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

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| Name of designated centre: | Mullingar 5 |
| Name of provider: | Muiríosa Foundation |
| Address of centre: | Westmeath |
| Type of inspection: | Announced |
| Date of inspection: | 21 October 2025 |
| Centre ID: | OSV-0002760 |
| Fieldwork ID: | MON-0039790 |

## About the designated centre

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

This designated centre offers a full time residential service to three residents over the age of 18 in a detached bungalow in close proximity to the nearest town. Each resident has their own bedroom which will be personalised in accordance with their preferences.
In addition to personal bedrooms, there are adequate communal areas, including a living room, kitchen and dining area. There is a large enclosed garden to the rear, and a lawned front garden.
The provider describes the support offered as being based on a social model of care for individuals with high support needs. Support is offered to people with an intellectual disability, autism, sensory needs and complex medical needs.
Staffing will be provided on a 24 hour basis, with waking night staff, and numbers and skill mix will be in accordance with the needs of residents.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 3 |

## 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 |
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| Tuesday 21 October 2025 | 10:15hrs to 18:30hrs | Karena Butler | Lead |

## What residents told us and what inspectors observed

This announced inspection found that while residents generally enjoyed a good quality of life, improvements were needed in six regulations: protection, staffing, staff training, governance, medicines management, and incident notifications.

Improvements were required in relation to: resident compatibility, continuity and consistency of staffing, outstanding staff training, the availability of the annual review and provider-led audits, medicines intake, and in the timely submission of incident notifications. These regulations and identified areas for improvement will be further discussed later in this report.

The inspector had the opportunity to meet the three residents that were living in the centre. The residents had alternative communication methods and did not share their views with the inspector. They were observed throughout the course of the inspection in their home. The inspector also had the opportunity to observe some staff practices and interactions with the residents which were found to be relaxed and caring.

The inspector had the opportunity to speak with the person in charge and the three staff members on duty on the day of this inspection. They came across as knowledgeable in relation to the support needs and preferences of the residents. The inspector observed the staff to have jovial interactions with the residents. For example, they joked with one resident about their love of getting into their pyjamas early and getting comfortable for the evening. The inspector also observed a staff member support a resident with eating their dinner. The staff member took their time and they did not rush the interaction.

Residents were supported to participate in activities of their preference ranging from cycling trikes, music sessions in the library, going for coffee out, and one resident has recommenced linking in with a day service on one day a week in order to promote friendships. On the day of this inspection, one resident went litter picking in the community and went for coffee out with friends. The second resident visited a friend and the third resident attended for a massage and then went to a park to use the exercise machines.

The inspector had the opportunity to speak with two family representatives, one on the phone and one in person. They were very complimentary about the service. Neither had any concerns with regard to the service. When asked if they had any concerns about the care and welfare in the centre one responded by saying "absolutely none". The other said they would feel '100% comfortable raising a concern if they had one and would feel listened to'. One family representative stated that the centre "was exceptional" and that 'without a doubt their family member gets choice in their own decisions'. They stated that the 'staff have their family member spoiled.'

As part of this inspection process residents' views were sought through questionnaires provided by the office of The Chief Inspector of Social Services (The Chief Inspector). Three of the residents had the questionnaires completed on their behalf by a staff member prior to the inspection, to give their feedback on the services provided in this centre. The questionnaire included questions about, whether it was a nice place to live, if residents got to make their own choices and decisions, if the staff helped when the residents needed it and if the staff knew the the residents likes/dislikes, and if residents felt safe. All answers were ticked 'yes' for happy with all aspects of the services and care provided apart from the questions related to 'do you have your own money to spend, and do you get on well with the people you live with'. Those questions were ticked 'it could be better'. One question had additional commentary saying that the resident 'prefers their own company and does not interact with their peers who live with them'.

On the day of this inspection, the centre looked clean and tidy. The inspector observed the premises to be more homely since the last inspection. The sitting room and living room/dining room now had the appearance of being more purposefully laid out and decorated.

Each resident had their own bedroom and residents shared bathroom facilities. The bedrooms were all decorated with residents' personal items and family photographs.

