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:	Mullaghmeen Centre 4
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	01 July 2025
Centre ID:	OSV-0005479
Fieldwork ID:	MON-0047606

About the designated centre

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

The designated centre is a detached bungalow in close proximity to the nearest small town which can accommodate up to three adult (male and female) residents, each with their own room, and with suitable communal and private areas. The provider describes the service as supporting individuals with modern to severe intellectual disabilities and additional specific support needs in relation to physical disability, behaviours of concern, autism and mental healthcare needs. The centre is staffed 24 hours a day, including waking night staff. The staff team comprises social care workers and support staff. The residents are supported to access local amenities including leisure facilities, shops, bars and restaurants.

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
Tuesday 1 July 2025	11:15hrs to 18:00hrs	Julie Pryce	Lead
Thursday 10 July 2025	10:45hrs to 16:45hrs	Julie Pryce	Lead
Thursday 10 July 2025	10:45hrs to 16:30hrs	Florence Farrelly	Support

What residents told us and what inspectors observed

This inspection was announced to the provider, originally as an inspection to monitor on-going compliance with the regulations, and to help inform the registration renewal decision. However, following information submitted by the provider to the Office of the Chief Inspector in the days prior to the inspection, it was changed to a risk-based inspection.

The information received by the Office of the Chief Inspector of Social Services was in the form of a series of allegations of abuse witnessed by staff members, relating to incidents alleged to have occurred within a period of time over the six months prior to the date of the inspection. The inspection was therefore focused on the immediate safeguarding of residents and the response of the provider to the allegations.

The inspectors reviewed the systems put in place by the provider to ensure the safeguarding of residents and the effectiveness of these systems, and reviewed the actions taken since the allegations were made to ensure the on-going safeguarding of residents.

The inspection was facilitated by the person in charge (PIC) and attended by the person participating in management, and on the second day by the regional director.

It was evident on the first day of the inspection that the initial response of the provider to the allegations had been immediate and appropriate, and that the safety of residents had been immediately assured. On the second day of the inspection the provider presented the quality improvement plan that had been developed to ensure the on-going safety of residents. These initiatives are discussed in detail under Regulation 23: Governance and management of this report.

There were two residents living in the designated centre, and the inspectors met both residents during the course of the inspection. On arrival at the centre on the first day the inspectors found both residents relaxing in the living room with staff members. One resident was lying on the sofa and was smiling and laughing with their supporting staff. The other resident said a quick hello, and then indicated that they did not wish for any further interaction with the inspectors.

The premises were appropriate to meet the needs of the two current residents. Each had their own bedroom, and there were sufficient communal areas to ensure that they could spend time together, or separately as they chose. There was a spacious and pleasant outside area with a gazebo and outside furniture for the use of residents. During the course of the inspection the inspectors observed both residents to be enjoying the garden area with their supporting staff.

The application to renew the registration of the designated centre outlined that the centre could accommodate three beds, however, given the needs and presentation of the current residents it was agreed with the provider at the close of the inspection that the centre was currently only suitable to accommodate two residents. The provider submitted an updated application immediately following the inspection to reflect this agreement.

Throughout the inspection the inspectors observed staff to be supporting residents in accordance with their assessed needs, and to be communicating effectively with them. For example, on the second day of the inspection, one resident was in an anxious and heightened state, and the inspectors could hear them vocalising loudly. The inspectors observed that this resident required a low arousal environment and staff were observed speaking quietly and calmly to the resident. The staff were also observed to intervene in accordance with the resident's plan of care, including the use of music, and the resident's presentation deescalated during the day. In the afternoon they were observed to be enjoying the garden, and chatting to staff.

The inspectors spoke to family members of both residents during the inspection. One family member said that they were happy with the care and support offered to their relative, and that the needs of their relative were met. They also said that communication from the staff team was appropriate and transparent, and that they were kept informed.

Another family member said that they had been invited to a recent person-centred planning meeting in relation to their relative, and that they were happy with the level of communication from the designated centre, including communication from senior management in relation to recent events. They said that they had some concerns about staff working alone. As discussed later in this report, this issue had been addressed by the provider, and staff were no longer lone-working in the centre.

