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:	Mulhussey
Name of provider:	St John of God Community Services CLG
Address of centre:	Meath
Type of inspection:	Announced
Date of inspection:	27 January 2026
Centre ID:	OSV-0002967
Fieldwork ID:	MON-0040794

About the designated centre

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

Mulhussey designated centre, operated by St. John of God services is located in the countryside in Co. Meath and provides care and support to four adults with disabilities. The property comprises of a two-storey house with two sitting rooms, a dining room, two bathrooms, a large kitchen area and two offices. Each resident has their own private double bedroom. There is also a separate day activation unit to the side of the house where residents can engage in recreational and learning activities that they enjoy. The property is surrounded by large garden areas and grounds with the provision of adequate private parking facilities. Residents are supported on a 24/7 basis by a person in charge, a team of social care workers and healthcare assistants. The service has access to two modes of transport so as to support residents with the community-based activities.

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 27 January 2026	09:55hrs to 18:25hrs	Karena Butler	Lead

What residents told us and what inspectors observed

On the day of this announced monitoring inspection, the inspector found a relaxed atmosphere where the residents were receiving a good standard of person-centred care in their home. They were supported by a staff team who were patient and understood their individual needs.

While care practices were good, the inspector identified safety concerns. Specifically, fire safety upgrades were required to ensure residents were protected in the event of an emergency, and governance systems required improvement particularly in relation to ensure repairs were addressed quickly.

Despite the positive atmosphere, the inspector observed that aspects of the premises required maintenance. For example, repairs were necessary to ensure that water would not leak into the back porch. In addition, the storage of cleaning equipment required review as well as guidance for use of the equipment. The inspector also noted that improvements were required to ensure residents had timely access to allied healthcare professionals as needed. These points are discussed in detail later in this report.

The inspector had the opportunity to meet and observe the four residents living in the centre. They had alternative communication methods and did not share their views with the inspector. Instead, the inspector observed them in their home at different times during the inspection. They appeared relaxed and comfortable in the presence of the staff on duty.

One resident went out for a hot chocolate, another attended horse-riding followed by lunch out. The remaining two residents chose to stay in the centre relaxing in the sitting room or their bedroom.

The inspector had the opportunity to speak with three of the staff on duty and the person in charge. Staff were observed to be calm and respectful in their interactions. For example, when a resident indicated through their tone and body language that they wished to have time alone in the sitting room, staff were observed to respect this choice and exited the sitting room.

The provider had arranged for staff to have training in human rights. A staff member spoken with communicated how they had put that training into everyday practice. They felt that prior to having the training they may have done too much for residents with regard to household chores. They felt they had become more self-reflective since completing the training. They now try to encourage the residents to be more involved in chores and supported them to gain independence in these areas, for example putting their own dishes in the dishwasher.

The inspector had the opportunity to speak with two residents' family representatives on the day of this inspection and feedback received was very positive. The family representatives communicated that they felt their family members were safe. One stated that their family member was the "best looked after person in the world". They went on to say that the staff had not only been 'a strength to their family member but a support to them too' and 'staff always had time to ask how they were'. They said that "staff are unbelievable" and that 'staff create fun with their interactions with their family member and have a joke and a laugh.' The other representative stated that all staff have been excellent and knew their family member well and they were responsive to healthcare needs. Both felt welcome to visit the centre. They said they had no concerns at present and that if they were to have a concern they would feel comfortable raising it with staff or management. One stated that 'staff and management were approachable'.

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). Feedback from the four questionnaires was returned by way of staff representatives supporting the residents to complete the questionnaires. Feedback was positive and questions were ticked 'yes' for happy when asked about the service and care provided. Comments recorded related to staff supporting residents to make their own choices about their day. For example, choosing their own activities. Another comment related to a resident having recently purchased new bedroom furniture.

