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:	Mullingar Centre 1
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	23 September 2025
Centre ID:	OSV-0004090
Fieldwork ID:	MON-0048244

About the designated centre

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

Mullingar Centre 1 supports four male and female adults with some specific support needs in relation to health care and mobility needs. The provider aims to provide people with an intellectual disability and their families a service which promotes each resident's best interests, choices and that optimally captures the balance of empowerment and necessary safeguards. The designated centre comprises of one community house that has been subdivided into two apartments. The centre is in close proximity to a local town. Each resident has their own bedroom, and each apartment has adequate communal areas, bathrooms and garden areas. The residents are supported by both social care workers, care staff and nursing staff as required. Some residents attend formal day services and others are supported by the staff in the centre to have meaningful days. There are two vehicles available for residents to access community activities. The centre is managed by a person in charge who is also responsible for another designated centre under this provider.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 23 September 2025	15:35hrs to 21:15hrs	Karena Butler	Lead
Wednesday 24 September 2025	08:55hrs to 15:40hrs	Karena Butler	Lead

What residents told us and what inspectors observed

This was an unannounced inspection conducted over two days with a specific focus on how residents were safeguarded in the centre. From what the inspector observed, it was evident that efforts were being made to promote a holistic safeguarding culture and to ensure residents were safeguarded in their home. However, the inspector found that improvements were required under three regulations, individual assessment and personal plan, positive behaviour supports, and risk management.

Examples of some areas identified related to, conflicting information provided to staff in relation to an epilepsy protocol and care plan. In addition, not all identified recommendations from some residents' plans or behaviour support meetings were followed through on, and not all incidents received clinical guidance when required. Those regulations and identified areas for improvement will be discussed further, later in this report.

The inspector had the opportunity to meet the four residents living in the centre. In order to gather information for this inspection, the inspector spoke with two residents, observed interactions between some residents and staff, spoke with the person in charge and six staff members, and reviewed documentation over the course of the inspection.

One resident spoke to the inspector in some of the communal areas about general topics of conversation. However, they chose not to share their views on the service provided to them or with regard to their home. That choice was respected by the inspector.

On the evening of day one of the inspection, one resident returned from a general practitioner (GP) appointment, and personal shopping. They had purchased a new blanket and duvet set. The staff that had supported them said that the resident was really happy with their purchases and was enjoying cuddling up and relaxing with their new blanket on their return. The resident communicated to the inspector that they planned to relax for the evening listening to music. The second resident returned from a family holiday away and said they had a brilliant time. They showed the inspector some pictures of their time away. The third resident went for a drive and a walk in the evening.

The following day the first resident went shopping in a different town, the second resident attended an external day service programme, and the third resident attended an appointment as staff felt they required medical review.

This demonstrated to the inspector that residents were being afforded opportunities to engage in activities in the community and as per their interests. It also demonstrated to the inspector that staff were responsive to residents' developing

healthcare needs and appropriate medical attention was sought when required.

The inspector conducted a walkabout of the premises which was a house split into two separate apartments and found they were well maintained and clean. While some areas were observed to be in need of repainting in one apartment, the person in charge brought this to the attention of the inspector and that the works were already on the maintenance department list. There was an accessible front and back garden. The back garden had seating and a sun umbrella available for use on nice days. There were mature plants in the gardens and different areas had potted flowers in order to provide a welcoming look for the properties.

In one of the apartments, the resident's vehicle was not in use since the evening before and as it was awaiting a part. The person in charge has arranged for a replacement vehicle to be available for the resident from the day after this inspection. The resident relaxed in their apartment, on day one of the inspection, watching some television shows they liked and the staff confirmed that the resident had declined to go out that day. On day two of the inspection, the resident living in the single occupancy apartment went for a coffee and to purchase some coffee pods for their own coffee maker. On their return they said they had a nice time.

