerald
Chief Executive



Dr Máirín Ryan
Deputy Chief Executive and Director of Health Technology Assessment



Carol Grogan
Chief Inspector of Social Services



Finbarr Colfer*
Chief Inspector Designate



Sean Egan
Director of Healthcare Regulation



Rachel Flynn
Director of Health Information and Standards



Sean Angland
Chief Operations Officer



Bala Krishnan
Chief Information Officer



Marty Whelan
Head of Communications and Stakeholder Engagement



Susan Montgomery
Head of Human Resources and Organisational Development

* Finbarr Colfer was designated by the Board of HIQA to fulfil the functions of the Chief Inspector of Social Services in November 2024.

B. Report of the Chief Inspector of Social Services

Through regulation and monitoring activities by HIQA's Chief Inspector of Social Services, we enable improved outcomes for people using:

- ▶ Designated centres for people (adults and children) with disabilities, known as residential disability services
- ▶ Designated centres for older people, known as nursing homes
- ▶ Children's services.

To ensure providers are delivering good-quality care and support, regulation comprises a number of key activities:

- ▶ registering designated centres
- ▶ inspecting and reporting on the quality and safety of the services
- ▶ ongoing monitoring of compliance in services
- ▶ meeting and engaging with people who avail of the service to hear their experiences
- ▶ receiving, analysing and risk-assessing information from a range of sources to inform our regulation activity.

Inspection activity

During the year, we carried out 1,994 inspections of nursing homes, residential disability services and children's services. Inspections assess if service providers are meeting the regulations or national standards to ensure they are ensuring the people living there are receiving safe, quality care. Inspectors also review all information about a centre or service held or received by the Chief Inspector and use this to inform their judgments.

The Chief Inspector carries out inspections to:

- ▶ Assess compliance with regulation and or standards at a certain point of time
- ▶ Give a voice to residents or children living in a centre or availing of social services about what it is like to receive the service
- ▶ Inform the public about the quality of services being provided
- ▶ Make ongoing regulatory decisions.

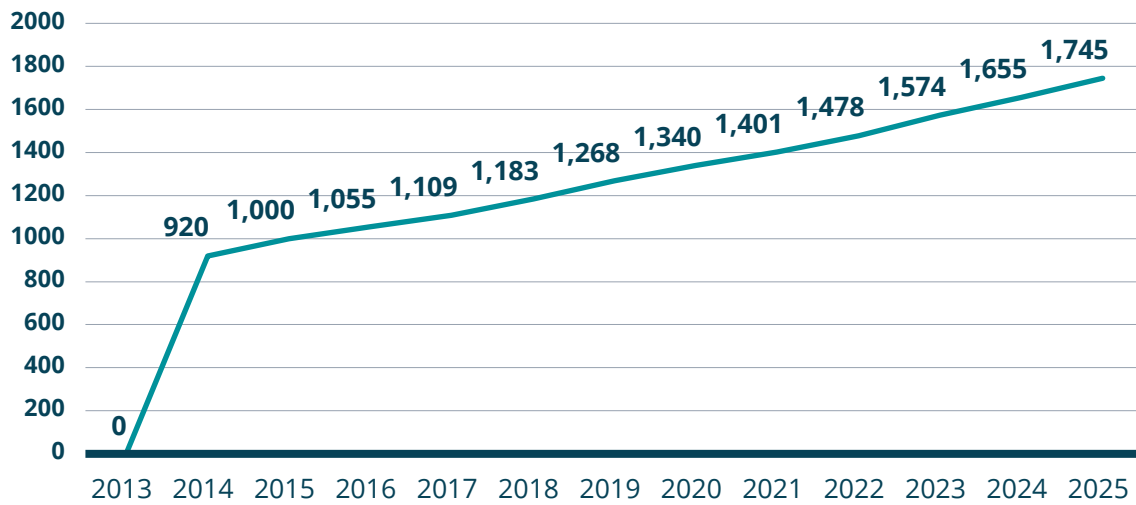
Regulation of residential disability services

Profile of residential disability services in Ireland

At the end of 2025, there were 1,745 registered designated centres for people with disabilities, an increase of 90 on 2024. These centres provided 9,481 residential places for children and adults with disabilities, which was a net increase of 235 places on the previous year.

Of these centres, 1,564 were for adults, 144 were specifically for children and 37 were for a mix of both adults and children. The mixed centres were usually either respite centres where adults and children were accommodated at different times or centres where the residents were transitioning to adulthood and wished to remain living together.

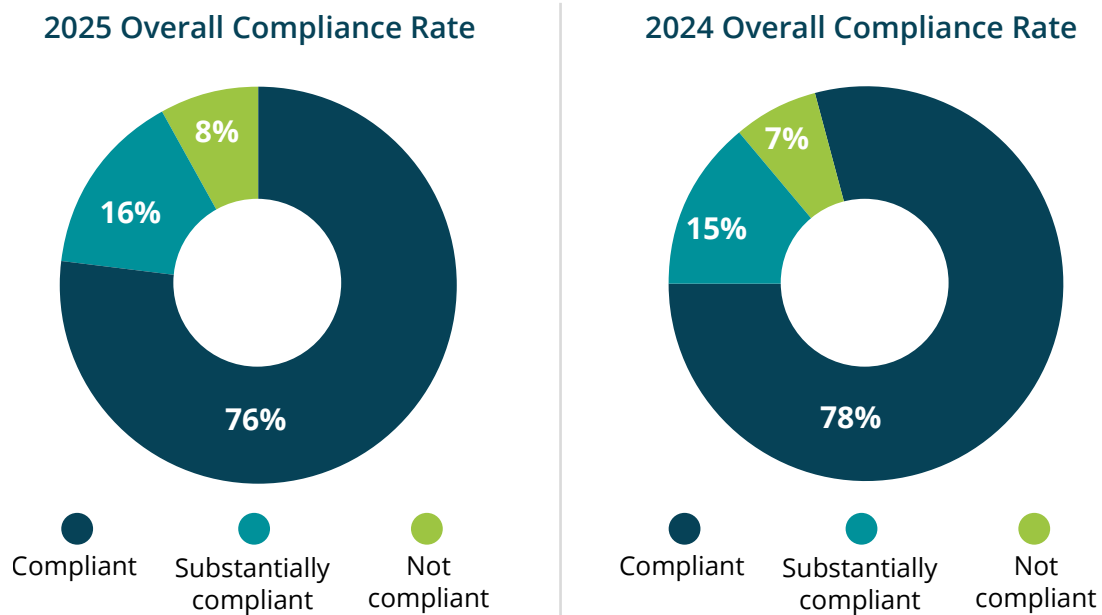
Figure A1: Number of designated centres for people with disabilities 2013 to 2025



At the end of 2025, there were 1,947 registered residential places in congregated settings, or larger campus-based settings, compared with a total of 2,111 at the end of 2024, a reduction of 164 people in congregated settings. This is positive, as we have consistently found that people who lived in a community-based setting had better outcomes than those who lived in congregated settings.