The inspector observed the house to be clean and tidy. There were multiple communal spaces available. For example, there were two sitting rooms and a separate activity building. Each of which had televisions for use. The activity building had a kitchen that could be used for baking and had many sensory items and decorations.

Each resident had their own bedroom. The bedrooms had adequate storage facilities for any personal belongings. The inspector observed there were personal pictures displayed in different areas of the house.

There was a wraparound garden with lots of space for parking. There was a gazebo with a table and seating that residents could use in times of good weather. However, there was a broken fence that was knocked over in the back garden that required repair.

At the time of this inspection there were no visiting restrictions in place and there were no vacancies or recent admissions to the centre. There had been no complaints received in 2025 up to and including the time of this inspection.

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 announced and was undertaken following the provider's application to renew the registration of the centre. This centre was last inspected in January 2025.

The findings of this inspection indicated that while areas for improvement were identified, the provider had the capacity to operate the service within substantial 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). The person in charge was operating the service in a manner which ensured the delivery of care was meeting the residents' needs.

The inspector reviewed the provider's governance and management arrangements and found that while systems were in place, improvement was required particularly in relation to the timeliness of completion of identified issues.

From a review of a sample of rosters across three months, the inspector found that there was adequate staffing in place to meet the assessed needs of the residents. However, the provider's staffing contingency plan was found to not always be effective.

Staff were found to be in receipt of training that would facilitate them to effectively support the residents, for example medication management.

In addition, the provider ensured that the centre was sufficiently insured against risk to the residents.

Regulation 14: Persons in charge

The person in charge was employed in a full-time capacity and had the necessary experience and qualifications to fulfil the role. For example, they held a qualification in social care, and in applied management of human services. They demonstrated a good understanding of the residents and their needs, for example what healthcare and behavioural support needs the residents required support with.

They were also found to be aware of their legal remit to the regulations and were responsive to the inspection process. For instance, they were aware that it was their responsibility to ensure the reporting of any adverse incidents that occurred to the Chief Inspector.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that while the staffing arrangements in the centre were effective in meeting residents' assessed needs, improvements were required to ensure a reliable, consistent staffing contingency was in place. Therefore, this regulation was found to be substantially compliant.

The inspector reviewed a sample of rosters over a three-month period from November 2025 to January 2026. While the centre did not have a full staffing complement and required one staff post to be filled, cover for those shifts was undertaken by familiar consistent relief or agency staff. This arrangement supported continuity of care for the residents and reduced the risk of them receiving inconsistent support from unfamiliar staff. The provider was actively recruiting to fill the positions.

However, the inspector found that on at least three occasions that staffing levels were reduced by one. This demonstrated to the inspector that improvements were required to the staffing contingency in place. This had the potential to limit the residents' choices regarding community activities.

In addition, the provider had not completed a risk assessment to determine safe minimum staffing levels or the control measures required to mitigate the impact of staff shortages on residents.

From the review of the sample of rosters, the inspector identified that the full names of temporary agency staff were not always recorded. This practice required review to ensure an accurate record of persons working in the centre was maintained.

The staff on duty on the day of the inspection were observed to be gentle and respectful towards the residents. A family representative emphasised that 'staff were the nicest and kindest people'. The other communicated that staff were ''attentive and caring'' and that 'staff looked after their family member very well'.

Staff personnel files were not reviewed at this inspection. However, the inspector reviewed a sample of two staff members' Garda Síochána (police) vetting (GV) certificates as well as one police clearance certificate. Two staff members' GV were completed within the time frame as recommended by best practice. This demonstrated that the provider had arrangements for safe recruitment practices.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider provided staff with opportunities to access a suite of training and meet the requirements of this regulation. While some improvement was required with the oversight of staff training, this is addressed under Regulation 23: Governance and management.

A review of a sample of certification and attendance records of six training courses for staff demonstrated to the inspector that staff received training in areas determined by the provider to be mandatory as well as refresher training. Staff had also received training in additional areas specific to residents' assessed needs.

