Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of healthcare service provider:	St John's Hospital
Centre ID:	OSV-001071
Address of healthcare service:	St John's Square Limerick V94 H272
Type of Inspection:	Announced
Date of Inspection:	01/04/2026 and 02/04/2026
Inspection ID:	NS_0195

About the healthcare service

Model of hospital and profile

St John's Hospital, founded in 1780, is a Model 2S* acute general public voluntary hospital and is part of the Midwest Regional Health Area†. It is governed and managed independently by a hospital board, is a registered charity under the Charities Regulatory Authority and is a service provider to the Health Service Executive (HSE) under section 38 of the Health Act 2004. Services are delivered in line with an agreed Service Level agreement (SLA) with the HSE and Midwest Regional Health Area.

Services provided by the hospital include:

- general medical
- general surgery
- gynaecology
- urgent care centre incorporating a minor injuries unit, medical assessment unit and cardiac assessment unit
- diagnostic services
- outpatient care.

The following information outlines some additional data on the hospital.

Number of beds	89 inpatient beds 10 day case beds

*A Model 2 hospital typically provides the majority of hospital activity including extended day surgery, selected acute medicine, local injuries, and a range of diagnostic services. A Model 2S allows the hospital to perform intermediate surgery that requires an overnight stay

† The Regional Health Area HSE Midwest provides health and social care services to Clare, Limerick, and North Tipperary.

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare Version 2* 2024 (National Standards) as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare.

To prepare for this inspection, the inspectors[‡] reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publicly available information since last inspection.

During the inspection, inspectors:

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

About the inspection report

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

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

1. Capacity and capability of the service

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

2. Quality and safety of the service

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

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

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
01/04/2026	*12:30 – 18:00*	Kay Carlos	Geraldine Ryan Angela Moynihan Elaine Egan Caroline Hession
02/04/2026	*08:15 – 14:30*	Kay Carlos	Geraldine Ryan Angela Moynihan Elaine Egan Caroline Hession

Information about this inspection

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

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

The inspection team visited four clinical areas:

- Urgent Care Centre (medical assessment unit)
- First Floor (infection prevention and control ward)
- Top Floor (medical and surgical ward)
- Theatre department.

The inspection team spoke with representatives of the hospital's Executive Management Team, Quality and Risk, Human Resources and Clinical Staff.

Acknowledgements

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

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

On the day of inspection, inspectors spoke with a number of patients who reported positive experiences while in the hospital. Patients stated that their medications were explained to them and were aware of their treatment and discharge plan. They expressed positive reviews regarding the food and stated the call-bells were answered quickly.

In the clinical areas visited, patients were happy with the food they received, one patient described it as "the best I've had in a hospital" and another stated there is a "good choice" and if hungry they could "always get a cup of tea and a biscuit or sandwich". Staff were described as "lovely and friendly", patients informed inspectors that the call-bells were answered quickly and their privacy and dignity

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

was maintained. Patients who spoke with inspectors stated that they saw the doctors every day or most days and affirmed that their medications were explained to them and were aware of their discharge plans.

Inspectors observed staff speaking and interacting with patients and their families in a respectful manor. While patients were complimentary about the care they received, some indicated they were unsure how to make a formal complaint, although they said they would speak with nursing staff if needed. Overall, patients provided positive feedback regarding the care they received.

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes the standards related to workforce and use of resources. St John's hospital was found to be compliant in two national standards (5.5 and 5.8) and substantially compliant in two national standard (5.2 and 6.1). Key inspection findings leading to these judgments on compliance are described in the following sections.

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

Inspectors found that the hospital had formalised governance arrangements for assuring the delivery of safe, high-quality healthcare services which were integrated, clearly defined and formalised. Organisational charts detailed the management reporting structures and reporting arrangements for governance and oversight committees. The governance arrangements outlined to inspectors were consistent with those detailed in the hospital's organisational charts. The hospital was governed by a Board of Management (referred hereinafter as the Board) who delegated the operational management of the hospital to the Chief Executive Officer (CEO), who in-turn led the hospital's management structure.

Executive Management team

The Executive Management Team (EMT), chaired by the CEO, was responsible for the day-to-day management of the hospital. The terms of reference, dated for review August 2023, outlined the purpose of the team which included responsibility for implementation of hospital strategies and policies, and provide day-to-day

leadership for the hospital. Although the terms of reference specified the CEO as chair and meetings were to be held weekly, minutes submitted and reviewed noted meetings were held every two weeks and the chair was rotational. Membership included the Associate Clinical Director, Director of Nursing (DON) and Quality and Patient Safety manager. It was evident that minutes were reviewed and approved at each meeting and an action log with time-bound actions were assigned to a responsible person.

Board Risk, Quality and Safety Committee

The Board Risk Quality and Safety (RQS) Committee was responsible for overseeing the management of risk, quality and safety across the service. It was chaired by a board member, reported to the Board and the membership included the CEO, DON, a representative from the medical board, head of Quality, Risk and Patient Safety (QRPS) and the chief pharmacist. The terms of reference submitted was dated for review in January 2024. The committee met four times per year in line with the terms of reference and it aimed to provide an objective review in relation to clinical and non-clinical risks, drive quality improvement and provide a level of assurance to the board that there were appropriate governance structures and effective systems in place that covered all aspects of risk, quality and safety. There was a set agenda, and minutes from meetings reviewed evidenced reports from quality, risk and patient safety, the four key areas of known harm committees and the corporate risk register as discussion items. However, minutes reviewed were not actioned or time-bound. Minutes evidenced reports from the infection prevention and control, deteriorating patient and the transitions of care committees were presented by the DON. Following discussions with the DON and the CEO it was recognised that, as the DON did not always attend these three committees, it would be more efficient and effective for the chair from each committee to present their own reports to the board RQS committee. Hospital management stated they would take this into consideration.

