Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	St John's Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Munster Hill, Enniscorthy, Wexford
Type of inspection:	Unannounced
Date of inspection:	09 April 2026
Centre ID:	OSV-0000604
Fieldwork ID:	MON-0044216

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

St. John's Community Hospital is located on the outskirts of a busy town. It is a purpose-built single-storey centre which can accommodate up to 104 residents. It provides rehabilitation, respite and extended care to both male and female residents over the age of 18, although the majority are over 65 years of age. The centre is divided into four units. In total, there are 20 four-bedded rooms, two twin rooms and 20 single rooms. All have full en-suite facilities. Other areas include day rooms, a smoking room, kitchenettes, offices and treatment rooms. There is also a large main kitchen and laundry. There are enclosed external gardens which are spacious and well maintained. Seating is provided there for residents and their visitors. There is parking space provided for residents, staff and visitors. According to their statement of purpose, St. John's aim to provide person-centred care to the older population of County Wexford. They aim to provide quality care in a homely environment where everyone is treated with dignity and respect.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	93

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 9 April 2026	07:10hrs to 16:50hrs	Aisling Coffey	Lead
Friday 10 April 2026	08:00hrs to 16:15hrs	Aisling Coffey	Lead

What residents told us and what inspectors observed

Overall, residents reported being happy living in St John's Community Hospital; however, some residents told inspectors that factors such as clothing not being returned after laundering and difficulties accessing internet services negatively impacted their day-to-day experience in the centre.

This unannounced inspection was conducted over two days by one inspector of social services. Over the two inspection days, the inspector spoke with 13 residents and five visitors to gain insight into residents' lived experiences at St John's Community Hospital. The inspector also spent time observing interactions between staff and residents and reviewing a range of documentation.

Residents were highly complimentary of the care received and the staff members who cared for them, telling the inspector that the staff were "pleasant", "lovely" and "kind". The inspector found that staff and management were knowledgeable about residents' needs, and that they promoted and respected residents' rights and choices. The inspector observed numerous friendly, compassionate, warm, dignified, and respectful interactions between residents and staff over the two inspection days.

St John's Community Hospital is situated in Enniscorthy, County Wexford. The premises are located within a healthcare campus shared with other healthcare services run by the same provider. The premises are single-storey and divided into four units: Elm, Oak, Ivy, and Beech. Elm and Oak provide long-term residential care for older adults, while Ivy provides dementia-specific residential care and one respite bed. Beech is a short-stay unit that provides a combination of rehabilitation, post-acute hospital step-down care, and respite services.

Bedroom accommodation in the centre is predominantly multi-occupancy, with over 75% of residents accommodated in 4-bedded rooms. Ivy accommodates 20 residents in three 4-bedded rooms and eight single rooms. Beech accommodates 32 residents in five 4-bedded rooms, two twin bedrooms and eight single bedrooms. Oak and Elm comprise six 4-bedded rooms and two twin bedrooms each. Due to the number of residents accommodated in multi-occupancy bedrooms in both Oak and Elm, there is a designated palliative care room in each of these units, also to accommodate residents who wish to have a single room as they approach the end of life. Each bedroom has en-suite toilet and shower facilities. There were also four assisted bath facilities in the centre.

All bedrooms seen by the inspectors were personalised with family photographs and items from home, such as paintings, bedding and ornaments. All the bedrooms had a television, a wardrobe, drawers, locked storage facilities, and a call bell. The

privacy and dignity of residents in multi-occupancy rooms were respected via the use of privacy screening as required.

The design and layout of the centre supported residents' movement throughout, with wide corridors, sufficient handrails, and comfortable seating in the various communal areas. These communal areas included a dining and sitting room in each unit. Additional communal areas included the activity room on Ivy, while Oak and Elm had relatives' rooms, and Beech had a separate day room. The inspector noted that Elm had a quiet room on the registered floor plans; however, on the inspection days, this room was observed to be used as a storage room. The provider was attempting to make communal areas comfortable and inviting, with domestic features such as bookshelves, ornaments, and dressers, providing a homely environment for residents. The inspector reviewed documentation outlining a project undertaken to improve the appearance and comfort of the Oak dining room, which was observed to be pleasantly decorated. Notwithstanding these efforts, many areas within the centre were experiencing decorative wear and tear and multiple aspects of the premises required repair as outlined under Regulation 17: Premises.

There was an on-site laundry service that laundered residents' personal clothing. This area was observed to be very clean and tidy, and its layout supported the functional separation of the clean and dirty phases of the laundering process. The inspector reviewed residents' clothing awaiting return from the laundry and noted that it had not been labelled. Some of the clothing had the resident's name written in pen or marker, and this identification was found to be faded.

While the centre was clean overall, action was required regarding infection prevention and control (IPC). For example, some inappropriate storage practices and unclean resident equipment were observed by the inspector,this will be outlined in the report under Regulation 27: Infection control.