Examples of the training staff had completed included:

- safeguarding vulnerable adults
- medication management
- epilepsy awareness and emergency epilepsy medication administration
- hand hygiene
- standard and transmission based precautions
- autism awareness
- fire safety.

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 the 'what residents told us and what inspectors observed' section of the report.

From a review of two staff members' files, this confirmed to the inspector that supervision was occurring as per the minimum frequency decided by the provider and that it was an opportunity to raise concerns if any.

Judgment: Compliant

Regulation 22: Insurance

As per the requirements of the regulations, the provider had ensured that the centre was adequately insured against risks to residents. Evidence of the insurance was submitted to the Chief Inspector.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that while the provider had governance and management arrangements in place improvements were necessary to ensure that actions required to address identified risks were completed in a timely manner. In addition, some

improvement was required with regard to the oversight of staff training. Therefore, this regulation was found to be not compliant.

While actions were being identified and escalated by the person in charge, the inspector was not assured that there was appropriate oversight to ensure actions were effectively addressed.

For instance, the person in charge had identified in February 2025 that a resident's fire containment door was missing a required intumescent strip (a heat protection strip). They had additionally followed up with the relevant internal department on 13 January 2026 and were assured that it would be followed up on. However, the inspector observed that it was still outstanding and therefore put the resident at increased and continued risk of the effects of a fire in the case of an emergency.

Additionally, maintenance issues self-identified by the person in charge in March 2025 remained outstanding. For example, although the person in charge had escalated the need to repair a broken fence on several occasions, the provider had not yet confirmed a date for these works to be completed.

It was self-identified that an additional vehicle would be beneficial to support the residents' community access due to the assessed needs of the residents. This had been identified as far back as March 2024. A staff member and the person in charge reported that one resident's frequent use of one of the centre's vehicles occasionally restricted other residents' ability to access the community at their preferred times.

Improvements were required regarding the oversight of staff training records. The inspector found that the training matrix did not accurately reflect all training completed, which made it difficult to verify the current status of all staff. Additionally, while refresher training was scheduled, there were instances where this was arranged for dates after the previous certification had expired. For example, epilepsy awareness training, and cardiac first response. Therefore, the provider needed to ensure that training is scheduled in a timely manner to maintain continuous certification for all staff so that they had the necessary skills to support the residents safely.

There were many audits being completed on different aspects of the service to facilitate a safe and effective service. For example, the provider had arrangements in place for an annual review, of which the inspector reviewed the 2025 version. There were arrangements for unannounced provider led visits every six months and the inspector found that they were taking place as required, evidenced by a review of the reports from February and August 2025. In addition, there were a number of periodic audits completed on medication management, finances, personal plans, and safeguarding.

The inspector observed from a review of the records of the team meeting minutes that they were occurring regularly. A review of three team meeting minutes, October and December 2025, and January 2026, demonstrated that any incidents that occurred within the centre were reviewed for shared learning with the staff team. Other examples of topics discussed at the meetings included, a discussion on

the residents, complaints, safeguarding, health and safety, and infection prevention and control (IPC).

Of the three staff spoken with, they communicated that they would feel comfortable going to the person in charge if they were to have any issues or concerns.

Overall, while there were many appropriate systems in place further improvements were required to aspects of the governance systems and oversight to ensure the residents were provided a quality, safe service.

Judgment: Not compliant

Quality and safety

Overall, this inspection found that the residents living in this service were supported in line with their assessed needs. However, significant improvement was required to the fire safety arrangements in the centre. Additionally, some improvements were required in relation to access to certain healthcare professionals, and in relation to aspects of the premises.

While there were fire safety management systems in place, such as regular servicing of detection and alert systems, the inspector identified a significant number of improvements that were required to ensure appropriate fire precautions were in place. For example, self-closing devices were required to be fitted to a number of fire containment doors.