As stated above, there was an infection prevention and control (IPC), drugs and therapeutics, deteriorating patient and transitions of care committee in place and all reported to the board RQS committee via quarterly reports. Each committee met in line with the terms of references and minutes of meetings reviewed indicated that actions were, in the main, assigned and time-bound. However, in relation to the drugs and therapeutics committee, actions were not time-bound.

St John's hospital Audit, Research and Innovation (ARI) Committee also reported to the board RQS committee and was responsible for ensuring that a structured process was in place to develop a reliable system for the collection of data. Chaired by a consultant, membership was multidisciplinary and the committee met quarterly. Actions from the meetings were assigned, however not always time-bound and it was unclear if they were followed up meeting to meeting.

St John's hospital performance management meeting

A service level agreement was in place with the University Hospital Limerick (UHL). The CEO had monthly performance meetings with the CEO for the Midwest Acute and Older Persons Services and regional management. There was no terms of reference submitted for this meeting; however, minutes of meetings reviewed evidenced hospital activity, staff training, finance and human resources as discussion items. A key performance metrics report was submitted to the CEO Midwest Acute and Older Persons Services monthly which detailed data relating to waiting times, performance, infection prevention and control, incidents, medication safety, deteriorating patient and staff training. Management and staff described an established and collaborative working relationship in place between local committees and their counterparts in UHL, for example the infection prevention and control team attended weekly meetings with UHL, representatives from St John's attended the group sepsis committee and there was regular contact with UHL regarding activity levels and bed availability.

Overall, inspectors found there were formal governance structures in place to support the delivery of high-quality, safe and reliable care. Based on documentation reviewed it was evident that a robust reporting structure was established for each governance committee to the board RQS and upwards to the Board. Notwithstanding the above:

- the terms of reference for the Board RQS and EMT committees required updating
- actions for some committee meetings were not always time-bound or actioned (Board RQS, Audit Research and Innovation).

Judgment: Substantially Compliant

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

Effective management arrangements were in place to support and promote the delivery of high quality, safe and reliable healthcare services. Hospital management had established committees to ensure effective arrangements were in place for the management of infection prevention and control, medication safety, safe transitions of care and the deteriorating patient.

Infection prevention and control

The Infection Prevention and Control Team (IPCT), lead locally by an Assistant Director of Nursing (ADON) in IPC, reported into the IPC committee. It was evident that they actively supported staff in implementing best practices in infection

prevention and control practices with the support from a consultant microbiologist and surveillance scientist from UHL. The consultant microbiologist from UHL had rotational sessional commitments to the hospital and inspectors were informed that the consultant visited quarterly to attend the IPC committee and participated in antimicrobial stewardship rounds. Staff informed inspectors and a committee organisational structure confirmed subcommittees such the hygiene services and decontamination committees reported into the IPCC. Reports from these committees along with antimicrobial stewardship (AMS), QRPS and occupational health reports were evidenced as items discussed at IPC committee meetings.

The IPC committee developed an annual infection prevention and control programme for 2026 outlining priorities for the year, including audit and surveillance, key performance indicators (KPIs) and education and training. Quarterly reports evidenced by inspectors were submitted to the Board RQS with updates on audits and surveillance, KPIs, quality improvement plans and risks.

AMS was overseen by the hospital's pharmacy department and the consultant microbiologist. While the position of AMS pharmacist was currently vacant, staff stated that recruitment was in progress and the pharmacy department was covering this service in the interim. The AMS programme was identified as items discussed in the minutes of the IPC and Drugs and Therapeutics Committee (DTC) and was included in the quarterly report from the DTC to the board RQS. Management also outlined membership of the Group Antimicrobial Stewardship Subcommittee included the AMS pharmacist from St John's hospitals.

A representative from the hospital's IPCT attended weekly meeting with the UHL hospitals' group IPCT. The terms of references outlined a multidisciplinary team, with representatives from Midwest acute hospitals. The minutes reviewed included updates on KPIs, multi-drug resistant organisms, outbreaks and building projects.

Medication safety

A chief pharmacist led the hospital's pharmacy service. The DTC, chaired by a consultant physician, was the overarching committee which oversaw the quality and safety of the pharmacy service, membership was multidisciplinary which included hospital management, risk management, nursing, medical and pharmacy staff. The committee reported to the Board RQS committee through formalised quarterly reports and items outlined in the report included audit results on KPIs. A Medication Safety Working group reported into the DTC, was chaired by the chief pharmacist and the membership was multidisciplinary. The purpose of this group was to monitor the progress of the medication safety programme, monitor trends in medication incidents and review and update policies, procedures and guidelines. A quarterly report was submitted to the DTC as evidenced in minutes of meetings reviewed.

Transitions of care

The hospital had a Transitions of Care (TOC) Committee to oversee the safe and effective transition of patients between care settings. The committee was chaired by an ADON, reported formally to the board RQS committee, the membership was multidisciplinary and met quarterly in line with the terms of reference reviewed. The quarterly reports submitted to the board RQS included delayed transfers of care figures, reasons for non-compliance with KPIs, incidents and risks relating to TOC.