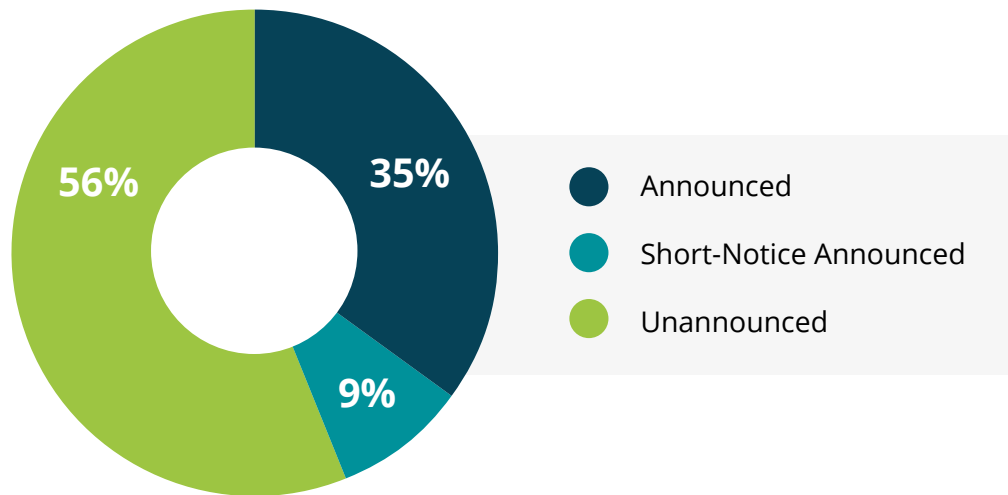
While there was a decrease in the number of residents in congregated settings during 2025, approximately 21% of the total number of people living in residential disability services are living in congregated settings.

Figure A2: Overall compliance in designated centres for people with disabilities in 2025 compared to 2024



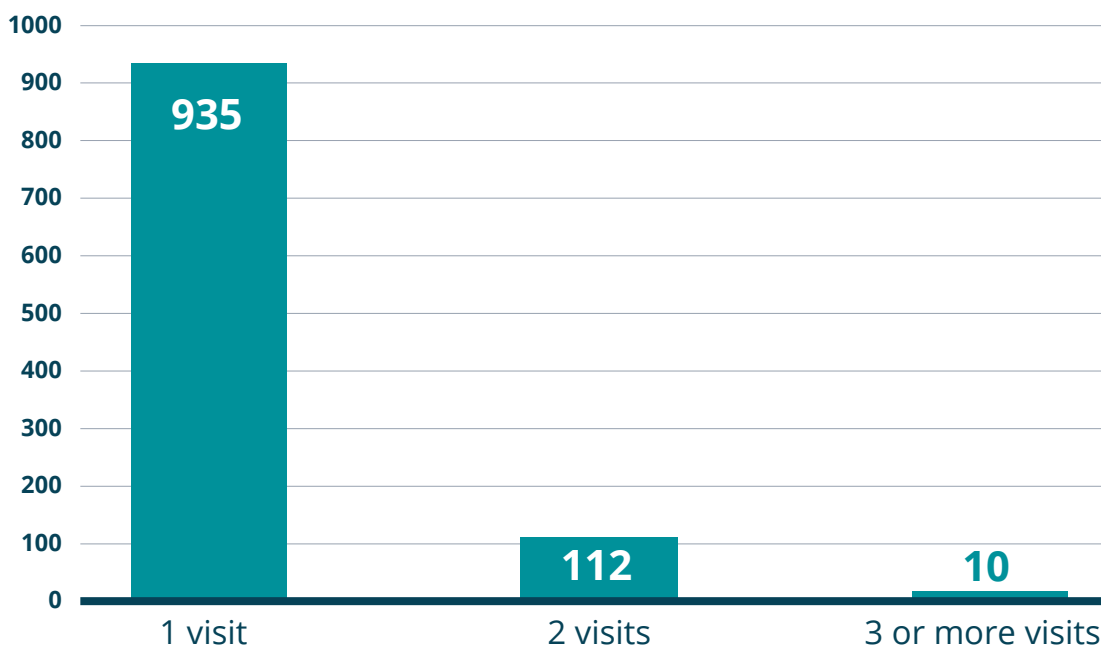
During 2025, inspectors completed 1,191 inspections of centres for people with disabilities, which included 196 inspections specifically focused on adult safeguarding. Inspections can be announced, unannounced or announced at short-notice and may take place at any time of day or night. Unannounced inspections increased from 39% in 2024 to 56% in 2025.

Figure A3: Percentage of announced and unannounced inspections of designated centres for people with disabilities carried out in 2025



The majority of centres (935) visited in 2025 received one inspection. This indicates that they had a good level of compliance and that, where there were non-compliances, the provider responded appropriately. In terms of non-compliant centres, 112 centres required two inspections to monitor compliance, with 10 centres requiring three or more follow-up inspections.

Figure A4: Percentage of inspection visits per centre inspected in 2025



Regulatory enforcement

While we found good levels of compliance in 2025, the Chief Inspector was required to engage in escalation and enforcement action to compel some providers to make improvements to the quality of support for residents in their centres.

In 2025, as a result of non-compliant findings on inspection, 47 warning letters were issued to providers. These letters warned providers that failure to come into compliance and improve outcomes for residents could result in cancellation of the registration of their centres, prosecution or attaching additional conditions to registration as outlined under the Health Act 2007 (as amended).

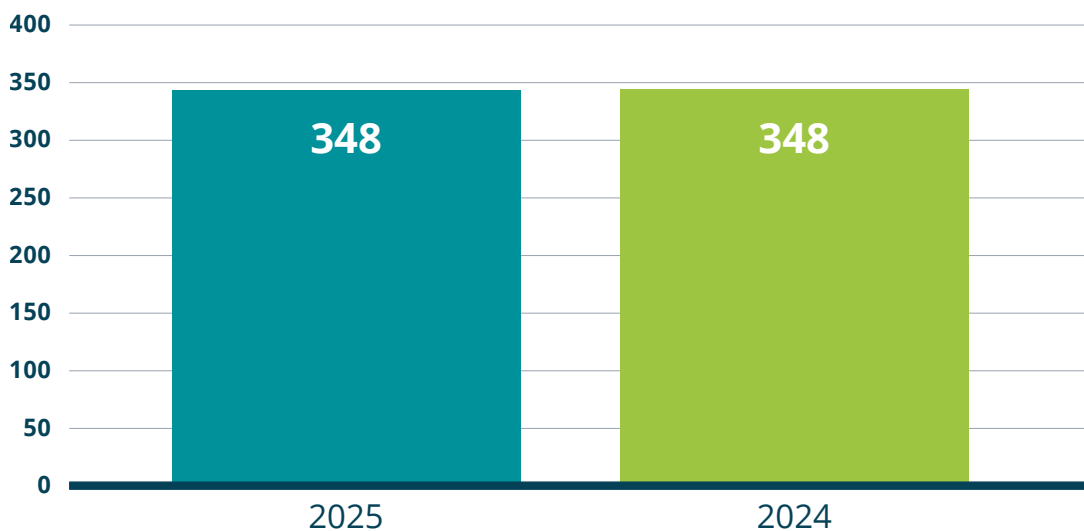
Where we found that improvements are not made to benefit residents, we take further action. In 2025, we issued 12 notices of proposal to either cancel or refuse the registration of centres if improvements were not made. Providers have the legal right to respond to these notices and the Chief Inspector received representations relating to these centres.

In two of these centres, providers failed to implement sufficient improvements to the safety and wellbeing of residents. The Chief Inspector took the decision to cancel the registration of these centres. The HSE took over the operation of one of these centres under Section 64 of the Health Act (2007 as amended). For the other centre, the provider exercised their right of appeal against the cancellation decision and initiated legal proceedings.

Feedback received from people about residential disability services in 2025

In 2025, we received a total of 348 pieces of feedback related to designated centres for people with disabilities. This was the same number that we received in 2024.

