



**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 James's Hospital
Centre ID:	OSV-0001102
Address of healthcare service:	James Street Dublin 8 D08 NHY1
Type of Inspection:	Announced
Date of Inspection:	24/03/2026 and 25/03/2026
Inspection ID:	NS_0196

About the healthcare service

Model of hospital and profile

St James's Hospital is a model 4* public voluntary hospital that provides services on behalf of the Health Service Executive (HSE) as per Section 38 of the Health Act 2004 (as amended) through a service level arrangement. St James's Hospital is governed and led by a Board of Directors and the hospital works in partnership with the HSE's Dublin and Midlands Health Region.[†]

Services provided by the hospital include:

- acute medical in-patient services
- national referral centre for several specialities including the national burns unit, the national tuberculosis centre and the national coagulation centre
- elective surgery
- emergency care
- intensive and high-dependency care
- diagnostic services
- outpatient care.

St James's Hospital is one of eight adult designated national cancer centres

The following information outlines some additional data on the hospital.

Number of beds	739 inpatient beds
	125 day case beds
	28 offsite beds

How we inspect

*A Model 4 hospital is a tertiary hospital that provides tertiary care and, in certain locations, supra-regional care. These hospitals typically have a category 3 or speciality level 3(s) Intensive Care Unit onsite, a Medical Assessment Unit, an Emergency Department, including a Clinical Decision Unit on site.

[†] The Regional Health Area HSE Dublin and Midlands provides health and social care services to Dublin South City and West and Dublin South West, Kildare, West Wicklow, Laois, Offaly, Longford and Westmeath.

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, 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.

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

[‡]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.

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	Support Inspectors
24/03/2026	09:00 – 17:20	Eileen O'Toole	Maeve McGarry Sorcha Burns Jenny Smyth Linda Daffy Elaine Farrelly
25/03/2026	09:00 – 15:50	Eileen O'Toole	Maeve McGarry Sorcha Burns Jenny Smyth Linda Daffy Elaine Farrelly

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*. The inspection focused in particular, on four key areas of known harm, these being:

- infection prevention and control
- medication safety

[§] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.

- the deteriorating patient** (including sepsis)^{††}
- transitions of care.^{‡‡}

The inspection team visited five clinical areas:

- Emergency Department
- George Frederic Handel Ward (29-bedded medical ward)
- Abraham Colles Ward (31-bedded surgical orthopaedic trauma ward)
- Hospital 5, Unit 2 Ward (28-bedded medical ward with 3 negative pressure rooms)
- Ward A located in St Luke's Hospital in Rathgar (28-bedded transitional care ward).

The inspection team also visited the Patient Flow Lounge, Medical Ambulatory Care Suite and Acute Medical Unit as described in this report.

During this inspection, the inspection team spoke with representatives of the hospital's Executive Management Group, Quality and Safety Improvement Team, Human Resources and Clinical Staff.

Acknowledgements

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

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

Inspectors spoke with a number of patients in the clinical areas visited who were complimentary about the care they received across all clinical areas as part of this inspection.

Patients who spoke with inspectors in the emergency department acknowledged that staff were "working very hard" and that everyone there was "kind" and "lovely". They also described how they were kept informed of their plan of care.

Patients cared for in the ward areas on the St James's campus informed inspectors that they were happy with the care that they were receiving and that "staff are busy but

** 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.

helpful” and “respond to call for help”. Patients also described the hospital as “very efficient” and “an excellent hospital” and stated that “the medical care was brilliant”.

Patients who spoke with inspectors on Ward A were complimentary of the care they received reporting that “staff are very welcoming and happy to help”.

Across all the clinical areas, patients said they had not received information about the hospital’s complaints process but if they wanted to make a complaint or had concerns about the care they received, that they would speak with a member of the nursing staff.

Capacity and Capability Dimension

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

St James’s Hospital was found to be compliant with two national standards, 5.2 and 5.5, and substantially compliant with two national standards, 5.8 and 6.1 assessed under this dimension. Key inspection findings informing judgments on compliance with these four national standards 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.

The hospital had integrated corporate and clinical governance arrangements in place which were appropriate for the size, scope and complexity of the service delivered.

Since HIQA’s last inspection of St James’s Hospital in September 2024, a number of changes had occurred at HSE level to align with the corporate and clinical governance arrangements in the new Health Regions configuration. St James’s Hospital was now part of the HSE Dublin and Midlands Health Region. As a voluntary hospital, the overarching governance body was the Hospital Board. The Board members were appointed by the Minister for Health and the day-to-day management of the hospital was delegated to the chief executive officer (CEO). Overall responsibility and accountability for the operational delivery of services in the hospital lay with the CEO who reported directly into the Board of Directors.

The hospital’s executive medical director provided clinical oversight and leadership and reported into both the CEO and the Board of Directors. The director of nursing (DON)

was responsible for the organisation and management of nursing services at the hospital and reported to the CEO and had a professional link with the regional director of nursing and midwifery. Clinical services were delivered under a clinical directorate model of which there were six directorates, each led by a clinical director (CD). The clinical directorate's team met monthly. In addition, the directorate management team met monthly with both the CEO and executive medical director to provide oversight of the performance and quality of service that was provided within each directorate.

As per previous inspection findings, the Executive Management Group (EMG) was the main governance structure at the hospital with responsibility for ensuring oversight and governance of the quality and safety across the hospital services. Reports were submitted by CDs and directors of hospital departments for EMG review. The EMG meetings were chaired by the CEO, met monthly in line with its terms of reference and specific actions were assigned to an individual.

Monthly performance meetings with the Health Region via an integrated healthcare area (IHA) manager were attended by members of the EMG. Key metrics were presented to members of the regional team in relation to quality, patient safety, scheduled and unscheduled care, human resources and finance.

The Executive Quality Safety Risk Committee was chaired by the CEO, met every two months and was responsible for overseeing that the quality of care was monitored and continuously improved. Inspectors saw evidence that updates from the directorates were reviewed alongside patient-safety incidents, patient and family feedback, audit activity and risk register review. Actions were followed up on actions from meeting to meeting.

The emergency department operational meeting had responsibility to coordinate and oversee operational performance in relation to patient flow, risks, staffing, and resource utilisation. The meeting was chaired by the clinical lead and reported into the medical and emergency directorate. Terms of reference outlined that the team met weekly however, minutes of meetings reviewed indicated that the team was meeting monthly. The meeting had a set agenda which included review of activity and key performance indicators, incidents and complaints, staffing and infrastructure. Inspectors saw evidence that data and national key performance indicators (KPIs) in relation to the emergency department were discussed at the medical and emergency directorate monthly meetings.

The hospital's Prevention and Control of Hospital Associated Infections (PCHCAI) Committee was chaired by the chief operations officer (COO), met in line with their terms of reference and reported into the Quality, Safety and Risk Management Committee. The PCHCAI Committee was accountable for developing and delivering an integrated infection prevention and control programme, the progress of which was

monitored at their quarterly meetings. Antimicrobial consumption was reported on at this committee meeting.

The Pharmacy and Therapeutics (PT) Committee was assigned with responsibility for the safe and effective use of medication in the hospital. The committee, co-chaired by consultant physicians, reported into the Quality, Safety and Risk Management Committee, met according to their terms of reference and minutes reviewed demonstrated that this committee was action oriented. The Medication Safety Committee was a subcommittee of the PT Committee and was responsible for developing and reporting on a medication safety plan for the hospital.

The hospital had an overarching Transitions and Escalations of Care Steering Committee which was responsible to oversee escalations of care, Early Warning Systems (EWS)^{§§}, sepsis management, resuscitation and clinical handover within the hospital. Inspectors were informed that this governance structure was currently under review, that the steering committee had not met recently and the terms of reference were being updated. The subcommittee responsible for overseeing the implementation, evaluation and monitoring of the EWS was chaired by a medical physician had met on two occasions in 2025 and minutes reviewed demonstrated that this committee discussed audit, adverse incident reports, complaints and workforce education and training. A sepsis subcommittee had managed the implementation of the updated National Clinical Guideline on Sepsis Management for adults, the new national sepsis form and the updated mandatory training for all clinical hospital staff. This sepsis subcommittee was also tasked with oversight of auditing performed with the use of the revised sepsis form.