The inspector observed the house to be clean and tidy. However, some aspects of IPC arrangements required review, for example the storage of mops and buckets. In addition, some areas were identified in need of repair or replacement. For example, the back porch did not have flooring other than the bare concrete.

While staff were familiar with residents' healthcare support needs and were providing care in line with their assessed needs, some residents required access to particular allied healthcare professionals, such as an occupational therapist (OT).

There were adequate systems in place to meet the requirements of the regulations associated with: positive behaviour support, protection, communication, personal possessions, and general welfare and development.

For example, where required, staff had access to a behaviour support plan to help guide them should the resident be experiencing periods of distress. There was a safeguarding policy in place to guide staff should they have any safeguarding concerns. Residents were supported to have access to their personal possessions

and their possessions were safeguarded. The inspector found that the residents appeared to engage in regular community access in line with their preferences.

Regulation 10: Communication

Communication was facilitated for residents in accordance with their assessed needs and preferences.

All four residents had been assessed by a speech and language therapist (SLT) to ensure they were receiving appropriate supports with their communication. The SLT had devised in January 2026 a communication profile on behalf of each resident as to how they communicate and how staff should communicate with the residents.

In addition, when recommended, residents were supported in their communication with the use of visual aids and communication devices. In the case of one resident, the communication device was used by staff to support a resident's understanding with no expectation on the resident to use the device to communicate in return. The three staff spoken with were clear on required communication supports.

The inspector also observed that residents had access to phones, televisions and the Internet while in the centre which would further support their communication and facilitate compliance with this regulation.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had access to their personal belongings and there were systems in place to support their personal possessions to be safeguarded.

The inspector found that the residents in this centre had personal financial accounts.

A review of two residents' inventory lists demonstrated that a record of all of their belongings was maintained in the centre. This helped ensure residents' personal possessions were safeguarded and for their use only.

The person in charge was completing quarterly finance audits and staff completed twice daily finance checks of residents' money. This was to ensure their money was accurately accounted for and to assess the systems in place to safeguard their money to ensure that they were working.

Judgment: Compliant

Regulation 13: General welfare and development

This inspection found that the residents were supported to participate in activities of interest in their home and in the community.

Residents were supported to maintain relationships with family. Both family representatives spoken with said they felt welcome to visit the centre.

Through a review of the two residents' online records for the last week in January 2026, from photographs of them attending activities in December 2025 and from discussions with three staff, the inspector observed that residents were being offered activities that interested them. Activities ranged from music therapy, lunch out, go-karting, going to the pub, trips to a theme park, visiting family, and horse riding. Some residents engaged in limited activities; however, this was found to be the residents' choice. While staff were encouraging the residents to participate in external activities, if a resident declined the activity and offer of alternatives then staff respected that choice.

Residents were supported to set and achieve personal goals to enhance their quality of life. For example, from a review of a sample of two residents' goals, they were undertaking goals related to planning individual holidays and one resident went on their first overnight to a hotel in December 2025 which was successful. Another goal related to learning to use and be comfortable on public transport, for example a train.

Judgment: Compliant

Regulation 17: Premises

The layout and design of the premises was appropriate to meet residents' needs. The premises was found to be clean and tidy. The facilities of Schedule 6 of the regulations were available for residents' use. For example, there was access to cooking and laundry facilities. However, some areas required repair or replacement. Therefore, this regulation was found to be substantially compliant.

The house was observed to be spacious with different communal areas available for use and privacy. For example, there was a sensory room in the main house. The separate activity building beside the main house afforded the residents with additional space for privacy or opportunities to engage in recreational and leisure activities. Each resident had their own bedroom individually decorated with sufficient space for their belongings.

Areas identified that required repair or replacement included:

- the inspector observed staining on a resident's bedroom ceiling that appeared to be from a leak
- there was broken and fallen fencing around the old septic tank area
- the fascia over the back porch was broken
- the porch area to the back of the house required a hole to be fixed that was allowing water in
- the porch required flooring as it was bare concrete
- the security device on the window in the downstairs bathroom required a cover as the wiring was exposed
- the light in the downstairs office required a light cover.

