Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Mullingar Centre 4
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	11 February 2026
Centre ID:	OSV-0004213
Fieldwork ID:	MON-0048577

About the designated centre

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

Mullingar Centre 4 is a designated centre, providing support for a maximum of two adults with an intellectual disability and high dependency and support needs. The centre comprises of two bungalows situated in a quiet, historical village in North Co. Westmeath, surrounded by Lough Derravaragh. One bungalow has two medium sized bedrooms, one with an en-suite, staff office, a utility room, an open plan kitchen, dining and sitting room and a main bathroom. To the rear of the house is a large fenced enclosed garden and a lawn area to the front of the house. The second bungalow has two medium sized bedrooms, one with an en-suite, staff office, a utility room, an open plan kitchen, dining and sitting room and a main bathroom. There is a large fenced enclosed garden to the rear of the house and a lawn area to the front of the house. Both houses are wheelchair accessible. Services are provided from the designated centre to male and female adults (i.e. over 18 years old). 24 hour support is provided 7 days a week, with waking night and sleepover staff support. The centre is close to local amenities including shopping centres, numerous pubs/bars and restaurants, cinema, swimming pools and town park. The staff team consists of direct support workers and social care workers managed by a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Wednesday 11 February 2026	10:00hrs to 18:20hrs	Karena Butler	Lead

What residents told us and what inspectors observed

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

While the centre was performing well in many areas, the inspection did identify some areas for improvement to ensure the safety and care in the centre would be consistently met. One regulation was found to be not compliant as the governance and management arrangements required a number of improvements to ensure they provided adequate and consistent oversight. Without improvement in the oversight, this could put the residents at increased risk of an unsafe environment or service provided.

Improvements were required to ensure residents had timely access to healthcare professionals as needed. Additionally, improvements were required to how the roster was presented to ensure all required information was included. The premises were also found to require repair or additional cleaning. These points are discussed in detail later in this report.

The inspector had the opportunity to meet and observe both residents that were living in the centre. They briefly shared their views with the inspector and the inspector observed them in their home at different times during the inspection. They appeared very relaxed and comfortable in the presence of the staff on duty. For example, the inspector observed a jovial interaction between a resident and a staff member. The resident started to dance and the staff member asked if they wanted to dance with them. The resident laughed and said "no" and the staff laughed and asked 'why am I too old to?', to which the resident, laughing, replied "yes". Both appeared to really enjoy this interaction. They went on to tell the inspector about a time when the resident did not want to leave a swimming pool and the staff member started to get a red face as it was so warm. The resident liked to remind the staff member about how red their face had gotten and they laughed about it.

One resident attended their day service programme and, upon their return, they chose to relax in for the evening by watching television. The inspector observed the resident being offered a choice of what they would like for dinner. The dinner looked very appealing when served and included a freshly prepared salad. The resident confirmed they had a nice day.

The other resident went bowling with a friend. They had arranged for their friend to attend their home for a Valentine's lunch. They had made homemade pizza and had purchased sparkling wine to serve with the lunch. The staff on duty had brought in nice champagne glasses for the wine to be served. The resident was very excited

about their plans for the day and later told the inspector that it went very well and that they had a great day.

The inspector had the opportunity to speak with the six staff that had been on duty, and the person in charge. Staff were observed to be relaxed and caring in their interactions. For example, staff were observed taking time with a resident to chat to them about their day and if they wanted to watch something particular on the television.

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 been conscious about residents spending their own money on expensive items. Since having the training they realised that the residents have a right to spend their own money as they saw fit, even if it is on an expensive item. They tried to advise and educate the residents to understand that if they bought the item then they may not have money left to do other things and that there may be a cheaper item available. However, if the resident choose to buy the item then it was their choice.

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 and had their assessed needs met by the staff team. 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 the person in charge. They felt they would be listened to. One stated that they were "absolutely delighted with the service". When asked if they felt their family member was treated with respect by the staff team, a family representative stated "most definitely yes".

The inspector observed the houses to be tidy and they appeared homely. The sitting rooms and bedrooms had televisions for use.

Each resident lived in one of the houses comprising this centre and had their bedroom. The bedrooms had adequate storage facilities for any personal belongings. New wardrobes had been fitted since the last inspection. There were personal pictures displayed in bedrooms and in different areas of the house. One resident had recently completed a collage of pictures over a number of months and it was displayed in their sitting room. The resident proudly showed the inspector when speaking to them.