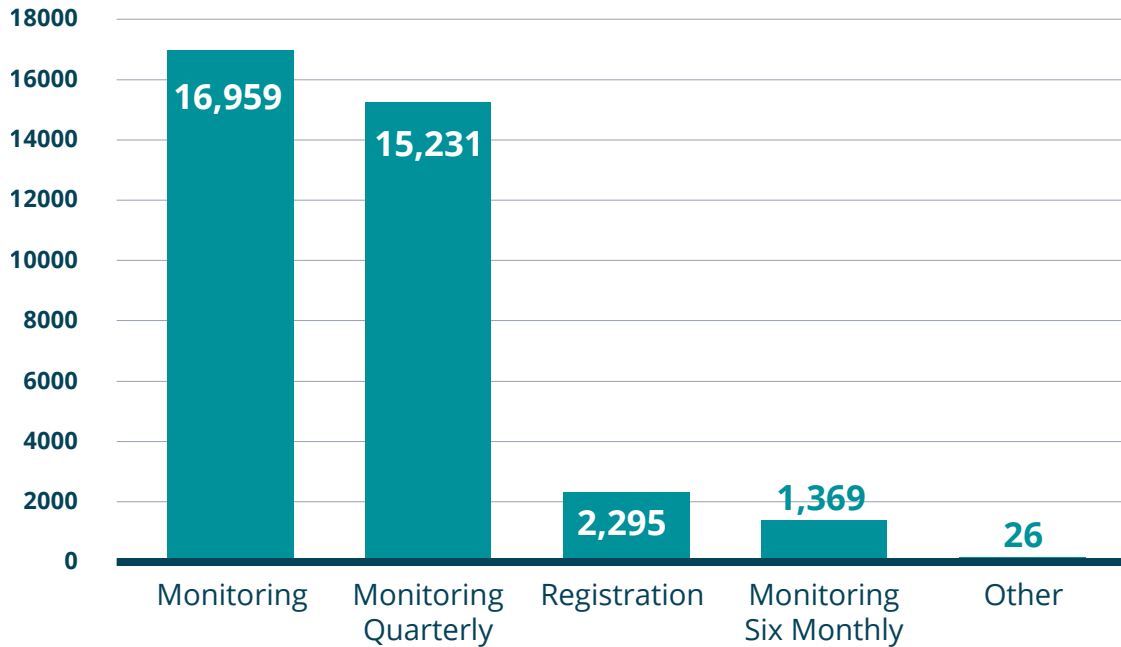
Figure A5: Number of pieces of feedback received about designated centres for people (adults and children) with disabilities during 2025 compared to 2024



Information submitted by providers of residential disability services in 2025

During 2025, 35,880 notifications were received relating to services for people with disabilities. This is an 11% increase on the number of notifications received in 2024.

Figure A6: Regulatory notifications received from services for people with disabilities in 2025 per type



Regulation of Nursing Homes

Profile of nursing homes in Ireland

At the end of 2025, there were 545 designated centres for older people (commonly referred to as nursing homes) providing 32,408 beds. This reflects a reduction in the number of nursing homes (from 548 in 2024) while the number of registered beds increased marginally, up 38 from 32,370 in 2024.

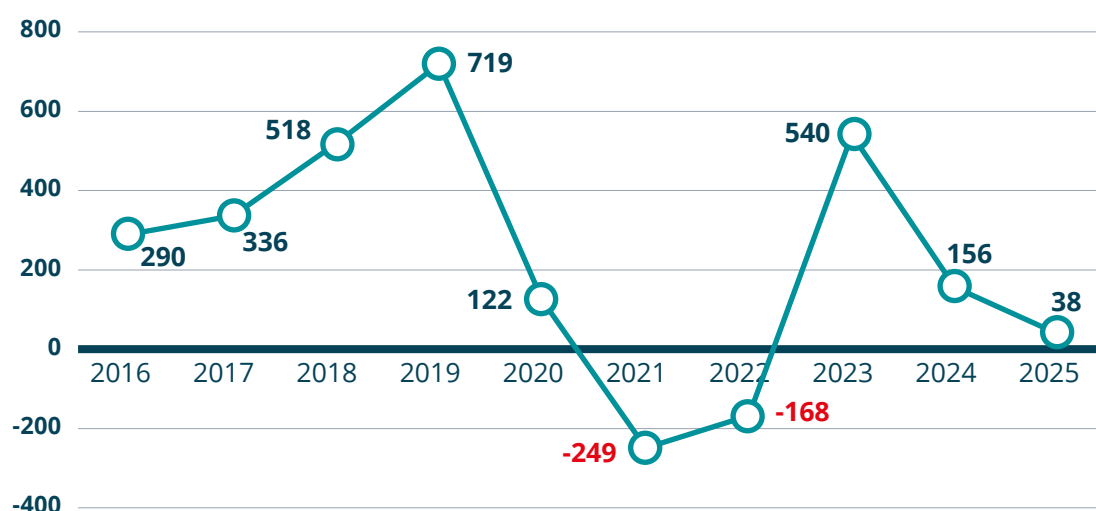
Table A1: Number of Registered Centres and Beds between 2013 and 2025

Year	Number of Centres	Year on Year Variance of Centres	Number of Beds	Year on Year Variance of Beds
2016	580	+3	30,396	+290
2017	579	-1	30,732	+336
2018	581	+2	31,250	+518
2019	585	+4	31,969	+719
2020	573	-12	32,091	+122
2021	567	-6	31,842	-249
2022	557	-10	31,674	-168
2023	553	-4	32,214	+540
2024	548	-5	32,370	+156
2025	545	-3	32,408	+38

Over the course of 2025, seven nursing homes closed while four new nursing homes were registered. Of these four new nursing homes, only two were newly-built and developed sites. One of the four nursing homes was a replacement premises for an existing centre, while the fourth new nursing home registered in 2025 was a nursing home that was registered with a new provider following cancellation of the previous provider's registration in 2024. Therefore, although it is included in the list of new nursing homes, it should be considered in the context of providing replacement beds as opposed to the number of new beds. These four nursing homes provided a total of 241 beds, with 176 of these beds coming from two newly-built facilities.

The positive impact of the additional capacity created by the four newly-registered nursing homes was offset by the loss of 186 beds in the seven nursing homes which closed in 2025. The average number of beds in the nursing homes which closed was 26.5.

Notwithstanding the continued reduction in the number of registered nursing homes, the total number of beds available showed a slight increase of 38 beds since 2024. This increased capacity is partly due to the number of nursing homes that extended their premises to increase the number of beds. In total, 217 new beds were registered in existing nursing homes surpassing the increased capacity that became available through new builds.

Figure A7: Year-on-Year Variance of New Registered Nursing Home Beds between 2016 and 2025

Nursing homes are owned and operated by a number of legal entities, including the Health Service Executive, HSE-funded bodies under sections 38 and 39 of the Health Act 2004 and private providers. The profile of ownership is set out below in Table 2.

Table A2: Profile of ownership of nursing homes as of 31 December 2025

Registered Provider Type	Registered Centres	Registered Beds
Health Service Executive (Public)	114 ² (20.8%)	5,235 (16.2%)
HSE-funded bodies under Sections 38 and 39 of the Health Act 2004	19 (3.5%)	1,075 (3.3%)
Private Providers	415 (75.6%)	26,098 (80.5%)
Total	545	32,408

During 2025, the HSE operated five nursing homes as if the registered provider for varying periods of time, until the nursing homes in question either closed after the transfer of residents to alternative nursing homes or a new provider was registered to operate the nursing home. The numbers in the table above include the three nursing homes the HSE continued to operate as if the registered provider as of 31 December 2025.

Registration

The registered provider of a nursing home must apply to renew their registration every three years. In 2025, 114 providers were granted a renewal of their registration.

² This includes three designated centres for older people which are being operated by the HSE pursuant to section 64 of the Health Act 2007 (as amended). These designated centres were previously operated by a private registered provider, and their registration was cancelled pursuant to section 51 or section 59 of the Health Act 2007 (as amended).