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.

However, there was insufficient evidence that the staff team were consistently and appropriately supervised in the months prior to the inspection, or that they were appropriately garda-vetted. While allegations of abuse had been responded to immediately and appropriately, there had been a failure of staff to report concerns as they arose.

In addition the practices in relation to medication management required improvement and the support offered to residents in relation to their personal finances was not always person centred.

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, however, the sporadic nature of the presence of the person in charge or other members of the management team was inadequate to ensure that staff were consistently and effectively supervised.

There was an appropriately qualified and experienced person in charge who was knowledgeable about the care and support needs of residents, and who had begun to make improvements since their appointment two months prior to the inspection.

There was a consistent 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, although improvements were required to ensure that any concerns were raised in a timely manner.

The practices in relation to garda vetting of staff were not adequate, and the organisation's policy on recruitment did not give sufficiently clear guidance in this matter.

There was a clear and transparent complaints procedure available to residents.

Regulation 14: Persons in charge

The person in charge was new to the role since the start of May 2025. They were appropriately skilled and experienced, and had gained a good knowledge of the care and support needs of the residents.

They facilitated the inspection in a transparent and open manner, and undertook to make improvements in any areas where failings were identified. They had also identified areas that required improvement, for example improvements were required in the support for residents' communication as further discussed under Regulation 10: Communication.

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 any shortfalls arose, they were filled initially by the permanent staff team doing extra shifts, and failing that they came from a regular relief panel.

Prior to the allegations of abuse there had been two staff on duty each day until 16.00hrs, and then one staff for the evening and overnight. The provider had already increased the staffing numbers to ensure two staff on duty at all times prior to the first day of the inspection.

A sample of three staff files and garda vetting for all staff members was reviewed by the inspector. While there was information in the staff files as required by the regulations, including garda vetting, the garda vetting for one staff member had not been renewed since 02 June 2016, nine years prior to the inspection. There were gaps in the employment history in one of the files, and the photographic identification in another was out of date.

The inspectors spoke to three staff members on duty, the person in charge, the person participating in management and the regional director 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 delivering care in accordance with the care plans of each resident, and in a caring and respectful way.

Judgment: Not compliant

Regulation 16: Training and staff development

All staff training was up to date and included training in safeguarding and positive behaviour support. Training in safeguarding included both on-line training and face-to-face training, and all staff had received the face-to-face training with the exception of one staff member who was on long term leave at the time of the inspection.

The inspectors reviewed the content of this training with the trainer and found that it was a comprehensive training covering all aspects of safeguarding of residents, including the reporting requirements. Staff could describe their learning from this training, and knew their responsibilities in terms of reporting any concerns, including the expected timeframes of reporting.

However, despite the training in place, staff did not report alleged abuse in a timely manner. The allegations indicated that abusive interactions could have occurred over a six month period prior to the staff reporting, which meant that residents may have been subjected to abuse for a prolonged period of time.

In addition, staff supervision was not taking place as per the provider's own processes. There was a schedule of quarterly supervision conversations in place for the staff team, to be undertaken by the person in charge. Of the six permanent staff members, only four had received formal supervision in the first quarter of the year, and again only four in the second quarter. The inspectors reviewed the records of eight supervision conversations going back over the previous five quarters, and found that a standing item for discussion was the opportunity for staff to raise any concerns.

The inspectors were significantly concerned about the lack of day-to-day supervision of staff by the person in charge or more senior members of the management team. The person in charge was based in the organisation's offices, and there was no clear roster or schedule for attendance in the designated centre and no definitive record of attendance. Up until the beginning of June the person in charge signed the visitors' book when they attended the centre. Between 1 January 2025 and 15 May 2025 the person in charge had signed this book 15 times, and from 5 February until 3 March there was no record of any management or supervisory presence in the designated centre, and therefore no evidence that staff were supervised in any way.

The current person in charge had made some improvements on this level of supervision, for example they had attended the designated centre every weekday between 9 to 13 June, and from 23 to 30 June, although there was no record of the length of time of these visits, and it was unclear as to whether the visits were for a specific task, or for a prolonged period of time.