One en-suite bathroom had been renovated since the last inspection; however, areas for improvement remained due to the standard of the finish. The other resident's bathroom was due for renovation. The person in charge communicated that they had been escalating those issues.

There was a front garden mainly used for parking. Each back garden contained a table with benches that residents could use in times of good weather.

The inspector found that there were no vacancies or recent admissions to the centre.

While there had been a complaint in the last year, from communication with the complainant, it had been dealt with to their satisfaction and the complaint was closed.

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 unannounced and was undertaken as part of on-going monitoring of 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 July 2023.

The findings of this inspection indicated that the provider had the capacity to operate the service within substantial compliance with the regulations. While the service was generally operating in a manner which ensured effective, person-centred care to the residents, some improvements were identified.

The inspector reviewed the provider's governance and management arrangements and found that while systems were in place, oversight was inconsistent in some areas and improvements were required to ensure timely completion of identified issues. For example, a recommended replacement of a boiler part had been outstanding since September 2025.

From a review of a sample of rosters across three months, the inspector found that while there was adequate staffing in place to meet the assessed needs of the residents, improvements were required with regard to how the rosters were maintained.

The residential staff were found to have access to training that would facilitate them to effectively support the residents, for example epilepsy awareness.

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 supervisory management skills. They demonstrated a good understanding of the residents and their needs, for example what behavioural support needs the residents required assistance 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.

They were responsible for this designated centre along with one other designated centre. They attended the centre regularly to provide oversight and provide informal supervision for staff. They were supported in this role by a team leader for each of the houses that made up this centre.

A family representative communicated that the person in charge was very approachable.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that the staffing arrangements in the centre were effective in meeting residents' assessed needs. However, improvement was required to how the rosters were maintained to ensure they provided all applicable information. Therefore, this regulation was found to be substantially compliant.

The inspector reviewed a sample of rosters over a four-month period from November 2025 to February 2026. While one of the houses that made up the centre did not have a full staffing complement and required one staff post to be filled, the majority of the cover for those shifts was undertaken by familiar, consistent 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 position.

However, the roster review demonstrated that the names of temporary staff, such as agency staff were not recorded on the roster. In addition, the day-staff that worked Monday to Friday were not recorded on the roster. The roster was misleading as it listed residential staff as working mid-week day shifts in the centre. In reality, these staff had swapped shifts with day-service personnel and were working in a different location during those hours. While this was the resident's preference, improvements were required with the maintenance of the roster to ensure it was an accurate reflection of what actually took place.

Staff personnel files were not reviewed at this inspection. However, the inspector reviewed a sample of nine staff members' Garda Síochána (police) vetting (GV)

certificates as well as one police clearance certificate. This demonstrated that the provider had arrangements for safe recruitment practices.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were provided with opportunities to access training as required. While some improvement was required with the oversight of day-staff training, this is being actioned under Regulation 23: Governance and management.

A review of a sample of certification of six training courses for staff that worked in the centre demonstrated to the inspector that staff were in receipt of 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
- fire safety.

While it was difficult to ascertain if all day-staff training was up to date, this is being addressed under Regulation 23: Governance and management.

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.

Two staff members confirmed to the inspector that supervision was taking place and that it was an opportunity to raise concerns if any.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that while the provider had governance and management arrangements in place, oversight was inconsistent in some areas. For example, oversight was inconsistent regarding staff training, the timely completion of actions from external servicing as well as internal action plans, and the quality of internal

safety checks completed by staff. Therefore, this regulation was found to be not compliant.

Oversight of staff training required improvement in relation to staff providing in-house day-service support for one resident. The current oversight of training for those staff was not overseen by the person in charge and therefore it was not known to the person in charge if those staff had the necessary skills and knowledge as well as mandatory training to support the resident. The person in charge arranged for some certification to be made available for those staff and the inspector found that the safeguarding certification for one of those staff had expired in September 2024. This meant that the staff member may not have have up-to-date skills and knowledge to ensure the resident was appropriately safeguarded.

While the majority of actions from the previous inspection were addressed by the time of this inspection the flooring in one staff bedroom was not replaced as per the provider's own compliance plan agreement.

After review of the boiler servicing for both houses from September 2025, the inspector found that there was an outstanding action from one of the houses to have a part replaced. While the person in charge confirmed that this had been followed up, it was still outstanding at the time of this inspection with no set date for completion. This was a repeated finding from the last inspection as the inspector had identified at that inspection that there were delays in completing actions identified in the boiler servicing. Therefore, the inspector was not assured that issues identified by external servicing providers were being followed up in a timely manner. This had the potential to put the residents at increased risk from a boiler malfunction or from lack of heating should the boiler break down.

