Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

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| Name of healthcare service provider: | Peamount Healthcare |
| Centre ID: | OSV-0007266 |
| Address of healthcare service: | Newcastle Road<br>Newcastle<br>Co. Dublin<br>D22 Y008 |
| Type of Inspection: | Unannounced |
| Date of Inspection: | 03/02/2026 and 04/02/2026 |
| Inspection ID: | NS_0190 |

## About the healthcare service

### Model of hospital and profile

Peamount Healthcare is an independent voluntary organisation that provides rehabilitation services on behalf of the Health Service Executive (HSE) as per Section 38 of the Health Act 2004 (as amended). Peamount Healthcare is governed and led by a Board of Directors and the rehabilitation unit works in partnership with the HSE's Dublin and Midlands Health Region.* Peamount Healthcare also comprises designated centres in intellectual and disability services and older person services.

This inspection focused on the rehabilitation services provided by the organisation.

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| **Number of beds** | Rehabilitation services comprise 100 inpatient beds:<br>▪ 50 age related rehabilitation beds<br>▪ 25 respiratory rehabilitation beds<br>▪ 15 neurological rehabilitation beds<br>▪ 5 rheumatology rehabilitation beds<br>▪ 5 winter initiative beds (short term initiative). |

## How we inspect

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

To prepare for this inspection, the inspectors† reviewed information which included previous inspection findings, information submitted by the provider, unsolicited information and other publicly available information since last inspection.

* 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.

†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.

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 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 |
|---|---|---|---|
| 03/02/2026 | 12:30 – 17:45 | Eileen O'Toole | Maeve McGarry<br>Linda Daffy |
| 04/02/2026 | 8.30 – 15:15 | Eileen O'Toole | Maeve McGarry<br>Linda Daffy |

## 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
- the deteriorating patient[§] (including sepsis)[**]
- transitions of care.[††]

The inspection team visited three clinical areas:

- Cherryfields (a 25-bedded ward for patients over 65 years of age requiring rehabilitation care)
- Age Related Rehabilitation Unit (ARRU) (a 25-bedded ward for patients over 65 years of age requiring rehabilitation care)
- Greenfields (a 25-bedded ward which comprised of 15 beds for patients requiring neurology rehabilitation care, five beds for patients requiring rheumatology rehabilitation care and five beds that were used as part of the HSE's winter initiative on the day of inspection).

During this inspection, the inspection team spoke with representatives of the hospital's Executive Management 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. Patients were complimentary about the care they received across the three clinical areas visited as part of this inspection. Inspectors noted that patients used the communal

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

areas in the wards and were encouraged to socialise together as part of their rehabilitation programme. There were spacious dining rooms for meals, which were observed as well utilised on the first day of inspection. Patients had access to games, art and sitting areas with radios, all contributing to a welcoming environment.

Patients were complimentary about the staff and the care received, commenting that some staff *"could not do enough for you"* and that they felt *"well cared for".* Inspectors observed effective communication between staff and patients which was supported by patients who said that they *"had a good relationship with the doctor"* and *"all you have to do is ask".*

The majority of 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 found staff approachable and would talk to them.

## 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.

The rehabilitation service at Peamount Healthcare was found to be compliant with two national standards (5.2 and 5.5) and substantially compliant in two national standards (5.8 and 6.1). Key inspection findings leading to these judgments 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 rehabilitation service 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 in August 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. The rehabilitation service in Peamount Healthcare was now part of the HSE Dublin and Midlands Health Region. As a voluntary organisation, the overarching governance body was the Board of Directors.

Overall, responsibility and accountability for the operational delivery of rehabilitation services in the hospital lay with the chief executive officer (CEO) who reported directly into the Board of Directors. The hospital's consultant lead for the organisation provided clinical oversight and leadership and also reported to the Board of Directors. At the time of inspection, the lead consultant role rotated every six months between four specialities. Inspectors were informed that there was change in progress in that the consultant lead position would be for a period of two years, with a commitment to Peamount Healthcare of one day per week.