There were facilities in place to support hand hygiene, such as hand wash and disposable towels. There was a colour-coded system in place for the cleaning of the centre to minimise the chances of residents contracting a healthcare-related illness, for example colour coded chopping boards.

However, certain aspects of the guidance available to staff regarding the use of mops and buckets required review to ensure it accurately reflected staff practices. For instance, it guided staff for cleaning the basin and wash room surfaces with the yellow mop and bucket which the person in charge confirmed was not accurate. Furthermore, the storage of this equipment required improvement, buckets were observed to contain pooled water and debris, and mop heads were stored wet within the buckets, which posed an infection control risk.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Although some suitable fire safety practices were in place, significant improvements were required to ensure the safety of residents in the event of a fire. Therefore, this regulation was deemed to be not compliant.

Several issues regarding fire containment doors were identified. For instance, one resident's bedroom door did not have a mandatory heat protection strip. This compromised the door's effectiveness, leaving the resident more vulnerable to the spread of fire. Post-inspection evidence confirmed the provider arranged for this strip to be fitted the following day.

Other issues included:

- the required self-closing device on another resident's bedroom door was faulty
- neither the sitting room-to-dining room doors nor the adjacent activity building internal doors were fitted with self-closing devices
- the provider could not demonstrate that the glass panels in some doors were fire-rated

- the top of the architrave of two fire protection doors had a large piece removed when the doors were fitted with a self-closing device. This could compromise the integrity of the door and increased the risk to the residents.

Post inspection a senior manager for the organisation confirmed that any required self-closing devices were ordered.

A review of the four fire practice drills conducted in 2025 revealed that one resident consistently declined to evacuate. While their refusal was documented in their personal emergency evacuation plan (PEEP), there was no guidance for staff on how to manage this risk other than waiting for the emergency services. Although the person in charge had ensured fire safety information was discussed with the residents, and an external expert had reportedly accepted this arrangement, the inspector was not assured. There was no evidence that alternative evacuation strategies had been trialled to support the resident to evacuate safely.

In addition, two other residents had declined to participate in an early morning drill. However, their PEEPs incorrectly stated that they had evacuated on that specific date. This conflicting information meant staff might be unaware of the residents' actual evacuation history, potentially affecting their ability to provide safe support during an emergency.

It was unclear if external emergency lighting was installed. The lack of such lighting would place residents at risk when attempting to reach the assembly point during a power outage.

Additionally, it was not evident if alternative evacuation routes were being practised with the residents in order to ensure that residents could safely evacuate from all areas of the house.

Finally, the inspector questioned whether the fire alarm system in place was of a suitable level of coverage for the centre as it was not evident from the documentation reviewed.

Judgment: Not compliant

Regulation 6: Health care

While residents were supported in line with their healthcare needs by a staff team familiar with their required supports, access to some allied health professionals was required. Therefore, this regulation was found to be substantially compliant.

Based on a review of two residents' files, they were found to have access to a range of allied healthcare services, such as a general practitioner (GP), dentist, physiotherapist, and a neurologist.

However, the provider's own audits identified that residents in this centre required a psychiatrist review of their medication due to particular medication they were prescribed. This was found to be identified since August 2024 and it was still required at the time of this inspection.

In addition, despite follow up on the provider's behalf in November 2025, one resident had a recommendation since April 2025 for an OT sensory assessment that was found to be outstanding at the time of this inspection.

Two staff spoken with were knowledgeable with regard to required healthcare supports for residents.

Where applicable, there were healthcare plans in place to guide staff as to what supports residents required, for example hospital passports to guide hospital staff should a resident require a stay in hospital, and epilepsy care plans and associated emergency epilepsy medication administration protocol.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents were supported to experience best possible mental health. Where required they had access to the support of a principal psychologist to support them with behaviours that may cause themselves or others distress.

