



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

Issued by the Chief Inspector

Name of designated centre:	MooreHaven Centre (Tipperary) DAC
Name of provider:	MooreHaven Centre (Tipperary) Designated Activity Company
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	14 January 2026
Centre ID:	OSV-0003723
Fieldwork ID:	MON-0048865

About the designated centre

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

The designated centre is located in a large rural town. It provides residential care for 19 adults over the age of 18 years. The centre provides supports to full-time residents both male and female with an intellectual disability and autism. The centre is comprised of four dwellings in close proximity to local amenities and facilities within the town. The service operates on a 24 hour, seven days a week basis with staff present by day and night. One house was a two-storey dwelling comprised of a ground floor with a living room, a kitchen / utility room, a bedroom for staff and a bedroom en-suite. The first floor contained a bedroom en-suite, three bedrooms and a bathroom. One house was a two-storey dwelling comprised of a ground floor with a living room, a kitchen / utility room and a bedroom. The first floor contained a bedroom en-suite, three bedrooms and a bathroom. One of these bedrooms was the staff sleepover room. One house was a bungalow comprised of a ground floor with a sun room, a living room, a kitchen, a bedroom for staff and a bedroom en-suite, four bedrooms and a bathroom. One house was a bungalow comprised of a ground floor with a sun room, a living room, a kitchen / dining room and utility room, a bedroom for staff, five bedrooms and three bathrooms. All dwellings had front and rear gardens. The staff team was supervised by a person in charge who was a social care leader. The staff supporting residents include a person in charge, team leaders, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 14 January 2026	09:10hrs to 17:00hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed by one inspector of social services over the course of one day. Following an inspection in this centre in August 2025, where poor levels of compliance were found to be having a negative impact on aspects of residents' quality of care, the Chief Inspector of Social Services met with the provider and issued a warning letter to them. The provider submitted a response to the Chief inspector which outlined the actions they planned to take to move into compliance. The purpose of this inspection was to review these actions to determine if they were resulting in improved compliance and having a positive impact for residents.

The findings of this inspection were that the actions taken by the provider had led to improvements, particularly relating to governance and management, staffing supports, risk management, the premises and safeguarding and protection. These improvements were found to be having a positive impact on the quality and safety of care provided for residents. Overall, the inspector found that the provider was aware of areas where further improvements were required. This included improvements to residents' assessment and personal plans and continued improvement to premises condition. These areas will be discussed further in the body of the report.

The designated centre provides a community residential service for up to 19 adults with an intellectual disability. The centre comprises of four premises a short distance from each other in a large town in County Tipperary. There were 18 residents living in the centre at the time of this inspection and the inspector had an opportunity to meet eight of them over the course of the inspection. The remaining residents were resting, engaging in the community or attending day services when the inspector visited.

Over the course of the day the inspector visited each of the premises that made up the designated centre and spent time in three of the houses engaging with residents and observing aspects of their day. There were no residents home in the one house when the inspector visited. Documentation was also reviewed throughout the inspection about how care and support is provided for residents, and relating to how the provider ensures oversight and monitors the quality of care and support in this centre.

In addition to meeting and engaging with residents, the inspector had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre including the person in charge, a team leader and three staff members. In addition, the Chief Executive Officer (CEO) and the integrated service manager attended feedback in the provider's offices at the end of the inspection.

Throughout the inspection residents appeared comfortable and content in their homes and with the levels of support offered by staff. They were observed spending time chatting with each other and with staff, or to spend time alone. They were also observed seeking out staff support, should they require it. Three residents told the inspector that they were happy and felt safe living in the designated centre. They were complimentary towards members of the staff team and aware of who to speak to if they had any worries or concerns. They spoke about the important people in their lives, their pets and their favourite things to do.

Over the course of the inspection residents were observed coming and going from their homes. For example, one resident left with staff as part of their wrap around service, two residents left to attend day services, one resident left to attend an adult literacy class and one resident came home for a short period before returning to day services. The residents who were at home were observed taking part in the upkeep of their home, relaxing listening to music and relaxing watching television.

Based on discussions with residents and staff, residents were regularly engaging in activities they find meaningful. For example, they were visiting or being visited by their family members and friends, completing courses and training, taking part in Special Olympics training and events, attending knitting group, working and volunteering.

