



**Health
Information
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An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Peamount Healthcare Neurological Disability Service
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	22 January 2026
Centre ID:	OSV-0003505
Fieldwork ID:	MON-0040067

About the designated centre

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

The aim of Peamount Healthcare's Neurological Disability service is to promote the long term physical and psychological wellbeing of all residents through consultation, co-operation, collaboration and communication with them, their families or advocate and healthcare staff. The centre provides continuing care services for up to 19 residents, who have prolonged disorders of consciousness, complex medical needs associated with a neurological disability and require 24 hour nursing support. The centre is based in a large campus setting, situated in a rural area of County Dublin.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 22 January 2026	09:30hrs to 18:00hrs	Brendan Kelly	Lead
Thursday 22 January 2026	09:30hrs to 18:00hrs	Tanya Brady	Support

What residents told us and what inspectors observed

This announced inspection was completed in Peamount Healthcare Neurological Disability Service to inform a decision regarding the renewal of registration for this designated centre. The inspection also assessed the providers ongoing compliance with The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

In the main the provider was found to be meeting their regulatory requirements with high levels of compliance observed by the inspectors. Improvements were found to be needed in relation to staffing and governance and management. Concerns were also discussed with the provider in relation to the long term plan of residents sharing a bedroom in particular the provider's future plans for renewal of registration for a shared bedroom. This concern was also highlighted by a family member in response to a survey offered to all residents prior to the inspection.

Peamount Healthcare Neurological Disability Service comprises a large single storey premises located on the provider's campus in Co. Dublin. Currently the centre is registered for 19 residents and on the day of inspection the provider had two vacancies. 15 of the 17 residents had their own bedroom with the remaining two residents sharing a larger bedroom, inspectors found that two single bedrooms were not occupied.

On arrival at the designated centre the inspectors were met by the centre person in charge. Through the inspection the inspectors had the opportunity to meet fifteen residents, family members of two residents, the director of nursing, assistant director of nursing and four of the staff on duty in addition to ancillary staff such as housekeeping and kitchen support.

One of the inspectors had the opportunity to meet with two family members of residents who were visiting on the day of inspection. The first family member was of a resident who has lived in the premises for three years. The family member was very complimentary of the service their loved one receives telling the inspector 'this is heaven' explaining that the extended family see the centre as 'a home from home'. The family member explained that their loved one had been in another location in the immediate aftermath of their accident and in their opinion there was no comparison to the care they receive now.

The family member discussed how family can come and go as they please when visiting their family member. The staff in the centre they stated are always kind and considerate. The inspector observed a positive interaction from staff while talking to the family member. A staff nurse came into the room, introduced themselves to the resident and informed the resident that they needed to examine their feeding tube. When the staff member left the room the family member commented to the inspector 'that happens every time they come in' making reference to the staff

member introducing themselves and explaining the purpose of what they were doing to the resident.

The resident's family member went on to explain to the inspector how important it has been for the extended family that the centre staff supports them to bring the resident home back to their family home. They went on to explain that when the resident comes home they are always clean and well presented.

An inspector also met family members of a second resident. This resident had been living in the centre for only a number of months. One of the family members described the centre as 'fantastic'. They spoke positively about the staff team and in particular said that the nursing care was 'very good'. The resident's family member also spoke of the importance of family being able to visit as they wished. The family member spoke positively about the multi-disciplinary team within the premises. In particular for their loved one, the physiotherapy department which had helped make physical improvements for the resident since their arrival to the location.

The inspector met with a second family member of this resident later in the afternoon. This family spoke of the importance of initiatives such as a music group each week put in place by the provider. The family spoke of how this creates a bond between the family members which, in their view was important because of the shared journeys of the residents and their families.

Inspectors had the opportunity to engage with a number of residents over the course of the day. One resident explained that they liked to use a diary and notebook to help them to remember what was planned or had happened during the day. The resident asked inspectors to write their names and the purpose of their visit into the diary and later in the afternoon this written prompt was used to remind the resident of the reason for the inspectors being in the centre.