From a review of two residents' files, the inspector observed that where required, residents had a positive behavioural support plan in place which was reviewed by the principal psychologist. It was found to have been reviewed within the last year to ensure accuracy of the information provided to staff. This in turn ensured that the resident was receiving up-to-date appropriate supports.

Both behaviour support plans and the protocol for a restrictive practice hold prescribed for one resident, were found to outline strategies that staff needed to follow to support the residents in times of distress. For example, staff were provided with guidance to support one resident that declined having personal care completed in the bathroom.

Behaviour support plans guided staff as to the response to take when the resident may be becoming anxious or experiencing behaviour that may cause distress to themselves or others. It also explained what the resident might be trying to communicate when they are displaying those behaviours.

Two staff spoken with were very familiar as to the supports a resident required and both talked the inspector through a particular restrictive practice hold they may be required to be used on occasion to support the resident. Both staff members' accounts were consistent with the behaviour support plan and protocol in place.

In addition to the training staff received in managing behaviours of concern, they also received a yearly advanced version of the training tailored to guide staff in supporting one particular resident. This demonstrated that training was being provided to staff to ensure they had the appropriate knowledge and skills to meet the assessed needs of residents.

Judgment: Compliant

Regulation 8: Protection

There were suitable arrangements in place to protect the residents from the risk of abuse. For example:

- there was an organisational safeguarding policy in place last reviewed April 2024
- staff had received training in safeguarding vulnerable adults
- there was a reporting system in place with a designated officer (DO) nominated for the organisation
- two staff spoken with were able to identify who the DO was to the inspector, and the identity of the DO was displayed in the centre.

The inspector reviewed safeguarding incidents for the last year and found that any potential safeguarding risks were escalated, reviewed, and reported to the relevant statutory agencies. There were safeguarding plans in place to minimise the chances of recurrence of incidents. For example, staff were reminded that, although one resident did not require eyes on supervision in the bathroom, they need to ensure they are present outside of the room should the resident need them.

The two family representatives and the three staff spoken with felt comfortable raising concerns. At the time of this inspection, neither the family representatives nor the staff members spoken with had any concerns.

Two staff members spoken with were familiar with the steps to take should a safeguarding concern arise including a witnessed peer-to-peer incident or an unwitnessed disclosure. For example, the staff members explained that they would ensure the safety of the resident impacted by a peer-to-peer incident by separating the individuals. In the case of an unwitnessed disclosure both staff confirmed that they would not promise confidentiality and would gather the facts while ensuring they weren't leading the individual.

From a review of the two residents' files, the inspector observed that there were clear care plans in place that outlined residents' support needs in relation to the provision of intimate care. This would facilitate consistency of care and the delivery of dignified care practices.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Mulhussey OSV-0002967

Inspection ID: MON-0040794

Date of inspection: 27/01/2026

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

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A recruitment campaign has commenced, and the vacancy will be filled by a permanent Social Care Worker (to be completed by 20 04 26) In the interim, consistent and familiar relief staff will cover the post to ensure continuity of care. A risk assessment has been completed (28 02 26) to ensure safe staffing levels are maintained and to mitigate any potential impact arising from staff vacancies. A roster review was completed on the 28 02 26, and the full names of all relief and agency staff is now being updated weekly to ensure an accurate record of all staff working at the designated centre is maintained effective from 28 02 26). To provide oversight and reduce the risk of this occurring again, the Person in Charge will complete 6 monthly roster audits to ensure that all staff working in the service are clearly identified by their full names. The roster will also be reviewed weekly to ensure accuracy and compliance. Any discrepancies identified will be addressed promptly, and ongoing monitoring will be maintained to ensure governance and oversight of staffing arrangements within the service by the PPIM and the PIC.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The intumescent strip was fitted on 28/01/26, and photographic evidence was submitted to the Inspector on the same date. The Maintenance department has been notified of the requirement for fire door closers and has engaged contractors to arrange their installation, which is scheduled for 13 03 26. SJOG is transitioning to a digitized training system to improve accessibility to training modules and to ensure accurate, up-to-date records of all staff training and certification. This will support enhanced compliance monitoring and more transparent training	