Inspectors were assured that the oversight of transitions of care took place across a number of committees and huddles in the hospital. Inspectors attended the daily huddle which was a succinct information sharing and action oriented meeting, and was attended by representation from all the directorates and appropriate hospital leadership. This meeting was informed by information contained on the visual board, which was a digital system that captured data on the patient discharge date, pathway and destination. The Access Committee met monthly and were tasked with providing oversight and monitoring of safe scheduled and unscheduled care services and the utilisation of hospital services. There were regular scheduled meetings in relation to patients with delayed transfers of care, complex discharges and forums with community partners to discuss patient pathways.

^{§§} Early Warning Systems (EWS) are used in acute hospitals settings to support the recognition and response to a deteriorating patient

As identified at the previous HIQA inspection, St James's Hospital had formalised governance arrangements to ensure the delivery of high quality and safe healthcare services.

Judgment: Compliant

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

The hospital had effective management arrangements in place to support and promote the delivery of safe and reliable healthcare services.

An annual plan was developed by the infection prevention and control team (IPCT) which set out the goals, objectives and subsequent time-bound actions required for 2026. A copy of the infection prevention and control report for 2025 was provided to inspectors following on from the inspection. Inspectors saw evidence that details of the hospital's performance in relation to the monitoring of surveillance and compliance with infection prevention and control practices and standards was reviewed at the quarterly Hospital Board, Safety and Risk Committee prior to submitting to the Board for approval.

The hospital's pharmacy service was led by the director of pharmacy. A medication safety programme was overseen by the Medication Safety Committee which in turn reported into the Pharmacy and Therapeutics Committee. An annual report outlining the medication safety data, trending and reviews undertaken was completed for 2025. The report also contained information on medication safety initiatives achieved. A work plan for 2026 was developed which detailed the focus of quality initiatives for the upcoming year. The Antimicrobial Stewardship Committee was a subcommittee of the PT Committee and provided reports on the hospital's antimicrobial stewardship programme to both the PT Committee and the PCHCAI Committee.

The hospital had management arrangements in place to support the identification and management of the deteriorating patient. The Irish National Early Warning Score (INEWS)^{***} was in use within the hospital and the Irish Maternity Early Warning System (IMEWS)^{†††} was implemented in designated areas to care for women with a confirmed

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

^{†††} Irish Maternity Early Warning System (IMEWS) is for use in all cases during pregnancy and during the first 42 days after the end of pregnancy irrespective of the gestation and irrespective of the presenting condition of the person.

pregnancy and for up to 42 days in the postnatal period. The chair of the Early Warning Systems Committee was also the named clinical lead for both early warning systems in use. At the time of inspection, the Emergency Medicine Early Warning System (EMEWS)^{***} was not implemented within the emergency department and plans for phased implementation were outlined to inspectors. Senior management had identified the need for a nurse lead position to oversee the implementation of the updated National Clinical Guideline on Sepsis Management for adults, which was in place at the time of inspection.

The Situation, Background, Assessment and Recommendation tool (ISBAR) clinical handover tool was built into the electronic patient record and was managed through the Transitions and Escalations of Care Steering Committee, with oversight by the quality and safety improvement directorate. Inspectors were informed that there was ongoing quality improvement projects in relation to clinical handover, for example, the creation of a patient management list for on-call medical teams.

There were established management arrangements in place to monitor hospital activity, address factors impacting healthcare service demand and the safe and effective transitions of care. These management arrangements were supported by the use of digital visual boards which provided a platform for all staff to input and gain information of the status of all patients. Data and information was entered by the ward or clinical area where the patient was cared for. The visual board was used for planning, identifying patients' needs and opportunities to expedite any resources or diagnostics required. Hospital activity and capacity, patient acuity and responsiveness to meet service demand was monitored and managed through a number of formalised daily and weekly meetings. The utilisation of trolleys in the emergency department and surge beds outside of the emergency department was described as a dynamic process based on assessment of patient numbers, patient acuity and balancing the need to provide scheduled care.

On the first day of inspection, there were a total of 38 surge beds utilised for admitted patients outside of the emergency department. The acute medical assessment unit (AMU) functioned entirely as a surge capacity area. The total available number of 18 beds in Surgical Day ward was utilised as surge beds. There was surge bed capacity in use on one ward area visited with two additional patients placed in multi-occupancy rooms which was designed to accommodate two patients but accommodated three patients. Whilst awaiting a hospital bed, patients could also be transferred to the Patient Flow lounge which had capacity to take up to four admitted patients. The Medical

^{***} Emergency Medicine Early Warning System (EMEWS) is an early warning system tool used in emergency departments to identify patients at risk of physiological deterioration. This system provides a structured way to monitor key physiological signs, assign a score, and escalate care to prevent adverse outcomes and ensure timely intervention for patients.

Ambulatory Care Suite (MACS) was functioning as intended.

Similar to findings at the time of HIQA's previous inspections, the mismatch between demand and availability of inpatient bed capacity continued to impact on the effective management of the emergency department. The hospital reported that on average, the hospital occupancy rate was over 100% in 2025 and year-to-date in 2026. Inspectors were informed that the number of trolleys utilised for admitted patients fluctuated based on the acuity of patients within the emergency department. The hospital had an escalation protocol, with a series of clearly defined incremental steps to address demand for urgent and emergency care. On the first day of inspection, there were 42 admitted patients accommodated in the emergency department and the hospital was in black escalation, which was the highest level of escalation, with actions determined in the escalation underway. Staff informed inspectors that the hospital faced several ongoing challenges impacting patient flow and scheduled care delivery. These included; an increase in emergency department attendances of 8% in 2025, a further 8% increase in 2026 up to the time of inspection, high care needs of patients awaiting discharge and demand for diagnostics which exceeded capacity.

The hospital had defined lines of responsibility and accountability for medical and nursing leadership in the emergency department. Operational governance and oversight of the day-to-day workings of the department was the responsibility of the onsite consultant in emergency medicine who was supported by non-consultant hospital doctors (NCHDs). A consultant in emergency medicine was the clinical lead for the emergency department. The clinical nurse manager (CNM) grade 2 reported into the CNM grade 3 who reported to the assistant director of nursing (ADON), who in turn reported to the DON.

The hospital had access to a range of convalescence, rehabilitation and residential beds in stepdown facilities and hospital management had contracted additional capacity in private facilities, to maximise flow of patients through the hospital.

St James's Hospital had access and clinical governance over 28 beds located offsite. Patients were pre-assessed for suitability for admission to this offsite ward and were medically discharged from their teams in St James's Hospital. General practitioners (GPs) were responsible for the medical care of patients admitted who attended the ward three times a week and nursing staff had access to medical advice from GP services 24/7. Nursing staff work under the clinical governance of St James's Hospital, reported into a clinical nurse manager, grade 3 and reported that they felt well supported and integrated into the nursing team. Patients who required a higher level of care or with suspected deterioration of their condition were transferred back to the emergency department in St James's Hospital. The transfer could be activated with medical input from the GP services. From review of data received after inspection, there was a total of 50 patients that required transfer back to the emergency department for a higher level

of care in 2025. The patients transferred to this ward accessed services in both hospitals which resulted in each patient having two medical record numbers. The electronic patient record system that was available in St James's Hospital was a read only system and not used as a patient record in these offsite beds which resulted in a hybrid system. Inspectors were informed that there was work ongoing in an attempt to work towards further implementation of the electronic patient record. This is discussed further under national standard 3.1.