The deteriorating patient

A Deteriorating Patients (DP) Committee was in place to provide oversight in implementation of the safeguarding and delivery of care to the deteriorating patient. Chaired by a consultant physician, the membership was multidisciplinary and it met quarterly in line with its terms of reference. The committee reported directly to the board RQS committee quarterly through a formalised report which highlighted results from audits on key performance indicators such as; compliance with Irish National Early Warning Score (INEWS)[§§] observation charts, INEWS escalation and response protocol and ISBAR[***] communication tool. Other items reported included, quality improvement initiatives in progress, updated policies, procedures, protocols and guidelines (PPPGs) and risks.

To summarise, evidence reviewed during the inspection indicated that there was effective oversight and management arrangements in place for infection prevention and control, medication safety, safe transitions of care and the deteriorating patient, which supported and promoted the delivery of high-quality, safe and reliable healthcare services.

Judgment: Compliant

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

Inspectors found there were systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services. Information on a range of measurements and data related to the quality and safety of the healthcare services was provided. This included metrics, hospital activity, patient-safety incidents, complaints, healthcare associated infections, workforce, training and quality and safety risks. Performance data was reviewed at relevant meetings and submitted to the board RQS committee quarterly

[§§] INEWS is an early warning system to assist staff to recognise and respond to clinical deterioration.
[***] ISBAR communication tool stands for Identify, Situation, Background, Assessment and Recommendation. The tool is a structured framework which outlines the information to be transferred.

as the oversight and governance committee and to the CEO for the Midwest Acute and Older Persons Services through the monthly key performance metrics report.

Risk management

Risk management structures were in place and aligned with the HSE's Risk Management Framework policy. The head of QRPS chaired the local Quality and Safety Committee and reported incidents, risks, complaints and compliments to the board RQS committee via a quarterly report. The management of reported risks relating to the four areas of known harm; infection prevention and control, medication safety, deteriorating patient and transitions of care are discussed further in national standard 3.1.

The management of the corporate risk register was overseen by the board RQS committee. Agenda and minutes of the meetings reviewed reflected that the corporate risk register was included as a discussion item, with any changes agreed at the meeting recorded in the minutes. The corporate risk registered reviewed, documented risks in relation to the four known areas of harm with mitigating actions and controls in place. Inspectors reviewed a recent report on the corporate risk register which outlined the current number of open risks, associated risk ratings and existing control measures in place.

Incident management

Inspectors found that there were processes in place to identify and manage patient-safety incidents. Patient-safety incidents were recorded on the National Incident Management System (NIMS[†††]). This is discussed further under national standard 3.3.

There was a Serious Incident Management Team (SIMT) in place to oversee the management, review and investigations of all category 1 and category 2 incidents including Serious Reportable Events (SREs). The SIMT was chaired by the CEO and membership was multi-disciplinary. As outlined in the terms of reference, the team met every two months with additional meetings as required and emphasised meetings were to convene within 24 to 72 hours of notification of a serious incident. A log of incidents was maintained and discussed at the meetings which evidenced the completion of preliminary assessments, if further reviews were required and key findings and recommendations made following the review.

Audit activity

[†††] The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

The Audit, Research and Innovation (ARI) Committee was responsible for ensuring reliable systems were in place for the collection of data. An annual audit plan was in place and the 2026 audit schedule evidenced planned audits across multi-disciplinary staff. The audit plan outlined the lead person responsible, methodology and expected completion date. Audits relating to the four key areas of known harm were included in the schedule.

Reports submitted evidenced audits were completed on medication safety, hand hygiene, environmental, INEWS, ISBAR, sepsis, delayed transitions of care, average lengths of stay and predicted date of discharge. Quality improvement plans with assigned time-bound actions were was also observed by inspectors.

Feedback from service users

Feedback from service users was via the HSE's Your Service Your Say (YSYS)[‡‡‡] and oversight was through the quality and safety department. A complaints and compliments report for 2025 identified the number of formal complaints received per month, broken down per category and department and comparisons with 2024 data. Quality improvement initiatives were highlighted and the number of compliments, with associated common themes such as 'professional and compassionate', 'high standard of food' and 'cleanliness' was also included in the report.

Overall, inspectors found the hospital had effective monitoring and evaluating arrangements in place to improve the quality and safety of the healthcare service.

Judgment: Compliant

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

Inspectors found that the hospital had effective workforce arrangement in place to support the delivery of safe, effective and reliable care.

The hospital had an onsite Human Resources (HR) department, who reported to the CEO in St John's hospital and to the Head of Human Resources in University Hospital Limerick in relation to the service level agreement. Minutes of meetings reviewed indicated that HR and mandatory training were standing agenda items on the hospital's EMT's fortnightly meetings and the monthly hospital performance meetings held with management from St John's hospital and the CEO for the Midwest Acute and Older Persons Service. Items discussed at these meetings included whole-time equivalent (WTE) numbers, absenteeism, performance

[‡‡‡] Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints. Dublin: Health Service Executive. 2017. Available online from https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf

achievement rates and compliance with mandatory training. Minutes of meeting from February 2026 recorded the absenteeism rate at 4.9% which was confirmed during discussions with management, stating the rate was 'around 5%' over the past number of months (HSE target of 4% or less). Management explained that since the introduction of an electronic system to record back-to-work interviews, a decline in absenteeism was observed.

Workforce

Management affirmed that the hospital was approved for 405 WTEs and was currently fully staffed to that allowance. An additional 7.5 WTEs had been approved under the HSE Framework for Safe Nurse Staffing and Skill Mix[§§§], however management stated that staffing constraints under the HSE Pay and Numbers Strategy[****] was a risk and was included in the hospital's corporate risk register.