The director of nursing (DON) was responsible for the organisation and management of nursing services within the rehabilitation service and reported to the CEO. The director of rehabilitation services was responsible for the rehabilitation service, pharmacy services and line managed the health and social care professionals (HSCPs) and reported to the CEO.

The CEO reported on activity data, incidents, human resources (HR), infection prevention and control (IPC) and risks at board meetings which took place six times per year. The Quality, Safety and Operational Risk Committee met quarterly, was accountable to and reported into the board and provided assurance to the board that there were appropriate and effective systems in place within the rehabilitation service. This committee was tasked with the oversight and monitoring of risk management processes and quality initiatives. The Quality, Safety and Operational Risk Committee was chaired by a board member, had appropriate membership and was a forum where quality reports were presented which included information on complaints, risks, incidents and trending, service improvement updates, quality walkabouts, mandatory training and IPC surveillance. These committee meetings were action orientated with actions assigned to individuals, however these actions were not always time-bound.

The rehabilitation service had quarterly meetings with the integrated healthcare area (IHA) manager from the Health Region where key performance metrics were reported pertaining to activity, risks, complaints, incidents, HR and staff training. Inspectors saw evidence that these meetings were action oriented with specific time-bound actions assigned to an individual.

The Executive Management Team (EMT) met every two weeks where updates on corporate, nursing, HR, finance, rehabilitation services, strategy and quality and safety was discussed. The EMT meetings were action orientated with actions assigned to individuals, however these actions were not always time-bound.

The Quality and Safety Steering Group met quarterly and was, in the main, an information sharing forum for department managers. The group was chaired by the CEO and an overview of incident management including trending and learning was presented at this forum. An overview of quality and safety was also presented which included complaints, IPC surveillance, compliance with mandatory training and medication reconciliation. This group reported into the Quality, Safety and Operational Risk Committee.

The Infection Prevention and Control Committee (IPCC) was chaired by the director of nursing, met in line with their terms of reference and reported into the Quality, Safety and Operational Risk Committee. The IPCC was accountable for developing and delivering an integrated infection prevention and control programme. Meetings followed a set agenda which included surveillance, audits, training and antimicrobial stewardship. Meetings were not always action oriented, not always assigned to individuals and not time-bound. The terms of reference was out of date.

The Drugs and Therapeutics Committee, chaired by the clinical lead for the organisation, reported into the board and the Medical Advisory Committee (MAC) and was assigned with responsibility for the safe and effective use of medication in the hospital. This committee met once in 2025 which is contrary to the terms of reference which stated twice per year and inspectors were unable to determine if the membership was appropriate or if there was multidisciplinary attendance. The minutes reviewed by inspectors were not action oriented. The chief pharmacist from Peamount Healthcare attended the Drugs and Therapeutics committee in an observer capacity at Tallaght University Hospital.

The Medication Incident Review Group provided oversight of medication incidents, was chaired by the senior pharmacist and reported into the Drugs and Therapeutics committee and the Quality and Safety Steering Group. Membership of this group included pharmacy, nursing and quality. From minutes reviewed, there was evidence of follow up and actions taken following medication incidents.

As found at the previous HIQA inspection, the rehabilitation service had formalised governance arrangements to ensure the delivery of high quality and safe healthcare services. There is an opportunity to ensure that all committees are action oriented.

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 rehabilitation service had effective management arrangements in place to support and promote the delivery of safe, high-quality rehabilitation services in relation to the four areas of known harm which were the focus of this inspection — infection prevention and control, medication safety, deteriorating patients and transitions of care.

The Infection Prevention and Control Team (IPCT), had completed an annual report for 2025, provided in draft format, which provided an overview of the IPC program for 2025. It outlined how the hospital performed in relation to the monitoring of surveillance and compliance with infection prevention and control practices, outbreak and incident management, audit results and training provided. A consultant microbiologist was not available on site at the hospital, however staff had access to microbiologist advice remotely on a 24/7 basis through the IPCT or through nursing administration out of hours. Peamount Healthcare had no antimicrobial pharmacist in post and a pharmacist undertook antimicrobial stewardship activities and presented at each of the IPCC meetings.

