Health Information and Quality Authority

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:	Centre A1
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	10 February 2026
Centre ID:	OSV-0005386
Fieldwork ID:	MON-0043466

About the designated centre

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

Centre A1 is a designated centre based on Peamount Healthcare's campus setting in West County Dublin. It consists of two individual units and can support up to 11 adults with intellectual disabilities. It provides 24 hour residential supports to residents and is supported by a staff team which is made up of staff nurses, care assistants, house hold staff, a clinical nurse manager and a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

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
Tuesday 10 February 2026	09:30hrs to 18:30hrs	Brendan Kelly	Lead

What residents told us and what inspectors observed

This was an unannounced inspection completed in the designated centre A1 to monitor the provider's ongoing compliance with The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

During the course of this inspection the provider was informed that an urgent action plan was required to be submitted in relation to Regulation 28: Fire Safety. The findings that led to the decision to issue an urgent action are outlined later in this report. Overall this inspection showed that residents were happy in their home. While the provider had multiple staffing vacancies in the centre the residents were supported day to day by a competent staff team. Issues were identified for the provider to address in Regulation 23: Governance and Management, Regulation 15: Staffing and Regulation 28: Fire Safety. The findings for each of these regulations are discussed later in the report.

Centre A1 is located in the provider's campus setting in Co. Dublin. The centre currently comprises two premises that support up to 11 residents. One of the premises had a single occupancy apartment attached to the main building. On the day of inspection there were eight residents over the two locations. The provider is in the process of reconfiguring this and other centres on the campus with applications to vary conditions of registration being submitted to the Chief Inspector of Social Services outlining the proposed changes.

On the day of inspection, to help form judgments on the regulations reviewed, the inspector met with the person in charge, seven residents, two front line staff and reviewed documentation maintained by the provider.

The inspector was met by members of the front line team in one location on arrival. The inspector completed a walk-around of the premises with the front line staff. During the walk-around the inspector observed one of the resident's bedroom fire doors was wedged open with a pillow. The inspector spoke to the staff member regarding this and also brought the observation to the person in charge.

The inspector observed each resident had their own bedroom with all bedrooms decorated to residents' individual liking. The inspector observed evidence of pictures of family and friends where residents wished. The inspector observed evidence of ample supplies of food items in the kitchen including fruit, vegetables and snacks. Residents were enjoying a variety of breakfasts when the inspector arrived.

The premises had a kitchen where resident meals were prepared, and a large open plan sitting and dining room area. One resident chose to have their breakfast in a room by themselves where they had smart technology in place to allow them to

listen to their favourite music. Bathrooms observed by the inspector were fully accessible for the resident profiles in the centre.

The inspector reviewed the single occupancy apartment. It consisted of a kitchen-dining area, bedroom and en-suite. The inspector briefly met with the resident in their sitting room. The resident was happy to meet with the inspector. The resident indicated they were very happy and appeared to be comfortable with the staff team. The apartment contained its own means of escape in the event of an emergency.

The residents in this premises all appeared to be happy and content in their home. Residents appeared comfortable in the presence of the supporting staff team. The inspector had the chance to briefly engage with two of the residents. Both residents were getting ready for breakfast and indicated they were happy to see the inspector. The residents indicated they were happy, they appeared healthy and were comfortable with the staff.

The inspector then visited the second premises with the person in charge. In June 2025 the residents moved to this premises on the providers campus as a result of significant repair works needed in their original home. The provider has now decided that this premises will be the residents' permanent home. The inspector observed evidence of transition plans that have been in place for the residents of this premises since this decision was taken. The inspector also observed evidence of a resident being supported to write to senior management from the provider requesting an update on works to their home. The inspector observed a person centered response written by senior management to the resident outlining the processes.

The inspector had the opportunity to meet with this resident. They indicated that they were anxious about moving permanently initially but were very happy now in their new home. The resident indicated that the staff team had worked with the resident in getting their home to how they would like it.

The premises had been refurbished prior to the residents moving in June 2025. Each resident had their own bedroom which they had helped to decorate. For example one resident proudly showed the inspector their bedroom which contained a feature wall painted in their home county colours and the walls were decorated with sporting memories from that county. Other residents' bedrooms contained photos of family and friends and evidence of resident hobbies.