There was a delay in commencing an external review of the service for one resident as per an action agreed on a safeguarding plan from October 2024. The person in charge confirmed that it had commenced several months prior to this inspection and while some of the delay was due to circumstances outside of the control of the provider, the review was not finalised at the time of this inspection.

Mildew was observed on the washing machine seals in one house. Although cleaned before the inspection was concluded, this was a repeat finding from a previous inspection. The person in charge had introduced weekly cleaning of the washing machine. However, the inspector observed that it was recorded that the washing machine had been cleaned four days prior to this inspection.

One fire containment door was observed not to close itself due to a broken lock and the person in charge arranged for the lock to be replaced on the day of this inspection. However, from a review of staff checks on the closure of internal doors which included the day prior to this inspection, the inspector observed that staff had been signing each day to say the doors were operational. Therefore, the inspector was not assured as to the quality of the checks and periodic cleaning being completed in the centre.

The inspector observed from a review of the records of the team meeting minutes that they were occurring monthly. A review of three team meeting minutes,

October, November, and December 2025 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, safeguarding, health and safety, and IPC.

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 draft of 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 with the last two taking place in April and November 2025. In addition, there were a number of monthly audits completed by staff members on infection, prevention, and control (IPC), finances, vehicle checks, and health and safety.

All six staff spoken with communicated that they would feel comfortable going to the person in charge if they were to have any issues or concerns and felt that they would be listened to.

Overall, while there were many appropriate systems in place further improvements were required to aspects of oversight listed above 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 receiving appropriate care and support. However, some improvements were required in relation to healthcare, and the premises.

While staff were familiar with residents' healthcare support needs, one resident had been waiting long periods to access certain allied healthcare professionals, such as a dietitian.

Staff were familiar with how residents communicated and there was guidance in place to inform staff how to promote effective communication.

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

For example, where required, residents had positive behaviour support plans in place to guide staff 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. Residents were supported to have visits to their home as per their preferences. The inspector found that the residents appeared to engage in regular community access in line with their preferences.

While the inspector observed the house to be tidy and in a good state of repair externally, improvements were required to areas of the interior to ensure the residents' homes were aesthetically pleasing as well as able to be effectively cleaned.

There were adequate fire safety management systems in place, such as regular servicing of detection and alert systems. For example, the fire extinguishers were serviced annually.

There were appropriate arrangements in place for medicines management. Prescribed medicines were dispensed by a local pharmacy, and found to be appropriately stored.

Regulation 10: Communication

Staff were found to facilitate communication for residents in accordance with their needs and preferences.

For instance, staff were supporting one resident to complete some learning and games to support their communication in line with a recommendation from a speech and language therapist (SLT). Staff spoken with were familiar as to how each of the residents communicated and how to best communicate with them in order to be effective communication partners.

While one resident was still waiting on a further recommended SLT assessment and SLT therapy, this is being addressed under Regulation 6: Healthcare.

From a review of two residents' files they had documented communication needs in a communication dictionary as well as in other documents to guide staff as to what they may be trying to communicate and support effective communication. For example, the inspector found guidance information with regard to communication in the residents' hospital passports. For example, it recommended that two-three words at a time should be used when communicating with one resident to support their understanding.

The inspector observed there were visuals displayed in areas of one of the houses that related to emotions. This was to aid one resident to be able to express their emotions and communicate how they are feeling. The resident talked through the different emotions with the inspector.

In addition, there were social stories available on certain areas in order to support the residents' understanding of the topics. For instance, there was a social story to help a resident understand that sometimes other people are busy.

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

Judgment: Compliant

Regulation 11: Visits

At the time of this inspection there were no visiting restrictions in place.

While there was a visiting protocol in place for one resident, it was in order to minimise anxiety levels for that resident as they did not like to receive unfamiliar guests after a certain time of the day.

There was a private space available for residents should they wish to have visitors in private.

Both family representatives spoken with felt welcome to visit with one stating that 'visiting on short notice was no problem'.

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.

Residents in this centre had personal financial accounts with a bank card to ensure that they always had access to their money when they needed it.

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

From a review of the audits completed in the centre in 2025 and January 2026, the inspector observed that financial audits were completed periodically of the residents' finances. 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.

