Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

## Issued by the Chief Inspector

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| Name of designated centre: | Mullaghmeen Centre 2 |
| Name of provider: | Muiríosa Foundation |
| Address of centre: | Westmeath |
| Type of inspection: | Announced |
| Date of inspection: | 04 June 2025 |
| Centre ID: | OSV-0005477 |
| Fieldwork ID: | MON-0038319 |

## About the designated centre

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

The designated centre provides support to two adults (male or female) with intellectual disabilities in two self-contained apartments located in close proximity to the local town. The provider describes the service as offering support for up to two adults (male and female) with an intellectual disability, and with specific support needs in relation to behaviours of concern, high dependency needs, mental health needs, sensory impairment and autism. The centre is staffed over 24 hours, with sleepover staff overnight. Residents have access to local amenities including restaurants, shops, leisure facilities and library. The staff team comprises social care staff and support workers.

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

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| 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 4 June 2025 | 10:30hrs to 15:30hrs | Julie Pryce | Lead |

## What residents told us and what inspectors observed

This inspection was conducted in order to monitor on-going compliance with the regulations, and to help inform the registration renewal decision.

There were two residents on the day of the inspection, each living in a semi-detached self-contained apartment. On arrival the inspector immediately met the resident in the first apartment, who opened the door and invited the inspector into their home. They were very interested in the inspector's identification card, and did not show any interest in discussing anything else. They did, however, have a chat with the staff about their passport, and an upcoming holiday.

They agreed to the inspector having a look around their home which was clean and well maintained, and included various personal items. There were also several examples of social stories which had been developed to assist the resident's understanding, for example in relation to phone calls with their family.

The resident was then heading out to their work, which was a job doing recycling for the organisation. They spoke to staff about which coffee shop they wished to go to after work, and spoke about one where the staff were friendly and said 'good afternoon' to them.

The inspector then visited the second resident, who agreed to the visit and shook hands with the inspector. They also chose to direct their interaction towards the staff rather than the inspector, and discussed the forthcoming activity which was bowling and then ice cream. They then fist-bumped the staff and went off on their activity. The inspector noted that they had their own front door key, and that they locked their door behind them.

Residents had been offered the opportunity to complete questionnaires sent out by the Office of the Chief Inspector in advance of the inspection. Staff had helped them to fill in these questionnaires, however they had been specific about the questions they asked the residents, and what their responses were. For example, it was clearly documented that one of the residents had initially repeated the question back to staff before answering. One of the residents could name all the staff members who worked with them, and said that the staff were their friends. The other resident spoke about wanting a bigger home so that they could have more visitors, and so it was clear that they felt comfortable in raising issues with their supporting staff.

The inspector reviewed the situation with regard to visits, and found that there were no restrictions. Whilst the resident's apartment had only one living area which was the kitchen, dining area and living room in one room, it was spacious and there was plenty of seating for visitors.

Staff had all received training in human rights, and discussed the ways in which they respected and supported the rights of residents. Maintaining the independence of

each resident was outlined as being an important aspect, both in their living arrangements, and in the daily choices they made, whilst ensuring that staff were available as required. For example, one resident had a one-to-one staff member until 10pm each evening, and was then only supported if required by the staff member in the next-door apartment, thus ensuring the safe maintenance of their independence.

Overall residents were supported to have a comfortable and meaningful life, with an emphasis on supporting choice and preferences and there was a good standard of care and support in this designated centre, although some improvements were required in supporting resident to manage their bank accounts as further discussed under regulation 12 of this report.

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

## Capacity and capability

There was a clearly defined management structure in place, and lines of accountability were clear. There were various oversight strategies which were found to be effective.

There was an appropriately qualified and experienced person in charge who was involved in the oversight of the centre and the supervision of staff.

There was a competent staff team who were in receipt of relevant training, and demonstrated good knowledge of the support needs of residents, and who facilitated the choices and preferences of residents.

All the required documentation was available in the designated centre, including clear and transparent contracts of care.

## Regulation 14: Persons in charge

The person in charge (PIC) was appropriately skilled and experienced, and was involved in the oversight of the centre. It was clear that they were well known to the residents, and that they had an in-depth knowledge of the support needs of each resident.

Judgment: Compliant

## Regulation 15: Staffing

There were sufficient numbers of staff to meet the needs of residents both day and night. A planned and actual staffing roster was maintained as required by the regulations. There was a consistent staff team who were known to the residents, including any relief staff. If additional staff were required, they came from a regular relief panel, and as a last resort from nearby designated centres operated by the provider.