Peamount Healthcare's pharmacy service was led by the chief pharmacist who reported to the director of rehabilitation. A medication safety strategy was developed for years 2022 to 2027, approved by the Drugs and Therapeutics Committee, alongside a dynamic medication safety implementation plan with goals, progress and review status which was updated quarterly. The rehabilitation service did not have their own medication formulary, but pharmacy staff and medical staff could access medication information from an online application. There was no antimicrobial pharmacist post within Peamount Healthcare but inspectors were informed that the pharmacy had processes in place to support safe antimicrobial practices. An extensive pharmacy service was provided to the rheumatology rehabilitation patients which included an assessment of the appropriateness of the patients' own drugs for use on the ward and enhanced education for patients on medication management.

The rehabilitation service had the Irish National Early Warning System (INEWS) in place to support the recognition, escalation and response to the deteriorating patient. Peamount Healthcare had medical and senior nursing cover onsite 24/7. Patients who required a higher level of care or with suspected deterioration of their condition were transferred to the nearest acute hospital by emergency ambulance. This transfer could be activated by any medical personnel and was underpinned by a hospital standard operating procedure. The volume or reason for transfers were not

tracked or trended but inspectors were informed that the number was minimal.

The rehabilitation service had policies and procedures in place for admission to their service depending on the service to which the patient was referred to. Patients that were transferred from an acute hospital required assessment for suitability for rehabilitation and were required to be deemed medically stable by referring teams prior to transfer. The appropriate medical teams and the operations lead in Peamount Healthcare reviewed all referrals prior to admission. The community rehabilitation inpatient specialist program (CRISP) was a nurse-led programme which provided direct access for patients in the community referred by their general practitioner.

The rehabilitation service had continued the provision of five beds for the HSE winter initiative which had started in December 2025. There was no date of completion of this initiative at the time of inspection.

It was evident to inspectors that there were management arrangements in place to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in the four key areas of harm.

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.**

Systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services across the rehabilitation service was in place. Data was collected on a range of different clinical measurements related to the quality and safety of healthcare services. Data relating to activity, incidents and trending, complaints, HR and care metrics was presented and discussed at board level, to the IHA manager, at Executive Management Team and at the Quality, Safety and Operational Risk committee. Peamount Healthcare produced an annual report which was available on their website which provided information on their rehabilitation activity, patient outcomes and key performance indicators.

There was evidence of risk management structures and processes in place to proactively identify, manage and minimise risk, and arrangements to monitor the service's performance. The CEO had governance and oversight of the corporate risk register and risk management was discussed at board meetings which included the number of risks escalated to the IHA manager. The management of reported risks

related to infection prevention and control and medication safety is discussed further in national standard 3.1.

All wards within the rehabilitation service had an annual audit plan. Evidence of audit activity in relation to IPC, medication safety and the deteriorating patient was provided to inspectors. Nursing care metrics was collected monthly in each of the three clinical areas visited at the time of inspection with good compliance observed. Compliance with the early warning system's escalation and response protocol, sepsis and the use of the use of Identify, Situation, Background, Assessment and Recommendation tool (ISBAR)[‡‡] tool communication tool formed part of this audit. Within the audits undertaken and reviewed by inspectors the ISBAR tool was consistently not being used for escalation of care or there was no audit undertaken in relation to the use of ISBAR. Audit results also demonstrated that the use of the sepsis screening form was consistently found not applicable. Medication safety and medication storage and custody also formed part of the nursing care metrics with all three wards demonstrating high compliance in these areas. The pharmacy department undertook a monthly review of prescribing discrepancies found on medication administration records and collected data on the number of pharmacy interventions completed. The percentage of medication reconciliation completed at the time of admission in each of the clinical areas was also captured.