management.
The requirement for a new vehicle has been escalated to the Regional Director, and the Director has escalated same to the external funding provider.
The external contracted Fire Safety Officer and Health and Safety Officer has reviewed the glass panels and deemed that they are fire-rated, based on the Fire Door marking located at the top of the door.
The contractor reviewed the requirement for external emergency lighting on 03/03/26 and has committed to completing the required work by 30.04.26.
Monthly Designated Centre meetings are scheduled for the year on site at the designated centre with Person in Charge, Residential Coordinator and Programmne manager in attendance.
All actions from the Designated Centre meetings are recorded on the Designated Centres Quality Enhancement Plan and escalated by the Programme Manager to the Regional Director of Services at the scheduled monthly Programme Manager meetings. There is a monthly Programme Managers meeting where all quality and safety data is reviewed across the regions and area of concern related to barriers in the designated centers are escalated for the Director to address accordingly.
To track and ensure completion of actions identified in this compliance plan, progress meetings to review all outlined actions have been scheduled to take place weekly with the designated centres management team until all work has been completed. These meetings will take place during March and April 2026. All works will be prioritized accordingly and any barriers to completion will be escalated by the Programme Manager to the manager responsible for liaising with the landlord of the property. The Registered Provider will ensure that the progress of all works is escalated in the event that a delay is indicated by the landlord.
To provide robust governance and oversight of all HIQA and SJOG Quality Team regulations in the Designated Centre and to mitigate the risk of delays occurring, the Person in Charge will monitor all actions relating to all regulations on the DCs QEP. This log will be reviewed monthly with the residential management team to monitor progress, ensure accountability, and confirm that actions are progressing within agreed timeframes. Any delays or risks identified will be escalated promptly through the appropriate management structures. This monitoring process will support improved oversight and ensure that issues are addressed in a timely manner.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The broken fence has been reported to the landlord's maintenance department. It was reviewed on 03/03/26 by the landlord, and works are scheduled for completion by 30/04/26.
The resident's bedroom ceiling was painted on 03.03.26
Works relating to the fascia and flooring will be completed by the 30 04 26.
The contractor has assessed the security device on 03.03.26, which requires a cover. Installation is scheduled to take place by 30 04 26
A light cover was fitted in the downstairs office on 19/02/26.
Infection Prevention and Control (IPC) guidance and updated LOP has been

communicated to staff and was discussed in detail at team meeting on 11.03.26
To provide oversight and mitigate the risk of similar issues arising again, the Person in Charge will maintain an environmental and maintenance action log to track all identified works and ensure they are progressed within agreed timeframes. This log will be reviewed regularly by the management team and support services to monitor progress and ensure completion of same takes place. There is an updated checklist in place for monitoring the storage of IPC equipment.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The intumescent strip was replaced on 28/01/26 and photographic evidence was submitted to the Inspector on the same date.
The Person in Charge (PIC) has liaised with the local Fire Department regarding a resident who does not comply with fire drill evacuations.
A Fire Safety Officer completed a review of the designated centre and report received on 11 03 26 states:
1.Fire doors are in situ in at the designated centre.
2. Regarding one resident that historically required additional supports to evacuate during fire drills had successfully evacuated safely during a fire drill at the designated centre on 02 03 26. This was very positive and the staff team will continue to encourage the resident to participate in fire drill evacuations by incorporating additional supportive approaches with the resident such as desensitisation to fire drills, including the use of the First–Then approach and the further development of personalised social stories and visual images.