Regarding fire safety, the inspector observed some inappropriate storage throughout the centre, which posed a risk to resident safety in a fire emergency. A number of fire doors were noted not to close fully. These and further fire safety findings are discussed under Regulation 28: Fire precautions.

In terms of outdoor space, the centre had several enclosed, secure gardens that were clean, tidy, and pleasantly landscaped. The gardens had comfortable seating, garden decorations, raised flower beds, and seasonal plants.

Over the two inspection days, the centre maintained a calm, relaxed atmosphere. On the first inspection day, the inspector observed residents participating in art in the morning and bingo in the afternoon. On the second inspection day, residents engaged in hand and head massage and hair care in the morning, while arts and crafts took place in the afternoon. Residents who did not participate in group activities were seen relaxing in their bedrooms and various communal areas, reading, watching television, listening to the radio, or hosting a visitor.

The inspector observed the dining experience over the two inspection days. Mealtimes were observed to be sociable and relaxed, with residents chatting and staff providing discreet, respectful assistance when required. The inspector observed

that most residents ate in the dining rooms, while a small number ate in their bedrooms. Drinks were readily available for residents at mealtimes and throughout the day in bedrooms and communal areas. While many residents were complimentary of the food and were offered a choice at meals, a small number expressed dissatisfaction with the available options on the menu.

Visitors were observed coming and going throughout the two inspection days. Visitors spoken with were complimentary of the care received by their loved ones and of the communication with them as a family. While praising the centre, some visitors informed the inspector of problems with clothing being mislaid and difficulties accessing the centre's internet services, which impacted their ability to involve the resident in video calls with family and friends.

The following two sections of the report present the findings of this inspection regarding the centre's governance and management arrangements and how these arrangements impacted the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

While established governance and management systems were in place to oversee the quality of care delivered to residents, this inspection found that further action was required to improve regulatory compliance across a number of regulations, including governance and management, as outlined in this report.

This was an unannounced inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended) and to review the registered provider's compliance plan arising from the previous inspection of 13 May 2025. The provider was seen to have progressed with the compliance plan following the last inspection; however, not all actions had been taken to ensure full regulatory compliance across several regulations, including premises and fire precautions, as set out in this report.

The inspector also followed up on two pieces of unsolicited information of concern received by the Office of the Chief Inspector since the last inspection. This information related to resident care, welfare and safety, inadequate staffing levels, arrangements for agency staff vetting, poor falls management, servicing and maintenance of residents' equipment, resources for resident care and management of responsive behaviours. The overall findings of this inspection indicated that residents were well cared for by kind and attentive staff. The inspector found the centre to be very well resourced, both in terms of staffing levels and other resources, including consumables, required for resident care. Falls management and the management of responsive behaviours were seen to be well managed and in accordance with the providers' procedures and individual residents' care plans.

However, concerns regarding the maintenance of resident equipment were partially upheld, and these findings are discussed under Regulation 23: Governance and management.

The inspection also informed the provider's application to vary conditions 1 and 5 of their registration. St John's Community Hospital was assessed as not compliant with Regulation 28: Fire precautions on six inspections since November 2019. The fire safety non-compliances identified had not ensured the safety and well-being of the residents in the designated centre. In particular, the Chief Inspector was not assured that the registered provider had:

- taken adequate precautions against the risk of fire.
- made adequate arrangements for containing a fire.
- or made adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and the safe placement of residents.

The Chief Inspector attached a restrictive condition requiring the registered provider to arrange for a fire safety risk assessment of the designated centre to be carried out and submit a copy of the report to the Chief Inspector by 30 September 2024. This assessment was required to identify, assess, and rate all fire risks throughout the centre, informed by the resident profile, with particular emphasis on the accommodation and fire safety requirements of all residents. The provider continued to engage with the Office of the Chief Inspector regarding this condition, and an updated risk assessment was received in November 2025.

The provider had undertaken works to address fire safety in the centre, namely:

- a new widened exit had been fitted in the Beech Ward, and the external route from this exit had been upgraded and
- new sixty minute fire rated doors were fitted in the Oak and Elm to protect the bedroom corridors from a fire in the day rooms

However, significant further action was required by the provider to review the fire safety strategy in the centre for nursing home use and the additional fire safety risks arising from that use. For example, there were still:

- extended travel distances
- excessively large fire compartments to facilitate horizontal evacuation
- inadequate numbers of final exits

These risks, along with the majority of the outstanding works assessed as necessary by the provider's risk assessment, had not been completed at the time of this inspection. However, the provider had secured funding for the works, appointed a contractor and obtained a revised fire safety certificate from the local authority. The provider informed the inspector that works were due to commence in the coming weeks and that the estimated completion date was 30/09/2026.