The Infection Prevention and Control Committee had oversight of audit activity in relation to hand hygiene observational tool, hand hygiene facilities and patient equipment audits which were carried out on an annual basis. However, there was a lack of evidence that these audits were undertaken in the Cherryfields ward in 2025. There were IPC link practitioners on the wards but auditing was not part of their remit. An annual environmental cleaning audit was undertaken by the housekeeping department with supervisory oversight by IPCT. Inspectors saw evidence of action plans undertaken when compliance fell below 85% with remaining actions open since 2025.

There was a process in place to proactively identify and manage patient-safety incidents in line with the HSE's Incident Management Framework. Patient-safety incidents were entered on to the National Incident Management System (NIMS).[§§] The hospital's Serious Incident Management Team were responsible and had oversight of serious patient-safety incidents and the status of reviews that were underway.

[‡‡] ISBAR: Identify, Situation, Background, Assessment and Recommendation tool is used to support communication in relation to the deteriorating patient.

[§§] 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).

Patients received a patient satisfaction survey at the time of discharge which, when completed, was collated by the clinical nurse managers on the wards. The patient satisfaction survey results were then published in the annual report with patient stories, suggestions for improvements by patients and quality improvement initiatives. There were effective processes to deal with patient complaints which will be discussed further in national standard 1.8.

Overall, the rehabilitation service had systematic monitoring arrangements in place to support continuous improvement in the quality, safety, and reliability of healthcare services. Areas for consideration would be to increase the frequency of audit activity in relation to IPC practices and to ensure consistency of audit activity across all clinical areas. Audit of the ISBAR tool and use of the sepsis screening form would benefit from review and focus.

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.**

Workforce arrangements at the rehabilitation service were planned, organised and managed to ensure high-quality, safe and reliable healthcare which was supported by a workforce and implementation plan. The human resources department (HR) had overall responsibility for the key performance indicators (KPIs) related to workforce.

The absenteeism rate within Peamount Healthcare was slightly above the HSE's target absenteeism rate of ≤4%. Inspectors were informed that back-to-work interviews were conducted by clinical nurse managers (CNMs) at ward level and an occupational health facility was available for all staff.

HR reports were submitted at the quarterly board meetings and to the IHA manager which included information on KPIs and recruitment. Staff vacancy reports were submitted at the weekly EMT meetings. From information supplied after the inspection, inspectors were informed that Peamount Healthcare had a total of 599 whole time equivalent (WTE) employees with minimal vacancies in the rehabilitation service. Recruitment to fill the vacant positions was ongoing and candidates were identified.

The planned nurse-to-patient ratios were 1:8 during day time and rising to 1:12.5 at night time. Healthcare assistant-to-patient ratio of between 1:6 and 1:8 during day time and between 1:8 and 1:12.5 at night time which were the staffing levels in

place at the time of inspection. Inspectors reviewed nursing rosters for the weeks preceding the inspection with minimal shortfalls noted. Inspectors were informed that if patients were assessed as requiring one-to-one care that extra staff were supplied via bank*** and or agencies.

Hospital management confirmed that consultants working in the rehabilitation service were on the relevant specialist division of the register with the Irish Medical Council.

At ward level the clinical nurse managers had good oversight of mandatory training undertaken by nursing and healthcare assistants (HCAs). The education and practice development manager, the DON had oversight of compliance with mandatory training which was discussed and tracked at the Quality, Safety and Operational Risk Committee.

Despite these processes there were opportunities for improvement in relation to the uptake of training as evidenced by:

- Donning and doffing personal protective equipment: 74% of nursing staff and 54% of HCAs were up to date with their training
- INEWS: 66% of nursing staff and 64% of medical staff were up to date in their training
- Basic Life Support: 50% of medical staff and 83% of health and social care professionals were up to date in their training
- Clinical handover: 69% of nursing staff were up to date in their training
- Complaints management: 22% of nursing staff were up to date in their training.

However, good compliance with training was evidenced by:

- Standard Based precautions: 100% of nursing staff, HCAs and household staff were up to date in their training
- Hand hygiene: 98% of nursing staff, 100% of HCAs and 85% of medical staff were up to date in their training
- Basic Life Support: 100% of nursing staff were up to date in their training.