The front garden was used for parking. There were some window flower boxes and potted flowers at the front door to help make the front area look more appealing. There was a garden to the back of the property, which was used for when residents wished to sit out in times of good weather.

At the time of this inspection, there were no vacancies and there were no complaints raised in the centre since the last inspection.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements and how these arrangements impacted the quality of care and support being provided to residents.

## Capacity and capability

This inspection was announced and was undertaken as part of the provider's application to renew the centre as well as part of an ongoing monitoring with 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). This centre was last inspected in October 2024.

For the most part, there were effective governance and management systems in place in order to provide an effective service for the residents. For example, the provider ensured that six monthly unannounced provider led visits occurred as part of the requirements of the regulations. However, some improvements were

required, for instance with regard the centre receiving the annual review and provider led visit audits in a timely manner in order to follow through on agreed actions.

The provider had ensured that there was a statement of purpose and function completed for the centre along with ensuring that the centre was adequately insured against risk to the residents.

While staff members on duty were found to be knowledgeable and caring, the centre did not have a full complement of staff which impacted on the continuity for the residents and the consistency of care provided to them.

Training had been provided to staff to ensure they had the necessary skills to support the residents. However, at the time of this inspection some staff training was found to be required.

## Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted an application to the Office of the Chief Inspector to renew the registration of the designated centre which included all of the documents that are required to be submitted with this application. While some very minor improvements were required to three documents, they were not deemed significant enough to warrant an action under this regulation.

Judgment: Compliant

## Regulation 14: Persons in charge

The person in charge met the requirements of this regulation. They were a qualified social care professional with an additional qualification in management.

They were employed on a full-time basis managing three centres. They were supported in their role for this centre by a team leader.

The person in charge had good knowledge of the residents needs in the centre and it was evident that the residents were comfortable in the presence of the person in charge. The person in charge was transparent, responsive to the inspection process and had a good knowledge of their legal remit under the regulations.

Judgment: Compliant

## Regulation 15: Staffing

The centre did not have a full complement of staff in place, leading to an over-reliance on temporary and agency staff. This had a direct negative impact on the safety and well-being of residents on at least three occasions. While the provider was actively recruiting and one new staff was due to commence working as a core staff member the week of this inspection, improvements were required, and this regulation was judged to be substantially compliant.

A review of rosters from August to November 2025 showed a significant reliance on non-permanent staff. Between June and October 2025, 17 agency staff worked a total of 63 shifts, and four relief staff worked 120 shifts. This level of temporary staffing was not suitable for residents who require consistency of care.

The use of unfamiliar or inconsistent staff led to some negative outcomes for residents.

For instance:

- an agency staff member failing to administer medication required to control epileptic seizures, subsequent to the omission a resident had a seizure
- inappropriate supervision by an agency staff member, which led to a potential risk for a resident
- a resident being unable to participate in a preferred activity because an agency staff member declined to support them.

While those incidents were managed correctly by the provider after they occurred, the ongoing high use of temporary staff meant the risk of similar events reoccurring remained.

The inspector noted that the family representatives spoken with were highly complimentary of the core staff team. One family representative spoken with said that the 'staff are just brilliant with communication' and that 'staff work well with their family member and know them so well'. They said that it was 'not just a job for staff that it is a vocation.' They believed that staff 'just love their family member and that staff are a really lovely bunch'. They stated that they felt 'staff were like an extension of the family'. The other representative spoken with said that "staff are so good". They said that 'you would always know by their family member's reactions if they were not happy and that the family representative would know straight away if someone was putting on a show in front of people'. They further stated that when staff interact with their family member they were 'observed smiling or laughing'.

Staff personnel files were not reviewed at this inspection. However, the inspector reviewed a sample of five staff members' Garda Síochána (police) vetting (GV) certificates including one staff member's police clearance certificate. This demonstrated that safe recruitment practices were in place, with appropriate follow-up for re-vetting in progress for one staff.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

While the majority of staff had the required training in order to appropriately support the residents and meet their assessed needs, some training was found to be required. Therefore, this regulation was found to be substantially compliant.