There were 106.23 WTE approved and filled staff nursing posts which did not include the 7.5 WTEs approved under the safe nurse staffing and skill mix framework. 38 WTE healthcare assistance (HCAs) supported the nursing staff along with 4.63 WTE multi-task attendants and 1.21 WTE household staff. Inspectors were informed that shortfalls in staffing was managed through redeployment, stating that staff would be moved to the areas of greatest need. Agency staff were also used equating to approximately 60 shifts per week which included, HCAs, staff nurses and patients requiring 1:1 care. Rosters reviewed and discussions with staff in clinical areas identified no deficits in staffing.

Cleaning throughout the hospital was provided by an external company. Discussions with staff and management highlighted there was no cleaning personnel on duty out of hours. This was considered a significant risk for the hospital and was reported on the IPC and clinical areas' risk registers. This was accentuated to hospital management as an area to be addressed; a letter was submitted by the hospital to HIQA following the inspection confirming that a schedule for cleaning out of hours was being progressed.

Inspectors were informed that the hospital was approved for 6.0 WTE consultants, with two on the specialist division of the register with the Irish Medical Council (IMC) and on permanent contracts. Four consultants were on temporary contracts of which two were approved and two were awaiting approval by the Consultant Applications Advisory Committee. There was an associate clinical director in post since December 2025, management stated the previous clinical director had vacated the post in September 2025. Twenty nine WTE non-consultant hospital doctors (NCHDs) were in post at the time of inspection (17 WTEs at registrar grade, 10 WTEs at senior house

§§§ Framework for Safe Nurse Staffing and Skill Mix

**** The HSE Pay and Numbers Strategy (PNS) 2025 focuses on controlled workforce growth, targeting a maximum of 133,306 WTE (Whole Time Equivalent) staff—a net increase of 3,553.

officer grade (SHO) and two at intern grade which provided 24/7 medical cover for the hospital, fulfilling one in four weekend rotas.

The hospital was funded for 6.0 WTE pharmacists. On the day of inspection there were 5.2 WTEs in post and 1 WTE at offer stage of the recruitment process. Staff described to inspectors that while there were challenges due to staffing deficits, they had fulfilled targets such as medication reconciliation completion on 80% of admissions to the hospital in a 24 hour period.

Staff education and training

A centralised system to monitor and record training was being rolled out at the time of the inspection, with the QRPS department proposed to have oversight of same. Inspectors were informed that clinical areas had not started using the system as yet, however there was a plan in place to commence same. Mandatory training for nursing and HCAs was overseen by clinical nurse managers. A review of training records submitted showed varying levels of compliance across staff groups.

The hospital's overall training records showed mandatory training was high for nursing staff in hand hygiene, standard and transmission-based precautions, INEWS, sepsis management, basic life support (BLS) and medication safety. However, individual clinical areas reported varying levels of compliance for nursing staff, with

- hand hygiene ranging from 77% to 100%,
- sepsis management 77% to 89%,
- INEWS 87% to 100%
- BLS 77% to 100%.

High levels of compliance was recorded across each of the clinical areas visited in relation to medication safety, 96% to 100%.

Although there were no paediatric admissions to the inpatient areas within the hospital, children 5-years and older are seen in the minor injuries unit. Paediatric Early Warning Score (PEWS) training was delivered to nursing staff with attendance reported at 89%.

Record of NCHDs' training across the hospital also showed good levels of compliance with hand hygiene, medication safety and sepsis management, however BLS attendance was recorded at 71% and INEWS at 69%.

Attendance records for HCAs in relation to hand hygiene and standard and transmission based precautions was 91% however BLS was recorded at 73%.

Compliance records among HCSP staff was consistently good (hand hygiene 97%, standard and transmission-based precautions 92% to 100% and BLS 100%).

Children's first training across the disciplines varied from 88% for HCAs, 89% nursing staff, 90% NCHDs and 97% for HSCPs. Attendance at children's first training for staff in the urgent care centre, where children are seen for minor injuries, was 100%.

Advanced cardiac life support training was delivered to members of the cardiac arrest team and senior staff nurses. Compliance levels for nursing staff was 92% and NCHDs 79%.

To summarise, there was evidence that hospital management were planning, organising and managing the workforce to support the delivery of high-quality, safe and reliable healthcare. However, management needs to ensure attendance with mandatory and essential training is improved among staff for example in: hand hygiene, sepsis management and INEWS.

Judgment: Substantially Compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred. St John's hospital was found to be compliant in two national standards (1.8 and 3.3), substantially compliant in two national standards (1.6 and 3.1) and partially compliant in one national standard (2.7). The following sections describe key inspection findings leading to these judgements.

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

It was evident from observations and discussions with patients that there was a person-centred approach to care. A safeguarding statement was visible in the main reception. Communication with patients was observed to be kind and compassionate, a healthcare assistant was observed assisting patients at meal times and when asked for additional snacks, same was provided. Patients conveyed that their dignity and privacy was maintained, for example, when asked if privacy curtains were used for personal care a number of patients stated "oh yes always." Staff were observed knocking on a toilet door to enquire if the patient

required assistance. Patients expressed positive feedback in relation to menu choices and the quality of the food provided.

Closed Circuit TV (CCTV) was in operation in the reception and other public areas within the medical assessment unit. Inspectors observed that appropriate signage was in place notifying patients and visitors on the use of CCTV.

The physical environment did not always promote privacy and autonomy, for example, bed spacing in multi-occupancy rooms was not in line with national guidance, however privacy curtains were used. To promote the patients' dignity, privacy and autonomy in the medical assessment unit (MAU), inspectors were informed that patients were brought into the office for conversations. It was noted that the cubicles in the MAU did not have a call-bell system in use and this was highlighted at the time of the inspection to the clinical nurse manager. In the other clinical areas visited call-bells were available and noted to be answered promptly.