The inspector observed a large open plan kitchen-dining area that residents were using when the inspector arrived. Residents were engaging in various activities including table top activities with staff. The inspector observed evidence of the provider plans to utilise spare rooms in the premises for resident use including a planned relaxation room.

The inspector met with each of the residents in the centre. Each resident who met with the inspector appeared happy and comfortable in their home. One resident told the inspector they liked the space and they had "a big warm bedroom". The resident told the inspector they helped to decorate their room. The resident informed the

inspector they liked the staff team, stating "they answer my questions and know what I like".

The resident told the inspector they engage in activities they like including the centre re-cycling and going for hot chocolate afterwards. The resident told the inspector they like to help with the cooking. The inspector observed evidence of this on the day of inspection.

Throughout the inspection in both locations the staff and residents appeared to happy and comfortable together. The staff who the inspector met with and spoke to were knowledgeable of their roles in the centre. Staff displayed a strong knowledge of the residents care plans and spoke confidently regarding key risks in the locations.

The next two sections will outline in greater detail the capability and capacity of the providers systems and how these systems directly impact on the quality and safety of the residents experiences.

Capacity and capability

Overall the inspector found that while the provider had systems in place to support the oversight of care and support provided to residents improvements were required in a number of areas. The provider had a defined management structure in place with clearly defined roles and responsibilities for each level of management. The person in charge had responsibility for this centre only. However, the inspector was not assured as to the effectiveness of provider led audits that should be aimed at improving the long term quality of the service. The inspector was also not assured as to the resources available to both locations, specifically, the allocation and reliability of service vehicles.

The provider had a number of vacancies in both the nursing and care staff teams which was impacting on their ability to provide a consistent continuity of care to residents. The provider had in so far as possible attempted to use familiar relief staff as a priority, however, this was not always possible leading to the use of multiple agency staff on some occasions.

Regulation 15: Staffing

The provider had ensured there were planned and actual rosters in both locations. Rosters were planned a month in advance which allowed time for the actual roster

to be compiled with any cover required sourced. The rosters were maintained by the person in charge as part of their oversight responsibilities.

On the day of inspection, the inspector reviewed the centre rosters for December 2025 and January 2026. The locations were staffed by teams of staff nurses and care assistants. On review of the rosters and in conversation with centre management the inspector observed a total of 5.7 whole time equivalent vacancies (WTE) in the care assistant team and 1.5 WTE vacancies in the staff nurse team.

The contingency plan for the staffing vacancies, planned and unplanned leave consisted of the use of relief staff, agency staff and members of the permanent team working additional hours. The inspector observed that due to the number of vacancies in each team the provider was required to use relief and agency staff each week.

It was evident through the roster review that the provider used agency staff as a last resort with the majority of weeks having more relief staff than agency staff. Where agency staff were used the provider used a number of different agencies. One line on the roster showed a line of unfunded hours that allowed for one resident to avail of 2:1 supports. This line was exclusively staffed through the providers own relief panel.

The rosters contained all the information that is required by the regulations. The names and grades of staff is outlined. The hours worked by the person in charge are listed. The shift patterns worked by the staff team are listed. There was evidence of team meetings and training for staff. Lines worked by additional staff were outlined in a different colour, for example relief staff were noted in red and agency staff noted in blue.

The inspector met with and spoke to two of the front line team in one location. One of the staff members was a staff nurse and they have been in the premises for a number of years. They spoke positively about the role stating that they liked the guidance from the person in charge who checks in every day.The staff member spoke of the key risks in the centre and the safeguarding processes in place from the provider.

The second staff member who met with the inspector was a care assistant who also spoke positively regarding their experience in the centre. They had also been working with the provider for a number of years. The staff member spoke positively regarding the quality of life experienced by the residents. They were happy with the dynamic in the staff team and spoke about colleagues who will frequently support each other.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had a comprehensive list of training in place for the staff team in line with what had been identified in their policy and the statement of purpose for the centre. The training log was maintained by the person in charge as part of their oversight responsibilities.

To support staff development the provider had a supervision schedule and regular supervision sessions for each staff member on the team. On the day of inspection the inspector reviewed the provider's training log, supervision schedule and two supervision records of the staff team.