Inspections

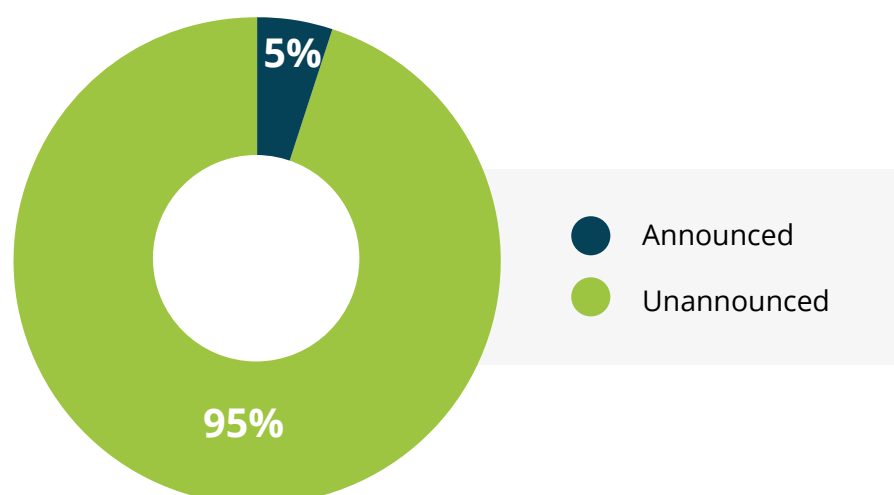
In 2025, inspectors of social services conducted 757 inspections of nursing homes. Every nursing home was inspected at least once during the year, with 31% of centres having two or more inspections. During the year, due to significant concerns for the health and safety of residents, 22 centres required more than two inspections with one centre being inspected nine times. The 757 inspections completed equated to 1,325 inspection days, as some inspections were carried out by more than one inspector, or may have been carried out over a number of days.

Table A3: Number of inspections per nursing home in 2025

Number of Inspections in 2025	Number of Centres
1 Inspection	378
2 Inspections	151
3 Inspections	17
4 Inspections	3
5 Inspections	1
9 Inspections	1

In 2025, 95% of all inspections of nursing homes were unannounced meaning that the registered provider and their staff were not aware that the inspection was happening on that day. The remaining 5% of inspections were announced, meaning that the registered provider was given one month's notice of the date of the inspection. When the inspection is announced, a pack is sent to the registered provider with resident surveys and a poster to advertise when inspectors will be in the centre. This is to allow residents and families the opportunity to provide feedback on the service they receive and to make plans to meet the inspector if they wish to do so.

Figure A8: Percentage of announced versus unannounced inspections of nursing homes carried out in 2025



Regulatory enforcement

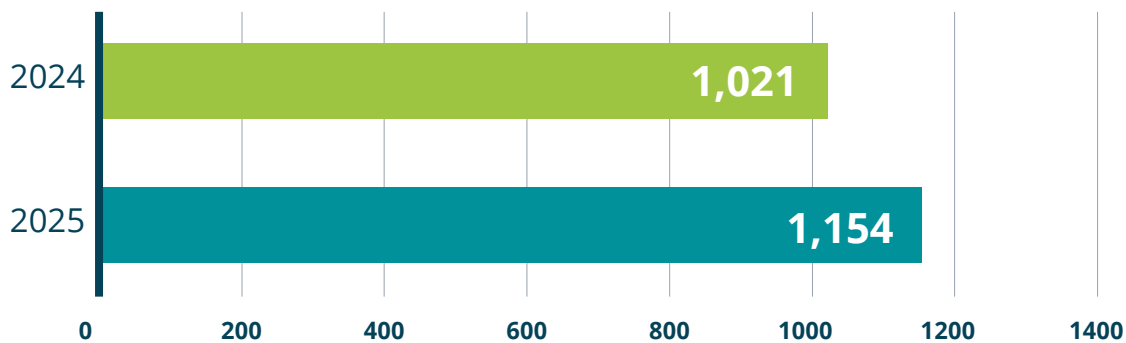
We use a risk-based escalation approach to ensure the safety of residents in nursing homes. When a nursing home shows persistent non-compliance with the regulations and standards, or there are deemed to be persistent risks to the health and safety of residents, the Chief Inspector can take several escalating regulatory enforcement steps. In 2025, this included:

- ▶ 162 assurance reports requested from registered providers
- ▶ 51 cautionary meetings held with providers
- ▶ 40 warning meetings held with providers
- ▶ 48 additional restrictive conditions were attached to the registration of 41 nursing homes, with the result that at the end of the year there were 100 restrictive conditions attached to the registration of 85 nursing homes
- ▶ 1 application to the District Court to cancel the registration of one nursing home provider in the interests of the health, safety and quality of life of the residents
- ▶ 217 applications to remove or vary a condition approved and 10 applications to remove or vary a condition were refused. These applications were refused where the Chief Inspector was not satisfied it was appropriate in the circumstances, and would not adversely affect the persons who are resident in the designated centre

Feedback received from people about nursing homes in 2025

During 2025, we received a total of 1,154 pieces of feedback related to nursing homes, representing a 13% increase on the number received 2024.

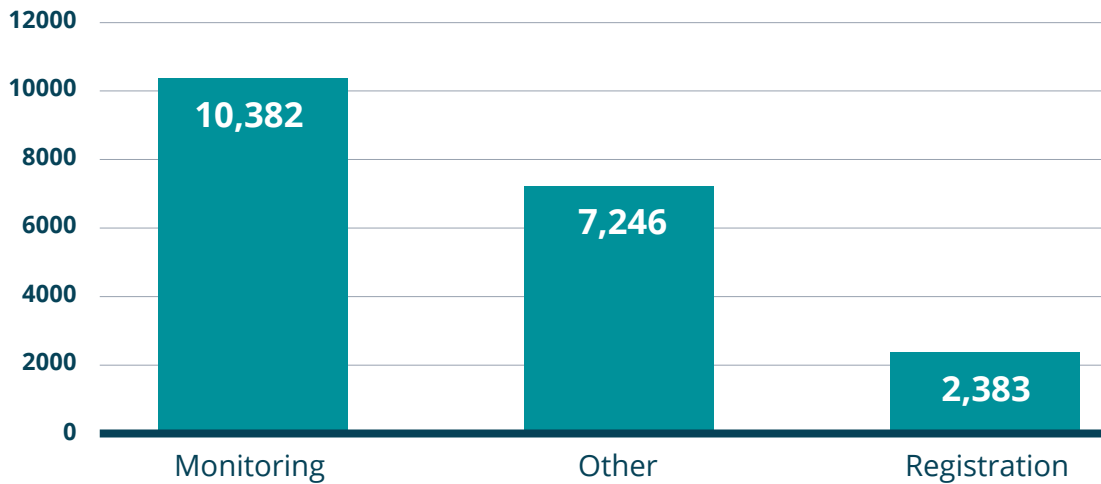
Figure A9: Number of pieces of feedback received about nursing homes during 2025 compared to 2024



Information submitted to HIQA by nursing homes in 2025

During 2025, we received 20,011 pieces of information from nursing homes, which reflects a decrease of 8% in comparison to 2024.

Figure A10: Regulatory notifications received relating to designated centres for older people in 2025 per type



Regulation and monitoring of children's services

During 2025, HIQA carried out 46 inspections across children's services. Of these inspections, 67% were unannounced inspections while 33% were announced inspections.