Inspectors also greeted and spoke with some residents who were relaxing in the communal area of the centre where the television was on. A resident told inspectors that they had recently had some medical support and showed off some bruises on their hand, they had been supported by staff they explained during this time. They also spoke to the inspectors about how they had challenges with their stomach and staff supported them to manage this on special days when they wished for example to attend church. Inspectors also joined a resident as they went to start their physiotherapy with the resident confirming that they found stretches challenging.

Prior to the day of inspection the residents were given the opportunity to complete a HIQA survey. The aim of the survey is to capture the resident opinions on various aspects of life in their home. The inspectors were given six completed surveys and the content of these were reviewed. Due to the complex nature of the resident profiles in this location the inspectors observed that two of the surveys were completed by resident family members and four completed by staff on behalf of the residents and with their input where possible.

Again, due to the complexities of resident needs some of the questions were not applicable to the residents living in the location. For example inspectors observed responses regarding questions seeking residents' opinions on the food they eat, as

some of the residents who did not respond are fed via percutaneous endoscopic gastrostomy (PEG) tubes.

The responses to the questions asked were positive in terms of the staff team and the care the residents received. In terms of areas of improvement, one questionnaire completed by staff outlined that a resident does not like it when they have to go to hospital as they feel the staff there do not know them well enough. One questionnaire completed by a family member outlined that is not the residents choice to share a bedroom. When asked if they have their own bedroom the family member answered 'it could be better'.

Throughout the day of the inspection both inspectors observed the staff team interacting in a person centred and caring manner with the residents and family members. Residents were observed being supported to leave the centre to attend their day service and one resident was supported to go into the community with staff support.

The centre was also home to two cats who were important to a number of residents and inspectors observed that the staff ensured some residents were seated in locations where they could see their pets. For one resident who enjoyed watching garden birds the staff had supported them to purchase a bird feeder that was positioned so it was visible from their bedroom.

The next two sections of the report will provide greater detail on the capacity and capability of the provider to manage the service and how this impacts on the quality of life experienced by the residents.

Capacity and capability

The provider had in place a staff team that consisted of staff nurses and health care assistants. Given the complex nature of the resident profile in the premises the provider also had ensured access to health and social care professionals such as physiotherapy, occupational therapy, speech and language therapy and social work. A doctor also attended the centre every day and was available to review resident health and to support with routine health checks.

On the day of inspection the provider had 0.5 whole time equivalent (WTE) vacancy in their nursing team and 5.5 WTE vacancy in their health care assistant team. A contingency plan was in place with regard to the vacant lines. The contingency plan consisted of regular relief staff and agency use. The provider had ensured the staff team were in receipt of both induction and refresher training in line with the statement of purpose.

The provider had a clear governance structure in place that consisted of an on-site person in charge who reported to the assistant director of nursing. The provider also

had in place a system of internal and external audits that outlined actions aimed at improving service delivery. However, inspectors observed that not all actions outlined in audits had been completed in the time lines identified by the provider.

The provider had submitted all required documentation and annual fee to support their application to renew the centre registration.

Registration Regulation 5: Application for registration or renewal of registration

Prior to the inspection, the inspectors had reviewed the provider's submitted documentation regarding the application to renew the centre registration. Information reviewed contained for example, the provider's application form, floor plans, insurance documents and information on the management team of the centre.

All information submitted by the provider met with the regulatory requirements.

Judgment: Compliant

Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

Prior to the inspection the inspectors observed confirmation that the provider had paid the annual fee for a registered designated centre.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured they had planned and actual rosters for the location. The planned and actual rosters were maintained by the person in charge as part of their oversight roles and responsibilities.

On the day of inspection the provider had 0.5 WTE vacancy in their nursing team and 5.5 WTE vacancy in their health care assistant team. The provider had a contingency plan for these vacancies. Three of the provider's relief staff were working permanent lines on the health care assistant team. The remaining vacancies were filled with a mix of relief and agency staff. The centre nursing vacancy was covered with agency nursing staff.

The inspectors reviewed rosters from November 2025, December 2025 and January 2026. Inspectors observed each week of reviewed rosters contained agency staff

sourced from multiple agencies. The frequency and number of agency staff had an impact on the provider's ability to provide a consistent continuity of care. In their annual review of 2024 the provider had committed to recruiting into vacancies in the centre by December 2025 but on the day of inspection were unable to meet this deadline.