The registered provider is the Health Service Executive (HSE). There was a clearly defined management structure which identified lines of accountability and

responsibility for the service. The person in charge is responsible for the centre's day-to-day operations and reports to the manager of older persons' services. The manager of older persons' services represents the provider on regulatory matters and was present at the end of the inspection to receive feedback. This manager, in turn, reports to the general manager for older persons' services. The general manager was a person participating in management. This is a senior manager who supports the person in charge in their operational management and clinical oversight of the centre.

The person in charge worked full-time, five days per week, and was supported by two assistant directors of nursing, ten clinical nurse managers (CNMs), a team of nurses, healthcare assistants, catering, activities, housekeeping, portering, laundry and administration staff. Deputising arrangements were in place when the person in charge was absent. The centre was very well-resourced and benefited from health and social care professional services available on campus, which enhanced the care delivered to residents, including on-site access to physiotherapy, occupational therapy, speech and language therapy, and dietitian services. The provider employed agency staff, and these staff were vetted by the hiring recruitment agency in accordance with a written agency framework document agreed between the provider and the recruitment agency.

In terms of staff training and development, records reviewed found that staff had access to a suite of mandatory training to support them in their role. Records provided evidenced that staff had completed training on safeguarding vulnerable persons from abuse, fire safety, and manual handling, for example. Agency staff were noted to have confirmed their mandatory training requirements before commencing work in the centre. Notwithstanding this good practice, some gaps in adherence to mandatory training requirements required action. These matters are discussed under Regulation 16: Training and staff development.

There was documentary evidence of the communication systems in place between the person participating in management and the person in charge. The inspector reviewed the minutes of governance meetings. These meetings discussed key aspects of care provision for residents, including staffing, facilities, fire safety, infection control, risk management and health and safety. Within the centre, there was evidence of regular staff meetings focusing on key aspects of quality and safety, such as fire safety, staffing, staff training, care-planning, clinical incidents and complaints management.

The provider maintained a risk register to monitor and manage known risks. The provider monitored monthly quality care metrics for wounds, antibiotic use, falls, nutrition and hydration, and restraint use. The provider had an audit schedule examining key areas, including the dining experience, care planning, fire safety and environmental hygiene. These audits identified some service deficits and risks and were accompanied by time-bound quality improvement plans. Notwithstanding these good practices, the inspector found that the monitoring systems in place were ineffective in identifying the areas of concern identified by the inspector on this

inspection. This will be discussed under Regulation 23: Governance and management.

The provider had completed the annual review of the quality and safety of care delivered to residents for 2025. The inspectors saw evidence of consultation with residents and families reflected in the review. In this review, the registered provider also identified areas requiring quality improvement, for example, strengthening arrangements for the on-site management of residents' funds. The inspector also noted that there were action plans to improve quality and that the provider had taken steps to advance their quality improvement plans.

While the provider had a system to oversee accidents and incidents within the centre, further oversight was required to ensure all notifiable incidents are reported to the Chief Inspector of Social Services within the required timeframes, as discussed under Regulation 31: Notification of incidents.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

An application to vary conditions 1 and 5 of the centre's certificate of registration was received by the Chief Inspector.

The proposed variations involved the addition of several external facilities to the registered floor plans and the change of the date to comply with condition 5 in relation to fire safety to 30/09/2026.

The application was complete, contained all required information, and, at the time of the inspection, was under review.

Judgment: Compliant

Regulation 15: Staffing

Based on the inspector's observations of day and night duty staffing levels over the two-day inspection, a review of the worked and planned rosters and from speaking with residents, it was evident that the provider had sufficient staff with an appropriate skill mix to meet residents' needs. There were seven registered nurses in the centre at night.

Judgment: Compliant

Regulation 16: Training and staff development

While staff had access to a suite of training programmes to enable them to perform their respective roles, the inspector noted some gaps in adherence to mandatory training requirements, for example:

- 13% of staff had not completed training in managing challenging behaviour.

Several staff were overdue refresher training, for example:

- 17% of staff were not up-to-date in safeguarding vulnerable adults at risk of abuse.
- 14% of staff were not up-to-date in fire training general awareness.
- 8% staff were not up-to-date in fire extinguisher training.

Gaps in adherence to IPC training are discussed under Regulation 27: Infection control.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider was in breach of Condition 1 of their registration as they had made changes to the purpose and function of a number of rooms. The provider had not informed the Chief Inspector and had not applied to vary condition 1 of the centre's registration. The changes made included the following:

- The Oak housekeeping room was operating as an archive store and did not contain housekeeping facilities.
- The Ivy laundrette was operating as a store room and did not contain any laundrette facilities.
- The Elm quiet room was operating as a store room.

