



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

Issued by the Chief Inspector

Name of designated centre:	Peamount Healthcare Older Persons Service
Name of provider:	Peamount Healthcare
Address of centre:	Newcastle, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	06 October 2025
Centre ID:	OSV-0007786
Fieldwork ID:	MON-0044977

About the designated centre

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

Peamount Healthcare (Older Persons Services) is an independent voluntary organisation which can accommodate 50 residents, both male and female, over the age of 65. Residents are accommodated in 42 single occupancy rooms and four double occupancy rooms. Each bedroom has direct access to the garden, and dining rooms, sitting rooms and quiet rooms are available to residents. The centre is located in Newcastle, Co. Dublin. Residents are admitted under the care of a consultant geriatrician and have 24-hour access to a member of the on-site medical team. Continuing care services are provided to residents with a range of needs, including cognitive impairment, dementia, stroke, physical disabilities and palliative care needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	50
--	----

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
Monday 6 October 2025	10:15hrs to 19:50hrs	Aisling Coffey	Lead

What residents told us and what inspectors observed

The overall feedback from all residents who spoke with the inspector was that they were pleased to be living in Peamount Healthcare Older Persons Services. Residents spoke in favourable terms about the centre and the kind and considerate staff that cared for them, with the staff being described as "super" and "great. The inspector observed many compassionate, warm, dignified and respectful interactions with residents and their visitors throughout the day of the inspection by staff and management.

This unannounced inspection was conducted over the course of one day. During the inspection, the inspector chatted with eight residents and one visitor to gain insight into the residents' lived experience in the centre. The inspector also spent time observing interactions between staff and residents, as well as reviewing a range of documentation.

The centre is located on the ground floor of the Aberdeen Centre within the grounds of the Peamount Healthcare campus. The Aberdeen Centre is a purpose-built two-storey building which was constructed in 2019. The first floor is not part of the registered designated centre. The ground floor also houses other services not part of the designated centre, such as a café operating seven days per week, offices and training facilities. The café facility is accessible to residents and their visitors. The designated centre consists of two 25-bed units, Meadow View and Mountain View, and support services such as a multidisciplinary room and a main kitchen.

Bedroom accommodation comprised 42 single and four twin bedrooms, all containing en-suite facilities, including a shower, toilet, and wash hand basin. Bedroom facilities included a television, call bell, wardrobe and seating. Bedroom accommodation was spacious, with sufficient storage space for residents' clothing and possessions. Residents had personalised their bedrooms with photographs, artwork, religious items, soft furnishings and ornaments. The bedrooms had pleasant views out over the adjoining countryside or into the well-maintained internal courtyards. Resident privacy was maintained through the use of privacy window film installed by the provider.

While the centre was appropriately decorated, generally clean and in good repair, some areas were experiencing wear and tear and required maintenance to ensure residents could enjoy a pleasant living environment. The inspector also noted some fire safety concerns during the walk around the centre. For example, some fire doors were seen not to close, and five oxygen cylinders were seen to be insecurely stored in two separate areas. Given the safety concerns, an immediate action was issued, and the person in charge addressed the oxygen storage before the end of the inspection. These matters are discussed under Regulation 17: Premises and Regulation 28: Fire precautions.

Internally, the centre's design and layout supported residents in moving throughout the centre, with wide corridors, sufficient handrails, furniture and comfortable seating in the various communal and rest areas. These communal areas included two living rooms, two dining rooms and two quiet rooms. There were also two breakout areas seen. These breakout areas, located on the corridor opposite the nursing stations on both units, had comfortable seating and recreational materials for residents to engage with, such as books, games and music. The amount of communal space was limited, with the living rooms also operating as dining areas during mealtimes. The inspector also noted that the provider had relocated the two quiet room facilities to smaller rooms, reducing the amount of communal space available for residents by 4.7m². This matter is discussed further under Regulation 23: Governance and management.

Externally, residents had access to two enclosed and pleasantly landscaped courtyard gardens from the living and dining rooms. There were also well-maintained gardens surrounding the centre, which looked out over green fields. Residents were seen to enjoy these external areas on the inspection day.

Upon arrival at the centre, many residents were up and dressed in their preferred attire and appeared relaxed and well cared for. There were two staff members on duty during the inspection, facilitating activities in the two living rooms. While some residents participated, others chose to relax in their bedrooms, reading, listening to the radio, watching television, and using the internet.