On the day of inspection the inspectors had the opportunity to speak with four of the front line staff team. Inspectors spoke to the activities coordinator, two of the nursing team including an agency nurse and one of the health care assistants. The staff who met with the inspectors all displayed a strong knowledge of the residents in the centre. Staff were aware of key plans in place for residents.

Staff were complimentary of the dynamic within the staff team and also of supports from the provider. Staff discussed the importance of the supports from the provider given the complex nature of the location.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspectors found that staff had the training, knowledge and skills appropriate to their roles. They received support and supervision to ensure they were aware of their roles and responsibilities for providing a good quality of care and support for residents. This was of particular importance given the complexity of residents' assessed clinical needs with the provider ensuring staff had access to specialist training important for the provision of person centred care and support..

The inspectors reviewed the staff training matrix and found that staff had completed training listed as mandatory in the provider's policy, including fire safety, safeguarding, children first, manual handling, and infection prevention and control (IPC). The training matrix was maintained by the person in charge as part of their oversight responsibilities. The person in charge was responsible for requesting refresher training for staff as required.

The inspectors reviewed probation and supervision records for four staff. These were being completed in line with the provider's policy. Discussions were held in relation to areas such as staff strengths, areas for further development, their roles and responsibilities, training and development, safeguarding, risk management, and fire safety.

Staff who spoke with the inspectors said they were well supported and aware of who to raise any concerns they may have in relation to the day-to-day management of the centre or residents' care and support. They spoke about the provider's on-call system and the availability of the person in charge or assistant director of nursing if they required support.

Judgment: Compliant

Regulation 22: Insurance

Prior to the inspection the inspectors reviewed the provider's submitted information regarding insurance. The insurance documents were found to meet the regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

The provider had a clear governance structure in place for the centre. The person in charge reported to an assistant director of nursing who in turn reported to the director of nursing. Each level of management for the centre had clear roles and responsibilities. The person in charge had oversight responsibilities for this centre only and was on-site Monday to Friday. The inspectors were assured that the person in charge had the knowledge and support systems from the provider that allowed them to effectively carry out their role.

The provider had a system in place for both internal and external audits. The provider completed their own provider led unannounced six monthly audits and an annual review. There were also internal specific audits in place such as infection control, restrictive practice and medication management. External audits were also observed by the inspectors for example an external fire agency had completed an audit of the fire arrangements in the centre.

The provider also held governance meetings every two weeks attended by persons in charge from across the providers locations and chaired by senior management. The person in charge also held monthly local team meetings and quarterly meetings for all nursing staff.

On the day of inspection the inspectors reviewed a sample of the audits and meeting minutes completed in the centre. The inspectors observed that while the audits and meetings allowed for timed actions aimed at service improvement, not all actions were completed within the provider's agreed time lines. The inspectors also observed that the provider led audits did not identify and set targets that would provide long term continual improvements for the centre.

The inspectors reviewed the provider led unannounced six monthly audits for June and December 2025. In the June audit the inspectors observed actions identified by the provider as requiring review. In this June 2025 audit the provider had identified only five actions with three of these to be completed within a very short timeframe

by the end of July 2025. Actions included staff to sign a policy and to review the centre's quality enhancement plan.

The December 2025 audit also contained actions that required review. For example in the June audit the need for updated communication passports was identified to be completed by July 2025. This was again identified in the December 2025 audit with the completion date now March 2026. The audit does not identify the rationale for the delay in completing the action. A statement in the audit raised an issue in relation to the capacity of the family room in the centre, however no action was identified as a result of the finding.

The providers local audits were found to be comprehensive and identified issues with clear time lines for actions. For example a medication management audit was completed in June 2025 that identified issues with instructions for crushing medications. In a follow up audit in December 2025 this action to review instructions was completed.

On review of the external fire audit carried out in February 2025 inspectors were not assured of the timely response of the provider to issues identified. For example, the audit identified four issues that were classed as Category A with a time line of immediate or as soon as possible. On the day of inspection none of the four areas identified in the audit had been completed, and this was highlighted directly to the provider on the day of inspection.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose is a key governance document for the centre that identifies the service to be provided and provides key information to residents and their representatives. Prior to the inspection the inspectors reviewed the centre statement of purpose. The document met the regulatory needs of a statement of purpose.