Toilet and bathroom facilities were limited in some of the wards visited, for example the top floor accommodated 35 patients who, had access to six toilets and five showers. There were no single rooms with en-suites available on this floor.

Patients in the MAU, which had capacity for seven patients, had access to one toilet. However, when asked, patients expressed no concerns in accessing toilet facilities when required with one patient stating "they are always free". The first floor, the designated ward to care for patients requiring transmission-based precautions for infection control reasons, was a 34 bedded ward with 10 single rooms all with en-suite facilities and had 6 additional toilet and shower facilities throughout the ward. Infrastructure is discussed further under national standard 2.7.

Inspectors found that patients' personal information was not always protected. Information boards were noted above some patient beds with personal information displayed. This was brought to the attention of the CNM to be addressed. Inspectors found the hospital was compliant with the handling and storage of healthcare records in clinical areas.

Overall, there was evidence that hospital management and staff at the hospital were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the hospital. However information boards above patients' beds containing personal information needs to be reviewed.

Judgment: Substantially Compliant

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

Inspectors found that there were systems and processes in place to respond to formal and informal complaints. It was evident from meetings with staff that all were committed to ensuring complaints and concerns were responded to promptly, openly and effectively, and encouraged patients to provide feedback or raise concerns.

Point-of-contact resolution was encouraged and supported by management. Staff stated that they endeavoured to resolve complaints at the point of care. All complaints were documented on a point of care resolution form, a log of which was kept in clinical areas as evidenced by inspectors. The head of QRPS stated they reviewed the log on a regular basis.

The head of QRPS was the designated complaints officers responsible for managing formal complaints. Their role included acknowledging the complaint, assigning a suitable person to investigate the complaint, coordinating the investigation and communicating the findings with the complainant. Minutes of meetings reviewed noted that complaints were discussed fortnightly at the EMT meetings. A quarterly report compliled by the head of QRPS was sent to the board RQS committee. This report outlined the number of formal complaints received, broken down into sub categories and number of complaints closed out.

Management provided a complaints and compliments report for 2025 and an associated quality improvement plan. The report documented 29 formal complaints, with quarter four showing 100% compliance with resolution within 30 working day as per the HSE's timeframe. The report broke down complaints into subcategories and compared trends against 2024 figures. The report identified that the number of complaints reported in 2025 was notably lower than 2024. Communication was acknowledged as a common theme and a quality improvement action plan was developed in response to same. Recommendations and actions included staff training on effective communication, reviewing the current process in relation to patient and family call logs and updating hospital patient information leaflets as areas of focus. Actions had a target date for completion and the status of each action was clear.

Although some staff in clinical areas stated they did not receive tracking and trending on complaints, the head of QRPS stated they circulated trend reports to the clinical areas via email. Staff who spoke with inspectors were aware that communication was a common theme in complaints received.

Complaints management training was provided and attendance records showed a compliance rate of 71% for nursing staff. Although there was no Patient Advocacy

and Liaison Service[††††] (PALS) in the hospital, staff stated that access to the PALS officer in UHL or national services were available for patients. Patients who spoke with inspectors were not aware of the HSE's 'Your Service Your Say' (YSYS)[‡‡‡‡] to provide feedback on the service, however affirmed they would speak to a staff member if they had a concern or complaint to make. Information leaflets on YSYS and patient advocacy services were available and feedback boxes were observed throughout the hospital. A Quick Response (QR) code linking to YSYS feedback was evidenced on patient information leaflets such as 'the emergency hospital transfer (protocol 37)' and the 'HSE Midwest advice for when you leave our hospital'.

In summary, there was evidence that the hospital had effective systems and processes in place to respond to complaints and feedback.

Judgment: Compliant

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

St John's Hospital was founded in 1780, and despite efforts to address issues, the original layout and ageing infrastructure are increasingly incompatible with modern healthcare standards. Examples of this included narrow corridors, restricted space in patient areas and other clinical areas and limited toilet facilities available for patient use. Management formally acknowledged the identified risks and demonstrated a clear commitment to addressing same by outlining plans for a 78 bed new build which was at stage one of planning, with the expectation that works will begin in 2027.

Inspectors visited four clinical areas, the Top Floor, First Floor, Medical Assessment Unit and the Theatre department, and found that the physical environment across all clinical areas required attention.

The top floor, a 35 bedded ward with four and six-bedded bays, accommodated surgical and medical patients, there were no single rooms on this floor. Six toilets and five showers were available for 35 patients. Although the environment was found to be clean, infrastructural issues noted included; walls requiring painting and general wear and tear. The physical bed spacing was less than one metre apart, with staff reporting the need to move beds to provide personal care for patients.

[††††] The Patient Advocacy and Liaison Service (PALS) team acts as a point of contact between patients, their families or carers and the hospital to assist in addressing concerns about any aspect of care or service in the hospital.
[‡‡‡‡] Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints. Dublin: Health Service Executive. 2017. Available online from https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf

Inspectors were informed that patients requiring transmission-based precautions were transferred to the first floor and accommodated in single or co-hort isolation rooms. Risks identified are discussed under national standard 3.1.

The first floor was a 34 bedded ward with 10 single rooms with en-suite facilities, and the remainder of the ward made up of two and five-bedded bays. This ward was designated to care for patients requiring transmission-based precautions. The ward was found to be clean, however the corridors were found to be narrow, physical distancing between beds in some of the multi-occupancy bays were less than one metre apart and some areas required painting.