The rehabilitation service would benefit from a review of their mandatory training requirements as for example, INEWS was not deemed mandatory and on two of the clinical wards inspected the CNMs were unaware of the training in relation to INEWS undertaken by their nursing staff.

Peamount Healthcare was funded for 1 WTE chief pharmacist. The rehabilitation service was funded for a total of 2.25 WTE pharmacists and 0.5 WTE pharmacy technicians. As found at the HIQAs last inspection, the lack of an antimicrobial

*** Hospital bank staff are a pool of healthcare professionals, including nurses, doctors, and support staff, who work on a temporary or ad-hoc basis to fill staffing shortages within a hospital

pharmacist continued as a high rated risk on the pharmacy department risk register and was the only risk in relation to staffing on the corporate risk register. This risk had been escalated to the IHA manager.

The Infection Prevention and Control Team (IPCT) supported staff in implementing effective infection prevention and control practices across the hospital. At the time of inspection, the IPCT had 1 WTE CNM3 in position, 0.5WTE staff nurse and seven hours per week of administration support. Staff had access to microbiologist advice on a 24/7 basis through the IPCT or through nursing administration out of hours.

Overall, workforce arrangements at the rehabilitation service were planned, organised and managed. However, there were opportunities for improvement in relation to uptake of mandatory training and there was an opportunity for a review of the mandatory training requirements.

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.

The rehabilitation service at Peamount Healthcare was found to be compliant in three national standards (1.6, 1.8 and 3.3) and substantially compliant with two national standards (2.7 and 3.1). Key inspection findings leading to these judgments are described in the following sections.

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

Staff were aware of the requirement to respect and promote the dignity, privacy and autonomy of patients. Staff were observed to be caring, kind and responsive to patient's individual needs in the clinical areas inspected. The physical environment in the inpatient wards supported the delivery of care that respected and promoted the patient's dignity and privacy. Privacy curtains were used when providing care in multi-occupancy rooms in ARRU and were not necessary in the other clinical areas inspected. Within each of the clinical wards visited, there were clean, adequate showering and toilet facilities accessible and in close proximity to patients.

The patient's autonomy was promoted by the provision of weekly timetables which the inspectors observed as colour coded signalling the appointments with different multidisciplinary teams allowing the patients to plan their week accordingly. Patients were appreciative of receiving these plans and spoke about the benefit of knowing their plan of care for the upcoming week.

The physical environment was designed to promote the autonomy of people who used the service, with bright spacious communal areas which were observed as well utilised on the days of inspection.

Patients were familiar with their surroundings, had access to call bells and were aware of how to seek assistance from staff. Patients who spoke with inspectors said that their call bell was *"answered promptly"* and that *"staff were responsive".*

Healthcare records were appropriately stored and personal information was handled securely in the clinical areas visited.

Overall, there was consistency with what inspectors observed in the clinical areas visited and what patients told inspectors about their experiences of receiving care. There was evidence that management and staff were aware of the need to respect and promote the dignity, privacy and autonomy of people receiving care at the hospital.

Judgment: 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 within the rehabilitation service to respond to feedback and complaints received from patients and or their families. Peamount Healthcare had a designated complaints officer with responsibility for the management of complaints received who reported into the CEO.

Complaints received at the rehabilitation service 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, recorded at local level, escalated as appropriate and any actions taken was documented locally. Staff who spoke with inspectors at the time of inspection were aware of how to manage a complaint. Verbal complaints were not reported on or included in the complaint report which was presented at Quality and Safety Steering

Group, at board level and at IHA level.

Complaints were reported into the Quality and Safety Steering group quarterly on the number of complaints received. The complaint officer reported that the hospital was meeting their key performance improvement indicators of acknowledging complaints within five days and closing out complaints within 30 days. Inspectors were informed that the rehabilitation service received minimal complaints, a total of eight written complaints were received in 2025 and none to date in 2026.

Complaints were tracked and trended to identify emerging themes and categories. Communication, safe and effective care and access were the top three themes arising from the tracking and trending of complaints in 2025.

