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:	The Meath Community Unit
Name of provider:	Health Service Executive
Address of centre:	1-9 Heytesbury Street, Dublin 8
Type of inspection:	Unannounced
Date of inspection:	22 October 2025
Centre ID:	OSV-0000477
Fieldwork ID:	MON-0048148

About the designated centre

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

The Meath Community Unit is a 48 bedded Unit which provides residential, convalescence and respite care. There is a Day Care Centre on site which provides services for older people from the area. Rooms are located over three floors, Camden (1st floor), John Glenn (2nd floor) and Maureen Potter (3rd floor). These were named by the residents committee. The day room where some activities are run is located on the ground floor.
Access to residential care is following assessment by a Consultant in Medicine for the Elderly and completion of the Common Summary Assessment Report (CSAR). Respite services provide people with short breaks away from home, this service is offered to enable carers to take a holiday or a break to help them to continue caring. It is also provided to people who are living alone and require the support which is offered by occasional respite. Initial arrangements are made through Nursing Staff, Social Workers or General Practitioners, subsequent admissions are co-ordinated through the family and the Public Health Nurses and Nursing Administration in the unit.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	44

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
Wednesday 22 October 2025	08:15hrs to 15:35hrs	Laurena Guinan	Lead

What residents told us and what inspectors observed

The inspector was told by residents living in The Meath Community Unit that they were happy to live there, and that the staff were very kind. On arrival, the inspector walked around the unit which is spread over five floors. On the ground floor were two large communal rooms which were used for group activities. One of the rooms had a bar for social occasions, and displays of photographs and artwork were in both rooms. The rooms were clean and tidy, but neither had a call-bell which was brought to the attention of the person in charge. This will be discussed under Regulation 17: Premises. One of these rooms gave access to a secure courtyard with planting, furniture and safe pathways, and residents and visitors were using the area on the day of inspection. An appropriately furnished smoking area was also provided in the courtyard.

The first, second and third floors contained three residential units called Camden Unit, John Glenn Unit and Maureen Potter Unit. Each unit had a mix of single and twin bedrooms, two sitting rooms and a dining area. The inspector saw that all units were kept clean, and the corridors were clear of obstruction and had handrails so residents could mobilise safely. The corridors had old photos of Dublin and movie stars, and one of the units had a display of rugby, GAA and soccer jerseys and flags. Many of the bedrooms were personalised with residents' own photos, throws and cushions, and the centre as a whole had a warm, homely atmosphere. Residents in twin rooms told inspectors that while their preference would be for a single room, they were happy with their room and had space and privacy. There were appropriate privacy screenings in place, and each resident had their own TV.

The sitting rooms on each unit were seen to be well used on the day of inspection. The armchairs in the sitting rooms at the end of the corridor on the first and second floors appeared worn and unclean, which was brought to the attention of the Assistant Director of Nursing. The dining rooms were clean and tidy, but the floors had areas that were torn and unclean. This was a finding on the last inspection and was brought to the attention of the person in charge, who said funding for new flooring had been secured and the floor was scheduled to be replaced in January 2026. The tables were set in the dining areas prior to meal times, with the menu on display. Residents spoken with told the inspector that the food was tasty and plentiful. They said they were always given a choice, and their preferences were always accommodated. A review of the menus had recently been conducted by a dietician, and a number of the recommendations were being implemented. One of these was a measure to introduce menus with pictures and easy-to-read print, and a sample was shown to the inspector.

Each unit had its' own treatment, stores, sluice and cleaners' rooms. These were all seen to be appropriately secured and equipped, and kept clean and tidy. A bath was available for residents on the first floor, and the bathroom was seen to be clean and

accessible. Each unit had a pantry which was clean and stocked with food items to provide snacks and drinks to residents outside of meal times.

Visitors were seen coming and going on the day of inspection, and those spoken with told inspectors that they were very impressed with the care given to their loved ones, and the excellent communication with families. One visitor described the care as 'second to none'. Residents said they were free to have visitors at any time, and could also go out with their families if they wished.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspector also followed up on the compliance plan from the previous inspection in October 2024, and statutory notifications submitted to the Office of the Chief Inspector since that inspection.