Based on a walk around of the premises and a review of documentation a number of maintenance works had occurred since the last inspection and more were planned. Overall, the houses were found to be clean and well presented. However, due to the age of some of the premises general wear and tear was present and works were scheduled. These will be discussed further under Regulation 17: Premises.

There had been an increase in staffing numbers in one of the houses since the last inspection. This was in line with residents' changing and evolving needs. Through discussions and a review of documentation, this was found to have a positive impact on the availability of staff to support residents, particularly at times they required support with personal and intimate care or to take part in activities outside their home.

The provider was seeking the opinion of residents and their representatives on an ongoing basis. This was captured through their complaints and compliments process and formed part of the provider's annual and six-monthly reviews. The inspector reviewed two compliments relating to care and support for residents. These were particularly complimentary towards the staffing supports and how well staff know residents.

In summary, the provider had implemented the majority of actions to address areas of concern previously identified. However, some further actions were required to bring about further improvements in compliance levels. These areas such as residents' assessments and plans and the premises will be discussed in the body of the report.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Overall, the inspector found that improvements brought about since the last inspection had resulted in improved compliance with the regulations and were having a positive impact in relation to residents' experience of care and support. This included a reduction in presenting risks, improved staffing levels and how clean and homely the premises appeared.

The provider's systems for oversight and management of the centre were now being utilised and proving effective. They were self-identifying areas for improvement in line with the findings of this inspection particularly relating to areas such as residents' assessments and plans and the maintenance and upkeep of the premises.

Since the last inspection, the provider had recruited a full-time person in charge who commenced in their role in October 2025. They were found to be knowledgeable in relation to residents' care and support needs and demonstrated an awareness of the areas where improvements were required across the centre. They were completing audits, reviews and identifying the actions required to bring about these improvements. They were supported with the day-to-day management by four team leaders, one based in each of the houses. They reported to and received support from an integrated service manager and the CEO.

As previously mentioned, staffing numbers had increased in one of the houses since the last inspection. The provider had recruited to fill a number of vacancies and at the time of this inspection there was one whole time equivalent (WTE) staff vacancy. However, this was not found to be impacting on continuity of care and support for residents.

Regulation 15: Staffing

In line with the findings of the last inspection the provider had reviewed residents' assessments of need and submitted a business case to the funder to secure additional staffing resources. This had recently been approved and the provider had recruited staff to provide additional staffing supports in one of the houses. Two residents and three staff spoke with the inspector about the positive impact of increased staffing numbers, particularly relating to the ability of staff to provide support for residents in the morning and evenings. There were now effective

systems in place to ensure the residents' personal care needs were met during the day and at night.

The centre was not fully staffed as there was one WTE staff vacancy; however, this was not found to be impacting on continuity of care and support. Interviews were scheduled to fill the staff vacancy over two days on the week of the inspection.

There were planned and actual rosters and they were well maintained. The inspector reviewed a sample of rosters for six weeks and found that all the required shifts were covered and there was evidence of continuity of care and support for residents.

The inspector found that some of the supports in place to ensure that the staff team were carrying out their roles and responsibilities to the best of their abilities included, induction, probation, supervision, training, and opportunities to discuss issues and share learning at team meetings.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the inspector found improvements in the effectiveness of the provider's systems for governance and management in this centre. The improvements in the level of compliance found on inspection indicated that the provider had taken action and to ensure residents were in receipt of a safe service. They were aware of areas where further improvements were required and planned to take the required actions.

They had taken action to ensure the required staffing numbers were in place to safely manage presenting risks. They had also supported residents to access health and social care professionals in line with their assessed need; however, further improvements were required to their assessments and plan. The provider had also taken action to complete the required works and to improve the cleanliness of one premises. More premises works were required and planned across the centre.

The management structure was clearly defined in the statement of purpose and matched what was described by staff during the inspection. From a review of audits, the minutes of recent staff meetings in each of the four houses and through discussions with staff, it was evident that there were clearly identified lines of authority and accountability among the team.