The inspector reviewed the training oversight document as well as a sample of certificates of training from five different training that staff completed. From this review, the inspector found that three staff required training related to positive behaviour support. This training was required in order to support the residents in this centre due to some of the behaviours of distress that they may display. Two of the three staff were scheduled to complete the training in the weeks following this inspection. From the evidence presented, two of the three staff had commenced working in the centre, one in April and the other in June 2025, without having ever completed the training. The third staff had worked in a relief position in the centre occasionally since their training expired in May 2023 and there was no scheduled date for renewal for them due to their availability. This did not assure the inspector that staff working in the centre always had the correct skills and knowledge to be able to support the residents in line with their assessed needs given that there were known compatibility issues between the residents.

Other training required was:

- two staff required renewal of their training in standard and transmission based precautions
- one staff required refresher training in personal protective equipment (PPE) as their training expired in February 2025
- two staff required cardiac first response or basic first aid.

A sample of training sessions that staff had completed included:

- fire safety
- safeguarding vulnerable adults
- medicines management
- training related to eating, drinking and swallowing
- epilepsy awareness and emergency medication
- training related to infection prevention and control (IPC), for example hand hygiene.

Staff were also provided with formal supervision with the person in charge. This enabled staff to discuss their personal development and raise concerns about the quality of care if they had any. From a review of the supervision schedule, the current person in charge, since commencing their role in mid 2025, had ensured that all staff had received supervision as per the minimum requirement set by the provider. However, due to several changes in the person with responsibility for this

role in 2025, the frequency at which the provider deemed was best practice was not occurring for staff.

Judgment: Substantially compliant

## Regulation 23: Governance and management

While some effective management systems were in place, improvements were required in some of the provider's oversight arrangements. Issues were identified in the management of the annual review, the timeliness of receipt of the provider led visit report, timeliness of completion of certain identified actions, and the oversight of staff training. Therefore, this regulation was judged to be substantially compliant.

The provider conducted quality assurance visits every six months; however, there was a significant delay in sharing the findings of the latest visit. The report from the June 2025 visit was not given to the person in charge until 18 September 2025. This three-month delay prevented timely action on identified issues. Furthermore, the report lacked a recorded date of the visit.

The finalised 2024 annual review was not readily available in the centre. The June unannounced provider led visit had identified that the annual review had not been available in the centre. The version first presented to the inspector, that was present in the centre, was not the finalised version and was missing information. The person in charge was unsure if the annual review had been finalised. The final version was found online by a senior manager and was submitted for the inspector to review post inspection. The review provided contained confusing action points, such as an action for a holiday to be arranged for the residents that the person in charge felt was unsuitable for all residents. This had not yet been completed or planned despite the October 2025 deadline. Another action stated in the improvement plan was for a behaviour workshop to be completed in 2024 which it was in November 2024. Therefore, the inspector was not clear as to why it was included for action if it had already taken place.

There was an outstanding action for the floor in the main bathroom to be redone due to bubbling in an area. The provider had arranged for the flooring to be replaced after the issue was identified in 2022. However, the issue had reoccurred and was investigated by the owner of the property. While the provider and person in charge had made attempts to follow up with the owner on this matter, there was no set date as to when this issue would be resolved.

As detailed under Regulation 16, Training and staff development, management systems failed to ensure all staff had required training. The provider allowed three staff members to work for several months without required positive behaviour support training. This failure in oversight placed residents at an increased risk, given the known compatibility challenges in the centre.

On a more positive note, local audits for infection control, and health and safety were occurring periodically. Staff completed monthly audits, for example to health and safety, medication, vehicle, and fire safety. From a review of the last three reports, the inspector found that the person in charge conducted monthly oversight reports and spot checks.

There were monthly staff meetings occurring and the inspector observed the minutes since January 2025 with a more in-depth review of the September 2025 minutes. As part of the meetings, accidents and incidents were reviewed and learning shared with the staff team to promote consistency.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

The provider had not ensured that a written report was provided to the Chief Inspector at the end of each quarter of each calendar year in relation to all occasions on which a restrictive procedure was used. Quarter one and quarter two of 2025 had not been notified until after it had been brought to the provider's attention at this inspection.

In addition, the provider was late submitting an occasion of a major injury to a resident. The notification should have been submitted within three working days and instead was submitted after 29 days.