The inspector found, from a review of two residents' finance records from the first of January to the 10 February 2026, that staff were completing daily balance checks to ensure the residents' money was safeguarded. The inspector counted one resident's money in the presence of a staff member and found that it matched the amount recorded on the finance recording sheet. This assured the inspector that residents' finances were safeguarded.

Judgment: Compliant

Regulation 13: General welfare and development

This inspection found that the residents had access to opportunities for leisure and recreation. Residents engaged in activities in their home and community and were supported to maintain relationships with friends and family.

From a review of the two residents' files over a one-week period in February 2026 and from speaking with staff on duty, the inspector observed that residents were being offered activities that interested them. Activities ranged from massage, reflexology, trips to the cinema, going for walks, going out for lunch, and personal shopping.

Both residents and the two family representatives spoken with believed that the residents had choice in their activities and engaged in activities out of the centre.

Both residents were supported to go on holidays in 2025, for example Killarney. There were plans to arrange holidays in 2026 and one resident's goal was to trial a holiday abroad.

Other goals being supported in order to enhance residents' quality of life related to one resident maintaining their own garden by raking the leaves and cutting the grass. They also were trying to find a swimming pool that suited them in order to purchase a membership with a plan to go swimming weekly.

Judgment: Compliant

Regulation 17: Premises

The layout and design of the premises was appropriate to meet residents' needs. The premises internally was found to be generally in a state of good repair. The houses were observed to be homely and tidy. The facilities required by Schedule 6 of the regulations were available for residents' use. For example, there was access to cooking and laundry facilities. However, some improvements were required in particular to ensure all surfaces were in a good state of repair to facilitate

appropriate cleaning. Therefore, this regulation was found to be substantially compliant.

Examples of identified issues included:

- mildew was observed on a resident's bedroom blind which increased their risk of developing a respiratory illness
- one resident's side gate was more difficult to open at times of wet weather
- the staff bedroom floor in one house had chips in the floorboards, and the staff office flooring had gaps between the boards which compromised effective cleaning
- some areas required refilling, sanding and repainting, such as a windowsill in a utility bathroom, and areas around the en-suite ceiling fans
- some radiators had peeling paint or rust meaning they would be more difficult to clean
- some sky lights required cleaning
- improvements were required to both en-suite bathrooms, for example due to broken or discoloured grouting or residue present in certain areas which would make it difficult to clean adequately
- as per the last inspection some windows particularly a patio door appeared dirty due to the internal panes of the glass

While these issues did not currently restrict the residents' use of their home, improvements were required to ensure the premises were aesthetically well-maintained and could be effectively cleaned.

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 receiving a healthcare-related illness. For example, there were colour-coded cloths, mops and buckets in place.

Each resident had their own home. They each had an individually decorated bedroom with sufficient space for their belongings which included new wardrobes since the last inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were suitable fire safety practices in place which included staff having received training in fire safety. While some issues were identified during the inspection, they were addressed on the day and instead were actioned under Regulation 23: Governance and management due to improvements required to the oversight of fire safety checks.

From a review of seven fire practice drills across the two houses, the inspector found that regular fire evacuation drills were being completed in order to familiarise

the residents with safe evacuation in the event of an emergency. Some drills were completed during hours of darkness and the documentation demonstrated residents were supported to use alternative evacuation routes.

Personal emergency evacuation plans (PEEPs) were in place for both residents, outlining the specific support required during an emergency.

There were fire containment doors in place fitted with self-closing devices. All of the fire containment doors were tested to see if they closed properly and one was found to not close fully due to a broken lock and two doors had a larger than recommended gap along the bottom between the door and the frame. The person in charge arranged for all three doors to be repaired or adjusted prior to the end of the inspection. The issue in relation to safety checks was addressed under Regulation 23: Governance and management.

The inspector found that there were detection and alert systems, emergency lighting and firefighting equipment in place, each of which was regularly serviced. While one external emergency light was found to be not working on the day of this inspection, the person in charge arranged for it to be replaced prior to the end of the inspection.

The inspector sought clarification regarding the fire alarm system coverage. Post-inspection evidence confirmed the coverage was appropriate.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that there were suitable arrangements in place with regard to the ordering, receipt and storage of medicines.

The inspector found that medicines were appropriately stored in a locked press. The inspector reviewed a sample of one resident's medication and found that there was a pharmacy label attached as required. A sample count of two medications found that they matched the stock balance records that were kept by staff. This assured the inspector that there was appropriate oversight over residents' medicines.