The MAU accommodated six trolleys and two chairs. Staff stated the unit had capacity to review up to 14 patients on a week day. The waiting area had nine chairs, there was one toilet available for patient use and two designated bays to care for patients requiring transmission-based precautions. There were no single rooms in the unit. Overall the environment was found to be clean, however the space was found to be restricted within the whole unit. Piped oxygen was available in all bays, however call bells were available in the isolation bays only. This was brought to the attention of management.

Inspectors visited the theatre department and found it to be clean, however walls were marked, paint was chipped in some areas and the space was restricted throughout. There was a track and trace system in use for equipment used during surgery and there was evidence of segregating clean and used instruments within the department; however, the design of the facility did not facilitate unidirectional work flow for clean and used instruments, this was recorded on the local risk register and mitigating actions were in place.

Cleaning throughout the hospital was provided for by an external cleaning company. The environment was found to be clean, cleaning schedules were signed and up-to-date and privacy curtains were dated when last put up. It was highlighted to inspectors that there was no cleaning staff on duty from 10.00pm to 8.00am. This was discussed with the EMT and the IPC team. Following inspection, the CEO wrote to HIQA stating that a plan to implement cleaning staff at night was being progressed.

Inspectors found that the hospital followed correct segregation, storage and management of waste, linen and hazardous materials such as cleaning chemicals.

Appropriate isolation signage was used on entrances to rooms where patients required transmission-based precautions and there was personal protective equipment available for staff throughout the clinical areas.

Hand hygiene signage was visible and alcohol based hand rub was available throughout the hospital. There were a number of clinical hand-wash basins found to

be non-compliant with HBN[§§§§] standards and one sluice room on the first floor had no clinical hand-wash basin. Management acknowledged the number of non-compliant hand-wash basins and had a plan to expedite a sink replacement programme, the status of which will be followed up on the next inspection.

In summary, inspectors found that while management and staff of St John's Hospital (est. 1780) maintained high standards of cleanliness:

- the 18th-century infrastructure continued to present challenges to infection prevention and control and operational safety due to restricted space throughout (limited bed spacing, narrow corridors insufficient number of toilets)
- there was general wear and tear of infrastructure and flooring
- non-compliant hand-wash basins
- call-bells not available to patients accommodated in some bays in the MAU.

Judgment: Partially Compliant

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

The hospital had systems and processes in place to identify, evaluate and manage potential risks to people using the service.

Risk management

Each clinical area visited had their own departmental risk register and the CNM was responsible for maintaining and updating same. The risk registers reviewed, noted controls and mitigating actions were clearly documented for each risk. Examples of risks included infection prevention and control, medication safety and the deteriorating patient. The head of QRPS reviewed the local risk registers and gave advice and support to the department managers on completing risk assessments and this was confirmed by staff.

A local Quality and Safety Committee was responsible for governance and oversight of risks. Membership included heads of departments and services, the associate clinical director, staff representative from clinical areas and the QRPS department. They met every six weeks and produced a quarterly report for the board RQS committee. Risk assessments and risk registers were included as an agenda item, however, from minutes submitted, it was unclear if risk assessments were discussed at this meeting. A copy of minutes from the Urgent Care Centre CNM and ADON meeting reviewed, noted departmental risks were included as

[§§§§] HBN Health building notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities.

items for discussion in the agenda.

Departmental risk registers were reviewed quarterly by the CNM and head of quality risk and patient safety. Staff outlined that risks rated 15 or higher were escalated to the EMT. Once discussed with members of the EMT, an agreement regarding the decision to include the risk onto the corporate risk register or reduce the risk rating was made. The decision to close risks lay with the CEO and EMT.

The management of the corporate risk register was overseen by the board RQS committee. This was discussed under national standard 5.8.

Infection prevention and control

As discussed under national standard 2.7, the ageing infrastructure posed a significant risk to IPC practices. Bed spacing was less than one metre apart, there were limited numbers of isolation rooms and toilet facilities available, a number of clinical hand-wash basins were not compliant with HBN standards, and there was no cleaning staff on duty out of hours. These concerns were included on the corporate and departmental risk registers and there were measures in place to reduce the risk of spread of infection. A biological agents risk assessment submitted outlined measures to reduce the spread of infection when caring for patients requiring droplet, contact and airborne precautions.

There was a dirty utility room available in the MAU, however staff described the practice of emptying contents of a commode in a toilet prior to placing it into a bedpan washer. This was not in line with best practice or hospital infection prevention and control guidelines. A risk assessment was completed on this practice with control measure and actions identified.

Staff had access to an electronic alert system which linked to UHL that identified patients with a previous history of a multi-drug resistant organism (MDRO). Transfer letters to and from St John's hospital had a patient's MDRO status included in the forms. Inspectors were informed that the IPC team visited clinical areas daily, apart from weekends, to discuss patients requiring transmission-based precautions. Staff stated that NCHDs could contact microbiology in UHL for advice when required. Patients were screened for MDROs on admission and compliance with screening was audited by the IPCT. Results of audits completed for quarter one 2026, as evidenced by an inspector, showed compliance rates of >90%.

An outbreak reported submitted, evidenced closure of a recent norovirus outbreak. The report outlined regular outbreak meetings held with appropriate staff, control measures put in place, lessons learned and recommendations made following the outbreak. Staff in the clinical were aware of same.

Medication safety

The medication safety working group were responsible for monitoring the progress of the medication safety programme, provide education and training to staff, review PPPGs, complete audits and implement recommendations in relation to medication safety.