This meant that the provider was not fulfilling their regulatory responsibility in ensuring notifications were submitted and or submitted within correct time frames.

Judgment: Not compliant

## Quality and safety

Overall, the residents living in this centre were receiving a service that ensured their care and support needs were being met. However, improvements were required to two regulations under this section. They were Regulation 8: Protection and Regulation 29: Medicines and pharmaceutical services.

Medicines management practices required some improvements on the day of the inspection in relation to the checks staff completed when medication was taken into the centre in order to ensure potential medicines errors could be mitigated by addressing issues observed in a timely manner.

There were on-going compatibility issues occurring in the centre which were impacting on residents' quality of life. While incidents of this nature had reduced since June 2025, the potential risk of them occurring had not been mitigated and was reliant on staff maintaining effective supervision arrangements.

Residents were supported with their health and emotional needs and had access to allied health professionals where required. For example, they had access to a behaviour therapist, and general practitioner (GP).

Residents were supported with their general welfare and development which included maintaining links with their family. Residents were also supported to effectively communicate through documented guidance and with the support of the core staff team that knew how the residents communicated.

Excluding the compatibility issues with the residents, the premises was found to be suitable for meeting the assessed needs of the residents and was observed to be clean.

There was a residents' guide provided to the residents as per the requirements of the regulations. It included required information, for example it contained a summary of the services and facilities provided to the residents.

There were fire safety systems in place to minimise the risk of fire and ensure a safe evacuation of the centre if required.

## Regulation 10: Communication

Communication was facilitated for residents in accordance with their needs and preferences. The person in charge and a staff member spoken with were familiar with how the residents communicate and how best to communicate with them.

A review of two residents' files showed that communication plans, dictionaries and information in behaviour support plans were in place as required to guide staff on how best to communicate with the residents. They were found to have been reviewed within the last year in order to ensure information provided to staff was accurate and up to date. For example, one resident's plan explained that they show pain or frustration through biting their hand.

The majority of staff were trained in simple manual sign language. One resident's plan demonstrated what signs they may understand.

On review of other arrangements in place to meet the requirements of this regulation, the inspector observed that residents had access to a radio, television, Internet, and a phone.

Judgment: Compliant

## Regulation 11: Visits

The provider facilitated residents to receive visitors in accordance with residents' wishes. There were no restrictions to visiting at the time of the inspection and there were suitable facilities available in order to receive visitors in private. For example, residents could entertain their visitors in the sitting room or if the weather was nice visits could be facilitated in the garden.

One family representative was visiting on the day of this inspection. They communicated to the inspector that 'they are treated like royalty when they come to the centre' and that they are welcome to visit. They stated that staff are so welcoming.' The other family representative spoken with said they '100% feel welcome to visit'.

Judgment: Compliant

## Regulation 13: General welfare and development

Residents had access to opportunities for leisure and recreation. Residents engaged in activities of interest in their home and community and were supported to maintain relationships with their family.

From a review of the two residents' activity logs from 15 September to 5 October 2025, the inspector observed that residents were participating in activities that interested them. Ranging from going for tea out, meeting up with friends, going litter picking to help keep the community tidy, attending the library, bowling, massages, and going for walks.

The person in charge communicated that they believed that weekend activities could be improved upon and that staff were trying to come up with new ideas to work on and places to attend.

Residents were also supported to set and achieve goals for themselves. This included attending a sensory garden, taking part in a show which occurred in August 2025, and attending a summer concert. Setting and achieving goals supported the residents to enhance their experiences and improve their quality of life.

Judgment: Compliant

## Regulation 17: Premises

At the time of this inspection, the layout and design of the premises was appropriate to meet residents' needs. The premises was found to be tidy, clean, and in a state of good repair.

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

There were facilities in place to support hand hygiene, such as hand wash and disposable towels in the bathrooms. There was a colour coded system in place for the cleaning of the centre to minimise the chances of residents receiving a healthcare related illness. For example, there were colour coded mops and buckets in place and they were found to be stored in a manner that would facilitate adequate drying of the equipment.

Each resident had their own bedroom with sufficient space for their belongings. Bedrooms were observed to be set out to suit their preferences or needs with personal pictures displayed.