The document contained information for residents and their representatives on how the staff team, staffing numbers and centre management was configured. The statement of purpose also outlined the services offered by the provider and information on how the provider will build individualised care plans for each resident.

The names and contact information of key personnel in the centre was also provided along with complaints information if required.

Judgment: Compliant

Quality and safety

Inspectors acknowledge that the complex medical presentation of residents in the centre contributed to challenges for the provider in ensuring that the premises was homely rather than clinical in presentation. Inspectors found for example, in order to ensure residents' clinical and care needs were met that certain activities were carried out within the campus and not in the centre, including residents' laundry and the preparation of food. The provider had employed a social care team lead whose role was to ensure residents experienced a high quality of individualised care. Residents who wished were facilitated to visit family homes on a regular basis.

Given the complexities of the residents in the centre, risk management was a key consideration as part of engaging in everyday activities. The provider had identified key risks within the centre with appropriate assessments in place.

Individualised care plans were in place for each resident. Care plans provided staff teams with clear guidance on supports required for each resident. Care plans were subject to regular review.

The provider had ensured the complex medical and health care needs of the residents were both identified and adequately met.

Regulation 13: General welfare and development

The provider had employed a social care team lead who developed and implemented plans ensuring residents welfare and development was promoted.

The inspectors observed evidence of plans enabling residents to visit their family homes. The residents in the centre required significant medical and transport equipment to allow them to visit family homes. Individual plans were made that accommodated each individual need. Inspectors observed a list for each resident that outlined the individual requirements.

One family member who spoke to the inspector discussed how their loved one would regularly attend their barber prior to their accident. Since arriving in the centre plans were put in place that allowed the resident to continue to attend their barber which was an important activity for them.

Each resident's room was decorated to their individual liking. Each room contained photographs of families and friends and items or memorabilia of residents' areas of interest such as sports or music. The inspectors observed evidence of residents attending various events including weddings and family occasions.

Resident families could visit the centre as they wished. The inspectors also observed evidence of the provider creating events that allowed families to come together as a group such as themed parties and a weekly music group. Feedback from staff and families who spoke with the inspectors commented on the success of these events and their importance to residents and families.

Judgment: Compliant

Regulation 18: Food and nutrition

The inspectors found that while the provider had a kitchen in the designated centre it was not accessed by residents and the majority of food was prepared in a central kitchen on the provider's campus. The provider had however, a number of systems in place, to ensure that as much as possible, residents were supported to enjoy freshly prepared and cooked food and drinks in a safe manner in line with the recommendations of health and social care professionals.

The majority of residents in the centre did not eat and drink orally and their nutrition and hydration needs were provided via tube feeding systems. Guidance was in place regarding the provision of tube feeding from dietitians and residents' weight and health status was constantly reviewed and monitored. Where individuals were assessed as safe to try some tastes or small volumes of food for pleasure then this was supported by suitably trained staff.

In total six residents participated in eating and drinking orally with all of them needing staff support or supervision. Staff who spoke with inspectors were familiar with each residents' assessed support needs and were observed over the course of two meals to be considerate and caring when providing support. Inspectors observed staff setting the tables and ensuring individual residents had adapted cutlery or crockery available if required.

On a number of occasions during the day the inspectors found that there was a pleasant smell of freshly cooked meals in the centre as they were delivered from the campus kitchen. Residents had a choice of food on a daily basis which the kitchen support staff arranged following discussion with individuals. The staff discussed choices daily for meals and for snacks. Each residents' selection was prepared specifically for them in the main kitchen and where required the texture modified for individuals, meals were different for everyone. One resident for example was having curry which staff reported was one of their favourite lunches. The kitchen had fridges and freezers with some other options available if residents did not wish to have what had been provided.

Throughout the inspection, the inspectors observed breakfast and lunchtime experiences for residents and found that there were sufficient numbers of staff to offer assistance to residents in an appropriate way, as per their risk assessments and plans. The inspectors found that staff were each familiar with the presenting

risks for residents, the required specialist equipment and the recommendations of both dietitians and speech and language therapists. Specific meal plans were displayed in the kitchen for staff to follow and all staff had training on the modification of food and drink if this was required.