It was clear from speaking individually with two residents in more depth and from observations, that residents were comfortable with staff members, and that they were being supported in accordance with their needs and preferences. Residents spoken with said that they felt safe living in the centre. Both confirmed that they had no concerns and if they were to have any concerns that they would tell a staff member. Both felt that they had a choice in what they ate every day or activities they participated in. This demonstrated to the inspector that residents were afforded choice and their preferences were respected. Both confirmed they have regular staff supporting them and that the staff spoke nicely to them.

Staff were observed on different occasions to actively listen to residents, they gave them time to talk and did not rush them. For example, in the single occupancy apartment, when the inspector asked the resident a question, staff did not speak on the resident's behalf when the resident looked at them. Instead the staff member encouraged the resident to answer if they wanted to. The resident answered very quietly and it was difficult to hear them. The staff member encouraged the resident to take a deep breath, while physically demonstrating same. They encouraged them to take their time in order to support them to increase the volume of their voice.

The provider had arranged for staff to have training in human rights. One staff member spoken with was asked about how they were putting this training into everyday practice to promote the rights of the residents. They explained, they were taught with a human rights focus while completing their social care course. They ensured in their everyday work with the residents that they promoted their autonomy in all aspects and decisions that affected their lives.

The inspector reviewed the complaints log, and found that there were no complaints related to safeguarding. In 2024 and 2025 there was only one complaint and it related to the Internet in the day service which is not associated with this centre.

The inspector observed that the centre had received two compliments. One was from a resident in February 2025, saying that they 'loved the whole team and that they think they have the best team'. Another was from a family representative of that resident in November 2024 stating that 'all staff go above and beyond for their family member'. They went on to say that 'it was so good that they family member was treated as an adult and enabled to live an independent life'. Those compliments demonstrated to the inspector that residents in this centre were supported by a caring staff team who supported their dignity and autonomy.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

This inspection was an unannounced inspection with a focus to review the arrangements the provider had in place to ensure compliance with the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations) and the National Standards for Adult Safeguarding (2019). It followed a regulatory notice issued by the Chief The inspector of Social Services (The Chief The inspector) in June 2024 in which the safeguarding of residents was outlined as one of the most important responsibilities of a designated centre and fundamental to the provision of high quality care and support. Furthermore, that safeguarding was more than the prevention of abuse, but a holistic approach that promoted people's human rights and empowered them to exercise choice and control over their lives.

Overall, it was apparent that any concerns or allegations were taken seriously, appropriate actions and investigations were undertaken as required, and safeguarding was given high priority by the provider, the management team, and the staff team.

From a review of the provider's governance and management arrangements, the inspector found that, there were appropriate systems in place in order to ensure the quality and safety of the service. For example, there was a clearly defined management structure in place and three staff spoken with were familiar with the reporting structure should they have a concern.

There were adequate staffing levels available and staff had the required skills to meet the assessed needs of residents. The inspector observed that, staff were provided training including refresher training in mandatory areas, such as fire safety. Staff also received training in areas specific to supporting the assessed needs of the residents, for example epilepsy.

Regulation 15: Staffing

From a review of the staffing arrangements in place, the inspector found that the provider had adequate arrangements in place.

The inspector reviewed of a sample of rosters of two months in 2025, as well as a date from October 2024 when an incident occurred,. This review demonstrated to the inspector that there were sufficient numbers of staff to meet the needs of residents during the day and night.

New staff to the centre received an induction to ensure they had the required information to appropriately support the residents. In addition, new staff completed a number of shadow shifts whereby they were additional staff on the roster working along side core staff. This was in order to get to know residents and to reduce the likelihood of incidents. For example, one of the most recently employed staff confirmed to the inspector that they had completed five shadow shifts and showed documentary evidence of same.

There was a full complement of staff for the centre; however, a number of staff were out on long term sick. The person in charge was using a number of regular consistent relief and agency staff in order to fill the roster and promote continuity of care. This was in order to ensure staff were familiar with the residents' assessed needs and to promote a safe environment. The inspector had the opportunity to speak with one of those relief staff that were completing a night duty. They demonstrated that they were familiar with the communication methods of the residents and their healthcare support needs.