The inspector found that the management and oversight of service delivery, did not always ensure that the service provided to residents was safe, appropriate, consistent, and effectively monitored. For example:

- The provider's oversight systems in place to monitor risks, had not identified risks or driven quality improvement in areas such as premises, fire safety, staff training, infection control, communication difficulties, and residents' possessions, as found during this inspection.
- The oversight of incident reporting did not ensure that all notifiable incidents were identified and reported to the Chief Inspector within the required time frames.
- The oversight systems in place to ensure effective communication of up-to-date information regarding residents' clinical needs, had not ensured that the information in relation to the number and category of pressure ulcers onsite was accurate. Inaccurate information about this was provided to the

inspector on the first inspection day, however, the provider rectified the information over the course of the inspection.

- Management systems to ensure that equipment used by residents was safe, had not ensured that residents' equipment deemed by a technician to require replacement was promptly replaced. While acknowledging that the provider undertook annual servicing of hoist equipment, the inspector found several occasions in which the technician had recommended replacing a hoist, but this had not been actioned by the provider. The inspector found that four hoists were deemed to require replacement, dating back to December 2023; one hoist, to July 2024; and two hoists, to January 2025. Additionally, the continued use of the unsafe equipment had not been risk-assessed by the provider and was not included on the risk register.
- The inspector was unable to access records in relation to the provider's management of residents' pensions or confirm if residents' pensions and billing arrangements were being managed in accordance with the provider's policies, as the provider did not have any staff member available over the two inspection days who could access this electronic system. The provider was aware of these staffing skills deficits and was in the process of training staff members in this area.
- The secure storage of prescribed thickening agents was not fully effective, as the inspector found such products were accessible and not secured in multiple residents' bedrooms. These findings were brought to the attention of nurse management, who arranged for these products to be stored securely. These products must be used under supervision. Insecure storage of such thickening agents poses a risk of asphyxiation from accidental ingestion.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspector reviewed a sample of four residents' contracts and found that they set out the allocated bedroom number and occupancy. The contracts outlined the services to be provided and the fees to be charged, and referenced other services that residents may choose to avail themselves of at an additional cost, such as hairdressing.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider did not notify the Chief Inspector of three category II pressure ulcers sustained by residents in the quarter 4 period of 2025 and four category II pressure ulcers sustained by residents in the quarter 1 period of 2026. The provider

submitted an updated notification in relation to quarter 1 of 2026 after the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

The centre displayed its complaints procedure prominently at reception. Information posters on advocacy services to help residents make complaints were also displayed. Residents and families said they could raise a complaint with any staff member and were confident they could do so if necessary. The provider maintained a record of complaints received and the manner in which they were managed. The inspector reviewed all complaints received since the last inspection and found that they had been investigated and responded to in accordance with the regulation.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policies required by Schedule 5 of the regulations were in place, updated in line with regulatory requirements and made available to staff in the centre.

Judgment: Compliant

Quality and safety

While the inspector observed kind and compassionate staff treating residents with dignity and respect, enhanced governance and oversight were required to improve the quality and safety of service provision. Action was required to ensure regulatory compliance with premises, infection control, fire safety, communication difficulties, and personal possessions, as set out in this report.

Some residents in the centre had additional communication needs, including sensory needs, and a number did not speak English. These residents' communication needs were documented in their care plans, and the inspector found that staff were aware of them. Where a resident required access to a communication device, such as hearing aids, the staff ensured these aids were available to enable the resident's effective communication and inclusion. When a resident did not speak English, staff used paper-based communication aids with common phrases translated into the

resident's spoken language. The provider had also purchased some electronic tablet devices with a view to facilitating access to online translation services to support communication between residents and staff. Staff had access to these devices; however, when the inspector sought to observe such a device being used to access translation services, the device was unable to connect to the centre's internet services, impacting the resident's ability to communicate freely in accordance with their needs and ability. This matter is discussed under Regulation 10: Communication difficulties.

There were arrangements to support residents in accessing and retaining control over their personal property, possessions, and finances. Residents had adequate space in their bedrooms to store and maintain their clothing and possessions, including access to locked storage facilities. Residents who spoke with the inspector stated they were satisfied with the space in their bedrooms and storage facilities. Residents' clothing was laundered on-site by the provider's laundry staff, and towels and linen were laundered off-site by an external company. While residents were satisfied that their clothing was returned from the laundry clean, some residents and family members informed the inspector that their clothing was not always returned, others also reported delays in their items being returned. Staff spoken with informed the inspector that residents' clothing was sometimes sent to the external laundry provider in error. This matter is discussed under Regulation 12: Personal possessions.

The provider held small amounts of funds for four residents and also served as a pension agent for other residents. In respect of the small amounts of funds held, the records reviewed found that the provider had a transparent system for recording lodgements and withdrawals of residents' personal monies from their accounts. Records also found this system had been reviewed and strengthened in 2026 following a review by the provider. Regarding the management of residents' pensions, these funds are managed under the provider's "Patients' Private Property Guidelines," which are grounded in legislation. The inspector sought to review records relating to the management of resident pensions and nursing home charges; however, the provider had no staff available to access this electronic system during the two inspection days. This matter is referenced under Regulation 23: Governance and management.