The training log was reviewed on a monthly basis by the person in charge. The person in charge used a colour coded online system that indicated when staff required a refresher. It was the responsibility of the person in charge to schedule refresher training for staff.

The provider had a list of training for the staff team including:

- manual handling
- safeguarding
- medication management
- assisted decision making
- infection prevention and control
- basic life saving and choking

The provider's supervision schedule showed that each staff had been in receipt of supervision in line with the providers policy. The schedule also included the date of the staff members next session. The inspector reviewed two supervision sessions. Agenda items for the sessions included training, actions since the last session, skills development, concerns and an action plan was formulated.

Judgment: Compliant

Regulation 23: Governance and management

The provider had systems in place for internal audits, provider led unannounced audits, governance meetings and local team meetings. On the day of inspection the inspector reviewed a sample of all the governance led meetings that occur. The inspector was not assured that the meetings and audits were effective in identifying actions to improve the quality of the service.

The inspector requested to review the last two providers own unannounced six monthly audit reports which are a requirement of the regulation. The most recent audit was completed in December 2025 but had yet to be signed off by senior management and shared with the person in charge.

The inspector reviewed the audit completed in June 2025 and was not assured that the actions identified were comprehensive or aimed at long term service

improvement. For example the audit outlined five actions in total including staff to sign a policy, replace flooring in one of the centres and for staff to ensure they ventilate a bathroom.

All of the five actions identified were given a completion time line of August 2025 which meant that from August to December 2025 there were no provider led actions in place. Of the actions that were identified the August 2025 deadline was unrealistic. For example, the provider had identified that recruitment of staff for vacant lines was an action. This was identified in June 2025 and intended to be completed by August 2025 which allowed a two month time frame for vacancies to be recruited into.

The inspector was not assured that the centre was adequately resourced in terms of available transport. In the previous inspection report it was identified that the centre had the use of two vehicles. Since the previous inspection the centre has now the use of one vehicle which is required to support eight residents across two locations. On the day of inspection the inspector was informed that the one vehicle was currently not in use due to repairs that were needed. The vehicle had currently been out of use for approximately ten days and as of the day of inspection no definite time line could be given for the vehicles return.

The centre had a booking system in place for the one vehicle they did have and also to avail of the transport of other centers on the campus. It was not possible for more than one outing to happen at a time which needed to be planned in advance of the outing. The inspector also spoke to a resident about the possibility of going out if someone else was using the vehicle and they commented that they would need to wait.

It was not evident from any of the provider audits including the annual review or six monthly audits that the provider had identified the lack of transport as a long term concern to address.

Judgment: Not compliant

Quality and safety

The provider's systems were not found to be effective for the identification of potential fire hazards and the servicing of fire fighting equipment. As a result an urgent action was issued on the day of inspection. Further issues identified in relation to fire safety are outlined below.

The provider had effective systems in place in relation to behaviour supports, communication and resident welfare. Each resident had comprehensive health care

plan and individualised assessments in place that guided staff in supporting residents in meaningful way.

Notwithstanding the issues identified in fire safety, residents were supported in the main in a manner that promoted a positive quality of life. Residents who met with the inspector displayed and discussed a strong level of satisfaction in their homes.

Regulation 10: Communication

The provider had ensured residents had individual plans in place to address communication needs. Communication passports were in place for residents in each location. On the day of inspection the inspector reviewed the communication passport of a resident who required supports with sight and sound.

The communication passport gave clear guidance to staff in areas such as how the resident prefers to communicate, how the resident likes to ask questions, how the resident says no and how the resident indicates they are happy.

The resident had developed their own communication style using objects of reference and a writing pad. The inspector observed evidence of the resident with their writing pad. The resident's communication passport contained visual photographs of the resident using each of their objects of reference in the manner they chose to communicate effectively with the staff team. For example there were visuals in place for the staff to understand when the resident wanted tea, to speak to a friend, to have food, to have a shave or to wear their glasses.

Communication passports also guided staff in terms of residents' body language and gesture. One plan outlined how a resident used both to communicate what they needed. The inspector observed key information on resident preferences. For example the resident likes to lip read what you are saying therefore it is important to approach the resident from the front. The inspector observed the staff team approaching the resident from the front and getting to the resident's eye level before speaking.