There was a clearly defined management structure in place, with clear lines of accountability and responsibility. After the last inspection, it was found that the centre had been operating without a person in charge for a number of months. This had been addressed, with the appropriate notification submitted to the Office of the Chief Inspector retrospectively. A person in charge had been appointed who worked full-time in the centre, and they had the qualifications and experience as required under Regulation 14: Person in charge. The person in charge was supported in their role by a regional manager, two assistant directors of nursing and a panel of clinical nurse managers. The management was further supported by a team of nurses, health care assistants, and household, cleaning, kitchen, portering and administration staff.

The inspector reviewed a system of audits that had action plans in place to address areas identified as requiring improvement. This included a weekly call-bell audit which had been implemented as part of the compliance plan from the previous inspection. The audit showed that when faults were identified, they were rectified promptly. Regular schedules of management, staff and residents' meetings were seen. Issues highlighted at these meetings had action plans in place. For example, following a falls review meeting, training in the use of an incident reporting system was recommended. This training had been provided to a number of staff, with more sessions scheduled. The inspector reviewed the training matrix, which had been updated since the last inspection. The matrix was comprehensive and accessible, allowing for oversight of staff compliance in all areas of training required in the centre. The 2024 annual report was reviewed by the inspector, and this had a quality improvement plan. However, while the review identified what had been

achieved the previous year, it did not identify areas of improvement for the coming year. This meant that the quality improvement plan lacked initiatives aimed at enhancing the service provided. Individual departments, such as music therapy and social work, had quality improvement initiatives that were seen to be in progress or completed. Residents' satisfaction surveys were seen to have been conducted, but there was no evidence to show that these, or other methods of consultation with residents and families, had been included in the annual review. These will be discussed under Regulation 23: Governance and management. All commitments from the previous compliance plan had been implemented. Two issues remained outstanding and both were being addressed. The flooring of the dining areas as discussed previously, and fire containment risks which will be discussed later in the report.

The registered provider had been granted an application to convert a staff sitting room to a records store room. The room was clean, organised and well-ventilated, allowing for safe and secure storage of records. Each residential unit had a lockable cabinet at the nurses' station for the storage of current residents' records. Two of theses cabinets were found to be unlocked and without a key. Staff on each unit told the inspector that the key had been missing for some time and this had not been reported to maintenance. This was brought to the attention of the person in charge who said it would be addressed.

Following the inspection in October 2024, the registered provider had committed to implementing a checklist to ensure correct and timely reporting of incidents. Additionally, each unit now submitted weekly reports of incidents to the person in charge. These were then reviewed by the appropriate teams, and discussed at management meetings to ensure good oversight. The inspector saw that the checklist was in use, and all notifications submitted to the Office of the Chief Inspector had been received within the required time frames.

Regulation 14: Persons in charge

The registered provider had ensured that there was an appropriate person in charge.

Judgment: Compliant

Regulation 21: Records

The storage of residents' records on two of the residential units required review to ensure they were stored securely.

Judgment: Substantially compliant

Regulation 23: Governance and management

The preparation of the annual review requires review to ensure it includes consultation with residents and families, and identifies areas that require improvement.

The development of the quality improvement plan requires review to ensure it addresses issues highlighted by the annual review.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The Office of the Chief Inspector had been notified of incidents within the specified time frames.

Judgment: Compliant

Quality and safety

The inspector spoke with a number of residents and visitors during the day, and there was positive feedback about the quality of care and the activities provided.

The inspector reviewed eight care plans, with a focus on end-of-life care. Assessments were seen to be conducted within 48 hours of admission using validated assessment tools, and care plans were implemented based on these assessments. Where a resident had returned from a hospital admission, or had been resident for a lengthy period, the inspector saw a comprehensive re-assessment had been conducted, with care plans updated as necessary. Care plans were routinely updated on a minimum of a four monthly basis.