A person in charge had been recruited with sole responsibility for this designated centre and they were implementing the provider's systems to ensure effective oversight and monitoring in the centre. Based on a review of audits and action plans they were identifying and addressing issues as they arose.

The provider's latest annual review, their last two six-monthly reviews, their quality improvement plan, the minutes of two quality and risk meetings from 2025, the minutes of four board meetings, two care plan audits, two management team meetings and two team leader meetings were reviewed. These demonstrated that the provider was aware of and planned to implement actions to bring about further improvements in relation to residents' assessments and plans and to the premises across the centre.

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents had opportunities to take part in activities and to be part of their local community. They were spending time with their family and friends or keeping in regular contact with them. They had opportunities to set and achieve goals. However, improvements were required to ensure that residents' assessments and plans were fully reflective of their care and support needs. Improvements had been made to the premises and more were required and planned.

The inspector reviewed a sample of five residents' assessments and personal plans and found that these documents positively described their needs, likes, dislikes and preferences. They were accessing health and social care professionals in line with their assessed needs. However, two residents' assessments and plans were not found to be fully reflective of their current care and support needs. In addition, some documentation was not found to be accurate or fully guiding staff practice.

Residents, staff and visitors were protected by the safeguarding and risk management policies, procedures and practices in the centre. There was a system for responding to emergencies and to manage and review risks. There was a system for reporting and responding to adverse events, and to ensure that learning from these events was shared with the team.

Regulation 17: Premises

The inspector completed a walk around each of the four premises during the inspection and found a number of areas where maintenance and repairs and enhanced cleaning had been completed. A log was in place to demonstrate the outstanding maintenance works and repairs throughout the centre and plans were in place to complete these. In addition the provider had plans to complete extensions to one of the houses to meet the changing and evolving needs of residents.

Some examples of works completed since the last inspection included, the installation of thumb locks on a number of bathrooms, treating black mould on one ceiling, the installation of new flooring in a number of areas, painting throughout one of the houses, the replacement of furniture and beds across the centre, grouting and repairs in a number of bathrooms and a kitchen. Overall, the premises works completed to date ensured the homes were clean, well presented and homely in presentation.

However, some further premises works were required. Some examples of required works included, painting of rooms, doors and skirting boards across areas of the centre. It also included bathroom refurbishments and power washing of outdoor areas.

Overall, the inspector found that efforts were being made to ensure that all aspects of the premises were being maintained to a good standard. The provider was aware of areas where improvements were required, however this work remained outstanding on the day of inspection.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

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

At the time of the last inspection, risk assessments were not in place in line with presenting risks. Based on a review of documentation and discussions with staff, this was no longer the case. A review was completed of 20 incidents, the risk register and 12 individual risk assessments for seven residents. These were found to be reflective of the presenting risks in the centre at the time of this inspection. They were also up to date and regularly reviewed. The minutes of the provider's risk and quality minutes and board meeting minutes since the last inspection. These reflected the gaps and work completed to improve oversight of and documentation relating to risk.

At the time of the last inspection the risks relating to fire safety in one of the houses were risk rated at red (the highest level). A sample of five fire drills completed in this house in 2025 were reviewed and recent drills demonstrated why this risk had now reduced in line with additional controls implemented such as additional staffing and equipment. The additional controls ensured that fire risks were being well managed. For example, the two most recent fire drills were just over two minutes in duration.

There were systems in place to record incidents, accidents and near misses. The inspector reviewed the electronic systems for reviewing and tracking incidents and a sample of 20 incidents for 2025. This review demonstrated that effective control

measures were in place for identified risks as there were a low number of incidents relating to the identified risks.

There were systems to respond to emergencies and to ensure the vehicles in the centre was roadworthy and suitably equipped.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The assessments of need and personal plans for five residents were reviewed. These were detailed in nature particularly relating to residents' strengths and talents, their communication preferences and how they make choices and decisions in their day-to-day lives. However, improvements were required to ensure that residents' assessments were reflective of their current needs and guiding staff practice. For example, two residents' assessments of need had not been updated to reflect their current needs, assessments completed and recommendations by health and social care professionals made and changes relating to staffing supports in place.