As outlined earlier in the report the residents in this location had moved on an initial temporary basis due to maintenance works in their home. The inspector observed evidence of the provider engaging with the resident up to February 2026 in an accessible form regarding the ongoing plan for their new home.

Judgment: Compliant

Regulation 13: General welfare and development

The provider had ensured that where they wished, residents were engaged in activities of their choosing and liking. The provider maintained records that evidenced a variety of activities residents were engaged in such as goal trackers, cash books and person centred folders for each resident. On the day of inspection, the inspector reviewed the documents for two residents and spoke to a resident about what they get up to in the community.

In reviewing the goal trackers the inspector observed evidence of goals in 2025 being completed. For example one resident enjoys going to car showrooms. The inspector observed evidence of the local team making arrangements with showrooms for the resident to have viewings of their favourite cars. This included the resident being able to spend time in the showrooms and accessing all of the cars available. The resident spoke to the inspector proudly about this goal and how they enjoyed the experience.

Goals were in place for 2026 for residents. For example, one resident had been working on a goal to re-decorate their bedroom. One of the premises had a fish tank and one of the residents in this location wanted to increase the variety of fish in the tank and this was a goal they were currently working on.

The inspector reviewed resident cash books and observed that residents had been in local supermarkets, cafés restaurants, sports stores, hairdressers and bakeries.

The inspector reviewed the person centered folders in one location and observed evidence of residents engaging in various community activities. The residents had been to local garden centres and cafés. Residents had been on day trips to seaside towns. The inspector observed evidence of milestone celebrations such as birthday parties. The residents had been to visit Christmas lights and have a Christmas meal. The inspector also observed evidence in person centred plans of residents engaging in the providers positive aging week.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a risk register in place to identify, score and review centre and individual areas of risk. The person in charge maintained the risk register to ensure control measures were effective and reviews were taking place. On the day of inspection the inspector reviewed risk assessments for two of the residents in the centre and spoke to front line staff regarding risk. All risk assessments viewed by the inspector had been subject to review on a least one occasion in 2025.

On review of one resident's risk assessments the inspector observed identified risks in areas such as falls, injuries from sharp objects, absconding, aggression and property damage. The resident had risk assessments in place following an incident with a sharp object. Despite the serious nature of the incident the provider had taken a proactive approach to identified risk. Due to the control measures in place

the resident continued to access their community and meaningful activities with increased provider led supports.

The inspector spoke with the resident regarding the risk assessments. The resident was aware of the risk and the control measures the provider had in place. The resident also spoke about how they are supported by the staff team to continue to access all areas of their home and community with increased supports when they are required. The resident indicated to the inspector that they are happy and feel safe with the systems introduced by the provider since the incident.

The inspector reviewed the risk assessments in place for a second resident. The provider had identified key areas of risk for this resident such as falls, choking, behaviours of concern, bruising, and burns. The resident has a history of falls and bruising. In addition to the risk assessment the provider also had a falls recording system in place that was reviewed by the person in charge following falls.

The inspector met with staff to discuss key areas of risk in the centre. Staff who spoke with the inspector were knowledgeable of the risk assessments in place. Staff discussed resident falls as a key area and spoke of the control measures in place. One staff member also spoke of the risk assessments in place regarding sharp objects. In line with the control measures the staff member spoke of how the team ensure the resident continues to have a meaningful day and engage in their chosen activities.

Judgment: Compliant

Regulation 28: Fire precautions

On the day of inspection the provider was issued with an urgent action to submit an urgent compliance plan to the Chief Inspector in relation to Regulation 28: Fire Safety. The urgent compliance plan was requested to address concerns identified in relation to the effectiveness of fire fighting equipment and the checks in place to ensure the environment was as safe as possible to prevent a fire.

The provider had ample supplies of fire fighting equipment in both locations in terms of fire extinguishers and fire blankets. However, on review of the servicing of this equipment the inspector observed that no service had taken place since October 2024. On the day of inspection no plan was of yet in place to ensure the fire fighting equipment was in working order.