St John's Community Hospital was found to be not compliant with Regulation 17 on seven inspections since May 2019. Notwithstanding the pleasantly decorated outdoor areas and recent works completed to make the Oak dining room more homely and comfortable for residents, the inspector observed that significant maintenance and repairs were required to improve the premises to ensure they were safer and more comfortable for residents, this is further discussed under Regulation 17: Premises.

The centre's interior was very clean. There was evidence that surveillance of healthcare-associated infections and multi-drug resistant organism colonisation was undertaken and recorded. The volume of antibiotic use was also regularly monitored. The provider had appointed nine trained infection control link nurses to provide specialist expertise. Staff were generally observed bare below the elbow and

adhered to best-practice guidelines regarding hand hygiene. The person in charge had completed a review following a recent infectious disease outbreak. Notwithstanding these good practices, not all practices were in compliance with the *National Standards for Infection Prevention and Control in Community Services* (2018) and other national guidance on IPC, to protect residents from infection, as discussed under Regulation 27: Infection control.

The provider had fire safety processes in place. Preventive maintenance for fire detection, emergency lighting and fire-fighting equipment was conducted at recommended intervals. Staff had access to fire safety training, and there were regular fire evacuation drills within each unit in the centre, which covered a range of scenarios. Each resident had a personal emergency evacuation plan to guide staff in the event of an emergency requiring evacuation. The procedures to follow in the event of a fire were clearly displayed, and the staff spoken with were knowledgeable about these procedures. There was a system for daily and weekly checking of the fire alarm, means of escape, fire safety equipment, and fire doors. Laundry records of lint removal were available for review. The majority of fire doors checked on the inspection days were found to be in good working order. As referenced in the capacity and capability section of the report, the provider was preparing to undertake a programme of works to increase fire safety at the centre and address several risks identified during previous inspections and in the provider's own fire safety risk assessment. Notwithstanding these good practices, further actions were required to ensure that residents and staff were adequately protected in a fire emergency. These findings are set out under Regulation 28: Fire precautions.

Regulation 10: Communication difficulties

In circumstances where a resident did not speak English, these communication needs were documented in the resident's care plan, and efforts had been made to support communication through the use of paper-based communication aids with common phrases translated into the resident's spoken language. Despite these efforts, further action was required to facilitate communication between residents who did not speak English and staff, in line with residents' needs and abilities. For example, the inspector observed staff making efforts to enhance communication by using the provider's electronic tablet to access translation services online. However, the inspector observed that this electronic tablet device did not connect to the centre's internet services. While acknowledging these staff efforts to facilitate communication in these circumstances, these efforts were not fully effective in enabling a resident who did not speak English to communicate their needs freely.

Judgment: Substantially compliant

Regulation 11: Visits

The provider had a written visitor policy as required by the regulation. The inspector observed that visits to the centre were encouraged. The visiting arrangements in place did not pose any unnecessary restrictions on residents. The registered provider had several private and communal spaces for residents to host a visitor.

Judgment: Compliant

Regulation 12: Personal possessions

Not all residents had their clothes returned to them, while other residents informed the inspector of delays in returning their clothing. The inspector noted that similar feedback had been raised in resident and family questionnaires.

Judgment: Substantially compliant

Regulation 17: Premises

While the premises were designed and laid out to meet the number and needs of residents in the centre, some areas required further maintenance, repair and review to be fully compliant with Schedule 6 requirements, for example:

- Storage practices within the centre required review as the inspector found examples of inappropriate storage arrangements, for example, floor buffers, commodes and ladders were stored in residents' communal bathrooms on Oak and Elm.
- Some parts of the centre were experiencing decorative wear and tear, with damaged doorframes, loose tiles, scuffed walls, and plaster missing from resident bedrooms and communal areas. Other areas, had damaged bed frames and a cracked window.
- The floor was observed to be uneven in some areas, for example, the Elm day room, posing a risk of falls to residents.
- Some areas were seen to have exposed wiring, for example on Ivy and Beech units.
- The folding doors separating the Oak and Elm sitting rooms were very difficult to open and close.
- One of the washing machines in the laundry required review because it operated at a very high volume, audible to the inspector from bedrooms 1 and 3 on Elm.

Judgment: Not compliant

Regulation 18: Food and nutrition

Overall, residents were content with the food, snacks, and drinks available. Food was prepared and cooked onsite. Choice was offered at all mealtimes, and adequate quantities of food were provided during the day and in the evening. Residents had access to fresh drinking water and other refreshments throughout the day. There was adequate supervision and discreet, respectful assistance at mealtimes. There was evidence of written communication between the nursing and catering teams to ensure that the dietary needs of each resident, as prescribed by healthcare or dietetic staff, were met.