Figure A11: Number of inspections completed in children's services during 2025 by type

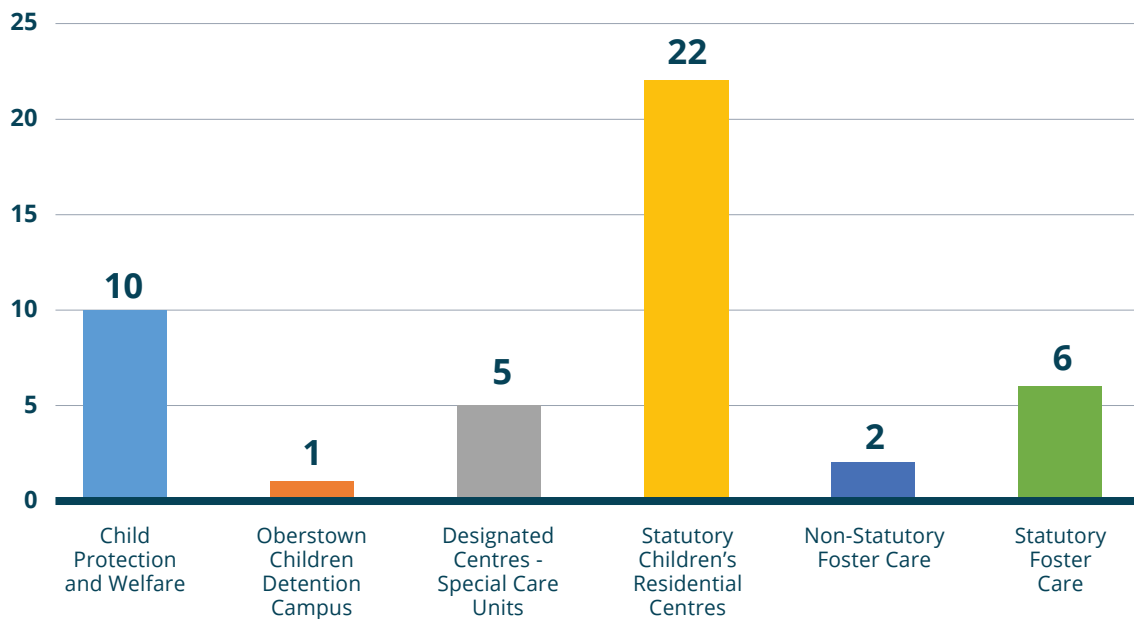
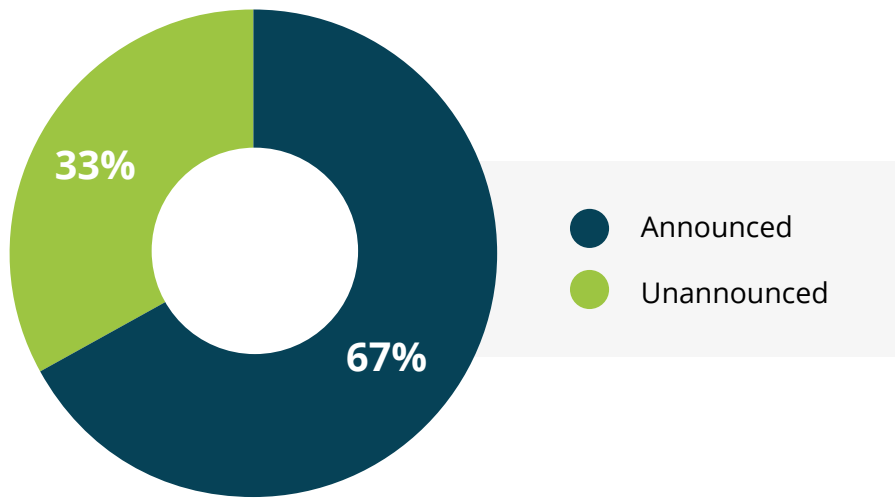


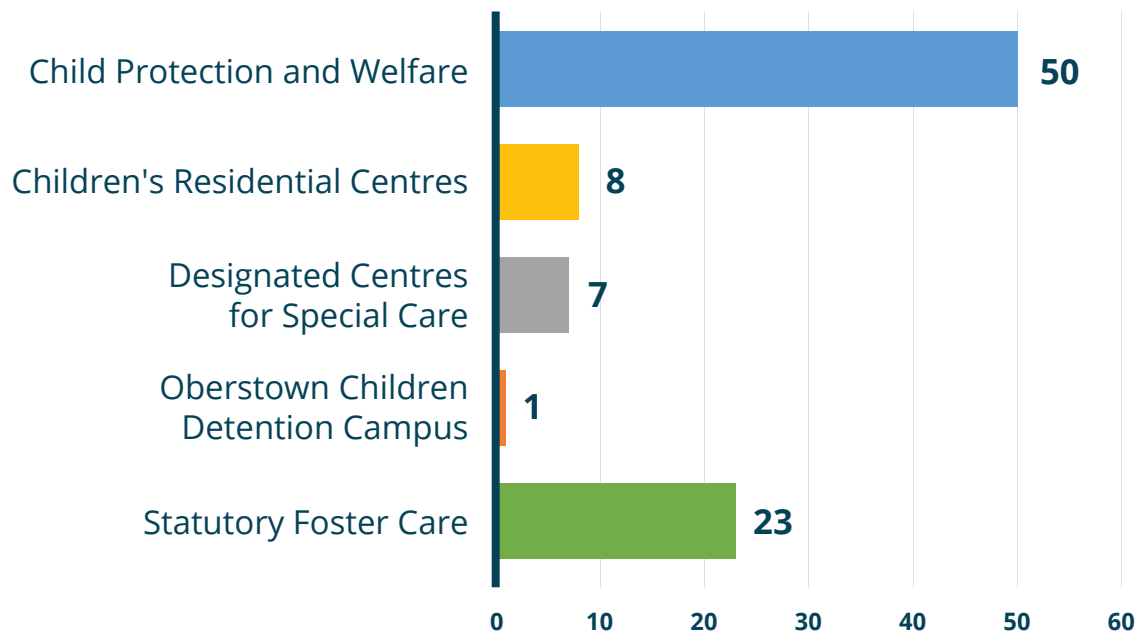
Figure A12: Percentage of announced and unannounced inspections of children's services in 2025



Feedback received from people about children's services in 2025

During 2025, we received 89 pieces of feedback about children's services that we inspect, monitor or regulate, representing a 22% increase on the number received in 2024.

Figure A13: Number of pieces of feedback received about children's services by type during 2025

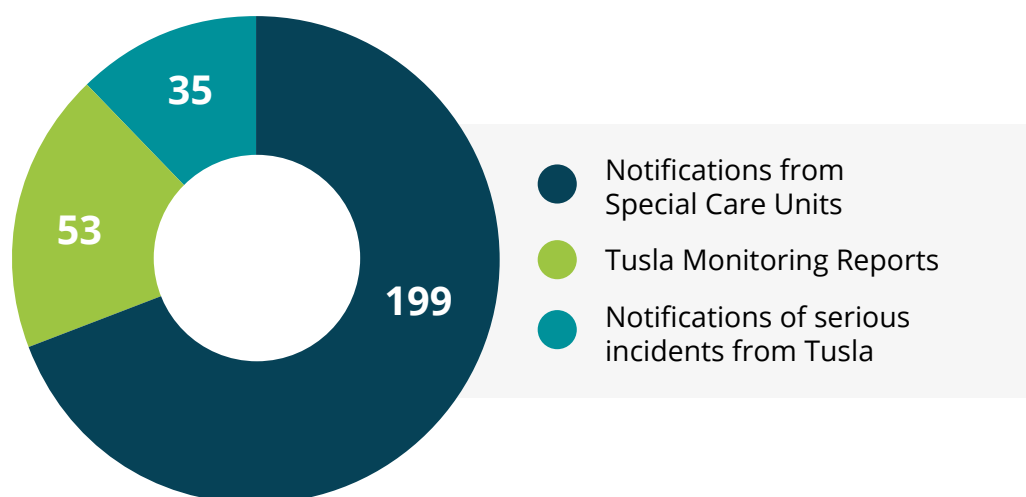


Information submitted to HIQA by providers of children's services and Tusla in 2025

During 2025, we received:

- ▶ 35 notifications of serious incidents including the deaths of children in care from Tusla, an increase of 10 on the 2024 figures. Tusla is required to notify HIQA of deaths and serious incidents involving children in care and children known to its child protection and welfare service. All information received was assessed and risk rated and used to inform our monitoring programme throughout the year.
- ▶ 53 monitoring reports from Tusla. These are reports provided by Tusla of its monitoring of non-statutory foster care services and statutory children's residential units.
- ▶ 199 notifications from special care units, which are required to notify us of key events in the centre, including 190 monitoring notifications and nine registration notifications.