Within the capacity constraints and subsequent high occupancy rates, hospital management had arrangements in place to support and promote 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.

The hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services. Performance data was reviewed regularly during performance meetings between the hospital and the IHA manager, at the EMG and upwards to the Hospital Board. There was evidence that the hospital took part in, and provided data to national quality and safety programmes and took a proactive approach to learning from the findings and recommendations from national reviews. The Quality Safety Improvement directorate produced a quarterly report providing analysis and assurance pertaining to the following: audit compliance, national audit reports, patient feedback, patient-safety incidents and reviews, medication safety, infection prevention and control surveillance, outbreaks, antimicrobial stewardship and staff training.

As per findings of the previous inspection, there was evidence of risk management structures and processes in place to proactively identify, manage and minimise risk in line with the HSE's risk management framework. Risk registers at directorate level were managed by the directorate management team. At ward level, the staff performed the risk assessments and escalated their concerns to the ADON. The risks were then managed at directorate level that had responsibility to escalate to the corporate risk register. Risks were discussed at monthly EMG meetings and reviewed at Hospital Board level twice a year. There was a process for escalating risks to the IHA manager and or Health Region. The management of reported risks related to the four areas of known harm – infection prevention and control (IPC), medication safety, deteriorating patient and transitions of care is discussed further under national standard 3.1.

The hospital had a central registry of all audit performed. The Quality Safety Improvement directorate, described as an enabling and supporting directorate, had oversight of all audit activity and supported staff to carry out audit activity.

Evidence of audit activity in relation to IPC, medication safety and the deteriorating patient was provided to inspectors. Assessment of hand hygiene compliance was mandated as an annual assessment in clinical areas. There was good compliance observed in the clinical areas visited at the time of inspection. However, in the emergency department, a hand hygiene audit performed in October 2024 showed 43.3% compliance, which was re-audited in December 2024 with 80% compliance and a further re-audit demonstrated a 90% compliance in February 2025. Inspectors did not see evidence that compliance with hand hygiene was re-audited in the emergency department from February 2025 to the time of inspection in March 2026. Monthly environmental audits which included assessment of patient equipment were performed in the clinical areas visited. There was no overall scoring mechanism built into these audits but identification of low, moderate or high risks were identified in accordance with a standardised hospital framework. Actions were identified and assigned to individuals and there was no timeline for completion. Environmental audits reviewed by inspectors demonstrated minimal risks identified in the ward areas inspected. The Hygiene Service Committee reported on the number of environmental audits carried out per month across the hospital through the Quality Safety and Risk Management Committee. In 2025, this varied between 37 and 52 per month and demonstrated oversight of the high risks identified.

Nursing care metrics which included compliance with INEWS recording, medication management and compliance with care bundles were collected monthly in each of the four ward areas visited at the time of inspection with good compliance observed. Inspectors were informed that where nursing metric results scored below 85%, the clinical nurse manager provided education at the time. There were no INEWS or medication safety audits performed in the emergency department. Audit of the use of Identify, Situation, Background, Assessment and Recommendation tool (ISBAR) was not routinely carried out as ISBAR was integrated into the electronic patient record as part of handover.

An audit of compliance with the INEWS escalation and response protocol was carried out in August 2025 which was a retrospective review of a total of 10 charts of patients that had an INEWS score of three or above. The audit demonstrated poor compliance with documentation of nursing request for senior review and documentation of medical review in response to INEWS trigger. There was no re-audit performed to time of inspection. Hospital management were assured of the escalation and response actions taken by hospital staff in the case of patient deterioration through monitoring of data collected for national quality and safety programmes. There was no dedicated resource

for audit activity in relation to INEWS escalation and response protocol and inspectors were informed that this impacted on the frequency of audit activity.

The updated HSE sepsis screening forms were rolled out in November 2025 and an audit had been undertaken to assess compliance with completion of new forms. The audit results demonstrated gaps in completion of forms and inspectors saw evidence of monitoring arrangements and ongoing plans to oversee the implementation of the initiative with planned cycles of audit. The emergency department had carried out two sepsis audits since the implementation of the new sepsis form. The audits did not identify an overall compliance rate or identify what actions were taken to address non-conformances.

There was a process in place to proactively identify and manage patient-safety incidents. Patient-safety incidents were entered on to the National Incident Management System (NIMS).^{§§§} The hospital's Serious Incident Management Team (SIMT) were responsible for ensuring that all serious reportable events and serious incidents were managed in line with the HSE's Incident Management Framework. In addition to scheduled monthly meetings, the SIMT was convened as required.

The Quality Safety Improvement directorate was responsible for monitoring and responding to findings from the National Inpatient Experience Survey (NIES) 2024. In response to the survey findings, inspectors observed evidence that their two quality improvement initiatives were implemented. St James's Hospital had an active patient representation council and there was evidence of ongoing engagement and input from members which is commendable.

Overall, the hospital had systematic monitoring arrangements in place to support continuous improvement in the quality, safety, and reliability of healthcare services. Areas for consideration include the frequency of some key audit activity in relation to hand hygiene and INEWS escalation and response protocol. Some audits did not identify an overall compliance rate, and did not identify what time bound actions were taken to address non-conformances.

Judgment: Substantially Compliant

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

^{§§§} The 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).

Hospital management had systems in place to plan, organise, and manage the workforce for high quality, safe and reliable healthcare supported by a People and Culture Strategy (2023-2027). Inspectors were informed that at the time of inspection there were 5,224.51 whole-time equivalent (WTE) employees in place. The overall vacancy rate was very low across all disciplines with 2% vacancy in nursing, 0.27% in medical staffing and 1% in health and social care professionals. The corporate risk register contained one risk in relation to staffing which identified the risk of maintaining quality staffing numbers as a high risk.

The hospital's absenteeism rate in 2025 was 5.6%, which is above the HSE's target absenteeism rate of $\leq 4\%$. The attrition rate was 10% in 2025.

Hospital management informed inspectors that the hospital had yet to receive funding and approval to implement the Department of Health's nursing staff frameworks**** for an approved 74 WTE nursing posts and therefore had yet to start the recruitment process. The emergency department had been approved for 17 WTE of these positions and in the interim, whilst awaiting funding, the Hospital Board had approved recruitment of 10 WTE staff nurses to support the management of admitted patients whilst awaiting an inpatient bed. The hospital's approved funded complement for nursing staff in the emergency department including management and other grades was 123 WTE with a vacancy rate of 4%, all vacancies being temporary. However, these temporary absences impacted on daily rosters. For example, rosters reviewed for the previous four weeks showed a deficit of 14 shifts which was not covered and a further 42 shifts covered by a mixture of overtime, bank or agency staff. On the first day of inspection, there was one vacancy which was filled by bank staff. Staff that spoke with inspectors on the first day of inspection viewed their workload as manageable.

Medical staffing levels in the emergency department were maintained at levels to support the delivery of 24/7 emergency care. The emergency department had nine WTE consultants in emergency medicine which was an increase of one WTE since the time of HIQAs last inspection. A senior clinical decision-maker++++ at consultant level was available 24/7 and was on site in the emergency department during core working hours and offsite outside core working hours. Thirty four NCHDs at registrar level (16 WTE), senior house officers (15 WTE) and interns (3 WTE) provided 24/7 medical cover in the emergency department.

Hospital management confirmed that the majority of permanent consultants were on the relevant specialist division of the register with the Irish Medical Council (IMC).

**** Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland and Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Ireland.

++++ Senior decision-makers are defined here as a doctor at registrar grade or a consultant who have undergone appropriate training to make independent decisions around patient admission and discharge.

Consultants that were not registered on a specialist division of the register with the IMC were overseen in accordance with the HSE's requirements.

The hospital was funded for a total of 54.3 WTE pharmacists with a 14.7% vacancy rate. The unfilled pharmacist positions impacted on the ability to provide a comprehensive clinical pharmacy service^{****} to all areas within the hospital and clinical areas that were deemed high risk were prioritised for this service. The hospital was funded for a total of 35.5 WTE pharmacy technicians with a 24% vacancy rate.