Both residents had a one-to-one staff member until 10pm each evening, and there as a sleepover staff in one of the apartments, who was also available to to the resident of the other apartment, and was alerted if this resident left their apartment.

A sample of three staff files was reviewed by the inspector, and all the information required by the regulations was in place, including Garda vetting.

The inspector spoke to both staff members on duty, the person in charge and the person participating in management during the course of the inspection, and found them to be knowledgeable about the support needs of residents. Staff were observed throughout the course of the inspection to be familiar with the care and support needs of each resident.

It was evident that the staffing arrangements were in accordance with the needs and preferences of each resident, and supported their independence whilst ensuring that support was always available to them.

Judgment: Compliant

## Regulation 16: Training and staff development

All staff training was up to date and included training in fire safety, safeguarding and positive behaviour support. Training in relation to the specific needs of residents had been undertaken, including the management of dysphagia and autism awareness. Staff could describe their learning from their training, and relate it to their role in supporting residents. Their learning had also been shared with residents, for example one resident was responsible for thickening their own drinks in relation to managing their dysphagia.

There was a schedule of supervision conversations maintained by the person in charge, and these were up to date. Supervisions were held every six months for established staff, and more frequently for new staff. The inspector reviewed the records of two supervision conversations, one a six month review for a long-term staff member, and the other a fourteen week review for a new staff member. There was a clear agenda for discussion including an opportunity for the staff member to raise any items, and a discussion around the staff knowledge in relation ot the care

and support needs of residents.

It was evident that staff development and training was supported, and that staff were appropriately supervised.

Judgment: Compliant

## Regulation 19: Directory of residents

The provider maintained a directory of residents which included the information specified in paragraph (3) of Schedule 3 of the regulations.

Judgment: Compliant

## Regulation 21: Records

All required records required by the regulations under Schedule 2 in relation to staff were all in place, including garda vetting, references and employment history.

All required records required by the regulations under Schedule 3 in relation to information in respect of each resident was in place including personal information, including the required care and support of residents and the information in relation to healthcare and a record of any belongings.

All required records required by the regulations under Schedule 4 were in place including a Statement of Purpose and Function, a Residents' Guide, and copies of previous inspection reports were maintained in the centre.

Judgment: Compliant

## Regulation 23: Governance and management

There was a clear management structure in place, and all staff were aware of this structure and of their reporting relationships.

There were various monitoring and oversight systems in place. An annual review of the care and support of residents had been prepared as required by the regulations, which had incorporated the views of residents and their families. Six-monthly unannounced visits had been conducted on behalf of the provider, and where areas for improvement were identified, it was the responsibility of the PIC to create an action plan to address the issues, and to monitor these until they were complete.

Any actions were then reviewed with the area director.

Actions from these process reviewed by the inspector were all complete, for example the management of a planned and actual roster had been improved, staff training needs had been fulfilled and there had been an improvement in the daily notes maintained on each resident.

In addition there was a monthly schedule of audit, including audits of fire safety, first aid and vehicle safety, form which any areas for improvement were identified, and monitoring of safety was documented, for example there was a comment that one of the vehicles was due a service.

Regular team meetings were held and minutes were maintained from each meeting. Items for discussion included the care and support needs of each resident, activities and staff training. The inspector reviewed the records of the previous two meetings indicated that they were useful and meaningful discussions, and saw that the behaviour therapist had attended meetings so review the positive behaviour support strategies with the staff team. All staff were required to sign the minutes of the meetings to indicate that they had either attended the meeting or read the minutes, and this sign in sheet was monitored by the PIC.

Daily communication between the staff team was managed by a written and verbal handover at the change of each shift, the written handover also being the daily report to the PIC. The inspector reviewed the records of these handovers and found them included detailed information on each resident so as to inform the care and support on a daily basis.

The designated centre was well resourced, so that there were sufficient staff to meet the needs of each resident, two vehicles, and all required equipment was supplied.

Overall there were effective oversight strategies that ensured that any areas for improvement were addressed, and it was evident that staff were appropriately supervised and that there was an emphasis on quality improvement.

Judgment: Compliant

## Regulation 24: Admissions and contract for the provision of services

While both residents had lived in the centre for many years, and there were no plans for any admissions, there was a clear admissions policy in place.

There was a contract of care in place for each resident which clearly outlined the terms on which that resident resides in the designated centre. These contracts were made available to residents in an easy-read version and included detail of any costs to be incurred by the residents.

For example, when residents went on holidays supported by staff members, the contract of care laid out exactly which costs were to be covered by the resident themselves, and which were covered by the organisation.