Information on how to make a complaint was on display on all the clinical areas visited during the inspection. A *'Your Service Your Say'* leaflet was available in the clinical areas visited which included information on advocacy services, the office of the ombudsman and a patient experience survey.

Patient experience surveys were collected at local level, collated by CNMs and reported on in the annual report alongside patient improvement suggestions and quality improvement initiatives.

Overall, as found at the previous inspection, there were effective processes in place to respond promptly and openly to complaints and concerns made by patients and/or their families.

Judgment: Compliant

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

During the inspection, the inspectors observed that the physical environment in the clinical areas visited was clean, spacious and tidy. In some clinical areas, there was evidence of some wear and tear such as cracked paint on walls and doors which did not facilitate effective cleaning and clinical nurse managers (CNMs) had informed inspectors that the issues had been logged and were awaiting action. Adequate physical spacing was observed to be maintained between beds in multi-occupancy rooms. The rehabilitation service had a total of 55 single rooms with ensuite facilities.

The CNMs who spoke with inspectors were satisfied with the level of cleaning resources in place. Cleaning staff confirmed they had received relevant training and

were knowledgeable about their role and cleaning processes. Inspectors were informed by the cleaning staff that when a patient was discharged a terminal[†††] clean was completed by the cleaning staff. Cleaning schedules were updated and monitored by the CNMs. Patient equipment was cleaned by nursing staff or healthcare assistants and there was a system to indicate the equipment was cleaned. Equipment observed in the clinical areas was clean. Hygiene monitoring checklists was completed monthly by nursing staff on the wards.

Hazardous waste was observed to be safely and securely stored. There was appropriate segregation of clean and used linen. Wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available for staff and visitors. Hand hygiene signage was clearly displayed throughout the clinical areas visited. As found at the previous inspection, not all hand hygiene sinks met the required specifications[‡‡‡] in the ARRU and funding was reapplied for in January 2026.

There was evidence of appropriate placement of patients requiring transmission-based precautions. Patients were isolated in single rooms with appropriate signage in place. Prior to transfer from acute hospitals the infection status of all patients was identified. On admission, all patients were isolated and screened for multidrug resistant organisms until screening was complete.

During this inspection, inspectors observed the security arrangements for the physical environment. In the ARRU, it was noted that the doors leading to corridors which housed offices were open and accessible to patients. On discussion with management it was ascertained that patient safety was maintained by individual patient assessment and subsequent increased levels of observation based on the assessment determination. The rehabilitation service would benefit from a review of ARRU to ensure all areas are secure.

As per the previous inspection, the physical environment supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care. However, not all hand hygiene sinks throughout ARRU conformed to national requirements and there is an opportunity to review the security of ARRU.

Judgment: Substantially Compliant

[†††] Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

[‡‡‡] Clinical hand wash basins should conform to HBN 00-10 part C Sanitary Assemblies or equivalent standards. National Clinical Effectiveness Committee. Infection Prevention and Control (IPC) National Clinical Guideline No. 30. May 2023. Available on line from: gov - Infection Prevention and Control (IPC) (www.gov.ie)

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

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

There were quarterly corporate risk register review meetings at EMT level which were then escalated to the board for approval. Risks were discussed at the quarterly meeting between the rehabilitation service and the IHA manager and risks that were rated high or where the necessary controls fell outside the risk owner's direct control were escalated to the IHA manager. The rehabilitation service utilised a tiered escalation process at ward level where the CNM managed and outlined operational risks, maintained a local risk register at ward level and reviewed the register with the quality department every three months or as necessary.

Risks related to infection prevention and control (IPC) of healthcare-associated infection were identified, monitored and reviewed along with risks at clinical ward level. Inspectors were informed that a member of the Infection Prevention and Control Team attended the ward risk review meetings. The corporate risk register contained risks in relation to an increased risk of outbreak (Carbapenemase-Producing Enterobacterales, influenza and respiratory virus) with existing and additional controls in place. The absence of a dedicated antimicrobial pharmacist was a long standing risk since 2018 on the corporate risk register and inspectors were informed at the time of inspection, that there was no funding provided to fill this post.