Interactions between staff and residents were observed to be respectful and caring. The inspector spoke with the person in charge and six staff members during the course of the inspection, and found them to be for the most part knowledgeable about the support needs and any safeguarding requirements for the residents. Improvement was required with regard to staff knowledge of a resident's epilepsy protocol. This is being addressed under Regulation 5: Individual assessment and personal plan.

The inspector observed four staff member's Garda Síochána (police) vetting (GV) certificate of which three staff had been invited for re-vetting due to the length of time since their last vetting. This demonstrated that the provider had arrangements for safe recruitment practices.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector viewed the staff training matrix and a sample of training certification

across seven training areas, for example medication management . This review demonstrated that staff had received a suite of training in key areas in order to ensure staff knew how to support the residents in line with their assessed needs as well as to safeguard and protect them.

Training provided to staff included:

- safeguarding of vulnerable adults
- children first
- people moving and handling
- epilepsy
- cardiac first response
- fire safety
- positive behaviour support.

In addition, staff were able to discuss the learning from various aspects of these trainings. For example, two staff spoke to the inspector about various forms of abuse, signs to look out for and what to do should they have a concern.

In addition, staff completed a number of trainings related to infection prevention and control (IPC), for example standard and transmission based precautions. Those trainings would support staff to have the necessary skills and up-to-date knowledge in key areas of IPC. This would facilitate residents being safeguarded from the risk of developing healthcare associated infections and manage infection control risks should they occur.

Staff had received additional training to support residents. For example, staff had received training in human rights. Further details on this have been included in 'what residents told us and what inspectors observed' section of the report.

Judgment: Compliant

Regulation 23: Governance and management

There were sufficient management systems in place for oversight of the safety of the residents in the centre. For example, there was a clearly defined management structure in place and a staff member spoken with was able to confirm the reporting structure to the inspector. Six staff explained they would be comfortable reporting any concern to management if one arose.

There were different monitoring and oversight processes in place in relation to the safeguarding of residents. For example, the person in charge completed a monthly report on the review of the service and it was sent to their manager for review. The inspector observed one was completed each month in 2025. Topics included, risk assessments, accidents and incidents, complaints, staffing issues, any safeguarding concerns and trust in care issues. It was evident that, any safeguarding concerns or

allegations were responded to appropriately and in a transparent manner.

The inspector reviewed the organisation's Schedule 5 policy folder. The regulatory requirement is that Schedule 5 policies were required to be in place, were made available to staff and were reviewed every three years or sooner if needed. All required policies where found to be present and within the three year review period. Up-to-date polices ensure staff are appropriately guided in line with best practice on how to support and keep residents safe. Therefore safeguarding them from inappropriate practices.

Monthly staff meetings were held and, from a review of the last two minutes of meetings, safeguarding was a standing item at each of these meetings. Discussion topics included, safeguarding, a discussion on the residents, complaints, IPC, fire safety, and restrictive practices. Incidents were also reviewed at meetings and any learning that arose was shared and discussed with the staff team for learning and to ensure consistency of approach.

As part of the annual review of the service, the provider had arranged for questionnaires to be given to residents and their family representatives. While the residents were supported to complete the questionnaires with staff support, families did not return any completed questionnaires. However, when speaking with families on the phone the previous person in charge had communicated that families were happy with the service and had no concerns.

No concerns were raised as part of the resident questionnaires and all answers were ticked yes to represent that they were happy with all aspects of their care. Questions included, "do you feel safe, do you feel supported, if something was bothering you would you feel comfortable telling staff?"

Judgment: Compliant

Quality and safety

This inspection found that residents received a good quality service which respected and promoted their rights. However, some improvements were required in relation to individual assessment and personal plan, positive behaviour supports, and risk management.