The IPCT supported staff in implementing effective infection prevention and control practices across the hospital. Staff confirmed they had access to microbiology support 24/7. At the time of inspection, there were no vacancies within this team and the IPCT provided a service seven days per week.

As per previous inspection findings, there was a centralised system to monitor the uptake of, and staff attendance at mandatory and essential training with oversight by the human resources department. Inspectors saw evidence that compliance levels were discussed at Hospital Board, the EMG and directorate level. Inspectors were informed that there was a Hospital Training Committee and that their records showed training compliance had increased by 6% this year. Despite this oversight, across the hospital, training records reviewed by inspectors showed that the uptake of essential and mandatory training needed some improvement. For nurses, INEWS compliance was 76%, IMEWS 64% and Basic Life Support was 74%. For healthcare assistants, all training compliance needed improvement (72%-76%). For medical staff, all training compliance needed improvement (22%-59%). There was some examples of good compliance rates, for example nursing staff were 100% compliant with both IPC education and medication safety education.

In the emergency department, evidence demonstrated that compliance rates for nurses with the uptake of mandatory and essential training was good (75% to 100%) with the exception of sepsis training where 62% of nurses had completed training. Compliance rates for medical staff required improvement, for example, 63% had completed training for EMEWS and 58% had completed training in Basic Life Support. Medical staff in the emergency department had good compliance rates (100%) in all training relating to IPC practices.

INEWS training was not deemed as mandatory training which is not in line with recommendations set out in the relevant National Clinical Guideline.^{§§§§}

**** A clinical pharmacy service – is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.

§§§§ <https://assets.gov.ie/static/documents/ncg-no-1-inews-v2-sep-2020.pdf>

Workforce arrangements in the hospital were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare. However, there were opportunities for improvement in relation to uptake of mandatory training and there was an opportunity to review the mandatory training requirements in relation to 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 James's Hospital was found to be compliant with one national standard 3.3, substantially compliant with one national standard 1.8, and partially compliant with three national standards, 1.6, 2.7 and 3.1 assessed under this dimension. Key inspection findings informing judgments on compliance with these five national standards are described in the following sections.

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

Staff who spoke with inspectors were aware of the need to promote and respect the dignity, privacy and autonomy of patients. Staff interactions with patients were observed to be kind, helpful and respectful. Patients who spoke with inspectors described staff as "nice, kind and friendly" and "lovely", also stating that the "nursing staff are fantastic". Patients who spoke with inspectors were aware of their plan of care.

In the emergency department, the physical environment did not always ensure that patients' dignity, privacy and autonomy were respected and promoted. Patients were cared for on trolleys and chairs on corridors within the emergency department where privacy screens were not being used and patients did not have access to a call bell. Conversations and personal information exchanged between patients, medical and nursing staff were carried out in this environment and could be overheard. Inspectors also observed that cubicles were utilised for more than one patient and patients that were brought in by ambulance were triaged in the corridor. On the first day of inspection the waiting room was observed as crowded with the 36 chairs occupied and a further 12 people standing. Patients who spoke with inspectors described negative experiences in the emergency department waiting room and expressed empathy for staff working in

that area having witnessed instances of verbal aggression directed towards staff.

In the wards visited there was evidence that patients' autonomy and independence was promoted, for example, a patient who had a functional deficit told inspectors that they received "enough support" on the ward and patients described that their consent was sought before any intervention. Many patients who spoke with inspectors described multiple examples of when they felt that their privacy was maintained. Inspectors observed patient information leaflets in the clinical ward areas visited providing information to patients about medical conditions and services available within the hospital. For patients cared for in surge beds on the ward, privacy was maintained through use of privacy screens between beds and physical spacing. However, patients did not have access to a call bell or have anywhere to store their belongings.

Hospital management had introduced initiatives to improve the patient experience within the hospital. The emergency department had some dementia friendly initiatives. Inspectors saw evidence of the "red tray" initiative, which highlighted patients who need extra support or time to eat. Inspectors also observed the newly opened "Changing Places" facility, which provided support for people with complex physical or intellectual needs who cannot use standard accessible toilets, providing an inclusive and equitable environment demonstrating commitment to patient dignity. Inspectors also observed an active patient volunteer service based in the main concourse of the hospital enhancing the patient experience and offering social interaction and assistance for patients and their families.

For the most part, patient confidentiality was maintained during the inspection. Healthcare records were stored electronically, and personal information was handled securely in the clinical areas visited.

Overall, there was evidence that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the hospital, and there was evidence of a commitment to improve the patient experience. Notwithstanding this, accommodating patients on trolleys and chairs within the emergency room impacted on a meaningful promotion of the dignity and privacy for all patients and was not consistent with the human rights-based approach to care supported and promoted by HIQA. The sharing of cubicles, triaging of patients on a corridor and the crowded waiting room also did not always support patients' dignity and privacy.

Judgment: Partially Compliant

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

There were effective processes in place at the hospital to respond to feedback and complaints received from patients and or their families. There was a team of four whole-time equivalent complaint officers who reported into the quality manager, person centered care lead, who reported into the director of quality and safety improvement.

Complaints received at the hospital were managed in accordance with the HSE's '*Your Service Your Say*' management policy. Hospital management supported and encouraged point of contact complaint resolution in line with national guidance. Verbal complaints were managed at local clinical area level where possible and were not tracked or trended which is an opportunity for improvement.

The hospital received a total of 1787 compliments and complaints in 2025, which demonstrated an increase of 24% from 2024. Compliments constituted 65 of received feedback. In 2025, over 90% of complaints received were acknowledged within the HSE's five working days' timeframe and over 75% were resolved within the HSE's 30 working days' timeframe.

Written complaints were tracked and trended to identify emerging themes and categories. Some of the key themes included communication difficulties, the cancellation of scheduled surgery and issues relating to discharge in 2025. The number of reviews undertaken following receipt of complaints was tracked per quarter. In addition, the number of patients accessing the Office of the Ombudsman was also monitored.

There was some evidence that quality improvement initiatives were developed and implemented to improve services and care as a result of complaints received. For example, one ward had implemented hourly safety rounds following receipt of complaints.

Information on how to make a complaint was on display in the clinical areas visited during the inspection and a quick response code was observed and available which had been developed in response to findings from the National Inpatient Experience Survey in 2024. Inspectors did not see information on independent advocacy services on display in all the wards visited.

Nursing staff sought feedback on nursing care from their patients and this formed part of the monthly nursing metrics which were displayed on notice boards on wards visited. The information displayed included the results received and some patient comments received during the feedback. Areas for improvement also formed part of this report and inspectors were informed that the results were discussed at staff huddles.

Overall, there were effective processes in place to respond promptly and openly to complaints and concerns made by patients and or their families. However, information on how to access independent advocacy services was not clearly displayed in all the clinical areas and there is an opportunity to strengthen learning from the tracking and trending of verbal complaints.

Judgment: Substantially Compliant

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

The physical environment did not consistently support the delivery of high quality, safe, reliable care.

Wall-mounted alcohol based hand sanitiser dispensers were strategically located and readily available with hand hygiene signage clearly displayed throughout the clinical areas. Inspectors noted that a number of hand hygiene sinks in wards visited did not conform to national requirements.***** Physical distancing of one metre was observed to be maintained between beds in multi-occupancy rooms.

In some of the wards visited there was evidence of general wear and tear observed with paintwork and wood finishes chipped. This did not facilitate effective cleaning. The Unit 2 visited in Hospital 5 had visibly worn areas on flooring which could not be effectively cleaned. Sterile supplies equipment were stored on the ground in storage rooms which did not enable effective cleaning of the floor underneath.