Prior to transfer from a referring hospital, patients' multidrug resistant organism (MDRO) status was determined and screening for Meticillin-Resistant Staphylococcus aureus (MRSA) and Carbapenemase-Producing Enterobacterales (CPE) was carried out on arrival to the rehabilitation service irrespective of status communicated. Patients were placed in a single isolation room until screening result was completed in line with hospital policy which set out defined criteria and type of isolation required if positive. Patients that were being admitted from the community had their MDRO status assessed prior to admission and if negative and had not been an inpatient for the past 12 months received no screening on admission unless symptomatic.

Outbreaks were reported on at the Quality Safety and Operational Risk Committee. An Outbreak Control Committee was convened as required to coordinate investigation, control measures, communication and learning. On closure of an outbreak, an outbreak report was completed and learning from outbreaks was identified. A total of 17 outbreaks within Peamount Healthcare were declared in 2025.

A clinical pharmacy service was provided to all clinical areas visited and the percentage of pharmacy-led medication reconciliation[§§§] undertaken at the time of admission was tracked and reported on at the Quality, Safety and Operational Risk Committee. In 2025, there were high levels of pharmacist-led medication reconciliation on admission in the clinical areas inspected. Inspectors were informed that there was no formalised process for medication review after the initial medication reconciliation was performed but was available if staff requested. The rehabilitation service had a list of high-risk medications and there was a list of sound alike look alike drugs (SALADs). Inspectors observed the use of risk reduction strategies to support the safe use of insulin, opioids, cytotoxic agents and potassium. Prescribing guidelines were available in hard copy format but inspectors observed that copies observed in the clinical areas were out of date. Medication monographs[****] were available online but not at the point of preparation. The risk to patient safety due to medication incidents was placed on the corporate risk register and will be discussed further in national standard 3.3.

The rehabilitation service was using INEWS, the national early warning system, to support the recognition, response and management of a deteriorating patient. The Identify, Situation, Background, Assessment and Recommendation tool (ISBAR) communication tool was used for the escalation of the care of the deteriorating patient and there were processes in place to ensure the timely management of patients with a triggering early warning score. Staff who spoke with inspectors were knowledgeable about escalation and response protocols. There was no committee tasked with oversight of the early warning system within the service and no designated consultant lead, both of which were contrary to hospital policy. Patients who required a higher level of care or with suspected deterioration of their condition were transferred to the nearest acute hospital by emergency ambulance.

There were systems and processes in place to support the efficient flow of patients and transfer of patients to and from referring hospitals and the community. Referrals for the use of rehabilitation beds were assessed by the appropriate medical teams and operations lead. Neuro rehabilitation beds were referred through the Managed Clinical Rehabilitation Networks (MCRNs) and there was a weekly review meeting held to review these referrals. The rheumatology rehabilitation beds were managed by the rheumatology team and patients had a determined period of admission. The Community Rehabilitation Inpatient Specialist Programme (CRISP) provided direct

[§§§] 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.

[****] A medication monograph is a factual, scientific document on a drug product that describes the properties, claims, indications, and conditions of use of the drug and contains any other information that may be required for optimal, safe and effective use of the drug.

access to rehabilitation beds for adults living in the community. The processes for admission to the rehabilitation service were underpinned by a policy and standard operating procedures which also outlined admission criteria, exclusion criteria and discharge procedures. The ISBAR3[††††] tool was not utilised for clinical handover which is an opportunity for improvement.

At the time of the inspection, the rehabilitation service had a total of one delayed discharge. In 2025, the average length of stay for patients receiving age related rehabilitation was 37.8 days, for patients receiving respiratory rehabilitation was 9.5 days and for patients receiving neurology rehabilitation was 72 days. Patients receiving rheumatology rehabilitation were admitted for a fixed period of admission. In 2025, bed occupancy ranged from 79.6% to 99% with similar rates of occupancy for 2026 to time of inspection.