A clinical pharmacist was available Monday to Friday for clinical areas. From a sample of patient charts reviewed, it was evident that medication reconciliation was completed on all new hospital admissions and compliance with this was audited by the pharmacy department. A sample of audits reviewed demonstrated that compliance with medication reconciliation within 24 hours of admission was between 86% and 100%. The clinical areas visited had a list of high-risk medications and sound-alike-look-alike drugs (SALADs). Risk reduction strategies were observed which included colour coded boxes for different strength medications, safe storage and use of insulin, opioids and potassium. Staff had access to medication information on an e-formulary, QR codes for access were witnessed in treatment rooms in clinical areas. Guidelines on high risk medications and medication reconciliation were available to pharmacy staff only; inspectors were informed that there was a plan to add these guidelines to the intranet to allow nursing staff access. Out-of-hours access to pharmacy was via the ADON on duty.

As outlined in national standard 5.5, the role of AMS pharmacist was currently vacant, this was included in the pharmacy risk register. The shortage of ready diluted potassium infusion bags and shortage of medications was also included in the risk register. Control measures and mitigating actions were in place with a timeframe for review.

A medication safety programme 2024 – 2026 submitted outlined a number of actions to be completed including updating risk reduction strategies, reviewing medication incidents and reducing administration errors and omissions. Key performance indicators such as medication reconciliation on admission and a detailed medication safety education plan was also included in the strategy.

<u>Deteriorating patient</u>

The hospital used the INEWS to record patient observations which included an escalation and response protocol. Staff were knowledgeable about the protocol, and a number of healthcare records reviewed by inspectors noted compliance with completing INEWS entries and the escalation process. The ISBAR communication tool was evidenced and an updated version of the Sepsis 6***** care bundle was available for staff. Inspectors were informed that patients requiring enhanced care

***** Sepsis 6 care bundle, components are blood cultures, check full blood count and lactate, IV fluid challenge, IV antibiotics, monitors urine output and give oxygen

were transferred to UHL. Risk assessments completed on the deteriorating patient outlined the existing control measure and actions in place.

National clinical guidelines on the early warning score and sepsis management were available for staff. Inspectors also found that there were a number local guidelines for managing the deteriorating patients available, which included transferring the patient to UHL and patients self-presenting to the hospital out-of-hours. Audits were completed on sepsis, INEWS charts and the use of ISBAR communication tools with quality improvement plans to accompany same.

Emergency equipment such as a resuscitation trolley and an automated external defibrillator (AED) with evidence of safety checks carried out was observed.

Transitions of care

The hospital had a system, supported by hospital policy, to support safe discharge and transfer of patients, internally and externally, to and from the hospital during and outside of core working hours. There was a Transitions of Care Committee that met quarterly and predicted date of discharge (PDD), delayed transfers of care (DTOC), incidents and audits were discussed, as evidenced in minutes submitted. An acting CNM 3 was responsible for the day-to-day management of bed flow. Management stated that the CNM 3 attended a local placement forum with community nursing homes to discuss patients waiting on transitions to long term care. Management outlined that the operational ADON from night duty collated information on beds and sent it to the CNM 3, a site activity report was then sent to UHL each day. Staff described a number of huddles throughout the day to discuss patient updates including planned admissions, this was evidenced by inspectors that attended same. Policies and procedures were in place which included admission and exclusion criteria and referral pathways.

Management stated that patients were accepted to the hospital from UHL following a call from a consultant or bed management in UHL. Transfer forms and doctors letters were used for all admissions and discharges and this was evident from a sample of patient charts reviewed. Communication to other healthcare facilities was completed using the ISBAR communication tool and it was noted that checklists were in place when transferring patients using the protocol 37†††††† or emergency transfer pathways. Delayed transfers of care was a key performance indicator and figures were sent daily to the HSE.

Hospital data provided details that the largest number of referrals to the hospital was from UHL. There were a small number of DTOC on day one of the inspection. While the reasons for the DTOC were not formally tracked, staff in clinical areas described reasons for delays included patients waiting for long term care or respite. Inspectors were informed that there was a plan to introduce formal tracking for DTOC in April 2026.

An Urgent Care Centre (UCC) end of year report 2025 reviewed outlined activity within the MAU and Injury Unit. The MAU received an average of 14 new patients per day from General Practitioners (GPs) and the UHL emergency department. The local injury unit reported activity levels increased in 2025 from 2024. The total number of attendances per month from January to December 2025 was between 1,302 and 1,895, with May showing the highest attendance rate, reporting 100 patients treated in a single day, highlighting an increase in service demand. The cardiac monitoring and diagnostic services saw an expansion of services in 2025. Examples of goal and actions plans included in the report identified infrastructure development, expanding virtual MAU services and improving referral pathways to streamline patient care as areas of focus in 2026.

In the operating theatre department the patient pathway was evidenced and discussed with staff. The patient flow within the department followed a standardised process in line with national guidelines, from the pre-operative preparation and assessment, inside the operating theatre, and out to the post-operative recovery room, as observed by an inspector. Staff completed key safety features using hospital approved safety checklists at each stage of the patient journey in theatre and included, for example, patient identification, site verification and consent. Staff demonstrated their knowledge of safe processes which underpinned a safe patient journey and increased overall theatre effectiveness.

A number of transitions of care incidents discussed during the interview with the TOC team did not have associated risk assessments completed. The TOC risk register was subsequently updated during the course of the inspection with associated risk assessments submitted to inspectors. These risks included; communication, service needs and intra hospital transfer documentation.

Policies, procedures, protocols and guidelines

Staff had electronic access to a number of PPPGs in relation to the four key areas of known harm and were mostly up-to-date. However as discussed above, some medication management policies such as medication reconciliation and the policy on high alert medications were not available to nursing staff. Inspectors were informed that a working group was re-established in recent months to oversee and approve PPPGs, prior to this service managers, clinical leads or hospital committees approved same.