The garden area to the front, had spaces for parking. The back garden was where the residents would use in times of good weather.

While there were issues identified with the bathroom floor this was actioned under Regulation 23: Governance and management.

Judgment: Compliant

## Regulation 20: Information for residents

The registered provider had prepared in writing a guide in respect of the designated centre. This guide was available to the residents and included a summary of the services to be provided. For example, it included how residents should be included in the running of the centre and where residents could access inspection reports carried out in this centre.

Judgment: Compliant

## Regulation 28: Fire precautions

There were appropriate fire safety systems in place to minimise the risk of fire and ensure a safe evacuation of the centre if required.

There were fire detection and alert systems in place as well as emergency lighting, fire extinguishers, and fire containment doors with self-closures installed. A record of checks conducted by by staff were stored in the designated centre, as well as

records to show that this equipment had been serviced as required. While two fire containment doors would not close fully by themselves on the day of this inspection, members of the maintenance department attended the centre during the inspection and fixed the doors.

Residents had personal emergency evacuation plans (PEEPs) in place outlining any supports they required. Fire practice drills, of which the inspector reviewed five, had been conducted to assess whether residents could be evacuated safely from the centre. One resident was refusing to evacuate the centre. Their PEEP did give some advice on what to do if the resident refused to evacuate in the event of a real fire, for example offer chocolate. The inspector observed that alternative doors were being used for these fire practice drills in order to assure the provider that residents could be safely evacuated from all parts of the centre if required.

Judgment: Compliant

## Regulation 29: Medicines and pharmaceutical services

The inspector found that for the most part there were appropriate arrangements in place for medicines management. However, some improvements were required and they related to the systems in place for when medication was received into the centre.

The inspector found that the stock intake of medicines into the centre did not take into account of all medicines prescribed that were received from the pharmacy. The form focused on what was received rather than what should have been received based on the medication administration sheet signed by a prescriber (called a kardex). This had the potential that staff may not observe if a prescribed medication was not received. There was no system for staff to compare the pharmacy label on the medication to the signed medication administration sheet. This comparison would help minimise potential medication administration errors.

In addition, while there was some guidance in place to help staff recognise medication received in blister pack format, not all information available was clear. This was required in order to ensure there was an appropriate level of detail for accurate comparison of what medication and what dosage was received versus what should have been received in order to prevent potential medication errors. The inspector found that one prescribed medication in a resident's blister pack was a different size and shape to that which was pictured for staff guidance. There was no evidence that staff escalated this issue to assure themselves that the medication received was in fact the one prescribed. These issues had the potential to put residents at risk of receiving incorrect prescribed medication which could impact on their health.

The inspector observed that there was no separate storage of out-of-date medicines or medicines to be returned to the pharmacy as required. However, this was addressed on the day of inspection by the person in charge.

The inspector also found that some prescribed fluid thickening agent did not have a pharmacy label attached as required. The ones with labels as well as the kardex had guidance that limited the amount of times in the day the residents could receive this thickener. However, the residents were due to receive this on every occasion they had fluids. The person in charge arranged with the pharmacy and the prescribing general practitioner (GP) to have the documentation amended by the day after this inspection.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents were being supported with their healthcare-related needs. They had access as required to a range of allied healthcare professionals. For example, a chiropodist, GP, speech and language therapist (SLT), dermatologist, and a dentist.

From a review of two residents' files, the inspector observed that they had healthcare plans for any identified supports needs, such as epilepsy care plans, and eating, drinking and swallowing care plans. A staff member spoken with was familiar as to the residents healthcare support requirements. The inspector also found that there were hospital passports in place that would be used to guide hospital staff should the resident require a hospital stay.

Residents were also supported to access national healthcare screening programmes as required. For instance, one resident had completed a prostate screening. From a sample of two residents files, the inspector found they had received their flu vaccinations in 2025.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Residents were supported to achieve best possible mental health. They had access to and support from a behaviour support specialist as required.