Staff had access to a range of up-to-date policies, procedures, protocols and guidelines through the hospital's intranet, the approval of which was tracked through the Quality and Safety Steering Group.

Overall, systems and processes were in place to ensure the identification and management of risks and potential risks to people using the service. However, the rehabilitation service would benefit from a review of their oversight arrangements for the deteriorating patient and the policy on management of the deteriorating patient requires review.

Judgment: Substantially Compliant

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

The rehabilitation service had systems in place to identify, report, manage and respond to patient-safety incidents. The HSE's Incident Management Framework to guide and support the management of patient-safety incidents. Patient-safety incidents were reported on the national incident management system (NIMS) via the electronic point of entry. Governance and oversight of patient-safety incidents was provided by the Quality and Safety Steering group.

[††††] ISBAR3: the nationally recommended tool for conducting effective clinical handover. Identify (staff), Situation (patient), Background, Assessment, Recommendation, Readback (checking understanding), and Risk Management.

A total of 1051 incidents in Peamount Healthcare were reported in 2025. Systems were in place for the tracking and trending of patient-safety incidents and trending was fed back to the clinical staff with breakdown of where the incidents occurred. In 2025, the most common type of patient-safety incident reported was slips, trips and falls. Staff who spoke with inspectors were knowledgeable about how to report, manage and respond to patient-safety incidents. Staff were also aware of the most common patient safety-incidents reported in their area.

There were a total of nine infection prevention and control incidents recorded in 2025 where oversight and learning was discussed at Infection Prevention and Control Committee.

The Clinical Incident Management Team was chaired by the CEO, had oversight of the management of serious patient-safety incidents and had oversight of the status of any reviews underway.

Medication related incident reports were reported through NIMS, were reviewed, collated and reported at the Medication Safety Committee and into the Drugs and Therapeutics Committee. The number of medication incidents reported in 2025 was 115. Each medication incident had a severity rating, a cause and outcome at time of incident. Pharmacy bulletins were developed and disseminated across Peamount Healthcare to share learning where a trend was noted. The risk to patient safety due to medication incidents was a yellow rated risk on the corporate risk register with existing controls and a recent review had resulted in a reduction in risk.

Overall, as found at previous inspection, there were systems in place to effectively identify, manage and report patient-safety incidents.

Judgment: Compliant

## Conclusion

**Capacity and Capability**

The rehabilitation service had integrated corporate and clinical governance and management arrangements in place which were appropriate for the size, scope and complexity of the service delivered. Systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services across the rehabilitation service was in place. Data was collected on a range of different clinical measurements related to the quality and safety of healthcare services however, there was some opportunity for an

increase in the frequency of audit activity.

Workforce arrangements within the rehabilitation service were planned, organised and managed. Records indicate that mandatory training requirements and staff attendance at and uptake of mandatory and essential training could be improved.

**Quality and Safety**

Staff were observed to be caring, kind and responsive to patient's individual needs. The physical environment in the inpatient wards supported the delivery of care that respected and promoted the patient's dignity and privacy. The physical environment also supported the delivery of high-quality, safe, reliable care and protected the health and welfare of people receiving care. Inspectors observed the clinical areas inspected as spacious, tidy and clean. Not all hand hygiene sinks conformed to national requirements and required investment.

There were systems and processes in place to identify, evaluate and manage immediate and potential risks to people using the service. A clinical pharmacy service was provided to all clinical areas visited and the pharmacy department was achieving high levels of medication reconciliation on admission. There was efficient flow of patients requiring rehabilitation care to and from other hospitals and the community. The rehabilitation service would benefit from a review of their oversight arrangements for the deteriorating patient.

There were effective processes in place within the rehabilitation service to respond to feedback and complaints received from patients and or their families. There were governance and oversight systems in place to effectively identify, manage and report 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. | Compliant |
| Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process. | Compliant |
| **Theme 2: Effective Care and Support** | |
| Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users. | Substantially Compliant |

| Theme 3: Safe Care and Support | |
|---|---|
| Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services. | Substantially Compliant |
| Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents. | Compliant |