The end-of-life care plans in place were person centred and provided sufficient information to ensure the residents' needs and wishes would be met. Six staff members from different departments had completed facilitator training in end-of-life care. This team was conducting reflections on the care provided to residents at the end-of-life stage, which included feedback questionnaires from families, to identify areas and recommendations for improvement. A single room on each unit had been allocated for residents who were at the end-of-life stage to afford them and their

families privacy. Families were provided with a bed to stay overnight, should they wish to do so. Pamphlets on end-of-life care and bereavement were also available on all units.

Over the course of the day, the inspector saw residents engaged in karaoke, colouring and watching TV. In the afternoon, a pet therapy dog visited and was seen to be well received. A review of residents' meetings showed that residents had requested more activities at the weekends and in response to this, the activity staff offered two different activities in the communal rooms downstairs each Saturday and Sunday. Residents spoken with said that they enjoyed the activities on offer, while others said they enjoyed the peace of their own room where they watch TV or read. Connections with the community were encouraged, including a music performance by residents and music students earlier in the year. Preparations were being made to facilitate residents to vote in the upcoming presidential elections.

The registered provider had made significant improvements in fire safety since the last inspection. Areas of service penetration in the communications room and in an electrical distribution room had been sealed, and fire evacuation chairs for both stairways on each floor had been provided. A record of fire drills was seen that included vertical evacuation, and there was high compliance of staff attendance at fire training. Fire evacuation maps were on display throughout the centre and there was emergency lighting to all exits. The registered provider had conducted a comprehensive fire safety audit and a schedule of works had commenced to rectify fire containment issues seen on the last inspection.

Regulation 13: End of life

The person in charge had ensured that the needs and wishes of the resident at end-of-life would be met, and that families were facilitated and communicated with.

Judgment: Compliant

Regulation 17: Premises

Not all areas of the premises conformed to the matters set out in Schedule 6 as evidenced by:

- Some communal rooms did not have call-bell facilities.
- Flooring in the dining areas were in a state of disrepair.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had taken adequate precautions against the risk of fire.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The registered provider had ensured that assessments were completed and care plans implemented within 48 hours of a resident's admission. Care plans were reviewed at a minimum of four monthly intervals.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had ensured that residents had adequate facilities and opportunities to engage in activities, communicate freely and exercise their rights. Residents were consulted about and participated in the organisation of the centre.

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	
Regulation 14: Persons in charge	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Meath Community Unit OSV-0000477

Inspection ID: MON-0048148

Date of inspection: 22/10/2025

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • Designated Centre's Person in Charge contact with representative from the maintenance department on the day of inspection to action new locks and keys for record storage area – Complete 17.11.25. • Daily ward checks by representative from the nurse management team to monitor that all records are stored, secured with a checklist put in place to provide governance oversight reassurance that records are maintained in the Nursing admin office – Complete 17.11.25 and ongoing monitoring thereafter.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Designated Centre's Person in Charge to ensure resident satisfaction survey includes consultation with family and residents. This feedback is reviewed and incorporated into service improvement plans as required – Complete 17.11.25 and ongoing monitoring thereafter. • Each resident has a yearly family meeting with Designated Centre's Multidisciplinary Team (MDT) or more frequently if needed. A key focus is to encourage open dialogue between residents regarding will and preferences with the team around the planning of their care – Complete 22.11.26. • Records of family engagements are available on each ward - required – Complete 17.11.25 and ongoing monitoring thereafter. • Review the planning and development of the existing Annual Review process and action plan generated to ensure quality improvement plans address issues highlighted by	

the residents annual consultation process - Complete 31.12.25 and ongoing monitoring thereafter.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Action plan has been generated to address the installation of new call bell facilities in identified areas within the communal areas identified in line with Schedule 6 – Complete 30.06.25.
• Action plan generated to address the flooring in the dining areas identified in disrepair – Complete 30.06.25.

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 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.	Substantially Compliant	Yellow	30/06/2026
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	17/11/2025
Regulation 23(1)(f)	The registered provider shall ensure that the review referred to in subparagraph (e) is prepared in consultation with residents and their families.	Substantially Compliant	Yellow	22/11/2026
Regulation 23(1)(h)	The registered provider shall ensure that a quality improvement plan is developed and	Substantially Compliant	Yellow	31/12/2025

	implemented to address issues highlighted by the review referred to in subparagraph (e).			