Judgment: Compliant

Regulation 27: Infection control

While the interior of the centre was very clean on the day of inspection, some further areas required attention to protect residents from infection and to comply with the *National Standards for Infection Prevention and Control in Community Services* (2018) and other national guidance on IPC, as well as ensuring staff received suitable IPC training, for example:

Storage practices posed a risk of cross-contamination, for example:

- Resident clinical equipment labelled as clean was stored next to equipment which was visibly unclean in the Ivy unit.
- Residents' seating and hoists were observed to be stored within shared ensuite toilet facilities.

The decontamination of resident care equipment required review, for example:

- Some residents' equipment, such as crash mats, were unclean with food and liquid staining and other debris.
- The inspector observed that two sluice rooms had toilet brushes located adjacent to the sluice hopper. Staff confirmed that these toilet brushes were used to clean the bedpans. Using a toilet brush to clean commodes increases the risk of environmental contamination with multi-drug resistant organisms (MDROs) and poses a splash/exposure risk to staff. Bedpan washers should be capable of disposing of waste and decontaminating receptacles.

Not all staff had received suitable training on infection prevention and control, for example:

- While 97% of staff had completed hand hygiene training and 92% of staff had completed one Antimicrobial Resistance and Infection Control (AMRIC) module, these training requirements were not aligned with the requirement

for staff training contained within the provider's published guidance on IPC training for staff entitled "*Core Infection Prevention and Control Knowledge and Skills: A Framework Document*" or the provider's staffing training and development policy for the centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

As referenced in the capacity and capability section, St John's Community Hospital has been assessed as not compliant with Regulation 28: Fire precautions on six inspections since November 2019. While the provider had undertaken some work to address fire safety in the centre, the majority of work remained outstanding on the inspection days.

Additionally, the inspector observed that some further areas of fire safety did not align with regulatory requirements, for example:

- The provider had not ensured that the means of escape were maintained at all times. The inspector found a wheelchair labelled as requiring return stored in front of an emergency exit, while three steel catering trolleys were stored in the corridor outside the catering department. These practices posed a risk of obstructing these escape routes in an emergency. Escape routes must be kept free of obstruction and inappropriate storage.
- Fencing was added outside the Beech day room, which enclosed the area directly outside an emergency exit. Meaning there was no way to access the escape route and in the event of an emergency the residents would be contained within the fenced area. The provider had not risk-assessed this matter to ensure the relevant controls were in place to prevent the fencing from hindering safe evacuation from the centre in an emergency.
- The provider had not ensured all fire doors provided effective containment of smoke and fire, for example, the inspector found that fire doors to the Oak equipment store and the conference library were not closing fully, while the cold smoke seal to the Elm hairdressing room was damaged. Fire doors not closing or with damaged seals posed a risk to these doors ability to contain smoke and fire in an emergency.
- Oxygen cylinders were stored at nursing stations, located in escape corridors and close to plugged-in electrical devices, on Oak and Elm wards.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed a sample of nursing notes and care plans for residents across three of the four units on-site. There was evidence that residents were comprehensively assessed upon admission using a suite of evidence-based risk assessment tools to evaluate risks, including falls, pressure sore development, malnutrition, manual handling needs, and dependency levels. Care plans were developed based on these assessment tools. The care plans viewed by the inspectors were person-centred and specific to that resident's needs. Care plans were reviewed at required intervals, and there was evidence of consultation with the resident and, where appropriate, their family during these reviews.

Judgment: Compliant

Regulation 6: Health care

The health of residents was promoted through ongoing medical reviews and access to a range of healthcare providers who provided on-site reviews, including chiropodists, physiotherapists, occupational therapists, speech and language therapists, and dietitian services. The records reviewed showed evidence of ongoing referral and review by these healthcare services for the residents' benefit.

Judgment: Compliant

Regulation 9: Residents' rights

Staff were respectful and courteous towards residents. Residents had the opportunity to be consulted about and participate in the organisation of the designated centre by attending residents' meetings and completing questionnaires. The centre offered weekly in-house religious services. Residents had access to radio, television, newspapers, and telephone services throughout the centre. Residents also had access to independent advocacy services.

There was a varied programme of activities and entertainment provided seven days per week, including bus trips, live music, and the celebration of special events such as St Patrick's Day, Mother's Day and Easter.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Substantially compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St John's Community Hospital OSV-0000604

Inspection ID: MON-0044216

Date of inspection: 10/04/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• Following inspection, a full review of training compliance was undertaken. The training matrix has been updated by the Practice Development Co-ordinator with oversight by the Person in Charge (PIC).