The provider assessed the residents' needs and support plans were developed as applicable, to help guide staff on how to support the residents in the best possible way. However, some areas were identified as requiring improvement. For example, one personal support plan provided conflicting information compared to the protocol for administration of an 'if and when needed' epilepsy medication. These areas will be discussed in more detail under Regulation 5: individual assessment and personal plan.

The inspector observed that the premises was suitable in providing a safe environment for the residents to live in. For example, ramps were installed to facilitate safe entry and exit from the premises.

It was found that while the provider was facilitating appropriate positive behaviour support in the centre it was not evident if some recommendations from professionals were followed through on. This was in order to ensure that residents were safeguarded, as far as possible, from any negative consequences of their behaviour towards themselves or others.

While there were restrictive practices in place, for example chemicals locked away, they were observed to be in place for the safety of a particular resident.

It was found that there were appropriate systems in place with regard to protection of residents. The inspector found that concerns or allegations of potential abuse were investigated and reported to relevant agencies.

The inspector observed that, the individual choices and preferences of the residents were promoted and supported by staff. Communication was promoted in relation to safeguarding as well as all aspects of daily life, for example referrals had been submitted for some residents for speech and language therapy.

While there were many appropriate systems in place for risk management to ensure that risks were identified and monitored, some areas for improvement were required and they will be discussed further under the specific regulation. For example, it was not evident that the coverage of the fire detection and alert system was fully appropriate for the centre, and improvements were required with regard to the management of medication errors.

Regulation 10: Communication

On the day of the inspection, the inspector saw that there were adequate arrangements in place to promote communication. The inspector saw staff interact with the residents in a dignified and person-centered manner.

The inspector found that one resident had received speech and language therapy (SALT) input in the past so as to maximise effective communication. Different approaches and technology had been trialled; however, the resident had chosen not to engage with them and that choice was respected. Recent referrals for review of three residents communication from SALT had been submitted.

From a review of two residents' files, one the inspector observed that there were communication dictionaries in place which detailed residents' preferred style of communication and how best to support them to communicate their needs. For example, "what I do, what it might meant, and what you should do".

Two staff spoken with were knowledgeable as to how residents communicated and

how staff should communicate with them. One staff provided examples to the inspector, such as if a resident was upset that talking about their childhood dog may help cheer them up. The inspector observed this on inspection and it appeared to work quite effectively.

Information was available for residents in an easy-to-read format in order to promote their understanding. For example, there was information on safeguarding, the centre's annual review of the service, right to make medical decisions, assisted decision making act, looking after my money, flu vaccines, and female health national screenings. Different topics were discussed at the weekly residents' meetings. The person in charge self-identified that they would like the resident meetings and associated minutes utilise different methods for engagement and promoting understanding and planned to bring this up at the next staff meeting. The person in charge had already adopted using pictures, at the meetings, of emotions as to how the residents maybe feeling and if they would like to explore those feelings.

In addition, residents had access to a television, radio, and the Internet.

Judgment: Compliant

Regulation 17: Premises

The safeguarding of residents included providing a safe living environment and the inspector found that the premises were suitable for the assessed needs of the residents.

The facilities of Schedule 6 of the regulations were available for residents' use. For example, residents had access to cooking and laundry facilities.

The apartments were kept in a good state of repair and were found to be clean and tidy. From observation of three bedrooms, the inspector found them to be individually decorated and set up to suit each resident's preference and assessed needs.

The door frame of one resident's fire containment door was found to be damaged along the bottom on one side. The provider arranged for that to be replaced post inspection with evidence submitted to the inspector. In addition, two fire containment doors were found to not fully close themselves which could allow for the spread of smoke or fire. However, the person in charge arranged for the doors to be amended during the inspection and all doors were found to be able to fully close.

The bathroom in the larger apartment had two areas that mildew had developed and were recently cleaned. The person in charge was in discussion with the maintenance department to assess could anything further be done to help prevent the mildew from developing again. This demonstrated to the inspector that the

person in charge was responsive to potential risks to residents' health from their home.