3.Upon advice from the external contracted fire officer, fires ordinarily start in a kitchen. The designated centre's kitchen is well compartmentalised from other areas of the house, reducing the risk of a fire spreading to other areas while staff and residents evacuate to identified assembly point. All the doors on the ground floor are fire doors and should a resident refuse to engage in evacuations, all resident bedrooms have a standard required fire door which protects from fire for thirty minutes allowing fire safety staff to complete evacuation within the expected timeframe of fifteen minutes, to evacuate them safely. However, the staff team within the designated centre will continue to conduct fire drills and complete desensitisation to fire drills with the residents.

Fire rated expanding foam filler will be applied to the fire door that was deemed compromised by the fire door closure no later than the 27.03.26.

In 2022 the registered provider completed a fire safety risk assessment by a procured external fire safety contractor for the designated centre. The fire risk assessment concluded that the fire detection system in place at the designated centre was deemed compliant in respect of providing automatic fire detection appropriate for the location.
A fire door closer has been repaired in one resident's bedroom. Additional door closers have been ordered and will be installed on doors in the activity building and the living area of the designated centre by 13 03 26
Emergency lighting will be installed externally to the designated centre by 30 04 26

Alternative evacuation routes will be practiced during each fire drill at the designated centre. Fire drills have been scheduled for the remainder of the year, with the fire location identified for each drill and alternative exits utilised accordingly.
A fire assembly sign was installed at the assembly point on 04 03 26.
All Personal Emergency Evacuation Plans (PEEPs) will be updated following each drill every quarter. The PIC will review and update the PEEPs in consultation with the staff team, and they will be reviewed and approved by the PIC.
The Person in Charge and the registered provider's Health and Safety Officer have reviewed and updated the Fire Risk assessment for the designated centre.
To ensure oversight and mitigate the risk of non-compliance, the Person in Charge will complete regular fire safety audits for the designated centre, including checks of fire doors, alarm systems, emergency lighting and evacuation routes. The PIC will also review the outcomes of all fire drills to ensure learning is identified and actions are implemented as required. Fire safety will remain a standing agenda item at the staff team meetings to reinforce staff knowledge and responsibilities. Any issues identified through audits, drills or environmental checks will be escalated promptly through the organisation's health and safety and maintenance structures to ensure they are addressed in a timely manner. Any barriers will be escalated to the Director and landlord accordingly.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Psychiatry: Meetings have taken place with the external funder and funding has been secured for the provision of psychiatry services. Progression to operationally securing provision of psychiatry services is currently being implemented with the expectation of psychiatry services being in place over the next three months.
An Occupational Therapy (OT) sensory assessment has been requested for one resident in the Designated Centre and is currently in progress with the Occupational Therapy Department.
A multidisciplinary team (MDT) meeting for this resident took place on 09.03.26
Monthly Designated Centre meetings are scheduled for the year and will take place on site in Mulhussey, with the Person in Charge, Residential Coordinator and Programme Manager in attendance.
All actions arising from the Designated Centre meetings are recorded on the Designated Centre Quality Enhancement Plan (QEP) and are monitored to ensure progression and completion. These actions are escalated by the Programme Manager to the Service Director at the monthly Programme Manager meetings.
To ensure effective governance oversight and mitigate the risk of issues arising, the Person in Charge will monitor the progress of all regulatory actions through the QEP and provide regular updates at Designated Centre meetings. This process will ensure that actions are tracked, reviewed and completed within agreed timeframes, with any delays or risks escalated through the appropriate governance structures. Any barriers will be escalated to the Director of Services and landlord accordingly.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/04/2026
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	28/01/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and	Substantially Compliant	Yellow	30/04/2026

	kept in a good state of repair externally and internally.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/04/2026
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/04/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/04/2026
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	30/04/2026
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health	Substantially Compliant	Yellow	30/04/2026

	professionals, access to such services is provided by the registered provider or by arrangement with the Executive.			