The provider also had a system of daily, weekly and monthly checks for front line staff to complete. However, on review of these checks the inspector was not assured they were completed as stated nor were governance checks occurring to ensure the completion of these key documents.

The provider has submitted a satisfactory urgent compliance plan that addresses both of the actions. The inspector has seen evidence that the fire fighting equipment

has now been serviced. The provider also submitted evidence of fire checks being completed on a more regular basis that first identified on the day of inspection. While the inspector acknowledges more checks were in place, this document was not available on the day of inspection and identified that the checks were not completed as directed in the guidance for staff.

As identified already in this report, the residents in one location had moved home since June 2025. However, the fire folder in the new location had not been updated with relevant information regarding the new building. For example, the inspector observed that the floor plans in the fire folder were of the previous location. Also the fire risk assessment completed by a competent fire person was in relation the previous location. When the inspector discussed this with centre management they were then shown a fire risk assessment completed by the same competent person for the new building. However, this assessment was last completed in 2023 and was not reflective of the premises with the current residents.

The providers emergency evacuation plan for one location did not assure the inspector due to the fact that staff in the location on unfunded hours formed part of the current evacuation plan. While the inspector was assured that there is no immediate plan to remove the unfunded supports in place, this still forms a potential risk that will impact on the staff ability to safely evacuate residents in the event of an emergency.

On a walk around of one of the premises in the centre the inspector observed that one resident's bedroom fire door was wedged open with a pillow. The resident was in their bedroom while the pillow was wedging the door open. The inspector identified this to both the front line staff and the person in charge.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider had ensured that each resident in the centre had an individualised care plan in place. Plans were reviewed and updated by the person in charge as part of their role to ensure plans were relevant and an accurate reflection of resident needs. The plans were intended to guide staff practice in each of the identified areas of need. On the day of inspection the inspector reviewed care plans for two residents.

One resident had plans in place in areas such as autism supports, safety awareness, intimate care, dietetic supports, mobility and money management. The plans were all reviewed on at least quarterly basis or sooner if required. The plans guided staff practice in each of the identified areas and set actions for staff to ensure the plans were effective. For example, the dietetics support plan instructed staff to monitor the residents weight on a monthly basis. The inspector observed via monthly weight charts that the resident last had their weight checked in January 2026.

The residents had access to the provider multi-disciplinary team (MDT). The inspector observed minutes from the providers MDT meetings in relation to the residents which took place in October 2025. Agenda items included behaviour supports, restrictive practices, meaningful engagement, emotional well-being, mental health and medical health. The meetings were comprehensive in nature and actions were developed at each meeting to be completed for the next meeting. There was a schedule in place for future MDT meetings for this and all other residents.

The inspector reviewed a resident's care plan from the second location. The resident had plans in place in areas such as mental health, sleep, bruising, choking, mobility, intimate care and privacy and dignity. Again, as with the previous plans, the guidance for staff was strong in each of the areas identified. For example, in relation to the plan for choking, clear guidance was in place from the providers speech and language therapist. There was also a place mat that gave clear instruction to staff at meal times for the resident. All of the plans the inspector reviewed for this resident were reviewed between September and December 2025.

Judgment: Compliant

Regulation 6: Health care

The provider had ensured that residents had access to health and social care professionals. Where required for identified healthcare needs, plans were in place to guide staff in supporting the residents to manage health conditions. Plans were subject to review and update from the front line staff team and person in charge. On the day of inspection, the inspector reviewed two residents' health care plans.

Each of the residents had an annual healthcare assessment in place for 2025 and the assessments for 2026 were planned. The health checks were signed off by residents' doctors. Where an additional need was identified a corresponding care plan was in place. For example the residents reviewed had additional plans in place for a weakened immune system, hypertension and wheezing and coughing. Due to changing needs and presentation, the inspector observed that one resident had undergone a dementia screening in October 2025.

Guidance was in place for staff that outlined both pharmaceutical and environmental supports. Plans were updated on a regular basis by the front line team and reviewed by the person in charge. The inspector observed that a complete review of all nursing and health care plans had occurred in November 2025 with the next review scheduled for February 2026.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had a multi-disciplinary team that included a behaviour support specialist. When required residents had access to the behaviour support team and a subsequent behaviour support plan was implemented. The provider also used restrictive practices in both of the locations. The person in charge maintained a restrictive practice log in the centre as part of their oversight responsibilities. On the day of inspection, the inspector reviewed two behaviour support plans and the restrictive practice reviews in place.