Judgment: Compliant

## Regulation 3: Statement of purpose

The provider had developed a statement of purpose which included all the information required by Schedule 1 of the regulations.

The statement of purpose outlined a range of information about the centre, including the facilities and services in the centre, the organisational structure, and the arrangements for consultation with residents.

Judgment: Compliant

## Quality and safety

There were systems in place to ensure that residents were supported to have a comfortable life, and to have their needs met. There was an effective personal planning system in place, and residents were supported to engage in multiple different activities.

The residents were observed to be offered care and support in accordance with their assessed needs, and staff communicated effectively with them and supported their choices and preferences. .

Healthcare was effectively monitored and managed and changing needs were responded to in a timely manner.

Fire safety equipment and practices were in place to ensure the protection of residents from the risks associated with fire, and there was evidence that the residents could be evacuated in a timely manner in the event of an emergency.

There were risk management strategies in place, and each identified risk had a detailed risk assessment and management plan.

Where residents required positive behaviour support there were detailed behaviour support plans in place. There were some restrictive practices in place, each of which was based on a detailed assessment of needs and with a documented rationale which indicated that the intervention was the least restrictive to mitigate the

identified risk.

The personal finances were well managed within the designated centre, but improvements were required to ensure that residents were supported to manage their income within their own bank accounts.

The rights of the residents were well supported, and residents indicated that they were happy in their home. Staff were knowledgeable about the support needs of residents and supported them in a caring and respectful manner.

## Regulation 11: Visits

There was a clear policy on visits to the designated centre which had been regularly reviewed. This policy supported open visiting, but also stressed the rights of the residents to decide on visitors to their homes. A visitors' book was maintained, and all visitors were asked to sign in and out via this book.

It was clear that visits were supported and encouraged, and that families and friends of residents were welcomed and supported to visit.

Judgment: Compliant

## Regulation 12: Personal possessions

Practices in support offered to residents in relation to the management of their personal finances were not all in accordance with the regulations.

Residents each had their own bank or post office account and associated debit card were supported successfully by staff to manage these. However, their income was paid directly into a Patient Private Property account held by the organisation and not into their own personal accounts. The residents then received a weekly allowance. Staff ensured that there was sufficient funds in these accounts for residents to make choices about their spending, but residents did not have full control of their finances.

Overall the inspector was not satisfied that management of money was always person centred or supporting residents to retain control of their own finances.

Judgment: Not compliant

## Regulation 17: Premises

The designated centre was appropriate to meet the needs of residents. Each had a self-contained apartment with their own garden area. The premises were well maintained inside, and personalised in accordance with the preferences of the residents.

The outside of the building required attention in relation to the paintwork, however this had been identified, and work was in progress a the time of the inspection.

Judgment: Compliant

## Regulation 26: Risk management procedures

There was a current risk management policy in place which included all the requirements of the regulations. Risk registers were maintained which included both local and environmental risks, and individual risks to residents. There was a risk assessment and risk management plan for each of the identified risks, and each of them was risk rated appropriately.

Risk assessments had been updated in response to any changing needs. For example the risk assessment relating to the resident having independence in their home in the evenings had been reviewed due to the changing presentation of the resident, including changes in mobility and sleep pattern, and this risk assessment had been escalated with recommendations for a change in staffing arrangements. These recommendations were supported by various member of the multidisciplinary team, including the physiotherapist and occupational therapist.

General and local risks which had been identified included fire safety, accidents and infection control. Each of these risks had a risk management plan including control measures to mitigate the risk

The inspector was assured that control measures were in place to mitigate any identified risks relating to residents in the designated centre.

Judgment: Compliant

## Regulation 28: Fire precautions

The provider had put in place structures and processes to ensure fire safety. There was well maintained fire safety equipment throughout the houses and there were fire doors throughout. The designated centre was divided into two separate apartments, but the fire alarm covered both apartments, and fire drills included both residents.

There was a current fire safety certificate and regular fire drills had been undertaken which indicated that residents could be evacuated in a timely manner in the event of an emergency. A record was maintained of each drill, and the person in charge monitored the records to ensure that each staff member was involved in this process.

There was a personal emergency evacuation plan (PEEP) in place for each resident which included guidance for staff should an evacuation be required. For example one PEEP included guidance to staff relating to the reluctance of a resident to walk at a fast pace.

All staff members had received fire safety training, and the inspector discussed fire safety with them, and they were confident about their role in ensuring the safety of residents and could describe the supports each individual resident would require in the event of an emergency.