The back garden had been redone since the last inspection of this centre with a new patio area for sitting out on as well as a number of ramps to ensure safe exit from the property based on the assessed needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

While there were many appropriate processes and procedures in place to identify, assess and ensure ongoing review of risk, further improvements were required to aspects of risk management.

Risk processes included, ensuring that effective control measures were in place to mange centre specific risks and support residents' safety within the centre and the community.

The inspector reviewed a sample of accidents and incidents which had occurred in the centre in the months prior to the inspection. They were found to be reviewed by the person in charge and learning from adverse incidents was shared with the staff at team meetings. However, from a review of a recent medication error, which resulted in a resident not receiving their evening medication, there was no evidence to suggest that the staff member that discovered the error had reported it to the on-call manager or nurse. In addition, there was no evidence to suggest that clinical advice was sought from a general practitioner (GP). In the absence of clinical advice on the situation, this had the potential to pose a risk to the resident's health and therefore required review.

One resident had sleep apnoea and had an associated care plan as well as guidance for staff on how to clean the machine. The plan with regard to caring for the machine did not guide staff as to how often parts should be replaced. The plan guided staff to clean the parts weekly and staff communicated that it was cleaned daily after each use. However, the inspector observed that the mask of the machine had some residue on it. A staff member arranged for the mask to be cleaned that day. Improvements were required in this area to ensure that all staff are consistent in their approach when the machine requires cleaning and parts replaced. This is to ensure that the machine and parts are hygienic and will work effectively for the resident.

The inspector reviewed the fire safety arrangements in place to safeguard residents from the risk or fire. For the most part, fire safety arrangements were appropriate. However, the inspector queried the level of cover of the alarm type to ensure it adequately covered the premises as it was not evident if it provided adequate coverage. The person in charge had this reviewed post inspection by the provider's competent fire person who confirmed further upgrades were required to the alarms

to bring them in line with national guidance. At the time of this report, no specifics were provided or time frames for these works.

One resident's door frame was damaged and another resident's bedroom fire containment door would not close fully by itself. Those identified issues could impact on the containment of smoke and fire in the event of an emergency. The person in charge arranged for the door to be fixed on the day of the inspection. The door frame was fixed within days of the inspection and evidence submitted post inspection.

The provider had ensured a risk management policy was in place to guide staff on risk management procedures. The policy was subject to periodic review and was last reviewed July 2025.

There was a risk register and associated risk assessments in place for identified risks both centre specific and risk assessments for individuals as required. Risk assessments contained control measures that were in place to minimise or prevent the likelihood of the risk occurring and reduce the impact on individuals. For example, there was a risk assessment in place with regard to allegations one resident may make. There were systems in place for all allegations to be taken seriously and reviewed as a potential safeguarding concerns.

On review of other arrangements in place to meet the requirements of this regulation the inspector found the provider had in place:

- the centre’s boiler was observed to last be serviced May 2025 to order to ensure it was safe for use
- equipment used to support the residents were last serviced May 2025 to ensure they were fit for purpose for the residents
- the centre's two vehicles were found to be serviced, taxed, insured and had an up-to-date certificate of road worthiness to ensure the vehicles were safe for the residents to travel in.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

While the provider had systems in place for the assessment of residents' needs and ensured that personal plans were in place as required, the inspector observed some areas that required improvement.

The inspector reviewed a sample of three residents' assessment of need documents and personal plans. While the assessment of need document contained a lot of important and clear information in order to ensure residents' needs were assessed, some topics were not covered by the assessment. For example, it was not evident to the inspector if areas related to independence in the home and community as well as road safety was assessed to ensure the correct supports were in place to

safeguard residents, and in order to facilitate residents' independence.

There were personal plans in place for people who required support in specific areas.

An example of plans included:

- feeding, eating and drinking
- hay fever
- low body weight
- skin integrity.