The CNMs who spoke with inspectors were satisfied with the level of cleaning resources in place. Cleaning schedules were updated and in the main, were overseen by the supervisor. Patient equipment was cleaned by nursing staff and or health care assistants and there was a system to indicate that equipment was cleaned but this system was not observed to be in use in the emergency department. Inspectors observed that chemicals used for cleaning were not consistently stored in a secure manner which was contrary to hospital policy, and was brought to the attention of management. Inspectors also observed a lack of consistency in the detergent products used across the hospital. Cleaning staff in Ward A were provided by St Luke's Hospital under an agreement with St James's Hospital.

***** Department of Health, United Kingdom. Health Building Note 00-10 Part C: Sanitary Assemblies. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf

The hospital outlined that it had insufficient single rooms to isolate patients with communicable infectious diseases or to protect those vulnerable to infection, having a total of 324 single rooms. This risk was escalated to the corporate risk register, with controls in place to mitigate the risks. The infection prevention and control nurses were available seven days per week to support and advise on single room prioritisation in line with the hospital's isolation policy. Signage in relation to the correct and appropriate use of standard and transmission-based precautions was displayed in clinical areas visited with the exception of the emergency department. Inspectors observed that on some wards the doors of rooms used for isolation purposes were open, which was not consistent with national guidance, was not supported by risk assessment and was raised with management.

The emergency department had a total approved capacity of 37 cubicles and on the first day of inspection there were 42 trolleys over this capacity leading to overcrowding. The number of patients in the department resulted in a congested environment in an already fragmented infrastructure. Staff spoke with inspectors about the challenges that the infrastructure posed and inspectors were informed of plans to change the existing footprint of the department to provide a better layout for patient care. There was insufficient space to ensure physical distancing for patients accommodated on trolleys and five toilets and two shower facilities, which according to staff was insufficient for patient's needs. As discussed in national standard 1.6, on the first day of inspection the waiting room was congested and overcrowded.

On the first day of the inspection, there were two surge capacity beds occupied in George Frederic Handel ward. Patients cared for in these surge beds did not have access to a call bell nor did they have storage for their personal belongings. On this ward, inspectors also observed staff not adhering to standard and transmission-based precautions which was immediately addressed. Staff in one clinical area were also observed as not adhering to the bare below the elbows principle. Hazardous waste was observed to be stored in an unsafe manner which was brought to the attention of management.

In another clinical area, inspectors observed the inappropriate storage of equipment which was blocking a fire exit which was brought to the attention of management for action and was rectified. One ward visited had no hand hygiene facilities provided in the ensuite facilities of seven isolation rooms where patients had to use the hand hygiene sink in the bedroom.

In summary, at the time of inspection there were inconsistencies to support the delivery of high quality, safe, reliable care. The following represents opportunities for improvement:

- overcrowding and inadequate spacing between trolleys in the emergency

department

- patients cared for in surge beds on the ward area did not have access to a call bell nor to storage facilities for personal belongings
- not all hand wash sinks were compliant with required specifications and there were no hand hygiene facilities in some ensuite rooms
- appropriate standard and transmission-based precautions were not in place as per national guidance, and doors of isolation rooms were open
- there were instances of staff members not adhering to standard and transmission-based precautions and the bare below elbows principle
- lack of secure storage of chemicals
- unsafe storage of hazardous waste in one ward
- unsafe storage of equipment blocking a fire exit in one ward
- storage of boxes on flooring impeding cleaning.

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

Overall, while St James's Hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people using the service, these systems were not fully effective.

The CNMs assessed, analysed and managed actual and potential risks to patients in their clinical areas by undertaking risk assessments. The risk assessments were then escalated to the CNM3 or ADON of the service. Risks were then evaluated at the directorate level and each clinical directorate had their own risk register. Risks not managed at directorate level were escalated to the Executive Management Group (EMG) for review and for consideration for recording on the hospital's corporate risk register. The EMG reviewed the risks and the effectiveness of mitigating actions on the corporate risk register at their monthly meeting. The corporate risk register was reviewed twice per year at the Quality, Safety and Risk Board subcommittee. Risks were escalated to the Hospital Board and then onto the Health Region for review and action. From the minutes reviewed, the key risks escalated to the Health Region were time sensitive care, diagnostics, financial management and cyber security.

Patients were screened for multidrug resistant organisms (MDROs) on admission to the hospital. The hospital's information patient management system alerted staff to patients who were previously inpatients with confirmed MDROs. Further screening of patients did not take place when the patients were transferred to beds offsite, unless they were symptomatic. Infection prevention and control risks were escalated to the corporate risk

register. The highest rated risk was the risk of patients acquiring healthcare-associated infections. A multidisciplinary outbreak team was convened to advise and oversee the management of outbreaks. Outbreaks reports were viewed by inspectors and inspectors found that the management of infection outbreaks was in line with national guidance.

The pharmacy team maintained their risk register and there was a process for escalation to the corporate risk register. A comprehensive clinical pharmacy service was not provided to all the clinical areas and pharmacy-led medication reconciliation was not undertaken for all patients. Data was collected on the numbers of patients that received pharmacy-led medication reconciliation in the hospital. Inspectors were informed that between 20-24% of patients received medication reconciliation within 24 hours of admission, 40-48% of patients within 48 hours of admission and 60-65% of patients within 72 hours of admission in February 2026. At the time of inspection, none of the clinical areas inspected received a complete pharmacy service. Medication reconciliation⁺⁺⁺⁺ was carried out on prioritised patients, in accordance with a defined inclusion criteria or at request by clinical staff. Medication reconciliation was carried out by the general practitioners for patients cared for in the beds offsite. Inspectors observed the use of risk reduction strategies to support the safe use of anticoagulants, insulin, opioids and potassium. Prescribing guidelines, including antimicrobial guidelines and other medication information were available and accessible to staff through an application for smartphones. Inspectors observed unsafe storage of medication in the emergency department, witnessing the keys in one medication storage cupboard and other medication storage cupboards unlocked which was brought to the attention of management and was rectified.

The hospital had implemented some systems in place to recognise, respond to and manage the deteriorating patient. The INEWS, version 2 was used for all adult (non-pregnant) inpatients. There was a "reach in and reach out" critical care team available 24/7 in St James's Hospital to review, manage and escalate care of the deteriorating patient. Staff were knowledgeable about the INEWS escalation and response protocol, and there were efficient processes in place to ensure the timely management of patients with a triggering early warning score.

In the offsite ward visited, there were arrangements in place for the deteriorating patient which involved contacting the general practitioner service and potential transfer back to the hospital's emergency department. In the case of an emergency, the resuscitation team based at St Luke's Hospital would attend, and there were no reported adverse outcomes for patients associated with this arrangement. The algorithm in place for escalation of care was not appropriate for use in this clinical setting as it did not

⁺⁺⁺⁺Medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.

reflect onsite clinical arrangements. A sample of healthcare records reviewed demonstrated that the escalation of care was not consistently carried out in line with the algorithm that was in place which was brought to the attention of senior management for review and action.

The Irish Maternity Early Warning System was in use in the hospital for the care of a woman with a confirmed clinical pregnancy and for up to 42 days in the postnatal period in a limited designated clinical area.

The Emergency Medicine Early Warning System (EMEWS) was not implemented in the emergency department and had not been identified as a risk in the emergency department or on the corporate risk register. This should be progressed by the hospital to support the recognition and response to the deterioration of patients in the emergency department. 'Sepsis 6' care bundle was utilised in St James's Hospital but was not in use for the patients cared for in the offsite beds as the patients were transferred back to the emergency department in the case of suspected sepsis. The Identify, Situation, Background, Assessment and Recommendation tool (ISBAR) communication tool was utilised for clinical handover and was embedded in the electronic patient record.