The inspector observed the corridor environment to be noisy at times. In Mountain View, a sensor alarm located on the window ledge of bedroom 10 sounded loudly for several minutes in the morning and after lunch. This noise was observed to affect residents in the breakout area adjacent to bedroom 10 during the morning. On Meadow View, a call bell was heard to sound for 8 minutes before being answered. One resident on the corridor where the call bell was sounding expressed dissatisfaction with the prolonged noise, stating it was a regular occurrence. These noise levels, when they occurred, were not conducive to a relaxed and homely environment, with the alarm sound disturbing the otherwise calm and comfortable atmosphere for residents. These matters are further discussed under Regulation 16: Training and staff development and Regulation 23: Governance and management.

Residents could receive visitors in the centre within the communal areas or in the privacy of their bedrooms. Some families were observed visiting their loved ones during the inspection day. Residents and visitors confirmed that there were no restrictions on visiting, while visitors reported feeling very welcome in the centre.

Lunchtime was observed with residents eating in the dining and living rooms, as well as in their bedrooms. Meals were freshly prepared on-site in the centre's kitchen. Residents confirmed they were offered a choice of main meal and dessert, while catering staff showed the inspector how residents' choices had been recorded the previous day on the provider's digital ordering system. The food served appeared nutritious and appetising. There were ample drinks available for residents at mealtimes and throughout the day. Staff provided discreet and respectful dining

assistance to residents requiring this support. Overall residents spoke positively to the inspector about food quality, quantity and variety.

The following two sections of the report present the findings of this inspection concerning governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

While governance and management systems were in place to oversee the quality of care delivered to residents, some improvements were required to ensure the service provided was safe, appropriate, consistent and effectively monitored, as referenced within this report.

This was an unannounced inspection to assess the registered provider's ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and review the registered provider's compliance plan following the previous inspection on 18 September 2024. The inspection also informed the provider's application to renew registration.

The registered provider had progressed with their compliance plan from the 18 September 2024 inspection; however, following this inspection, further improvements were required concerning several regulations, including governance and management, as outlined in the report. An immediate action was issued on the afternoon of the inspection concerning the insecure oxygen storage in two locations. The provider addressed these issues immediately when they were brought to their attention.

Peamount Healthcare is the registered provider for Peamount Healthcare Older Persons Services. Peamount Healthcare is an independent voluntary organisation providing a range of health and social care services to the Health Service Executive (HSE) under section 38 of the Health Act 2004. Peamount Healthcare is a company limited by guarantee and run by a voluntary board of nine directors. The provider has appointed a chief executive officer who reports to the board of directors.

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 assistant director of nursing, who in turn reports to the director of nursing and social care, who reports to the chief executive officer. The director of nursing and social care was a person participating in the management. This is a senior manager who supports the person in charge in their operational management and clinical oversight of the centre. The director of nursing and social care and the chief executive officer were present for feedback at the end of the inspection.

The person in charge worked full-time and was supported in their day-to-day management of the centre by four clinical nurse managers (CNMs), and a team including nurses, healthcare assistants, catering staff, housekeeping staff, and activity coordinators. On the morning of the inspection, the person in charge was on planned leave. The provider had deputising arrangements in place whereby the CNM2 staff deputised for the person in charge, and this was seen to be operating in practice. The person in charge arrived at the centre after an hour to support the inspection process.

The centre was very well-resourced, and benefited from services available on the campus to enhance the care delivered to residents, such as access to 24-hour medical support, a pharmacist, a range of nurse specialists, health and social care professionals, a quality and continuous improvement officer, a health and safety officer, facilities and maintenance personnel and practice development staff.

In terms of staff training and development, records reviewed found a suite of mandatory training was available for staff in the centre 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. However, improvements were also required in staff supervision to ensure that the assessed needs of residents were supported and that staff practices aligned with the provider's policies. These matters are discussed under Regulation 16: Training and staff development.

The registered provider had systems in place to monitor the quality and safety of care. There was documentary evidence of the communication systems between the person in charge and the director of nursing and social care. Minutes of governance meetings found that key aspects of care provision for residents were discussed, including human resources, procurement, visiting arrangements, infection prevention and control (IPC) and audit findings. On a day-to-day basis, further communication between the person in charge and the director of nursing and social care was facilitated through two daily written reports, where key clinical matters related to resident care and welfare were reported. Within the centre, there was evidence of communication between the person in charge and the staff team. During these meetings, key issues related to the quality and safety of the service delivered to residents were discussed, including care planning, residents' meals and mealtimes, fire safety and recent incidents.