A review of both residents' medicines documentation, demonstrated that their medicines were prescribed and reviewed by appropriate medical professionals, and dispensed by a pharmacist.

Staff were in receipt of training to support them to administer each resident's medication. There were guidance documents in place to ensure that medicines were administered as prescribed.

Judgment: Compliant

Regulation 6: Health care

For the most part, residents were supported in line with their healthcare needs. However, one resident's access to two professionals was outstanding. Therefore, this regulation was found to be substantially compliant.

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 an epilepsy care plan and associated emergency epilepsy medication administration protocol, and hospital care plans to guide hospital staff should a resident require a hospital stay. The hospital passport contained clear information, for instance what each resident's medical history was. They contained information related to infection prevention and control (IPC), for example if a resident was able to tolerate wearing a mask or if they could self-isolate if required.

Based on a review of both residents' files, for the most part they were found to have access to a range of allied healthcare services, such as a general practitioner (GP), dermatologist, an optician, and a physiotherapist when required.

However, one resident was referred to a dietitian since July 2024 due to them gaining some weight and despite the team leader following up on two occasions afterwards, this was still outstanding. Consequently, staff lacked the specific guidance that may help to support the resident in maintaining a healthy weight.

In addition, after a speech and language therapist (SLT) assessment in August 2024, it was recommended that the resident be put forward for further SLT assessment and SLT therapy to ensure their speech remains clear. However, this was still outstanding at the time of this inspection and a staff member reported that there had been some decline in the resident's speech.

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 behaviour therapist.

From a review of both residents' files, the inspector observed that as required, residents had a positive behavioural support plan in place which was reviewed by the behaviour specialist. Both were found to have been reviewed within the last year to ensure accuracy of the information provided to staff. In addition, a positive

behaviour support meeting was held, for example in the case of one resident their last meeting was October 2025 to ensure that the resident was receiving up-to-date appropriate supports.

The behaviour support plans were found to outline strategies that staff needed to follow to support the residents in times of distress and provided clear information to staff. For example, they included reactive and proactive strategies to undertake with the residents when the resident is becoming anxious or experiencing behaviour that may cause distress to themselves or others. They also included the response to be taken and what it may look like when the resident is returning to baseline.

In addition, the provider had arrangements in place for the staff team to receive safety intervention training specific to each resident with the behaviour therapist. This was to ensure that staff were appropriately guided and being consistent in their approach. One of the houses was yet to be scheduled and the other house received the training on 6 February 2026.

The inspector found that while there were restrictive practices in place, for example a perspex screen in a car, they were for the safety of the residents. They were subject to review by the provider's restrictive practice committee and the last review was 6 February 2026. A proposal for a new restrictive practice was discussed at the last meeting but was declined by the committee, as it was deemed unwarranted at the time. This assured the inspector that restrictive practices that were being implemented were the least restrictive and only when necessary.

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 which was last reviewed May 2025
- there was a reporting system in place with a designated officer (DO) nominated for the organisation
- a staff member spoken with was able to identify who the DO was to the inspector, and the identity of the DO was displayed in the hall in both houses.

Staff had received training in safeguarding vulnerable adults and for the most part refresher training. While one staff member was overdue their safeguarding training, this was addressed under Regulation 23: Governance and management.

The inspector reviewed a sample of the safeguarding incidents for the last two years 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. While there were delays in

implementing all aspects agreed in one particular safeguarding plan, this was addressed under Regulation 23: Governance and management.

The two family representatives and the five 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.

A staff member spoken with was 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 member explained that they would ensure the safety of the resident impacted by a peer-to-peer incident, check for any injuries, and report to their manager. Regarding unwitnessed disclosures, staff confirmed that they would not promise confidentiality or ask leading questions but would listen, document the facts and report.

From a review of the two residents' files, the inspector observed that there were care plans in place that outlined residents' support needs with regard to the provision of intimate care. This was to ensure residents received the correct level of support and promoted their independence where possible.