• Mandatory training gaps identified in safeguarding, fire safety and responsive behaviour are being addressed through a structured training programme. Staff identified as non-compliant or overdue have been scheduled for immediate completion.

• Infection Prevention and Control (IPC) training is currently underway, with Healthcare Assistants progressing completion as prioritised.

• Training for managing responsive behaviour is ongoing throughout the year and on target to complete by year end with 100% of staff trained. A second train the trainer is completing training in June to facilitate additional training days. On target to complete by Dec 2026.

• Safeguarding training is in place for all staff, with systems to ensure compliance is monitored and maintained. All staff are required to complete safeguarding training and remain up to date in line with organisational policy and regulatory requirements training has organised to get up to 100% by end of Sep 2026.

• Further Fire extinguisher training has been booked in July 27th & 24TH Sep. Targeted to be completed by end of Oct 2026.

• General fire training with HSE Land training will continue and reach target of 100% by Aug 2026.

• Compliance with mandatory training will be a standing agenda item at governance meetings. Regular audits of the training matrix will ensure sustained compliance, with escalation processes in place for any future lapses.

Date for compliance: 31 Dec 2026

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• A full review of room usage has been undertaken. The Elm quiet room, Oak housekeeping room and Ivy laundrette have been re-designated in line with their current function. Updated floor plans and a revised Statement of Purpose were submitted to HIQA on 24/04/2026. The provider will progress an application to Vary Condition 1 without delay, should this be required following HIQA review of our submission.

The risk management framework has been enhanced, and the risk register updated to include:

o Hoist replacement requirements and associated risks.

o Fire safety risks, including fencing and compartmentalisation.

o Risks relating to staff training compliance, including maintaining up-to-date mandatory training records and ensuring timely completion of required training.

o Risks associated with communication difficulties, which may impact residents' understanding, engagement, and the effective delivery of care and services.

o Risks associated with the management of residents' personal possessions and laundry, including the potential for loss, damage, or misidentification of items, and the impact this may have on residents.

• All hoists identified by external technicians as requiring replacement have now been approved following an external survey completed in April 2026. A replacement programme is in progress, and interim risks have been assessed, documented and are actively managed.

• Immediate action has been taken to ensure the safe storage of prescribed thickening agents. Secure storage arrangements have been implemented across the centre, supported by staff guidance and risk assessment.

• Arrangements to ensure continuity and oversight of residents' financial management (PPPA) are being addressed through targeted staff training. Additional staff are being trained to access the system to ensure appropriate oversight at all times.

• A robust process for recording and reporting pressure ulcers has been implemented, including the introduction of a Pressure Ulcer Register with monthly reporting to nursing management to ensure accuracy and oversight.

• Oversight of incident reporting has been reinforced. A review of notifiable incidents has been completed, and any required retrospective notifications have been submitted. Systems are now in place to ensure all notifiable incidents are identified and reported within required timeframes.

Date for compliance: 31 August 2026

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All outstanding retrospective notifications for Category II pressure ulcers (Q4 2025 and Q1 2026) have been submitted to the Chief Inspector.
• Weekly incident review by the PIC has been implemented to ensure all notifiable incidents are identified and reported within required timeframes.
• A Pressure Ulcer Reporting Log is now in place across all units, with monthly oversight by nursing management to ensure accurate tracking and timely notification.
• Staff training and guidance on notification requirements has been reinforced to support consistent compliance.
• Ongoing audit and oversight of notifications will be maintained through governance structures.
Date for compliance: Action completed on 30th April 2026.

Regulation 10: Communication difficulties	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication difficulties:

• Actions have been initiated to strengthen communication supports for residents with language needs. All such residents have a documented assessment and individualised care plan outlining appropriate communication strategies.
• Wi-Fi connectivity issues impacting the effectiveness of electronic translation tools have been escalated, with approval for additional modems. Wi-Fi enabling upgrades will be progressed as part of the Fire Improvement Works Programme from June 2026.
• Electronic devices are available, and interim translation supports are being accessed where required until full connectivity is in place.
• Staff continue to utilise paper-based communication aids, pictorial supports and translation applications where feasible. Multilingual staff are also utilised to support residents' communication needs.
Date for compliance: 30 December 2026