Overall, the hospital had systems and process in place to identify and manage potential risk to people using the service. Notwithstanding the ageing infrastructure of the building, the process of emptying contents of a commode in a toilet prior to placing it in a bedpan washer was not in-line with local and national guidelines.

[†††††] Protocol 37 is used for emergency inter-hospital transfers when a patient requires a time-critical intervention that cannot be provided at the referring hospital

Judgment: Substantially Compliant

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

The hospital had systems in place to identify, report, manage and respond to patient-safety incidents which was supported by a local policy on incident management and aligned with the HSE Incident Management Framework 2020. Incidents were reported on an electronic reporting system which uploaded incident on the National Incident Management System (NIMS) and staff who spoke with inspectors were knowledgeable about how to report patient safety incidents. The CNMs in clinical areas reported that they had oversight of incidents reported and discussed learnings at safety huddles.

The head of QRPS tracked and analysed reported incidents. Monthly reports were sent to relevant departments and discussed at the board RQS committee, as evidenced in minutes reviewed by inspectors. A 2025 annual report produced by the QRPS department analysed the number incidents reported since 2023 and broke down the incidents report in 2025 per category, highlighting the top three incidents related to clinical care and care management, exposure to physical hazards and exposure to behavioural hazards. The monthly performance report to the CEO Midwest acute and older persons also included incidents and serious reportable events from the hospital. The SIMT was discussed under national standard 5.8.

Inspectors were informed and documents reviewed noted that incidents reported on NIMS regarding infection prevention and control were discussed at the IPC team meeting monthly and IPC committee quarterly. Healthcare associated infections and a summary of outbreaks were included in quarterly reports sent to the board RQS.

A report from 2023 - 2025 submitted and reviewed outlined medication safety incident trends. Incidents were categorised according to the severity of outcomes using the National Coordinating Council for Medication Error Reporting and Prevention (NCCMerp[‡‡‡‡‡]) index. Additionally, it was verified that incidents were discussed monthly at the medication safety working group and quarterly at the drugs and therapeutics committee. A quarterly report to the board RQS committee also included a medication incident review report.

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

Documents submitted to inspectors outlined that transitions of care (TOC) incidents reported on NIMS were discussed at the TOC committee meetings, and the quarterly report to the board RQS committee included TOC trends.

Minutes of meetings reviewed noted that Protocol 37 transfers to UHL were discussed at the deteriorating patient committee, the transitions of care meeting quarterly and reported to the board RQS committee via the transitions of care report.

To summarise, the hospital had a system in place to identify, manage, respond and report on patient-safety incidents in line with national legislation, standards, policy and guidelines.

Judgment: Compliant

Conclusion

HIQA carried out an announced inspection in St John's hospital Limerick to assess compliance with the national standards from the *National Standards for Safer Better Healthcare*. The inspection focused on four key areas of known harm; infection prevention and control, medication safety, transitions of care and the deteriorating patient. Overall, the hospital was found to compliant in four national standards (5.5, 5.8, 1.8 and 3.3), substantially compliant in four national standards (5.2, 6.1, 1.6 and 3.1) and partially compliant in one national standard (2.7).

St John's Hospital was founded in 1780, and despite efforts to address issues, the original layout and ageing infrastructure are increasingly incompatible with modern healthcare standards. Management formally acknowledged the identified risks and demonstrated a clear commitment to addressing same by outlining plans for a 78 bed new build, with the expectation that works will begin in 2027.

Capacity and capability

Inspectors found that there were integrated, clearly defined and formalised corporate and clinical governance arrangements in place. Management arrangements supported and promoted the delivery of high-quality, safe and reliable healthcare services and there were systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services. Hospital management were planning, organising and managing the workforce to support the delivery high-quality, safe healthcare.

Quality and safety

There was evidence that staff were aware of the need to respect and promote the dignity, privacy and autonomy of patients receiving care and the hospital had effective systems in place to manage and respond to complaints and feedback. The hospital had processes in place to identify and manage potential risks. Patient safety incidents were reported and responded to in line with the National Incident Management Framework. Through observations and discussions with staff and patients, it was evident that a culture of kindness and consideration was promoted throughout the hospital.

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

Compliance Classifications

An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the national standards is identified, a compliance plan was issued by HIQA to the service provider. In the compliance plan, management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the progress in implementing the action(s) set out in any compliance plan submitted.

HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

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

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Substantially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Substantially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant
Theme 3: Safe Care and Support	

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Compliant

Compliance Plan for St John's Hospital Limerick

Inspection ID: NS_0195

Date of inspection: 01 and 02 April 2026.

Compliance plan provider's response:

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

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

1. Restricted space throughout (limited bed spacing, narrow corridors insufficient number of toilets)
The hospital's capital development programme for a new bed block remains a top priority for the Board and is under the attention of HSE Capital & Estates. It will include a works proposal to improve the condition of the existing bed block through refurbishment/reconfiguration of the inpatient accommodation to improve conditions. St John's will continue to advocate for and progress the development through to completion.

2. General wear and tear of infrastructure and flooring
An annual refurbishment programme is in place to address matters such as wear and tear of flooring, walls and general condition of the building. Areas in poor condition noted during the inspection will be repaired/updated during the current year.

3. Handwash basins
An annual sink replacement programme is in place with the goal to replace 17 sinks in priority clinical areas within the current year.

4. Call bells will be installed in MAU bays within 12 weeks.