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 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Mullingar Centre 4 OSV-0004213

Inspection ID: MON-0048577

Date of inspection: 11/02/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: House rosters have been reviewed by the Person In Charge. The roster template has been amended and now includes the full name (and relevant agency name) of all agency staff working in the location. The house roster template also now includes the names of day service staff providing a day service to the resident in their home.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To ensure the PIC has oversight of the training requirements for all staff working in the residential location, the day service manager will provide an updated monthly training matrix for the specific day service staff which includes dates of mandatory and location specific training. The PIC of the residential center will also ensure they hold copies of all up to date training certificates. The Person in Charge has confirmed that the day staff member who was out of date in safeguarding training, completed refresher training on the 12th Feb 2026 The PIC has followed up on the outstanding repairs required to the boiler and confirmed that the repairs were carried out on the 03/02/2026, due to this being a rented property there was a delay in the Muiriosa receiving the documentation. The person in charge reports premises related issues through the internal maintenance reporting system. These are monitored and escalated to the property & facilities department where required. The property & facility dept continues to follow up on outstanding items to ensure they are addressed. In circumstances where a response from the landlord is	

delayed, the facilities department continue to escalate the matter. Should the required works not be progressed within an appropriate timeframe in line with a risk management approach the organization will arrange for the works to be completed to ensure the safety and comfort of residents.
Following a complaint received in Nov 2024, all safeguarding concerns were followed up as per Muiriosa & National safeguarding policy, actions arising were implemented. In addition to this an external review was commissioned to ensure a quality service was being delivered to the resident. An external consultant was commissioned to carry out the service review and this commenced in 2025.
The property & facilities department assessed the marks on the rubber seal of the washing machine and advised that the marks are permanent and likely due to normal wear on the rubber seal, which can occur over time as the material contains recycled components. To ensure optimal hygiene standards, a replacement rubber seal has been ordered and will be fitted once received. In the interim, the seal has been thoroughly re-cleaned. The PIC has followed up with staff and confirmed that the scheduled cleaning of the washing machine is taking place as required.
The PIC has followed up with all staff members individually through supervision to re-iterate the importance of effective checks on all passive fire containment equipment. Fire management, including audits and checks is a standard agenda item at all staff team meetings.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The blind in one resident's bedroom was cleaned on the 11th of Feb 2025. To minimise the risk of mildew developing the Person in Charge has implemented a twice weekly cleaning schedule for all windows and window frames throughout the house. This schedule will include regular PIC spot checks to ensure that these cleaning tasks are completed and environmental hygiene standards maintained.
The outside gate at the side of one resident's home will be replaced by the 28th May 2026 •
The flooring in the staff bedroom in one house and the staff office to be repaired / replaced by September 2026. Areas in both houses that require refilling, sanding and repainting will be completed by 28th May 2026. This includes any radiators with peeling paint or rust.
Sky lights requiring cleaning to be cleaned by the 31st May 2026. Improvements required to both en-suite bathrooms will be completed by September 2026.
As per the compliance plan returned following the July 2023 Inspection; The windows have been examined previously and deemed fit for purpose and functionality. It was recognised that they were not aesthetically pleasing and this was highlighted and discussed with the landlord and the Muiriosa property team. As these are rented properties and the windows are not causing any undue risk or health issue, the landlord is not willing to replace them. Any deterioration in the windows will be reported to the

property & facilities department for review to ensure safety and Infection, prevention & control.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
One resident is on a primary care waiting list for non-urgent Dietetics support, the Muiriosa Foundation has no governance over public waiting lists. However, the PIC ensures the keyworker follows up with the relevant department to check the status of the referral. The individual has been supported to attend their GP for dietary supports and the Muiriosa physiotherapist to increase their exercise. The staff team work with the individual on healthy eating education and support. The individual has lost some weight with all current supports provided. One individual was reviewed by an external private Speech & Language Therapist in August 2024 who gave recommendations at the time. One of these recommendations was that the individual may benefit from some SLT therapy to ensure their speech remains clear. This external SLT suggested that a referral is submitted for further assessment and therapy for speech intelligibility. This recommendation was actioned by the staff team with a referral to the community SLT service on the 16/10/2024. The individual remains on the public waiting list for SLT supports. Due to an identified organisational need a fulltime speech & language therapist was employed by the Muiriosa Foundation in 2025, this resource covers the entire organisation therefore urgent referrals are prioritised. The afore mentioned individual was referred to this internal waiting list for non-urgent communication support by the internal SLT. The PIC has followed up with the staff team, the resident and their family to confirm that they can communicate their needs effectively with their staff team and family, if the individual is anxious or excited their speech can be more difficult to understand. There is documentation in place in the centre to support new or transient staff to understand the individual's personal communication style. Accessible documentation and support have been provided to the resident to ascertain their wishes in regard to paying for a private SLT review due to the long public waiting lists.

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(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	09/03/2026
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	30/09/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/09/2026
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Orange	30/09/2026

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	09/03/2026