The inspector was assured that all residents would be evacuated in the event of a fire.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

There were personal plans in place for each resident which were regularly reviewed and were based on a detailed assessment of need. There were sections in the care plans relating to healthcare needs and to planning daily and weekly activities.

Care plans in place included plans relation to healthcare and specific conditions, such as recurring infection. There was also a detailed plan in relation to activities and daily references, and the supports each resident required.

There was an annual person-centred planning meeting held for each resident to which families and friends were invited, and which residents attended. One resident was particularly interested in these meetings, and staff described how they had begun by thanking everyone, and had spoken about their team of staff and how they were supportive.

Both residents had a person-centred plan which was reviewed monthly with their staff. Goals and aspirations were documented, and the achievements of residents through this process included purchases for their homes, new hobbies such as flower arranging and new opportunities for spending time with animals.

There was an emphasis on ensuring that residents had a meaningful day, and that opportunities were made available to them, and each had been on a holiday or short break with the support of staff.

Easy-read copies of each care plan had been developed and it was evident that the

process was meaningful and person-centred.

Judgment: Compliant

## Regulation 6: Health care

Healthcare was well managed, and both long term conditions and changing needs were responded to appropriately. For example, staff had noticed that a change in personal habits and routine for one resident, and this had been followed up with a referral to the appropriate healthcare professional.

Residents had access to various members of the multi-disciplinary team, including their general practitioners, physiotherapist and positive behaviour support specialist, as required. Both residents had been referred to the speech and language therapist who had recently joined the organisation's team.

The inspector reviewed a healthcare plans in relation to high blood pressure, osteoporosis and end of life, and found they included sufficient detail as to guide staff, and evidence that residents were involved in the development of these plans.

Residents had been offered healthcare screening appropriate to their gender and age, and had availed of the screening.

Overall the inspector was assured that the healthcare needs of each resident were monitored and addressed.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Where residents required positive behaviour support, there were detailed plans in place, based on a detailed assessment of needs. The inspector reviewed the plans in place for both residents. Proactive strategies were identified, and staff could discuss the ways in which they were supporting residents to reduce the occurrence of incidents of behaviours of concern. The plans outlined any identified precursors and triggers to incidents of behaviours of concern, and guidance for staff at each level of escalation of any behaviours of concern.

The behaviours support plans were continually monitored, and formally reviewed by the multi-disciplinary team annually. In addition there was regular input from the positive behaviour support specialist who regularly attended the designated centre and joined in staff meetings to discuss the behaviour support required by residents.

Staff had all received training in the management of behaviours of concern, and all

staff engaged by the inspector were knowledgeable about their role in supporting residents, and could identify the strategies in place for each resident.

Where restrictive practices were in place to ensure the safety of residents, they were monitored to ensure that they were the least restrictive measures available to mitigate the identified risks. There was a restrictive practices register in place which included each intervention and the rationale for its use.

The inspector was assured that restrictions were only in place if they were necessary to safeguard residents.

Judgment: Compliant

## Regulation 9: Residents' rights

Staff had all received training in human rights, and spoke about the importance of supporting and respecting the rights of residents. Each resident was supported to maintain their independence as far as possible, for example one resident spent their evenings with only the distant support of staff from the next apartment. This arrangement was kept under constant review in relation to the changing needs of the resident, and also their increasing preference to make contact with the staff member, and it was clear that whilst all efforts were made to ensure that residents' independence was respected, their safety was paramount.

Both residents had chosen to go abroad on holidays last year, and had been supported by the staff team in this. They both engaged in a wide range of activities, both at home and in their local community, and new activities were made available to them, for example, a local active aging group was being explored for one resident.

It was evident that the rights of residents were respected and upheld.

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 | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 21: Records | Compliant |
| Regulation 23: Governance and management | Compliant |
| Regulation 24: Admissions and contract for the provision of services | Compliant |
| Regulation 3: Statement of purpose | Compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 12: Personal possessions | Not compliant |
| Regulation 17: Premises | Compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Mullaghmeen Centre 2 OSV-0005477

## Inspection ID: MON-0038319

## Date of inspection: 04/06/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 12: Personal possessions | Not Compliant |
| Outline how you are going to come into compliance with Regulation 12: Personal possessions:<br><br>Following discussion and consultation with residents, the PPIM and Person in Charge will plan for each resident's weekly income to be paid into their respective personal accounts. Once this is in place, arrangements will be made to close their PPPA account. When in place each resident will have access to their monies as required.<br><br>To ensure each person's finances are safeguarded a robust risk assessment will be developed. | |

## 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 12(1) | The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs. | Not Compliant | Orange | 30/11/2025 |