Judgment: Compliant

Regulation 20: Information for residents

The provider had ensured to have a document in place that provided information to residents and their representatives. The document was in an accessible format and was made available in the centre.

Prior to the inspection the inspectors reviewed this important document. Information was observed in relation to how residents can be involved in the day to day operations of the centre. The document also contained information on how the residents and their representatives can access regulatory reports.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider's risk management policy was reviewed and found to meet regulatory requirements. There was an emergency plan in place which was regularly reviewed.

The inspectors reviewed the centre risk register which contained 22 risks assigned to residents, 18 of which were at an 'open' or active status and four were at a monitoring status. A sample of individual risk assessments for each of the residents were reviewed. These were found to be reflective of the presenting risks in the centre. They were also up-to-date and regularly reviewed. For example, one risk related to visitors to the centre and this was found to be aligned to a safeguarding plan and staffing supports. In another risk assessment for choking, a control measure in place linked to staff knowledge of food texture modifications which is discussed further under regulation 18. This risk assessment was also found to be aligned to appropriate care plans and health plans.

There were systems in place to record incidents, accidents and near misses. The inspectors reviewed the systems for reviewing and tracking incidents. A sample of incidents for the preceding six months were reviewed. This review demonstrated that effective control measures were in place for identified risks, as based on the risk register and that the information contained in the incidents was used by the person in charge to inform any required changes.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Medicine management was an area where the provider had a number of systems in place to oversee and manage safe administration for residents.

A nurse on the staff team and one inspector reviewed the medicines prescribed to residents and what was present in the medication presses. It was noted that all residents had multiple medicines and the method of administration varied. Where residents presented with swallowing difficulties this was clearly indicated and textures of medicines prescribed were clearly marked on prescriptions/kardex. In addition where medicines were administered via feeding tubes this was also clearly stated and details on additional fluids also stated.

The provider had clear systems in place for control medicines which were safely stored and the inspector found that these were signed by two staff on administration records and in stock taking audits. There was a fridge in place as well as individual storage areas for medicines and all medicines were dated when opened and safely stored. The systems in place to ensure unused medications were stored appropriately and returned as necessary were also in place and found to be effective.

When residents were leaving the centre there was a copy of their administration records and the associated protocols for administration of medicines as required (PRN) sent with them. All protocols in place for regular and PRN medicine administration were reviewed by the doctors present in the centre on a regular basis. The provider had daily, weekly and monthly counts and checks in place and these were linked to ordering and return systems.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider had ensured that each resident had an individualised care plan in place. On the day of inspection, each inspector reviewed two resident care plans.

A key aspect of the plans reviewed by the inspectors was the handover guidelines from the discharging hospital post resident injury. Important information was contained in each of these documents such a comprehensive breakdown of injuries sustained by the residents and supports that were central to the care and support for the management of these. Also included were recommendations from health and

social care professionals and recommendations related to assistive equipment that may be required.

Inspectors met with one resident who had newly moved into the centre a couple of weeks prior to the inspection. The person in charge and staff team, in addition to the multidisciplinary team were ensuring that care and support guidelines from the resident's previous location were safely implemented while they completed updated assessments. Staff had access to photographs and step-by-step guidance on the management of seating and mobility equipment as well as equipment in place to safely support all activities of daily living.

Care plans for all residents were developed by members of the provider's multi-disciplinary team. Each care plan provided guidance for the staff team on managing a particular aspect of resident care. For example the inspectors reviewed intimate care plans in place for residents. One plan reviewed guided on the number of staff required to safely support a resident to shower. Guidance was also in place regarding frequency of oral care, shaving and skin care.

The inspectors observed care plans in place for areas such as feeding, eating, drinking and swallowing, health screening, communication, skin integrity, pressure sore prevention and management and mobility.

Plans were subject to regular review. The plans observed by the inspectors were last reviewed in December 2025. The person in charge and front line team were responsible for inputting daily data and updates on an online system which could then be used by the multi-disciplinary team to update care plans.

One care plan reviewed by the inspectors was around the management of a residents epilepsy. One of the measures outlined was to provide training for the resident's family. The benefit outlined was that the resident would then be in a position to spend more time in the family home.