There were systems and processes in place to support the efficient flow of patients and transfer of patients within and from the hospital. There were patient flow managers on site Monday to Sunday. As discussed in national standard 5.5, there were a number of daily, weekly and monthly meetings to review and manage issues impacting on the efficient flow of patients within and from the hospital aided by the visual board. St James's Hospital had above 100% occupancy rates in 2025 and in 2026 year-to-date. Inspectors were informed that access to diagnostics was a challenge across the full range of medical imaging technologies for both inpatients and outpatients and was escalated as a risk to the Health Region. Hospital management were exploring options to enhance diagnostic capacity. Hospital management had secured access to a range of beds in stepdown and private facilities, to maximise flow of patients through the hospital.

As discussed under national standard 5.5, St James's Hospital had access and clinical governance over 28 beds at Ward A which was located offsite. The patients transferred to Ward A accessed services in both St James's Hospital and the hospital where the ward was located, which resulted in each patient having two medical record numbers. The potential safety risks were not identified as risks locally in the clinical area or on the corporate risk register. Inspectors were informed that the integration of the electronic patient record was planned which would mitigate the risk. However, there was no risk assessment performed, nor were there documented mitigating actions to manage potential risks associated with the current practice.

A number of hospital admission avoidance initiatives were in place at the time of the inspection. The emergency department had a number of care pathways in place to support same day emergency care such as a pneumothorax pathway and an acute urinary retention pathway which were reported as working well. The St James's Hospital Frailty Intervention Team (JFIT) were operational within the emergency department. The medical ambulatory care suite had a total of 17 patients receiving treatment on the first day of inspection, which was open Monday to Friday for 10 hours per day and received patients via the medical teams in the hospital. The hospital's acute medical assessment unit (AMU) was not functioning as an alternate pathway for patients but was utilised for surge capacity and was reported as doing so for approximately two years.

The emergency department had a Senior Intervention Following Triage (SIFT) process in place six days per week, allowing patient assessment by a senior clinical decision-maker shortly after being triaged. This initiative was reported as decreasing the patient's length of time in the emergency department.

The emergency department team had identified a number of risks in relation to overcrowding, infrastructure and staffing deficits within an environment of increasing patient presentations. Infrastructural risks included the complicated footprint of the department, the inadequate size of the resuscitation cubicles and the small waiting room. Inspectors were informed that the hospital had plans which had been approved and would address the risks, add another triage room, a patient toilet and improve patient flow through the department.

Patients in the emergency department were triaged and prioritised in line with the Manchester Triage System. On the first day of this inspection, at 11.00am, the hospital was at the highest level of escalation and there were a total of 98 patients registered in the emergency department. Of these patients, forty two (42%) were admitted and lodging in the department while awaiting an inpatient bed in the main hospital. The average waiting time from:

- Registration to triage ranged from 2 minutes to 67 minutes with an average time of 25 minutes which not compliant with the 15 minutes triage time recommended by the HSE's emergency medicine programme and a deterioration from previous inspection findings of an average of 12 minutes.
- Triage to medical assessment ranged from 3 minutes to 9 hours and 22 minutes with an average of 160 minutes and represented a deterioration from previous inspection.
- Decision to admit to admission to an inpatient bed ranged from 3 hours and 43 minutes to 37 hours and 50 minutes which represented some improvement from the previous inspection.

The hospital continued to have some non-compliances with the HSE's patient experience times (PETs) at 11.00am on the first day of inspection but there was also some improvements noted from the previous inspection. Of the 98 patients registered in the emergency department:

- 37.8% of patients present in the emergency department were in the department for more than six hours after registration – this is not in line with the national target that 70% of attendees are admitted to a hospital bed or discharged within six hours of registration but represented an improvement on the 42% found in 2024.
- 32.6% of patients present in the emergency department were in the department for more than nine hours after registration – this is not in line with the national target of 85% of attendees admitted to a hospital bed or discharged within nine hours of registration but represented an improvement in the findings (38%) of 2024.
- 6.1% of patients present in the emergency department was in the department for more than 24 hours after registration – this is not compliant with the national target that 97% of patients are admitted to a hospital bed or discharged within 24 hours of registration but an improvement on findings (10%) of 2024.

Twelve (12.2%) patients in the emergency department were aged 75 years and over.

- There were 25% (3) patients aged 75 years and over in the emergency department greater than 6 hours after registration. This was not compliant with the HSE's target of 97% for this Key Performance Indicators (KPI)
- There were 25% (3) of patients aged 75 years and over in the emergency department greater than 9 hours of registration. This was not compliant with the HSE's target of 99% for this KPI.
- As found at the previous inspection in 2024, all patients aged 75 years and over were discharged or admitted to an inpatient bed within 24 hours (national target 99%).

Hospital data provided to inspectors indicated the conversion rate of patients admitted to an inpatient bed from the emergency department was 26.2% in 2025 and 26.9% in 2026 year-to-date which is in line with other HSE model 4 hospitals.

At the time of the inspection, the hospital had a total of 43 patients with delayed discharges and this was reported as an ongoing issue for the hospital and their patients. In January 2026, the average length of stay for medical patients was 11.1 days (HSE's target ≤ 7.0), for surgical patients that were admitted for emergency surgery was 8.3 (HSE's target ≤ 6) and for patients admitted for elective surgery was 7.1 (HSE's target

≤4.8). Inspectors were informed that the number of patients experiencing a delay in discharge impacted the data in relation to the average length of stay.

The hospital's patient flow lounge had capacity for up to 12 patients, had inclusion and exclusion criteria, was open Monday to Friday for 11 hours per day and had a hospital KPI of 20-25 patients per day. Inspectors were informed that up to four patients from the emergency department could be placed there whilst awaiting an inpatient bed. The hospital's Patient Flow Policy did not support the use of the patient flow lounge for admitted surge patients.

Staff had access to a range of policies, procedures, protocols and guidelines through the hospital's intranet. Hospital policies reviewed on the day of inspection relevant to the four key areas of harm were, in the main, up to date.

In summary, while systems and processes were in place to identify, evaluate and manage immediate and potential risks to people using the service, some inspection findings had the potential to affect patient safety. Specifically:

- a comprehensive clinical pharmacy service was not provided to all clinical areas, pharmacy-led medication reconciliation was not provided for all patients and none of the clinical areas inspected received a complete pharmacy service
- unsafe storage of medication in the emergency department
- the hospital was non-compliant with the majority of patient experience times
- the hospital's acute medical assessment unit was not functioning as an alternate pathway for patients
- the EMEWS was not implemented in the emergency department
- the hospital did not have an escalation and response protocol policy to support the early warning system in place for patients cared for offsite
- each patient cared for in the offsite ward visited had two medical record numbers, the potential safety risks were not identified as risks locally in the clinical area or on the corporate risk register with no mitigating actions or monitoring in place
- the electronic patient record was not extended for use for patients in the offsite beds.

Judgment: Partially Compliant

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

The hospital had systems in place to identify, report, manage and respond to patient-safety incidents. The hospital used the HSE Incident Management Framework to guide and support the management of patient-safety incidents and Serious Reportable Events

(SREs). Patient-safety incidents were raised by staff on the intranet and reported on the national incident management system (NIMS). Governance and oversight of patient-safety incidents was provided by the Quality Safety Improvement directorate.

A total of 2251 patient-safety incidents were reported in quarter four, 2025 with a total of 97.6% reported as resulting in low harm. Systems were in place for the tracking and trending of patient-safety incidents. Analysis of incidents were provided in the quarterly quality, safety and risk assurance reports. The most common types of patient-safety incident reported were falls and pressure ulcers. Staff who spoke with inspectors were knowledgeable about how to report, manage and respond to patient-safety incidents. Staff were also aware of the patient safety-incidents most commonly reported in their area.

The hospital's Serious Incident Management Team (SIMT) had oversight of the management of serious patient-safety incidents. The SIMT met at scheduled and emergency meetings in response to any patient-safety incidents that had resulted in most serious harm to the patient and included Serious Reportable Events (SREs) and Notifiable Incidents. The SIMT had responsibility to commission systems analysis reviews and determined the level of review required. Inspectors were informed that the hospital was non-compliant with the HSE target of review completion within 125 days.