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions: • Residents are supported to choose their preferred laundry arrangements (onsite or home). All clothing is labelled on admission, and families are requested to inform staff of additional items to ensure prompt labelling. • A strengthened labelling system has been implemented, including the purchase of a labelling machine, to ensure all items are clearly identified and returned to the correct resident. • Laundry processes have been reinforced with all staff, including agency staff, to ensure consistent adherence to procedures. • Systems have been implemented to ensure that all clothing laundered onsite is returned to residents the same day. • Ongoing monitoring and oversight of the laundry service are in place to promptly identify and address any delays or losses, ensuring improvements are sustained. Date for compliance: Action completed on 30 April 2026	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Immediate actions have been taken to address identified risks. Inappropriate storage of equipment (including ladders, commodes and floor buffers) has been removed from communal bathrooms, and all equipment is now stored in designated areas. This action was completed on 20/05/2026 and is subject to ongoing monitoring through environmental audits. • A programme of repair and maintenance has been initiated. Issues including damaged doorframes, scuffed walls, loose tiles, plaster defects and damaged bed frames have been logged and are being addressed under the centre's maintenance plan. The cracked window will be repaired by 15/06/2026. • Electrical concerns, including exposed wiring, have been assessed, with remedial works scheduled and prioritised based on risk. • Flooring issues, including uneven surfaces identified in the Elm day room, have been assessed by Maintenance – issues posing an immediate risk are being progressed without delay - a full survey will be completed following the Fire Improvement Works Programme and any remaining remedial works progressed. • The identified washing machine is being replaced, with quotations obtained and procurement in progress to reduce noise impact on residents. • Environmental improvements and refurbishment works, including upgrades to communal areas, will be progressed in line with the Fire Improvement Works Programme. • Premises and environmental standards will be regularly monitored through audit and governance structures to ensure ongoing compliance with Schedule 6 requirements.	

Expected compliance date: 31st December 2026

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Immediate corrective actions have been implemented:
• Inappropriate cleaning practices have ceased, and toilet brushes have been removed from sluice rooms (completed 10/04/2026).
• All resident equipment, including crash mats, has been deep cleaned and incorporated into routine cleaning schedules (completed 12/04/2026).
• Clear segregation of clean and unclean equipment has been established, with appropriate storage arrangements now in place to minimise cross-contamination risks.
• Equipment is no longer stored in shared ensuite facilities.
• Decontamination processes have been reviewed to ensure alignment with national IPC standards and best practice guidance. Appropriate methods and equipment for cleaning commodes and bedpans have been reinforced with staff.
• A full review of IPC training requirements has been completed by the Person in Charge to ensure alignment with the HSE "Core Infection Prevention and Control Knowledge and Skills: A Framework Document" and the centre's training policy.
• A revised IPC training matrix has been implemented, clearly outlining required competencies for all staff grades. All staff have been scheduled to complete outstanding IPC and AMRIC training modules.
• Ongoing monitoring of IPC practices and training compliance is now embedded through regular environmental audits, training audits and governance oversight to ensure sustained compliance with Regulation 27 and the National Standards for Infection Prevention and Control in Community Services (2018).

Expected compliance date: 31st July 2026

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Immediate actions have been taken to address identified fire safety risks:
o All obstructions have been removed from escape routes, and systems are in place to ensure corridors and exits remain clear at all times.
o Oxygen cylinders have been relocated to appropriate, designated storage areas away

from escape routes and electrical sources.
o Fire doors identified as defective have been repaired or scheduled for urgent repair, and damaged smoke seals have been replaced to ensure effective containment.
• Fire safety risks identified during the inspection, including escape route management, fencing restrictions, and compartmentation deficits, have been formally risk assessed and recorded on the centre's risk register, with appropriate controls implemented.
• The fencing at the Beech unit has been risk assessed. Works are underway to install a gate to ensure safe evacuation, with completion scheduled for July 2026.
• A comprehensive Fire Improvement Works Programme has been established, with funding secured and contractors appointed. This programme addresses key regulatory requirements, including:
o Means of escape and external exit safety
o Fire compartmentation and containment
o Travel distances and safe evacuation routes
• Interim fire safety measures, including enhanced staff vigilance, regular checks of escape routes, and reinforced fire safety training, have been implemented pending completion of works.
• Fire safety compliance and progress of works will be closely monitored through governance structures, with regular review at management meetings to ensure compliance with Regulation 28 and associated national standards.
Date for compliance: 30 September 2026

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that a resident, who has communication difficulties is facilitated to communicate freely in accordance with the residents' needs and ability.	Substantially Compliant	Yellow	30/12/2026
Regulation 12(b)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that his or her linen and clothes are laundered regularly and returned to that resident.	Substantially Compliant	Yellow	30/04/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff	Substantially Compliant	Yellow	31/12/2026

	have access to appropriate training.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/12/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/08/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	31/07/2026
Regulation 27(b)	The registered provider shall ensure guidance published by appropriate national authorities in relation to infection prevention and control and	Substantially Compliant	Yellow	31/07/2026

	outbreak management is implemented in the designated centre, as required.			
Regulation 27(c)	The registered provider shall ensure that staff receive suitable training on infection prevention and control.	Substantially Compliant	Yellow	31/07/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/09/2026
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/09/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/09/2026
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/09/2026
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all	Substantially Compliant	Yellow	30/09/2026

	persons in the designated centre and safe placement of residents.			
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2)(a) to (e) of Schedule 4.	Not Compliant	Orange	30/04/2026