The provider had systems to oversee accidents and incidents within the centre. The provider maintained a risk register to monitor known risks within the centre. Auditing of key aspects of service provision was occurring, for example, continence care, malnutrition reviews, falls prevention interventions and a suite of IPC audits. Notwithstanding this good practice, this inspection found that further robust oversight was required to ensure regulatory compliance. This will be discussed under Regulation 23: Governance and management and Regulation 31: Notification of incidents.

The provider had completed the annual review of the quality and safety of care delivered to residents for 2024. The inspectors saw evidence of consultation with

residents and families reflected in the review. Within this review, the registered provider had also identified areas requiring quality improvement.

The inspector reviewed regulatory requirements in relation to records. A sample of four staff files contained evidence of the staff member's identity, employment history and An Garda Síochána (police) vetting disclosures. However, one personnel file did not contain all of the documentation required to ensure safe and effective recruitment practices. The inspector also found gaps in relation to fire safety documentation that is required to be held in the designated centre. These matters will be discussed under Regulation 21: Records.

The provider had persons involved in the centre on a voluntary basis. The inspector sought a file for one such person and found evidence of An Garda Síochána (police) vetting. However, improvements were required to ensure appropriate records were maintained for volunteers and that people involved on a voluntary basis received supervision and support, as referenced under Regulation 30: Volunteers.

The centre had an up-to-date complaints management policy, which aligned with regulatory requirements. Information posters on advocacy services to support residents in making complaints were also displayed. Residents and families said they could raise a complaint with any staff member. There was an easy-read complaints policy located in a book stand in the breakout areas. While there was evidence produced of efforts made by nurse management to resolve complaints that had arisen in the centre, the inspector found some gaps in complaints management recording practices and action was required to comply with Regulation 34: Complaints procedure.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider applied to renew the designated centre's registration in accordance with the requirements in the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015. At the time of inspection, this application was under review.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge meets the requirements of the regulations. They are an experienced registered nurse with previous management experience and post-registration management qualifications.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a suite of training programmes to enable them to perform their respective roles. However, further action was required to ensure staff were appropriately supported and supervised at all times to ensure that the assessed needs of residents were supported and that staff practices aligned with the provider's policies. For example:

- Staff practices did not promote a calm and relaxed environment for residents. A sensor alarm sounded loudly for several minutes in the morning and after lunch on Mountain View, while a call bell was heard to sound for 8 minutes before being answered on Meadow View.
- The provider had a system for conducting regular fire safety checks; however, the provider had failed to identify gaps in staff adherence to completing this fire safety documentation, as referenced under Regulation 28: fire precautions.

Judgment: Substantially compliant

Regulation 21: Records

While there were good recruitment practices in the centre, some improvements were required to ensure all records as set out in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were kept in the designated centre and available for inspection, for example, one personnel file did not contain a reference from the staff member's most recent employer as required by the regulations.

The registered provider had not ensured that all Schedule 4 documentation was kept in the designated centre and available for review by the inspector, for example, records of each fire drill practice and maintenance records of fire-fighting equipment. These records were submitted by the provider after the inspection.

Judgment: Substantially compliant

Regulation 22: Insurance

There was an appropriate contract of insurance in place that protected residents against injury and against other risks, including loss or damage to residents' property.

Judgment: Compliant

Regulation 23: Governance and management

The management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored were not sufficiently robust, as evidenced by the following matters:

- While the registered provider had several assurance systems in place to monitor the quality and safety of the service provided, these systems required some strengthening, as they were not fully effective in identifying risks and driving quality improvement in areas such as staff supervision, care planning, healthcare, fire safety, premises, and complaints procedure, as identified during this inspection.
- The management systems that provided assurance with respect to fire safety were ineffective. Consequently, an immediate action was issued on the afternoon of the inspection concerning the insecure storage of oxygen in two locations. The provider addressed these issues immediately when they were brought to their attention.
- The oversight systems for monitoring staff response times to call bells were ineffective. The inspector's observation regarding a delayed call-bell response time was discussed with the management of the centre. However, the management team did not have access to call bell reports or conduct call-bell audits that could facilitate them to identify issues related to response times.
- The oversight of incident reporting required improvement as three statutory notifications to the Chief Inspector were not submitted within the required time frames.
- The doors to exit Meadow View were keypad-controlled. The code for the keypad was not on display for residents who wished to visit the café or stroll the external grounds. This restriction was discussed with management, who expressed concern about potential unexplained absence. However, the restriction and its rationale for implementation were not appropriately risk-assessed.
- The secure storage of prescribed thickening agents was not fully effective, as the inspector found such products were accessible and not secured in a resident's bedroom on Meadow View. This findings was brought to the attention of nurse management, who arranged for this products to be stored securely. These products are required to be used under supervision. Insecure storage of such thickening agents introduces a risk of asphyxiation by accidental ingestion of these products.

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 Meadow View quiet room, a facility measuring 13.4m² for residents and families, was operating as a staff break room.
- The Meadow View office, a facility measuring 11.9m² was operating as a quiet room.
- The Mountain View quiet room, a facility measuring 14.2m² for residents and families, was operating as a staff break room.
- The Mountain View office, a facility measuring 11.0m² was operating as a quiet room.

The inspector also found that three disabled WC facilities, one on Mountain View and two on Meadow View, had signage indicating that these facilities were designated for staff use only, which is not set out in the statement of purpose. One of the Meadow View disabled WC facilities also had a keypad lock, restricting access.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspector reviewed four residents' contracts. These contracts included the terms of residency, the resident's allocated bedroom number, and the fees to be charged for services received. Any additional fees were also clearly described.

Judgment: Compliant

Regulation 30: Volunteers

The provider had persons involved in the centre on a voluntary basis. The inspector reviewed a file for one such person and found a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. However, action was required to ensure appropriate records were maintained for volunteers in line with the requirements of the regulation, for example:

- the written roles and responsibilities for the volunteers.
- evidence that volunteers were supervised and supported appropriately in their role when on-site.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider did not notify the Chief Inspector of three unexplained absences, as required by the regulations. These notifications were requested following the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

Action was required to ensure compliance with the regulation, for example:

- The complaints procedure was not displayed in a prominent position in the designated centre as required by the regulation
- A number of complaints raised were not being managed in line with the provider's complaints policy and as required by the regulation. Verbal complaints raised by residents and families that had not been resolved at the point of contact and within 48 hours had not been escalated to the complaint officer for formal investigation.

Judgment: Not compliant

Quality and safety

While the inspectors 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. Improvements were required concerning individual assessment and care planning, healthcare, premises and fire precautions.

The inspector reviewed a sample of electronic nursing notes and care plans for residents. There was evidence that residents were comprehensively assessed upon admission to the centre 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. Care plans viewed by the inspector were person-centred and specific to that resident's needs. There was evidence of consultation with the resident and, where appropriate, their family during the revision of care plans. While acknowledging these good practices, further action was required concerning individual assessments and care plans to ensure that each care plan accurately

reflected the resident's assessed needs. This is discussed further under Regulation 5: Individual assessment and care planning.

The health of residents was promoted through ongoing medical reviews, including 24-hour medical services available for residents on-site. Residents had access to a range of specialist nursing services, including infection control, older persons, palliative care, tissue viability and behaviour support nursing specialists. Residents also had access to a range of health and social care professionals, including physiotherapists, occupational therapists, dietitians, speech and language therapists, and social work services. Notwithstanding this robust access to a wide range of healthcare services, the inspector found that action was required to ensure that residents had access to a high standard of evidence-based nursing care. This will be discussed under Regulation 6: Healthcare.

Overall, the premises' design and layout met residents' needs. The centre was found to be appropriately decorated, generally clean and in good repair. The centre had two well-maintained internal courtyard gardens and external grounds. Notwithstanding this good practice, action was required to ensure full compliance with Schedule 6 requirements, which will be discussed under Regulation 17: Premises.

The provider had systems in place to monitor fire safety. Preventive maintenance for fire detection, fire-fighting equipment, and emergency lighting was conducted at recommended intervals. Procedures to be followed in the event of fire were prominently displayed at the nurses' station. Staff had undertaken fire safety training and participated in quarterly fire evacuation drills. The inspector found the means of escape kept clear. Notwithstanding these good practices, additional actions were required to ensure the safety of residents in the event of a fire emergency. These findings are outlined under Regulation 28: Fire precautions.