Medication-related incident reports were reported through NIMS and were reviewed, collated and reported on at the Medication Safety Committee and Pharmacy and Therapeutics Committee. The number of medication incidents reported in 2025 was 911 and 171 in quarter one, 2026. Analysis of medication incidents was according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. There was evidence of trending of medication related incidents according to severity and in 2025, seven comprehensive or concise reviews were commissioned to identify causes and necessary actions on foot of such events.

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

Judgment: Compliant

Conclusion

St James's Hospital had integrated governance and management arrangements in place which were appropriate for the size, scope and complexity of the service delivered to support and promote the delivery of safe and reliable healthcare services.

Overall, the hospital had systematic monitoring arrangements in place to support continuous improvement in the quality, safety, and reliability of healthcare services. A review of frequency of audit activity in relation to hand hygiene and INEWS escalation and response protocol was an area for improvement. Workforce arrangements in the hospital were planned, organised and managed to ensure the delivery of high-quality, safe and reliable healthcare. However, there were opportunities for improvement in relation to uptake of mandatory training and in particular for the medical staff.

Inspectors observed that hospital management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care in the hospital. However, patients were accommodated on trolleys and chairs, some cubicles were shared and patients were triaged on a corridor within the emergency department which impacted on patients' dignity and privacy. The hospital had an active patient volunteer service demonstrating a commitment to enhancing the patient experience and offering social interaction and assistance for patients and their families.

There were opportunities to improve the physical environment to support the delivery of high-quality, safe, care and there were inconsistencies observed which require oversight and standardisation. St James's Hospital had systems and processes in place to identify, evaluate and manage immediate and potential risks to people using the service however, these systems were not fully effective. The emergency department was non-compliant with the majority of patient experience times and had not implemented EMEWS. The patients cared for in the offsite ward visited as part of the inspection had two medical record numbers, and the associated potential risks had not been formally identified and addressed.

There were effective processes in place to respond promptly and openly to complaints and concerns made by patients and/or their families and the hospital had systems in place to identify, report, manage and respond to patient-safety incidents.

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

Theme 3: Safe Care and Support

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

Partially Compliant

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

Compliant

Compliance Plan for: St James's Hospital

Inspection ID: NS_0196

Date of inspection: 24-25 March 2026

St. James's Hospital Compliance Plan In response to HIQA Inspection (ID: NS_0196); March 2026

Standard	Judgment
Standard 1.6: Patients' dignity, privacy and autonomy are respected and promoted.	Partially Compliant
1. Accommodating patients on trolleys and chairs within the emergency room impacted on a meaningful promotion of the dignity and privacy for all patients 2. The sharing of cubicles, triaging of patients on a corridor and the crowded waiting room also did not always support patients' dignity and privacy SJH Actions: ▪ Additional ED and acute bed capacity required to improve patient experience in ED. SJH have submitted plans to HSE Estates for (1) Reconfiguration of the ED's registration, waiting and patient triage areas (2) new Critical Care and Burn's facility, including a new Emergency Department Build (3) 96 additional acute beds ▪ SJH have completed the clinical design for these Capital Projects.	
Timescale(s): ▪ SJH's ED and Acute Beds planned new build is a component of the SJH Capital Project Development Plan (i.e., New Critical Care and Burns Facility & Emergency Department) commenced with the HSE in 2023. SJH continues to make multiple submissions on an ongoing basis in order to meet the complex and changing requirements to proceed through the HSE's capital build gateway process. ▪ Business cases to fund an uplift in current ED structures and resources was again included in the Hospital's Estimates Submission in 2026 and will be included in the hospital's 2027 submission in Q4 2026.	
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
3. Overcrowding and inadequate spacing between trolleys in the emergency department See above planned actions and timescales for Standard 1.6	
Timescale(s): See above planned actions and timescales for Standard 1.6	

4. Patients cared for in surge beds on the ward area did not have access to a call bell nor to storage facilities for personal belongings

SJH Actions:

- Currently there are no additional (surge) beds in use on the wards. i.e., all beds in use have access to a functional call bed system.
- The Hospital is currently exploring resourcing a wireless call bell solution that can be used in the event of escalation where the placement of additional surge beds on wards is required

Timescale(s): - Access to a wireless call bell system planned for October 2026

5. Not all hand wash sinks were compliant with required specifications and there were no hand hygiene facilities in some ensuite rooms

SJH Actions:

- The Hospital acknowledges that hand wash sinks should be located inside the ensuite facilities in order to meet with current specifications (HTM 64-1989); however, the facilities inspected by HIQA were built prior to this requirement. The Hospital having assessed the areas has determined that moving the basins at these sites would disproportionately limit the patients' space and cause the patient discomfort. The updated hand wash sink requirements are closely adhered to in all new builds and / or significant refurbishments. The location of the hand wash sinks outside the ensuite rooms as opposed to inside the facility is registered as a risk on the relevant risk registers.
- Identify all non-standard and / or damaged hand wash sinks in SJH through findings from the Hospital's Hygiene and IPC Environment Audits and develop a time bound plan for replacement.

Timescale(s):

- Exercise to identify all non-standard and / or damaged hand wash sinks was completed by SJH Facilities Management in May 2026.
- Scheduled programme of work currently in development, June 2026. Estimated completion date December 2027 to allow for access limitations as Hospital operates at 100% capacity continuously. Progress will be monitored and reported through the hospital's Hygiene Services Committee to the hospital's PCHACI Quality and Safety Programme.

6. Appropriate standard and transmission-based precautions were not in place as per national guidance, and doors of isolation rooms were open

SJH Actions

- Provide targeted refresher education to all staff on applying standard and transmission-based precautions
- Compliance will be monitored and followed up through IPC environment audits and IPC ward rounds

Timescale(s): Q2 and Q3 2026

7. There were instances of staff members not adhering to the bare below elbows principle

SJH Actions

- Promote awareness of the staff members' required practices in relation to the hospital's Hand Hygiene and Uniform / Dress Code policies through the following actions:
 - Mandatory Training Programme: Promote uptake in Hand Hygiene training through the

directorates. – Include Hand Hygiene as a topic in IPC staff refresher training programme. – Undertake regular updates using the Hospital's media options i.e., Intranet, Newsletters, Pulse i.e., the weekly staff ezine ▪ Monitor, report and respond to compliance through the increased schedule of Hand Hygiene audits i.e., HH audit frequency increased to twice yearly for all clinical settings.
Timescale(s): Q2 and Q3 2026
8. Lack of secure storage of chemicals SJH Actions ▪ Hygiene Services Committee to issue reminders to all staff to keep stores used for chemicals secured. ▪ Hygiene Services Committee to review and update training for Hygiene Services staff including the requirement to keep stores used for chemicals secured. ▪ Implement controlled swipe-access to all stores used for chemical storage. ▪ Monitor, report and respond to compliance through the Environment Hygiene audits. The Hospital's Environment Hygiene Assessment procedure and tools i.e., ECAT™, now extended for use to SJH's Transitional Care Unit (TCU) Ward A at St. Luke's Hospital.
Timescale(s): Q3 and Q4 2026
9. Unsafe storage of hazardous waste in one ward SJH Actions: ▪ Hospital's Environmental Services Team to promote awareness of correct waste segregation and disposal practices in clinical areas through the following: ▪ Increased frequency of Environmental Services Team toolbox talks ▪ Updates using the Hospital's media options i.e., Intranet, Newsletters, Pulse i.e., the weekly staff ezine ▪ Monitor, report and respond to compliance through the Environment Hygiene audits. The Hospital's Environment Hygiene Assessment procedure and tools i.e., ECAT™, now extended for use to SJH's Transitional Care Unit (TCU) Ward A at St. Luke's Hospital.
Timescale(s): Q3 and Q4 2026
10. Unsafe storage of equipment blocking a fire exit in one ward - Resolved at time of inspection
Timescale(s): Complete
11. Storage of boxes on flooring impeding cleaning SJH Actions: ▪ Hygiene Services Committee to issue reminders to all staff to keep floors clear for effective cleaning ▪ Hygiene Services Committee to review and update training for Hygiene Services staff to include

the action they should take when floors are not clear and impeding their cleaning

- Monitor, report and respond to compliance through the Environment Hygiene audits. Hospital's Environment Hygiene Assessment procedure and tools i.e., ECAT™, now extended for use to SJH's Transitional Care Unit (TCU) Ward A at St. Luke's Hospital.