Residents had a positive behaviour support plan in place outlining proactive and reactive strategies that needed to be in place to support them. The inspector found that this document was detailed and that a staff member was able to talk about how the resident liked to be supported and what techniques were effective to reduce the likelihood of incidents and anxiety for residents. For example, to try to promote a

good sleep pattern, staff were to ensure that the resident had fresh cardboard to rip up and remove used cardboard. These interventions were reviewed periodically at behaviour support meetings, the last of which was found to have taken place in Oct 2025.

Restrictive practices were not reviewed as part of this inspection.

Judgment: Compliant

## Regulation 8: Protection

While there were a number of suitable arrangements in place to safeguard the residents, due to identified compatibility issues between some of the residents there were on occasions when residents were negatively impacting on each other.

The registered provider had a policy in place to safeguard the residents, which included the procedures staff should follow in the event of an allegation of abuse being reported or observed. All staff had been provided with training in safeguarding vulnerable adults.

One staff spoken with was aware of the different types of abuse and informed the inspector about the actions they would take if they observed an abusive interaction occurring or if a disclosure was made.

However, there were a number of occasions whereby the behaviours of one resident was negatively impacting on others living in the centre. For example, on occasion the resident was up at night and was being loud which had woken their peers. Other incidents involved the resident pulling items out of their peer's hand that their peer owned. A compatibility assessment completed in April 2025 determined that the resident was not compatible for living with the other two residents. It described that 'on a daily basis staff time has to be diverted away from enhancing quality of life and onto requirement to keep the residents away from one another'. The person in charge communicated potential plans to extend and convert the shed in the back garden to a single occupancy accommodation for the resident with the fire officer, and property manager for the organisation completing a site visit in June 2025. However, at the time of this inspection this plan had not been explored any further due to the provider deeming the risk not high impact from a funding perspective.

The provider had increased staffing levels in the centre in order to better ensure suitable staff supervision levels of residents and facilitate in mitigating potential safeguarding risks. While this was a positive step, as per the compatibility assessment completed, the current arrangements meant that staffing attention could be diverted away from improving quality of life due to supervision requirements.

The person in charge communicated that the compatibility issues were never going to change even though since June 2025 the situation has improved with a reduction

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| of peer-to-peer incidents. Therefore, while it was positive that incidents had reduced, the safeguarding risk still remained and required a lot of staff supervision to ensure residents were not negatively impacted. |
| Judgment: Substantially compliant |

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Registration Regulation 5: Application for registration or renewal of registration | Compliant |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 31: Notification of incidents | Not compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 11: Visits | Compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 20: Information for residents | Compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 29: Medicines and pharmaceutical services | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Substantially compliant |

# Compliance Plan for Mullingar 5 OSV-0002760

## Inspection ID: MON-0039790

## Date of inspection: 21/10/2025

**Introduction and instruction**
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and 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:
As of 24/11/2025, the following has been implemented:
The use of agency staff is kept to a minimum. The PIC works with the agency staff provider to ensure staff previously inducted and familiar with the location and residents' needs only work there. All agency staff have received a comprehensive induction by the PIC. A local protocol has been developed for the management of agency usage which clearly details the steps to be followed prior to engaging an agency staff member
Agency Protocol, Steps involved
1. Explore cover within the team
2. Contact the relief panel
3. Check availability of day service staff
4. Consider swaps between teams
5. Use of agency as last resort
6. Check agency training

When booking agency;
1. All agency staff booked- training records must be checked
2. Induction completed for all agency staff
3. Onsite documentation retained

This includes a risk assessment focusing on health and safety and the potential relocation of staff to mitigate the risk. If any agency staff have not worked in the location for more than 4 weeks, a re-induction is completed to include all relevant updates relating to the residents and the location- this is signed off by the PIC.

Relief staff assigned to the location have received a comprehensive induction to the location by the PIC and relevant training required for the role. If relief staff have not worked in the location for more than 4 weeks, a re-induction is completed to include all relevant updates relating to the residents and the location- this is signed off by the PIC.

Ongoing recruitment is in place to back fill any vacancies in the current team.

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| Regulation 16: Training and staff development | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Location Specific Behaviour Support training is scheduled on 5th March 2026 for 2 staff outstanding. The other staff with outstanding training will not work in the location until this training is completed at a later date.