Regulation 11: Visits

The provider had a written visitor policy as required by the regulation. The inspectors 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 17: Premises

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

- The cleanliness and maintenance of multiple sinks throughout the centre, including clinical hand-wash facilities, required attention, as several sink waste outlets were observed to be visibly unclean and had a black residue.
- The maintenance of some residents' equipment, such as bed tables, required review as the covering was seen to be damaged, which impacted effective cleaning.
- The door from the Meadow View dining room to the internal courtyard was very heavy and difficult to open, making the facility inaccessible to residents without staff assistance to open the door.
- The decor in some areas, including resident bedrooms, bathrooms, and corridors, showed signs of wear and tear, with paint scuffed on walls.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

The inspector reviewed the records of a sample of residents who were transferred to and from the acute hospital. Where the resident was temporarily absent from a designated centre, relevant information about the resident was provided to the receiving hospital to enable the safe transfer of care. Upon the residents' return to the centre, the staff ensured that all relevant information was obtained from the hospital and placed in the residents' records.

Judgment: Compliant

Regulation 27: Infection control

The provider had systems in place to oversee IPC practices within the centre. Records seen found staff had completed IPC training. The provider had a clinical nurse manager (CNM) and an IPC nurse available to the designated centre with expertise to guide and support the centre's staff in safe IPC practices and oversee performance. The environment was generally clean and tidy on the inspection day. There was surveillance of healthcare-acquired infections in the centre. The inspector reviewed records of targeted IPC audits undertaken by the IPC CNM and IPC Nurse. These audits occurred regularly, were detailed and identified corrective actions to improve infection control in the centre, with findings related to hand hygiene and the decontamination of resident equipment, for example. The centre experienced an outbreak of respiratory syncytial virus (RSV) in January and February 2025. The IPC CNM had completed a review following this outbreak. Within the review, relevant

protocols and guidance were documented as having been adhered to, and learning was identified in the event of a future outbreak.

Judgment: Compliant

Regulation 28: Fire precautions

While acknowledging the provider's systems to monitor fire safety, the oversight of fire safety arrangements within the centre required review to ensure the safety of residents. The provider had not identified and managed some of the risks found on inspection, as outlined below.

Precautions against the risk of fire require review, for example:

- One oxygen cylinder was found unsecured in a resident's twin bedroom, and four more were found unsecured in the Meadow View clean utility. The provider addressed this issue immediately when it was brought to their attention with a temporary means of securing the cylinders until a permanent arrangement could be put in place.
- The provider had a system for conducting monthly inspections of the fire alarm panel, fire doors, emergency lighting and firefighting equipment; however, there were gaps in the records. For example, there were no checks recorded on the fire alarm panel, and a fault was evident on the day of inspection in Mountain View. Additionally, there were no records of fire extinguisher checks for September 2025.
- The inspectors found six large cardboard boxes being stored in the Meadow View server room. A risk assessment must be completed by a competent person to determine the appropriate controls needed to manage the risk when using these areas for storage.

While arrangements were in place for staff to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, further assurances were required to assure the provider that arrangements were in place to evacuate all persons, via all means of escape and in a timely manner, in the event of a fire, for example:

- Although quarterly evacuation drills had been conducted, covering progressive horizontal evacuation within the centre, there were no records of drills in the last two years that practised evacuation using the external escape routes.
- Although the provider had practised simulated night-time conditions, when staffing levels were at their lowest, two of three evacuation drills available to review found that compartment evacuation took over 7 minutes.

Arrangements to contain fire required improvement, as several doors were found not to close fully. These doors included the Mountain View store room, the Meadow

View cleaners' room and the Meadow View staff room. This meant these doors would not close in the event of the fire alarm activating, compromising their ability to contain the spread of smoke and fire in an emergency.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While comprehensive person-centred care plans were developed, based on validated risk assessment tools, action was required concerning individual assessments and care plans to ensure that each care plan accurately reflected the resident's assessed needs, for example:

- A resident with a specific care need related to their dressing and personal care requirements did not have corresponding records to evidence that this care need had been fully assessed and that a care plan had been developed based on that assessment, ensuring the resident's privacy, dignity, and comfort within the centre.
- A resident with a specific care need related to elimination and continence did not have this care need appropriately assessed. Additionally, the care plan reviewed referenced specialist nursing advice received in relation to the management of this healthcare need; however, there were no records of this specialist advice available for review.