Judgment: Compliant

Regulation 6: Health care

The provider had ensured that all residents' health care needs were assessed. Given the complex nature of the resident profiles, they required specialised treatment which was provided on site by the providers multi-disciplinary team. The inspectors engaged with some of the provider's physiotherapists, occupational therapists and speech and language therapists on the day of inspection. Inspectors also observed one resident engaging in a physiotherapy session.

On the day of inspection inspectors observed a doctor on site to review each resident. A doctor was made available by the provider each day within the centre.

Residents in the centre often required transfer to hospitals given acute changes in health care needs. Staff were aware of the guidelines for when this was required for each resident. The person in charge had notified the Chief Inspector of each time a resident was required to be admitted to hospital for specialised treatment as health care needs changed. On the day of inspection two residents had recently been admitted to hospital for such treatments.

Residents were observed by the inspectors to be well presented and comfortable. Inspectors observed an ample supply of key supplies such as supplemental feeds, dressings, medical supplies and incontinence wear. The inspectors observed that residents all had their own individual mobility aids that had been assessed to meet their specific needs. This included items such as individual moulded wheelchairs, specialist beds and tracking ceiling hoists in each bedroom.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspectors found that residents' were supported to access supports in line with their assessed needs. In addition, a number of restrictive practices were in place and the provider reviewed restrictive practices on a regular basis to ensure they were the least restrictive for the shortest duration. The provider had in place a restrictive practice log for each resident which maintained a record of what restriction was in use and how often it was checked and monitored. The log was reviewed by the inspectors on the day of inspection.

The restrictive practice log was maintained and reviewed by the person in charge as part of their oversight responsibilities. It included for example, the use of bed rails, tilt and recline chairs, lap belts, lap trays, bed wedges, positioning belts and sleep systems. All of these were restrictions observed by the inspectors during the inspection.

The restrictions in place were reviewed by the provider's multi-disciplinary team to ensure their use was still required and proportionate. The inspectors observed evidence of the provider attempting to remove restrictions where possible. For example one resident required the use of positioning belt with a wheelchair they required for everyday use. The provider then successfully sourced funding for the the resident to have an upgraded power chair. With the individual seat moulding that came with the chair there was no need for a positioning belt and therefore its use was removed following review.

Each of the restrictions had been notified to the Chief Inspector of Social Services as required by the regulations with a clear rationale provided for each restriction and its intended use.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Peamount Healthcare Neurological Disability Service OSV-0003505

Inspection ID: MON-0040067

Date of inspection: 22/01/2026

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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 15: Staffing	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: Ensure requisitions are completed so we can recruit into vacant posts. There is an open job competition. Interviews are scheduled on a reoccurring basis and will continue until such time that all vacancies are filled. One wte was successful at interview on 19th February and has been allocated to St Brides. She has begun the compliance process. Utilisation of the same relief staff allocated to the area will continue until such time that vacancies are filled to reduce any impact on residents. Agency will continue to be a last resort.</p>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management: A review is taking place of all audits and their associated time frames within action plans. The PIC and ADON are working together to ensure actions are achievable, and timeframes are realistic. We have adjusted these time frames and will be closely monitoring their progress. All Registered Provider Nominees have received bespoke training on completing Registered Provider audits. This included a piece on developing SMART goals that align with the Designated Centre and Organisational strategy to ensure continual improvements. Another part of the training, was ensuring the Registered Provider Nominee is aware of lines of enquiry, and supporting findings with actions, or vice versa. We have reviewed resources and adjusted the goal completion time for all Communication Passports to be updated. The Nursing Team have developed a list of the Communication Passports that need to be updated and arranged them in terms of</p>	

priority based on volume of change required on the information within. The PIC is working closely with SLT to ensure we are working towards the new time scale. Since the inspection, one communication passport has been updated in full, a second is being worked on, and the remainder are scheduled. The PIC has contacted the facilities department to arrange for all actions from the fire audit to be prioritised and completed. Facilities are arranging an external contractor to come in and complete the works to ensure we are fully compliant with any fire concern.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/09/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/09/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall	Substantially Compliant	Yellow	15/05/2026

	<p>carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.</p>			
<p>Regulation 23(2)(b)</p>	<p>The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.</p>	<p>Substantially Compliant</p>		<p>11/06/2026</p>