The behaviour support plans in place were each individual to the residents. Both plans were completed by the provider's behaviour support specialist. The plans guided staff in terms of how each individual needed to be supported to maintain behaviour supports.

The plans outlined what associated behaviours for the residents looked like, the frequency of the behaviours and what may trigger the behaviour for the residents. The plans then offer both reactive and proactive strategies for staff to implement as behaviours are at different stages. In terms of post behaviour, both plans offered guidance for staff in what supports the residents require when they are post incident.

The inspector observed one resident had additional supports in place in their plan for self- harm, social behaviour, anxiety and absconding.

Prior to the inspection the inspector had reviewed solicited information submitted by the provider to the Chief Inspector regarding the use of restrictive practices in the centre. The inspector was assured following a review of restrictive practice on the day of inspection that the provider had been notifying the Chief Inspector of all restrictive practices used in the locations.

The inspector reviewed the centres restrictive practice log and reviewed restrictive practice reviews from two residents. One resident had a restriction in place for the use of sharp objects including cutlery. The inspector observed evidence that the provider was actively engaging in a reduction plan with the resident. They were able to use sharps with staff supports. This was observed on the day of inspection with the resident supported by staff to prepare dinner. The provider had also attempted to use metal cutlery with the resident since the introduction of the restriction, however, the attempt was unsuccessful. Despite this, the person in charge informed the inspector that this will be attempted again to try and continue to reduce and eventually remove the restriction. The last review of this restrictive practice was in December 2025.

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	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Centre A1 OSV-0005386

Inspection ID: MON-0043466

Date of inspection: 10/02/2026

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
Outline how you are going to come into compliance with Regulation 15: Staffing: All requisitions have been completed by the H.R. department, and the recruitment process is ongoing with an open job advertisement, which will remain open until all posts are filled. A roster review has taken place to review the necessity of having relief staff on a line to ensure consistency within care provision. In the event of short notice unplanned leave, relief staff are utilised in the first instance where possible. Whilst we must seek agency support from the 21 suppliers of agency staff outlined within the H.S.E. Framework, the Nursing Administration request familiar agency staff where possible.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A.D.O.N. and P.I.C. met to discuss current process for governance meetings, both are assured that the current process is working well for all parties. Nursing Admin team have received training in minute taking, to ensure all discussion points from the P.I.C. meeting, chaired by the D.O.N., are effectively documented within meeting minutes. Each member of the P.I.C., Site Manager, A.D.O.N. and D.O.N. team, as well as some of the C.N.S. team, have received training in Regulation 23 Unannounced Six Monthly and Annual Review requirements, this includes specific emphasis on time frames for completion, using S.M.A.R.T. goal framework, and how to assess for meaningful improvements. The P.I.C. is liaising with the transport team to expedite the repair works required on the bus, as these are more extensive than initially anticipated when the bus was inspected at the garage.	

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Education has taken place with all staff regarding the importance and necessity of daily fire checks. A review has taken place within the Designated Centre to review all documentation to ensure there are no duplicate check lists so that the correct document is being completed as indicated. All firefighting equipment has either been replaced or serviced at the time of sending this report to ensure there are safe measures in place in the event of a fire. The correct floor plans are in the fire folder. The risk assessment has been completed and is relevant and appropriate to the residents living in the area. All P.E.E.P. and relevant fire evacuation documentation have been reviewed and updated. There is no indication that any resident could not be safely evacuated in the event of a fire. Education has taken place with all staff regarding wedging fire doors. All of these actions were implemented fully by 18/02/2026.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 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	15/10/2026
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.	Not Compliant	Orange	01/06/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall	Not Compliant	Orange	30/06/2026

	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.			
Regulation 23(2)(b)	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.	Not Compliant	Orange	30/06/2027
Regulation 28(1)	The registered provider shall ensure that effective fire safety	Not Compliant	Red	13/03/2026

	management systems are in place.			
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Red	13/03/2026