Timescale(s): Q3 and Q4 2026

Standard 3.1: The Hospital protect patients from the risk of harm* associated with the design and delivery of healthcare services

Partially Compliant

12. A comprehensive clinical pharmacy service was not provided to all clinical areas. Pharmacy-led medication reconciliation was not provided for all patients and none of the clinical areas inspected received a complete pharmacy service.

SJH Actions:

- Clinical areas with a resourced Clinical Pharmacy service: Current practice is where a vacancy arises a risk assessment is undertaken and available pharmacy resources are allocated to prioritised to areas of increased acuity and/or risk. The area's clinical staff are informed and asked to refer any urgent requests for advice or medicine reconciliation to the Chief 2 Pharmacist Clinical Pharmacy Services. this is reflected in the Hospital's Medication Reconciliation Policy
- Develop and submit repeat Business Cases to support the resourcing of a clinical pharmacy service in those areas not currently resourced for a clinical pharmacy service. The absence of clinical pharmacy services in all clinical settings is registered as a risk on the Hospital's Risk Register.
- Medication Reconciliation Completion and Reporting: Please refer to SJH's Draft Report Factual Inaccuracy / Feedback Form.

Timescale(s):

- Clinical Pharmacy vacancies will be managed in accordance with procedure described as they arise
- Revised and new business cases for the resourcing of a clinical pharmacy service in those areas not currently resourced will be prepared and submitted for inclusion in the Hospital's 2027 Estimates submission in Q3 2026.

▪ The unsafe storage of medication in the emergency department

SJH Actions:

- Lock replaced on medication storage facility in ED. Medication storage facilities are now secure and compliant.
- Staff education on the importance of safe medication management including storage is part of the ED's staff Inservice programme.

Timescale(s): Completed

13. The hospital was non-compliant with the majority of patient experience times

SJH Actions:

- To significantly improve the discharge PET, additional medical and nursing resources needed in ED. The Hospital has included an uplift in ED resources in the HSE Estimates process, and will continue to seek these resources in future estimates for the national service plan. To significantly improve the admitted the Hospital needs to operate at <85% capacity. As above in standard 1.6 above, capital investment needed to deliver this capacity.
- Progress the Hospital's Acute Floor Transformation Programme that is focused on improving patient-flow processes in and from the ED to the short stay wards.

Timescale(s):

- SJH's ED and Acute Beds planned new build is a component of the SJH Capital Project Development Plan (i.e., New Critical Care and Burns Facility & Emergency Department) commenced with the HSE in 2023. SJH continues to make multiple submissions on an ongoing basis in order to meet the complex and changing requirements to proceed through the HSE's capital build gateway process.
- Business cases to fund an uplift in current ED structures and resources was again included in the Hospital's Estimates Submission in 2026 and will be in the hospital's 2027 submission.
- SJH commenced the Acute Floor Transformation Programme in May 2026

14. The hospital's acute medical assessment unit was not functioning as an alternate pathway for patients

SJH Actions:

- The Hospital currently does not have the bed capacity to run an acute medical assessment unit. Applications for CAs per standard 1.6 above, capital investment needed to increase bed capacity on the campus.
- Progress the Hospital's Acute Floor Transformation Programme that is focused on improving patient-flow processes in and from the ED to the short stay wards. This redesign of acute patient-flow processes will include building capacity for an acute medical assessment unit and supportive ambulatory pathways.

Timescale(s):

- SJH's ED and Acute Beds planned new build is a component of the SJH Capital Project Development Plan (i.e., New Critical Care and Burns Facility & Emergency Department) commenced with the HSE in 2023. SJH continues to make multiple submissions on an ongoing basis in order to meet the complex and changing requirements to proceed through the HSE's capital build gateway process.
- Business cases to fund an uplift in current ED structures and resources was again included in the Hospital's Estimates Submission in 2026 and will be in the hospital's 2027 submission.
- SJH commenced the Acute Floor Transformation Programme in May 2026

15. EMEWS was not implemented in the emergency department

SJH Actions:

- EMEWS build in SJH ED's Electronic Patient Record now complete and tested. Commencement of use scheduled for 8th June 2026 confirmed in all areas except ED waiting room. Full implementation i.e., to include waiting room, is dependent on the provision of funding for nursing posts as the ED currently has 17 WTE staff nurse positions unfunded.

Timescale(s):

- EMEWS implementation in SJH's ED with the exception of the ED Waiting Room, is scheduled for June 8th 2026.
- Repeat Business Cases and requests for funding for the non-funded ED Nursing positions have and will be resubmitted in 2027 through the following processes:
 - SJH 2027 Estimates Submission as a component of Emergency Medicine requirements; Q4 2026
 - Monthly Safe Staffing submissions through the Chief Nursing Officer in the Regional Executive Officer (REO). These requests are discussed at each monthly SJH / Dublin Midland Region Performance Meeting.

16. The hospital did not have an escalation and response protocol policy to support the early warning system in place for patients cared for offsite.

SJH Actions:

- New Escalation for Clinical Deteriorating Patients protocol specific to SJH's Transitional Care Unit (TCU) -Ward A; St. Luke's Hospital developed.
- Policy to be included in the Transitional Care Unit (TCU)'s Staff Induction programme.
- Assurance through audit scheduled to commence Q3 2026. Findings to be monitored and reported through the Medical and Emergency Directorate (MED) monthly performance meeting with CEO and clinical leadership team.

Timescale(s):

- New Policy - Completed
- Assurance reporting schedule to commence in Q3 2026.

17. Each patient cared for in the offsite ward visited had two medical record numbers, the potential safety risks were not identified as risks locally in the clinical area or on the corporate risk register with no mitigating actions or monitoring in place

SJH Actions:

- Undertake Risk Assessment to identify any actual risks to patient safety from the use of two MRNs
- Develop and implement a local Patient Identification SOP directing staff in the safe management of the dual MRNs.
- Audit compliance with the SOP; monitor and report compliance through the directorate reporting structures
- Register risk on the Hospital's Directorate Risk Register.

Timescale(s):

- Risk assessment completed April 2026. Complete.
- Patient Identification SOP specific to SJH's Transitional Care Unit (TCU) -Ward A; St. Luke's Hospital is in development. Due for sign-off and registration Q3 2026.
- Assurance through audit scheduled to commence Q3 2026. Findings to be monitored and reported through the Medical and Emergency Directorate (MED) monthly performance meeting with CEO and clinical leadership team.
- Use of double MRNs in Transitional Care Unit (TCU) -Ward A; St. Luke's Hospital is registered as a

risk on MED Risk Register i.e., Complete

18. The electronic patient record was not extended for use for patients in the offsite beds.

SJH Actions:

- Further implementation of the electronic patient record to SJH's Transitional Care Unit (TCU), Ward A; St. Luke's Hospital is planned on a phased approach commencing with a scoping exercise scheduled for Q1 2027.
- A local risk assessment is underway; the findings will be used to identify any risk mitigating actions required.

Timescale(s):

- Local Risk Assessment - June 2026
- Further development of SJH EPR in SJH's Transitional Care Unit (TCU), Ward A at St. Luke's Hospital scheduled to commence Q1 2027