Judgment: Substantially compliant

Regulation 6: Health care

Notwithstanding residents' access to a wide range of healthcare professionals, action was required to ensure that all residents received a high standard of evidence-based nursing care. For example, the inspector found instances where neurological observation assessments were not monitored and documented in accordance with the provider's falls policy following an unwitnessed fall. Not completing the neurological observations may lead to delays in recognising a resident at risk of clinical deterioration.

Judgment: Substantially 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 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 30: Volunteers	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant

Compliance Plan for Peamount Healthcare Older Persons Service OSV-0007786

Inspection ID: MON-0044977

Date of inspection: 06/10/2025

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 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <ul style="list-style-type: none"> • The PIC has met with all staff to discuss the response times to fall alarms and call bells. Response times are communicated at daily safety pauses and daily handovers, and the daily handover sheet has been edited to reflect this. The PIC and CNS in Older Persons will monitor the time taken to respond by staff members through audits and develop action plans as required. • The PIC has identified additional staff to complete the fire safety checks and documentation as per regulation. The PIC/CNM will audit these checks monthly to ensure compliance. 	
Regulation 21: Records	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:</p> <ul style="list-style-type: none"> • The PIC has communicated with Human Resources who will ensure there is a reference for the staff member on file from their most recent employer. The HR manager will monitor schedule 2 documents on staff files through audit. • The PIC will ensure that the servicing records for firefighting equipment are available for inspection at the designated centre. Following a fire drill, the fire drill report is sent to the PIC, the PIC communicates this with the staff team through staff meetings and stores a copy of the report in the fire folder, which is available in both Mountain View and Meadow View. 	

Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ul style="list-style-type: none"> • Risk Assessments are completed on a local level when there is a risk identified using the ICC (Impact, Cause, Consequence) method. Any risk that cannot be managed at a local level is escalated. The CNM meets with the Quality and Continuous Improvement Manager on a quarterly basis, or more frequently if indicated, to ensure monitoring of risks and control measures. The Risk Department sends trend analysis on a quarterly basis to ensure learning from incidents takes place. The PIC has met with the CNMs to discuss quality and agenda for staff supervision. The Care Planning development and review has been completed. All oxygen cylinders are now secured in treatment room. Any issues identified with fire door closures have been resolved. The PIC has reviewed the complaints book to ensure any complaint has been either closed off or escalated if indicated. PIC is monitoring complaints in line with the policy to ensure all timeframes are adhered to. • The PIC will ensure notifications are submitted as per regulatory requirements. The PIC has educated the staff team regarding notifications and communication of notifiable incidents if they occur in the absence of the PIC. • The PIC has displayed the code for keypad at exit door to ensure all residents have freedom of movement. • The PIC ensures fluid thickeners are stored in a safe press when not in use and this has been communicated to all staff. • Both the staff room and the quiet space for residents have been reviewed, and these changes were originally implemented during the COVID-19 pandemic as part of safe operational requirements. At that time, the application for the variation or removal of a condition of registration was not submitted, and this was unfortunately overlooked. The provider will now engage with the chief inspector to make the necessary changes to ensure compliance with regulations. • The WC facilities have been reviewed, and there is now one designated WC for staff in both Meadow View and Mountain View. The Person in Charge will now apply to Vary (APT to Vary) form to the Chief Inspector for approval and make the necessary updates to the floor plan and the Statement of Purpose to reflect this change. • The code on the keypad has been disabled so there is no restriction on any access. 	
Regulation 30: Volunteers	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 30: Volunteers:</p> <ul style="list-style-type: none"> • The PIC will ensure the volunteers will adhere to the roles and responsibilities outlined as per Peamount Health Care policy. 	