Figure A14: Total number of pieces of information submitted relating to children's services by notification type in 2025



C. Regulation and Monitoring of Healthcare Services

Monitoring of Healthcare Services

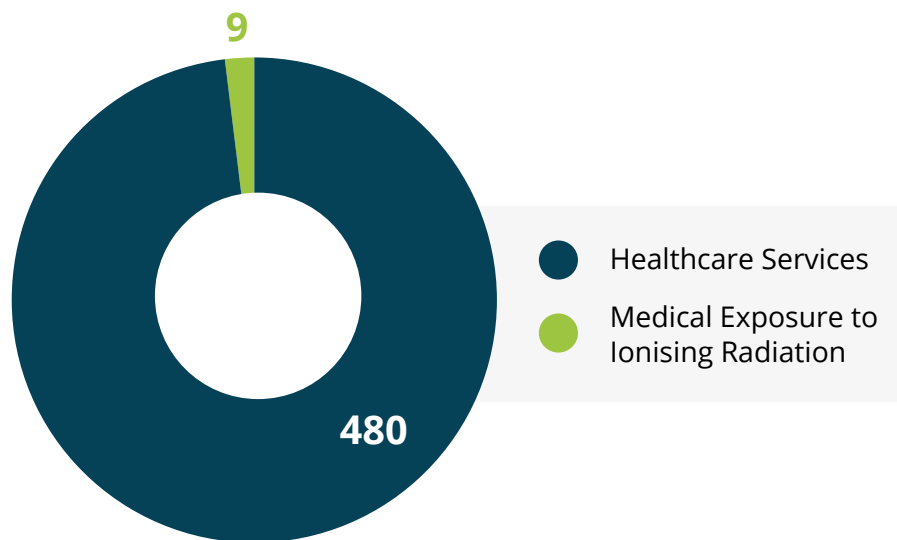
In 2025, HIQA conducted 60 inspections against the *National Standards for Safer Better Healthcare Version 2 - September 2024*. These included:

- ▶ 12 inspections of large public model 3 and model 4 hospitals which had an emergency department
- ▶ 5 inspections of specialist hospitals, for example orthopaedic, eye and ear and maternity
- ▶ 14 inspections of model 2 hospitals that do not have an emergency department
- ▶ 17 inspections of private hospitals
- ▶ 12 inspections in rehabilitation and community inpatient healthcare services.

Feedback received from people about healthcare services in 2025

Between 1 January and 31 December 2025, HIQA received 509 pieces of information on healthcare services under our remit, with 480 pieces relating to healthcare services and nine pieces relating to facilities providing medical exposure to ionising radiation. This represented a 56% increase from the previous year.

Figure A15: Total number of pieces of feedback received about healthcare services in 2025 compared



Notifications from health services under the Patient Safety Act

The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 commenced in September 2024, providing for mandatory open disclosure by health services providers of certain specified incidents (notifiable incidents), as well as requiring health services providers to notify HIQA (or other relevant regulators) when a notifiable incident occurs.

In 2025, HIQA received 144 notifiable incidents from health services providers. When the completed notification is received, the information is risk-assessed and HIQA uses this information as part of its monitoring of services.

Table A4: Breakdown of notifiable incidents received by incident type in 2025

Notifiable incident type	Total
1.10 An unanticipated and unintended stillborn child	19
1.11 An unanticipated and unintended perinatal death	6
1.12 An unintended death of a patient where the cause is believed to be suicide	5
1.5 Healthy patient undergoing elective surgery -unintended, unanticipated death	7
1.6 Unintended, unanticipated death directly related to any medical treatment	40
1.8 Patient death associated with a medication error	4
1.9 Unanticipated death of a woman while pregnant or within 42 days	2
2.1 (a) A baby who is referred for therapeutic hypothermia	61
Total	144

Regulation of medical exposure to ionising radiation

At 31 December 2025, HIQA was responsible for regulating 1,422 medical radiological facilities in Ireland which conduct medical exposure to ionising radiation. These include a range of services from large acute hospitals which deliver multiple types of medical radiological procedures to small dental practices.

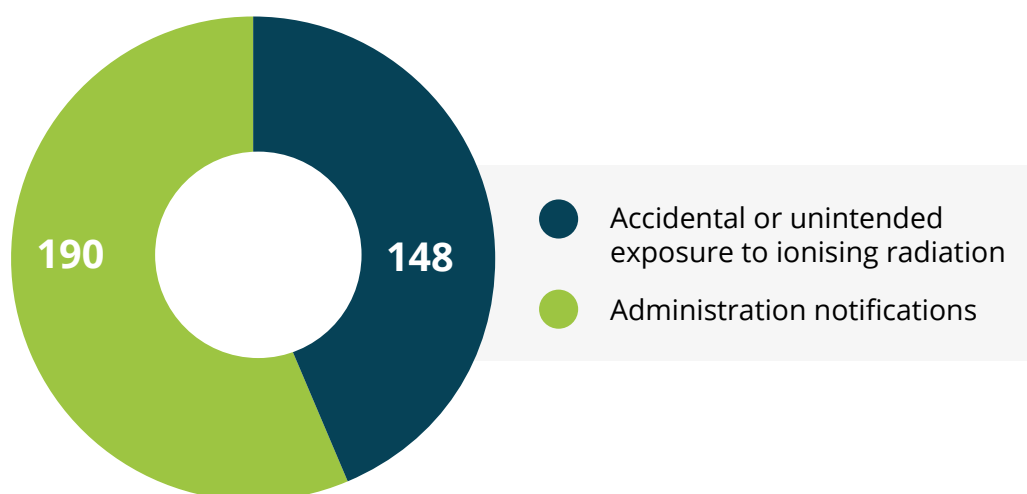
In 2025, we conducted 25 inspections of facilities providing medical radiological services. These inspections were prioritised as part of a risk-based approach to regulation. We received and assessed 46 self-assessment questionnaires for new service providers in 2025.

Medical exposure to ionising radiation notifications

We received 338 notifications in relation to medical exposure to ionising radiation in 2025. These included:

- ▶ 148 notifications of accidental and unintended exposures to ionising radiation. These notifications and subsequent follow-up reports were assessed, risk-rated and used to inform the inspection programme.
- ▶ 190 administrative notifications in relation to changes of service details, declarations of new undertakings and requests to access HIQA's online provider portal.