All plans reviewed by the inspector had received a review date within the last year to ensure information provided to staff was accurate. However, one resident's plan did not guide staff fully with regard to their epilepsy management. While they had an epilepsy care plan in place, it was very limited in the information contained within it and much of the information was unknown as the resident has not had a seizure in many years. For example, the plan did not guide staff as to the type of seizure a resident may have.

In addition, there was a protocol in place as to when to administer emergency medication should the resident have a seizure (after three minutes and a second dose after ten minutes). However, there was no evidence that the guidance with regard to time frames for when to administer the emergency medication, was directed by the prescribing professional. A separate document signed by the prescribing professional had not described any specific time frames of when to administer this medication, just the dosage that could be administered within a 24 hour period. Furthermore, the care plan guided staff to administer the first dose of the medication after two minutes which was conflicting information being provided to staff.

Two staff spoken with were not sure as to when the resident should receive their first dose of this medication and said they would refer to the resident's protocol for guidance. Those identified areas had the potential that if the resident were to have a seizure that they may not receive their emergency medication as it was intended for them and therefore this could increase their risk of complications from having a seizure.

Furthermore, one resident's plan directed staff to completed weekly weight checks for the resident. While the majority of weeks the inspector observed this was occurring, some gaps were observed whereby the resident's weight was not checked. For instance, from a review since June 2025, the inspector observed approximately five weeks of gaps in the recording. The person in charge had identified in June that gaps were occurring and had emailed staff to remind them to complete the weight checks. A further check of the recording charts had not been completed since. Those identified areas had the potential that changes in the resident's weight that may have required medical review may not have been picked up in a timely manner which had the potential that weight gain or loss would not be detected in a timely manner.

From a sample of the other plans reviewed, the guidance provided for staff in order to support the residents was found to be clear. Staff spoken with could explain their role in ensuring the safety of residents in those areas. For example, in relation to preventing constipation and the need to encourage high fiber foods, liquids and exercise.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents were provided with the necessary support to manage behaviours that may cause distress to themselves or others and in turn provide appropriate safeguards. However, while the inspector found that many professional recommendations were followed through on in the centre, it was not evident if some specific identified actions were completed by the time of this inspection.

The inspector found from reviewing the two plans and a behaviour support meeting, that some recommendations had been made in order to enhance supports in this area. For instance, in September 2024 at a behaviour support meeting it was recommended that an easy-to-read be developed by the behaviour specialist in order to educate a resident on a specific topic. In addition, the behaviour specialist was to link with the clinical psychologist in relation to a possible assessment of a resident's knowledge in relation to romantic relationships versus friendships. There was no evidence to suggest that those actions had been followed through on. That could mean that the resident may not have have all applicable information in a manner suitable for them to understand it, in order to support them with specific areas related to their behavioural support. This also meant that improvement was required in the provider's system for tracking and actioning multi-disciplinary inputs in order to ensure appropriate supports are implemented when recommended and to assess their effectiveness.

Residents had access to a behaviour support specialist and senior clinical psychologist. Where required, residents had a positive behavioural support plan in place which was reviewed by a behaviour specialist. From a review of two residents' plans they had clearly documented proactive and reactive de-escalation strategies that were incorporated as part of residents' behaviour support planning. The plans also included post incident guidance to staff.

Staff had received training related to positive behaviour support. The person in charge and two staff member spoken with, were knowledgeable as to how to respond to residents with proactive strategies, how a resident may present when distressed and what responses were appropriate under the circumstances.

While there were some restrictive practices in place, such as a partly locked wardrobe, and a locked chemical press, these were in place to ensure the safety of the residents. Any restrictive intervention had been assessed to ensure its use was

in line with best practice and they were subject to periodic review by organisation's restrictive practice committee. For example, some restrictive practices had been reviewed in September 2025.