<p>The PIC/CNMs will complete the induction for all volunteers upon commencement and provide supervision and support in their roles while they are on site.</p>	
Regulation 31: Notification of incidents	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 31: Notification of incidents:</p> <ul style="list-style-type: none"> • The PIC will ensure notifications are submitted as per regulatory requirements. The PIC has educated the staff team regarding notifications and communication of notifiable incidents if they occur in the absence of the PIC. • Retrospective 3 NFO5 forms were submitted on 4/11/2025 to meet the regulatory requirements and ensure compliance, as clarification was given to the PIC on the day of inspection regarding one resident with exit seeking behaviour and a care in place for this. 	
Regulation 34: Complaints procedure	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 34: Complaints procedure:</p> <ul style="list-style-type: none"> • The PIC has placed an additional complaints procedure on the residents' communication board at the entrance and placed as an agenda item at the residents' meetings. • The PIC will escalate complaints to the complaints officer if they are not resolved within 48 hours in line with the policy. The PIC/CNMs will complete reviews of complaints log to ensure compliance with the complaints process. 	
Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <p>The PIC has liaised with Household Manager, Infection Prevention and Control Nurse and Maintenance. A cleaning plan has been implemented to remove mould from the waste outlet of the sinks. The Household team will monitor the waste outlet of the sinks to ensure continued cleanliness and compliance. The PIC and Clinical Nurse Manager (CNM) will oversee this process to ensure full compliance.</p> <ul style="list-style-type: none"> • The PIC has ordered the bed side tables as required. 	

- The PIC has linked with maintenance team and the door to the internal courtyard has been reviewed and adjusted to allow easy access.
- Both units' rooms have been inspected, and a maintenance request has been completed for the required painting work to be completed.

Regulation 28: Fire precautions	Substantially Compliant
---------------------------------	-------------------------

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The oxygen cylinder in the Meadow View twin bedroom and treatment has been relocated to a secure area within the treatment room. All other oxygen cylinders across the unit have been securely stored in accordance with safety guidance.

- The PIC has identified additional staff to complete the fire safety checks and documentation in addition to the current fire warden. The checks will be completed by identified staff. The PIC/CNM will audit these checks monthly to ensure compliance.
- All boxes have been removed from the designated centre and stored in an appropriate storage facility outside of the designated centre. A notice has been put in place not to place cardboard boxes in this room.
- The Person in Charge (PIC) will ensure that all completed fire drill reports are filed in the designated fire folder and are readily available for HIQA inspection. The most recent simulated fire drill and evacuation took place on 05/11/2025, and the total evacuation time recorded was 3 minutes and 05 seconds.
- The PIC arranged a fire drill to be completed by the fire consultants which focused on the use of the external escape route. A written report will be completed for quality assurance.
- The identified fire doors have been fixed by the facilities team.
- The PIC has scheduled quarterly external escape route drills and ensures all drills are properly recorded, including staff roles and feedback.

Regulation 5: Individual assessment and care plan	Substantially Compliant
---	-------------------------

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

- The PIC will ensure that comprehensive assessments are completed for all residents with specific care needs, and that corresponding care plans are created or updated accordingly.
- The PIC has reviewed the layout and location of the resident's bed and door to ensure privacy and dignity is always maintained. The PIC has engaged in conversation with the resident to discuss maintaining their privacy and dignity.
- The PIC will request that all specialist advice be documented by the relevant specialist disciplines in the resident's medical file or Epic Care Notes.

- The PIC will ensure that all assessments and care plans are thoroughly documented, incorporating any specialist input, and that this information is clearly integrated into the overall care plan.
- The PIC will ensure quarterly audits of care plans are carried out to confirm that all resident needs are addressed and documented.

Regulation 6: Health care

Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

Nursing staff will receive refresher training on the policy requirements for completing timely neurological observations following unwitnessed falls.

- All neurological observations will be clearly recorded and easily accessible within residents' electronic files (Epic Care) to ensure transparency and continuity of care. Where a staff nurse attempts to complete any nursing care, and the resident declines, this is documented on the relevant record, and the nurse will offer again after a reasonable period.

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/12/2025
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	30/04/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/11/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	06/02/2026

	place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	30/12/2025
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	30/12/2025
Regulation 28(2)(i)	The registered provider shall	Substantially Compliant	Yellow	30/12/2025

	make adequate arrangements for detecting, containing and extinguishing fires.			
Regulation 30(a)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre have their roles and responsibilities set out in writing.	Not Compliant	Orange	30/12/2025
Regulation 30(b)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre receive supervision and support.	Not Compliant	Orange	30/12/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	04/11/2025
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position	Not Compliant	Orange	04/11/2025

	in the designated centre, and where the provider has a website, on that website.			
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	04/11/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/12/2025
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under	Substantially Compliant	Yellow	30/11/2025

	Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
--	---	--	--	--