Figure A16: Notifications received in relation to medical exposure to ionising radiation in 2025



D. Monitoring of IPAS centres

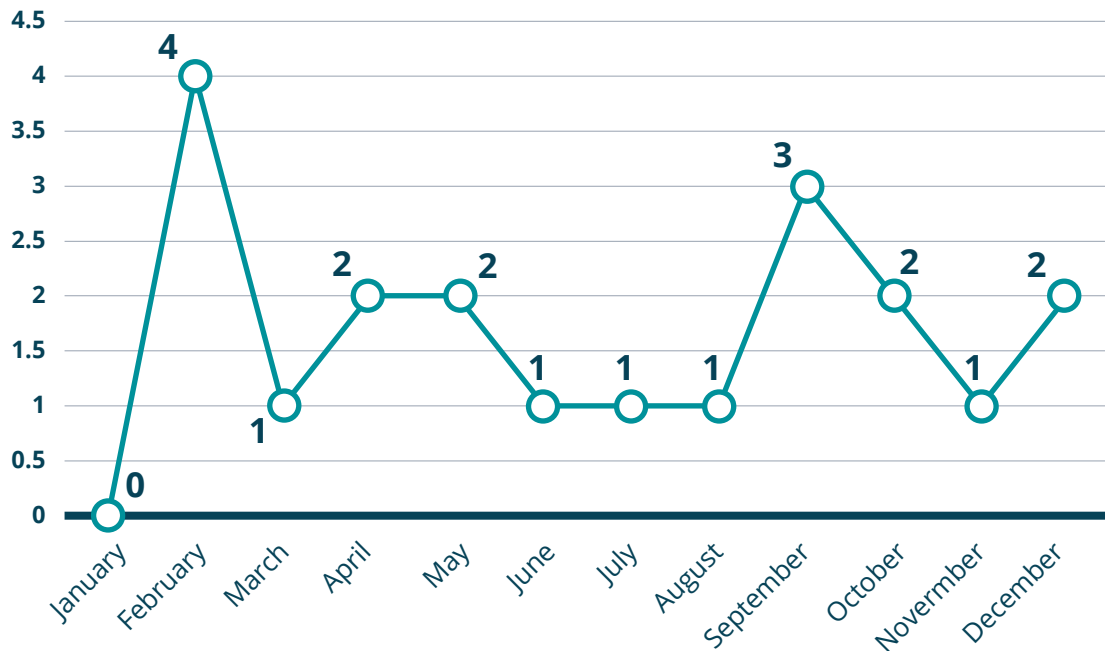
Between January and December 2025, HIQA conducted 37 inspections of 32 accommodation centres. Four accommodation centres had more than one inspection within this time frame. Of the 37 inspections conducted, 14 were announced with two days' notice and 23 were unannounced.

Feedback received from people about International Protection Accommodation Services in 2025

Throughout the year, we received a total of 20 pieces of feedback about accommodation centres under our remit.

People using services accounted for 75% (15) of the received about accommodation centres and a further 15% (3) were received from employees, while other sources (2) accounted for 10% of pieces of information received.

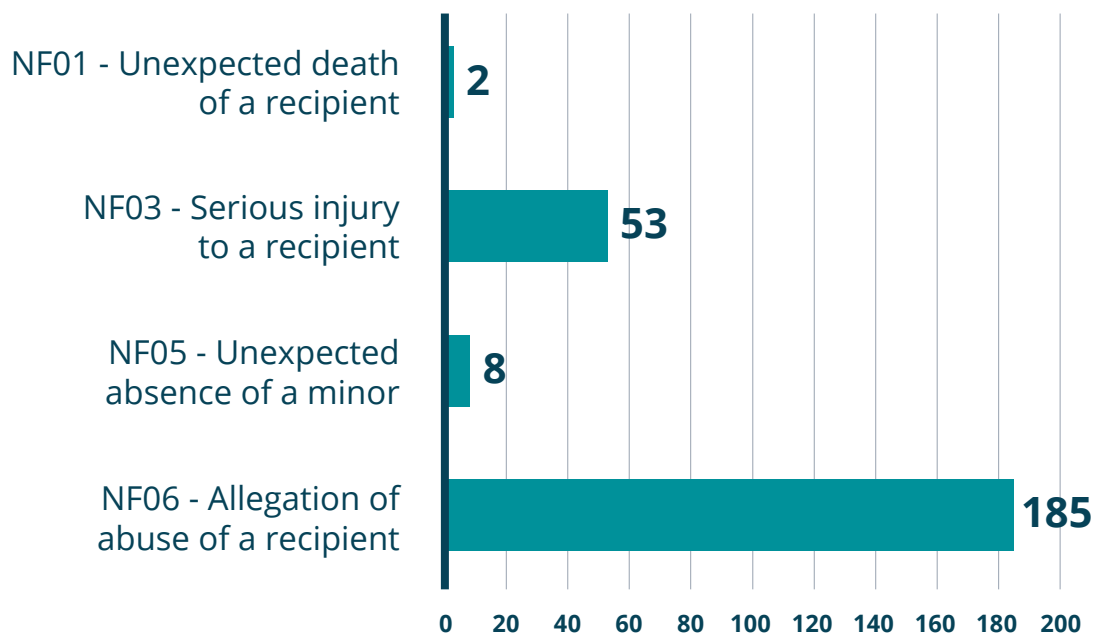
Figure A17: Number of pieces of feedback received about accommodation services per month in 2025



Information submitted to HIQA by providers of International Protection Accommodation Services in 2025

Between January and December 2025, 248 notifications were received from service providers.

Figure A18: Total number of pieces of information submitted relating to Accommodation Centres by notification type in 2025



E. Public Sector Equality and Human Rights Duty

HIQA is committed to promoting and protecting human rights and takes a human rights-based approach to the work it conducts in line with the Irish Human Rights and Equality Commission Act 2014.

During the planning process undertaken for the development of [Corporate Plan 2025-2027](#), we thoroughly assessed our current policies and practices to ensure they aligned with our commitment to promoting human rights, diversity and equality. This assessment involved a comprehensive review of our mission and values, along with an examination of human resources, diversity, and inclusion efforts, as well as the needs of people using services. We engaged with a variety of stakeholders to gather insights and ensure that diverse perspectives informed our approach, examining several key areas critical to upholding human rights and equality within our regulatory framework, including the regulation of health and social care services, monitoring and inspection practices, and efforts to promote quality and safety.

This identified opportunities for improvement and to align our strategic priorities to promote human rights, equality, and the integrity of health and social care services in Ireland:

- ▶ **Focus on outcomes:** We must prioritise measuring the real-world impact of our regulatory activities, shifting from merely tracking outputs to understanding how our actions promote human rights and safer and better care to improve care quality. We will continue to gather qualitative feedback from people using services to ensure their experiences inform our strategies.
- ▶ **Policy development:** There is a need to enhance our role in informing policy development by actively identifying systemic issues through our findings. By doing so, we can contribute to the formation of effective policies that align with human rights and equality standards.
- ▶ **Integration of human rights and equality in practices:** We should ensure that our regulatory frameworks continue to reflect commitment to human rights and equality. This involves integrating these principles into our monitoring and inspection practices to guarantee that all services uphold these values.
- ▶ **Workforce diversity and staff engagement:** Strengthening our focus on diversity within our workforce is essential to reflect the communities we serve. Recognising the importance of staff behaviours in upholding human rights and equality is key to fostering a supportive and inclusive internal culture. Engaging staff at all levels in meaningful discussions about human rights will ensure that these values are not only understood but actively integrated into our everyday actions. This approach will enrich our regulatory practices by embedding diverse perspectives into decision-making processes, enhancing our ability to deliver equitable outcomes.

As part of our Business Plan for 2025, we undertook actions to better support human rights and equality in the course of its work. These include implementing strategies that ensure diverse perspectives inform our work, actively engaging with stakeholders, and continuously improving our processes to uphold the integrity of the services we regulate. The below table provides a summary of the actions and progress on their implementation.