Overall, some recommended actions required implementation to ensure that residents received all potentially relevant supports that could benefit and promote their positive behavioural support. The inspector found that the use of positive behaviour supports already in use in this centre served as a key safeguarding mechanism by focusing on understanding needs and promoting well-being, rather than solely reacting to incidents.

Judgment: Substantially compliant

Regulation 8: Protection

There were appropriate safeguarding arrangements in place to protect residents from the risk of abuse.

There were clear lines of reporting and any potential safeguarding risk was escalated and investigated in accordance with the provider's safeguarding policy. Potential safeguarding risks were reported to the relevant statutory agency and where required safeguarding plans were developed and reviewed to ensure they were effective.

Staff had received safeguarding vulnerable adults training, and some staff had training in communicating effectively through open disclosures. This was in order to support and safeguard residents in their home.

Two staff spoken with confidently spoke about their role in ensuring the safety of residents. They were aware of the various types of abuse, the signs of abuse that might be of concern, and their role in responding to any concerns. All six staff spoken with confirmed that they would feel comfortable reporting any concerns they may have; however, nobody had any concerns at the time of this inspection. Three staff spoken with were aware of who the designated officer for safeguarding in the centre was.

One resident had been supported by the designated officer to undertake a number of art projects for national safeguarding day. For example, a 3-D poster about what can happen to you regarding abuse, who can help and how you feel when protected. The resident also completed a stop and go sign with the stop section related to different safeguarding areas, such as stop criticising, stop hitting and pushing etc. The go part of the sign related to making friends, be considerate etc. The poster was currently on display in one of the offices for the organisation and the stop and go sign was displayed in the resident's hall.

Residents' finances were safeguarded through the various checks and audits completed. For example, from a review of one resident's money balance sheet for

August 2025, the inspector observed that staff completed a twice daily balance checks and the sheet was signed off by staff. The inspector reviewed the money balance for that resident and found that their money balance sheet matched the amount of money in place. This demonstrated to the inspector that there was appropriate safeguards and oversight of residents' finances.

The inspector reviewed two intimate care plans and found they guided staff appropriately as to supports residents required in that area. This ensured they were afforded the correct supports in the right manner to promote independence, dignity, and their safety. For example, one resident independently dresses; however, they may not always appropriately for the weather and for staff to remind them to bring a jumper or coat if needed.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that there were adequate arrangements in order to uphold and promote the rights of residents.

The inspector spoke with two residents, the person in charge, and five staff members regarding rights and choices about everyday life choices. The inspector found that residents were supported to make their own decisions and choices about their daily lives. For example, what they wanted to eat and what they wanted to do each day.

Residents were also supported to have visitors, for example a family representative communicated that they felt welcome to visit. There was a private area available should a resident wish to see their visitors in private.

There were weekly residents' meetings taking place. From a more in depth review of the minutes from the meetings held during August 2025, the minutes demonstrated to the inspector that different topics were discussed in order to keep residents informed and aware of areas that may impact them. Topics included, an emotions check in to see how residents were feeling, to ask the residents if there was anything staff could do to further help support the residents to be more independent, to plan their weekly menus and activities, safeguarding, complaints, restrictive practices, and rights. For example, during the meeting that took place on 6 August, staff supported residents to have an understanding of the UN Conventions on the rights of people with disabilities by using an easy-to-read document.

The inspector found evidence that a resident was being provided with information and education with regard to the healthcare recommendations. The resident chose to not follow through on some of these recommendations, for example to use a stander as part of an exercise programme. The inspector found that the physiotherapist regularly met with this resident and explained the relevant information. The right to not to use some of the recommended equipment was

respected by the physiotherapist and the staff team. Additionally, the physiotherapist completed a one-to-one training session on the manual handling needs with any new staff that worked with this resident to ensure their intimate care and manual handling needs were in line with the resident's preferences and assessed needs. This ensured that the voice of the resident was being listened to and ensured that the resident would be safe during any manual handling interventions.