In addition, the inspector found that the recommendations made by health and social care professionals had not been fully implemented in the centre. For example, the majority of environmental adaptations recommended by an occupational therapist in April 2025 had not been implemented. The inspector acknowledges that a further assessment had been completed in December 2025 and the provider was waiting for the report and recommendations from this. However, the provider had failed to implement recommendations from the April report in a timely manner.

Overall, some documentation relating to residents' care and support was not found to be fully guiding staff practice or reflective of supports offered and implemented. For example, one resident's personal and intimate care indicated their preference for "regular bed baths" but did not reflect that they do not enjoy showers. Although staff were aware of this preference it was not accurately recorded in the relevant plan. In addition, daily logs for one resident were found to be conflicting on four occasions over a two week period. For example, on their personal personal care log it appeared that they had not had a body wash or shower over a six day period, but another daily log relating to transfers indicated they has been supported on six occasions.

Overall, in line with the findings of the provider's own audits and reviews the systems to ensure that residents' assessments and plans were reviewed and reflective of their needs were not proving effective.

Judgment: Not compliant

Regulation 8: Protection

Residents were protected by the safeguarding policies, procedures and practices in the centre.

From a review of the staff training matrix 100% of staff had completed adult safeguarding and protection training. The inspector spoke with the person in charge, team leader and the two staff and found that they were all knowledgeable in relation to their roles and responsibilities should there be an allegation or suspicion of abuse.

The provider had a safeguarding policy which was available and reviewed in the centre. There were had been a number of safeguarding concerns notified to the Chief Inspector since the last inspection. The records for these were reviewed and these had been followed up on in line with the provider's and national policy. It was evident that the control measures were being reviewed regularly to ensure they were effective. A number of residents had risk assessments completed in relation to any vulnerabilities to abuse they may have.

A sample of five residents' personal and intimate care plans were reviewed. The majority of these were detailed their abilities, preferences and support needs. One was not found to be sufficiently and this was discussed under Regulation 5: Individualised Assessment and Personal Plan.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for MooreHaven Centre (Tipperary) DAC OSV-0003723

Inspection ID: MON-0048865

Date of inspection: 14/01/2026

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 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <ul style="list-style-type: none"> - Painting works for all residential houses have been scheduled as part of the planned maintenance programme. These works will be completed to ensure a safe, well-maintained, and homely environment for residents. Residential painting works will be completed by 31 August 2026, with progress monitored monthly by management to ensure adherence to the timeline. - Power washing of all external areas (including pathways, patios, and outdoor communal spaces) has been scheduled to maintain cleanliness, safety, and environmental standards. Following completion of the current works, this task will be incorporated into a preventative maintenance schedule. Power washing of all outdoor areas will be completed by 30 June 2026 - Repairs to bathroom grouting have been identified and scheduled to ensure hygiene standards and prevent water damage. All identified bathroom grouting repairs will be completed and quality-checked by 31 August 2026. 	
Regulation 5: Individual assessment and personal plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <ul style="list-style-type: none"> - Individualised Occupational Therapy (OT) assessments and reports have been completed and formally issued. Recommendations outlined within these reports are currently being actioned. Where structural renovations are required, works have been scheduled and are on track for full completion by 31 August 2026. Progress will be monitored monthly to ensure timely implementation. - The Assessment of Need (AON) process will be formally reviewed at least annually, or 	

sooner if required due to changes in assessed needs or following multidisciplinary team (MDT) reviews. All updates will be documented on file within five working days of any identified change.

- An internal audit of care documentation has been completed. All staff have received written and verbal reminders of their responsibility to complete care logs accurately and on a daily basis, in accordance with regulatory and organisational standards. Follow-up audits will be conducted to monitor compliance, with the next full audit scheduled for completion by 31 March 2026.

- The Person in Charge (PIC) will conduct structured monthly governance checks, which will include a formal review of AON requirements to ensure any changes in need are identified promptly and recorded appropriately. This process has been implemented with immediate effect.]

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/08/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/06/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/08/2026
Regulation 17(6)	The registered provider shall	Substantially Compliant	Yellow	31/08/2026

	ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Yellow	31/08/2026
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the	Substantially Compliant	Yellow	31/03/2026

	resident's needs, as assessed in accordance with paragraph (1).			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	31/08/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/08/2026