Table A5: Public Sector Equality and Human Rights Duty Actions

	Action	Status
1	Conduct a rights-based programme of inspection of designated centres for older people that includes regulatory inspections, risk-based inspections, focused inspections such as infection prevention and control and thematic inspections as well as other requirements deemed necessary by the Chief Inspector.	Completed
2	Conduct a rights-based programme of inspection of designated centres for people with a disability that includes regulatory inspections, risk-based inspections, focused inspections such as infection prevention and control and thematic inspections as well as other requirements deemed necessary by the Chief Inspector.	Completed
3	Conduct a rights-based programme of inspections of child protection and welfare services and foster care services against the <i>National Standards for the Protection and Welfare of Children</i> (2012) and the <i>National Standards for Foster Care</i> (2003), as appropriate, which includes monitoring inspections, risk-based inspections (provider approach) as well as other requirements deemed necessary by HIQA.	Completed
4	Conduct a rights-based programme of inspections of children in the care of Tusla which includes the routine monitoring of children's residential centres services and a focused programme of safeguarding inspections.	Completed
5	Carry out a rights-based approach inspection of the Oberstown Children Detention Campus against the Oberstown Children's Rights Framework.	Completed
6	Carry out a rights-based inspection of special care units against the Care and Welfare Regulations of Children in Special Care Units 2017.	Completed
7	Continue the development of a methodology for a rights-based thematic programme reviewing the use of restrictive practices within secure care settings.	Completed
8	Develop a model to further involve people using services in HIQA's work.	In progress
9	Continue to engage with the Department of Children, Disability and Equality in relation to areas of mutual interest such as home support for people with a disability	Completed
10	Examine extending the National Care Experience Programme to private hospitals to align with HIQA's broader remit under the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023	Completed
11	Deliver the National Maternity Experience Survey and publish the associated national and hospital reports.	Completed

	Action	Status
12	Develop and update guidance and tools to support implementation of national standards into practice, including guidance on communicating in plain English, guidance for foster care and an academic resource on a human-rights-based approach.	Completed
13	Support learning in the wider social care sector through the publication of academic papers.	Completed
14	Conduct evidence synthesis and provide evidence-based advice to inform national public health policy in a work plan to be agreed with the Department of Health.	Completed
15	Develop a methodology based on best practice to consult with children during inspection.	Completed
16	Deliver the 2025 Human Resources Programme of Work related to specific deliverables identified within the HIQA People and Culture Strategy 2025–2027.	Completed
17	Publish a HIQA People and Culture Strategy 2025–2027.	Completed
18	Deliver all of the actions required to meet our commitments under the Public Sector Climate Action Mandate.	Completed

F. Grants and Awards

HSE Library Open Access Awards

HIQA and the RCSI won the Integrated Services Award at the HSE Library Open Access Awards 2025 for the academic paper, *If it wasn't for us, there would be no data: stakeholders' perspectives on patient involvement in the use of health data in Ireland*. The paper explored how patients, healthcare professionals, researchers and industry view consent, data ownership and public involvement in shaping Ireland's health data future.

Study Within A Review (SWAR)

An Evidence Synthesis Ireland funded Study Within A Review investigating the sensitivity and completeness of search strategies built using a text-mining word frequency tool (PubReMiner) compared to current best practice search strategy building concluded in June 2025. This study has been submitted for publication.

High-risk Medical Devices

Partnering with the School of Pharmacy, University College Cork, we have commenced a project entitled "Implications of the EU Regulation on Health Technology Assessment (HTAR) for high-risk medical devices and in-vitro diagnostics (IVDs) in Ireland." This project, which was conducted with financial support of Research Ireland, through CÚRAM, the Research Ireland Centre for Medical Devices, aimed to explore how the implementation of HTAR will influence reimbursement and decision-making processes for high-risk medical devices and IVDs across EU/EEA countries. This research produced two outputs in 2025 on: 'Mapping current decision-making pathways and reimbursement processes for high-risk medical devices in EU/EEA member states and the UK: a scoping review and 'The Early Experiences of Health Technology Assessment Bodies in the Implementation of the European Union Health Technology Assessment Regulation for High-Risk Medical Devices: A Qualitative Study'. These were submitted to the Department of Health to inform policy on the implementation of HTAR.

Applied Partnership Award

HIQA was a co-applicant on the Health Research Board Applied Partnership Award led by Dr Barbara Clyne, RCSI, entitled Rapid Health Technology Assessments (rHTA) in Ireland: when do we need them? This research aimed to elaborate the definition and role of rapid HTAs in the context of informing national level policy, health service decisions and international practice. This award, which concluded in 2025, continues to inform ongoing discussions on how HTA products can be undertaken differently.

Strategic Agenda for Medical Ionising Radiation Applications

HIQA was a co-applicant on a European Commission Strategic Agenda for Medical Ionising Radiation Applications (SAMIRA) preparatory Joint Action, funded by the EU4Health programme. Known as the PriSMA project, the preparatory Joint Action involved collaboration with 18 other Competent Authorities to support and sustain implementation of developments in the area of quality and safety issues concerning medical applications of ionising radiation across all EU Member States. The PriSMA project concluded in 2025 and we will participate in the main Joint Action, known as AURORad (Advancing Unified RoadMap on implementation of the strategic agenda for medical ionising Radiation applications), which is due to commence in 2026.

G. Code of Governance

HIQA is committed to operating to the highest standards of corporate governance. Our Code of Governance describes HIQA's governance structure and clearly set out for all parties, the Board, staff or external stakeholders, the key roles, systems and procedures in HIQA.³

The Code of Governance forms part of HIQA's overall Governance and Assurance Framework and reflects the legislation under which it must function, Government guidelines and organisational arrangements and practices for directing and controlling the business of HIQA. Together with the Code of Business Conduct, it sets out the governance standards and systems by which HIQA operates. All staff and Board members have a duty to exercise good governance and comply with the provisions set out in these Codes and in HIQA's policies and procedures. The Code provides guidance to support the Board, senior managers and all staff in exercising good governance in the performance of their duties.

On an annual basis, the Board presents a Governance Statement and Board Members' Report and a Statement on Internal Control. These statements are published in conjunction with HIQA's financial accounts.

H. Freedom of Information

HIQA received 65 new Freedom of Information (FOI) requests in 2025 and carried over three requests from 2024. Further details on these requests are provided in the tables below.

Table 6: Breakdown of notifiable incidents received by incident type in 2025

2025 FOI Requests	
Brought forward from 2024	3
Received in 2025	65
Total Requests Handled	68
Brought forward into 2026	0
Closed in 2025	68

I. Complaints Management

HIQA welcomes comments, suggestions and complaints about its performance and conduct in the discharge of its statutory duties and responsibilities. This feedback may come from service providers, patients, carers, relatives, private and voluntary organisations, statutory agencies and the general public. HIQA regards complaints as opportunities to review practice, procedures and identify areas for improvement. We aim to resolve complaints in an effective and timely manner and use an early resolution approach to complaints wherever possible. During 2025, 15 complaints were received by HIQA, all of which were processed and managed in accordance with our policy.

³ The Code of Governance is published on the HIQA website.

J. Official Languages Act

HIQA continues to work towards fulfilling its obligations under the Official Languages Act 2003 and (Amendment) Act 2021.

In 2025, we continued to educate our staff on our responsibilities under the Acts and promote the use of the Irish language through our internal communications and events. In line with our requirements, we provided bilingual stationery, updated voicemails and automatic response emails to be bilingual, created bilingual posters and continued to advertise in both Irish and English. We responded to queries we received in Irish, in Irish. We also ensured that information about HIQA was made available in Irish on our website.

HIQA submitted its 2025 report on minimum advertising requirements to An Coimisinéir Teanga in line with the legislative timelines.

K. Protected Disclosures

As per section 22 of the Protected Disclosures Act 2014, HIQA has published an annual report outlining the number of protected disclosures received in 2025 and the action taken. No internal reports were received under the Protected Disclosures Policy and Procedure during 2025.

Notes

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Notes

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Health Information and Quality Authority

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For further information please contact:

Health Information and Quality Authority

Dublin Regional Office

George's Court

George's Lane

Smithfield

Dublin 7

D07 E98Y

Phone: +353 (0) 1 814 7400

Email: info@hiqa.ie

URL: www.hiqa.ie

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