CPR training has been scheduled for two staff outstanding; this will be completed by 12th February 2026

All outstanding training required in standard and transmission-based precautions and the use of personal protective equipment (PPE) has been completed.
The PIC reviews the location training records on a quarterly basis and liaises with the Learning & Development Department for all staff training requirements.

The PIC has created the Staff Supervision & Support schedule for 2026. This will be sent to each staff member by 18/12/2025.

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| Regulation 23: Governance and management | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Annual Review for the designated centre will commence on 2nd January 2026, the preliminary report will be sent to the Regional Director on or before the 25th February 2026. The Regional Director will forward the final report to the PIC and PPIM by 11th March 2026. The PIC will ensure that a hard and soft copy of the annual review is available in the designated centre immediately.

2 x Six-monthly Unannounced Visits are conducted annually in the designated centre. The PPIM creates the schedules and assigns auditors to the designated centre. This schedule is forwarded to the PIC and relevant assigned auditors on or before the 23rd of January 2026.
Once completed the six-monthly review report is submitted to the PIC and the PPIM. The PPIM will discuss the outcome of the review and agree the action plan for improvements. A trend analysis of the six-monthly unannounced visits is completed by the Area Leader

in conjunction with the QRS department and submitted to the PIC, PPIM and Regional Director.
The six-monthly review action plan is reviewed monthly by PPIM with PIC.

Investigations into the leak in the bathroom have been undertaken. The current toilet to be replaced with closed coupled toilet fittings. Once the new toilet is in place, the landlord will arrange for the current flooring to be replaced. These works will be completed by 15/04/2026.

CPR training has been scheduled for two outstanding staff; this will be completed by 12th February 2026

All outstanding training required in standard and transmission-based precautions and the use of personal protective equipment (PPE) has been completed.
The PIC reviews the location training records on a quarterly basis and liaises with the Learning & Development Department for all staff training requirements.

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| Regulation 31: Notification of incidents | Not Compliant |

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Quarterly notification submission reminders are sent to all PICs from the PPIMs office at a minimum 28-day notice- 2nd January, 1st April, 1st July and 1st October.
All quarterly notifications are held in draft and reviewed by the Area Leader with the PIC to ensure accuracy and all relevant information is submitted, then submitted through the Hiqa Portal in the timeframes specified.

A confirmation email is sent from the PIC to the PPIM to inform them that all quarterly notifications have been submitted.

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| Regulation 29: Medicines and pharmaceutical services | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A new review of medication check-in system has been implemented to ensure accuracy of records. Discrepancies are documented on the Medication Stock Control forms along with NIMS and managed by the staff member on duty.

All fluid thickeners prescribed to residents have a pharmacy label.

A nurse-led medication audit is conducted weekly in the designated centre.

| Regulation 8: Protection | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 8: Protection:
Staffing resources are reviewed quarterly to ensure that all residents assessed needs, including risk of safeguarding concerns, are met.

The safeguarding plans implemented in the centre are monitored and reviewed monthly by PIC, PPIM and the designated officer.
All safeguarding concerns are reviewed monthly between PPIM and Regional Manager.

The provider has met with the landlord and Properties and Facilities Department to discuss options of development of an apartment on site where there is currently a storage shed- a preliminary meeting with the local planning office is required.
The Regional Director met again with the landlord representative on 5th December 2025 to further discuss the proposal, the landlord representative assured the Regional Director that they were submitting the request to the local planning authority that day.

## 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 |
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| Regulation 15(3) | The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis. | Substantially Compliant | Yellow | 01/12/2025 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. | Substantially Compliant | Yellow | 05/03/2026 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the | Substantially Compliant | Yellow | 15/04/2026 |

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| | service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | | | |
| Regulation 23(1)(f) | The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the chief inspector. | Substantially Compliant | Yellow | 01/12/2025 |
| Regulation 29(4)(b) | The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident. | Substantially Compliant | Yellow | 01/12/2025 |
| Regulation 31(1)(d) | The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident | Not Compliant | Orange | 01/12/2025 |

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| | which requires immediate medical or hospital treatment. | | | |
| Regulation 31(3)(a) | The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used. | Not Compliant | Orange | 01/12/2025 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Substantially Compliant | Yellow | 31/07/2026 |