In addition to receiving training on human rights, staff had received training around the assisted decision making act and training in the national consent policy was being rolled out to the staff team. Those trainings would facilitate a supportive culture and promote residents' rights.

One resident was supported to get two tattoos, one in 2024 and one in 2025 as per the resident's wishes. The resident proudly showed off their tattoos for the inspector. In addition, the resident was supported to have a pet cat. The cat was a stray and was found in September 2024. The resident chose to keep the cat and was supported to ensure the cat received appropriate reviews and vaccines from the veterinarian (Vet). The cat had many different items available for sleeping or climbing on within the apartment. The person in charge and the resident devised a 'care plan' for the cat to ensure staff knew how to support the cat. This demonstrated to the inspector that residents' known and expressed wishes were respected and supported in this centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and 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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Mullingar Centre 1 OSV-0004090

Inspection ID: MON-0048244

Date of inspection: 24/09/2025

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 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 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

The Person in charge has followed up on the medication error identified on the day of the inspection. A root cause analysis has been completed and follow up actions identified These include;

• Medication management will be discussed at the next staff team meeting, with particular emphasis placed on ensuring adherence to policy and best practice in relation to the administration of medication. This will include mitigating against the risk of drug errors.

The PIC has reviewed the cleaning guidance for the sleep apnea machine and updated it to ensure it is in line with best practice and adequately guides practice. This includes;

• A daily, weekly, and fortnightly cleaning schedule of the filter as recommended by the sleep apnea CNS.

• Guidance is in place for staff to complete a daily check for damage of the mask and tubing. Spare equipment is available onsite if required. The PIC has liaised with the organisation's infection prevention and control nurse to ensure guidance is up to date and comprehensive. Risk assessments have been updated and are in place for all associated identified risks.

• The PIC will carry out spot checks to ensure all guidance is being consistently followed.

The PIC has followed up with the Fire Officer regarding the fire alarm system currently in place in the centre. To bring the alarm system up to an L1 rating as per guidance, the following is required;

• 3 x additional Smoke Detectors & 1 additional x Call point - (Red Break Glass box unit mounted on wall)

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Assessment of need documentation is being reviewed to ensure it covers all aspects of a person's needs. This document will include all health-related information as well as information on what supports an individual requires to promote their independence and for social and community integration.

All epilepsy care plans have been reviewed by the PIC to ensure they contain all relevant information to effectively guide practice. This review included;
• All PRN guidance/ protocols correspond accurately with the most up to date medical prescription.
• Guidance is clear and unambiguous when PRN rescue medication is required for the management of epileptic seizure activity.
• Where an individual has not had any seizure activity in several years, guidance must clearly state this and advise that emergency medical attention is required following the administration of rescue medication as prescribed. If known, details are included as to how seizure activity presented for the person in the past, but it will be clearly noted that seizure activity after many years could look significantly different.
• At the Dec 2025 staff team meeting the PIC will discuss Risk management/ up-dates to care plans, protocols & guidance. The key working role will also be reviewed with all staff, this will include their responsibilities regarding the management of documentation and appropriate and timely review.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC followed up with the behaviour support team regarding the availability of easy-read information and an assessment of an individual's understanding regarding the difference between a romantic relationship and a friendship. Easy read information is now in place on relevant topics in a format individuals can understand.

A meeting was held on 29/04/2025 in the person's day service attended by the individual, behaviour support and day service staff, regarding relationships and friendships. The behavioural support therapist has confirmed that a piece of work was completed with the individual on 19/08/2025 in relation to relationships. Evidence of this has been provided to the PIC. Behavior support has clarified that going forward they will

ensure the residential centre is informed of all meetings and resulting actions.

The PIC has met with the day service manager and behavioural support therapist and going forward the PIC will ensure effective communication between the day and residential services of all residents to ensure holistic & effective support is being provided.

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 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/03/2026
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual	Substantially Compliant	Yellow	31/03/2026

	basis.			
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/03/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	24/10/2025
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	24/10/2025