On day 2 of the inspection a schedule had been introduced whereby the person in charge was required to be based in the centre for at least half a day for four days per week, and this had commenced immediately after day 1 of the inspection.

Overall, prior to the inspection the supervision of staff had been inadequate, and while staff had been in receipt of all the required training, the learning had not been put into practice in relation to reporting any allegations of abuse within 24 hours of becoming concerned, as required by the organisation's policy. This had the potential to put residents safety and welfare at risk.

Judgment: Not compliant

Regulation 23: Governance and management

As the focus of this inspection was the safeguarding of residents following a series of allegations of abuse, on the first day of the inspection the inspectors reviewed the immediate actions taken by the provider, and on the second day the quality improvement plan in relation to ensuring on-going safeguarding of residents.

The initial steps taken by the provider included the following:

- appropriate protective measures were immediately put in place

- the Trust in Care process had commenced and the preliminary screening had been completed
- a report had been made to An Garda Siochana as is required following an allegation of abuse
- there had been an increase in staffing levels to remove any lone working in the designated centre.
- discussions had been held with the families of the residents.
- a meeting of the Serious Incident Management Team had taken place.

The inspectors reviewed the minutes of the meeting of the Serious Incident Management Team and found that the following points and comments had been recorded:

- there was acknowledgement that the PIC was not centre based, although there had been an increase in the time spent on-site
- the team agreed that the PIC should conduct a one-to-one discussion with every staff member
- the team queried whether there was a culture of not reporting
- the Trust in Care process was discussed, and requirement for external review identified
- it was agreed that the issue would be discussed at the Integrated Management Review which was a monthly meeting, the next one scheduled for the day after the first day of the inspection.

In addition supports had been put in place for the residents. The PIC had already had a discussion with each, and referrals had been made to the psychologist for the following week. As part of the referral process, the psychologist requests a completed 'screening measure' assessment in advance of the appointment. This had been completed for one resident, and attempted for the other who had so far declined to participate.

On the second day of the inspection a quality improvement plan was presented to the inspectors. This was a comprehensive plan which confirmed all the measures immediately taken as outlined above, and included additional actions as follows:

- interim safeguarding plans had been developed and submitted to the national safeguarding team
- a full review of the mix of the current staff team to be undertaken
- monthly staff supervisions to be implemented
- monthly supervision and support for the PIC to be introduced
- updates and refresher training to be undertaken by all staff
- in person team training in relation to positive behaviour support planned
- easy read information on human rights to be provided to residents
- all staff to have updated Garda vetting
- one-to-one meetings to be undertaken with all staff in relation to the importance of immediate reporting of concerns
- a safeguarding culture survey to be undertaken, and training on the importance of a positive safety culture to be undertaken by the staff team.

The provider had established a safeguarding oversight group to meet weekly to progress the items in the quality improvement plan. The provider also undertook to share the learning and improved practice across all their services.

It was evident that appropriate actions had been taken following the receipt of allegations of abuse.

In general, the provider had in place various monitoring processes. For example, an annual review had been prepared in accordance with the regulations, and six-monthly unannounced visits on behalf of the provider had taken place. These processes identified areas for improvement, and those required actions reviewed by the inspectors had been completed within their required timeframes.

There was system of audits in place, although this system was not comprehensive, and not always effective. For example the audit on care plans consisted of a list of completion dates of documents, and did not review the quality of the content of the documents in the personal plans.

In addition, as discussed under Regulation 16 : Training and staff development, staff had not been appropriately supervised prior to the allegations of abuse, so that overall the inspectors were not assured that appropriate governance systems were in place to ensure that the service provided was safe and effectively monitored.

Judgment: Not 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

Regulation 34: Complaints procedure

There was a clear complaints procedure available to residents and their friends and families. The procedure had been made available in an easy read version and was clearly displayed as required by the regulations.

While there were no current complaints, there were comments and complaints forms available to residents and their families and friends.

Judgment: Compliant

Regulation 4: Written policies and procedures

All of the required policies were in place in accordance with Schedule 5 of the regulations. The inspectors reviewed the policy on safeguarding and found it to be evidence based, and is sufficient detail as to provide appropriate guidance to staff.

However, the policy on recruitment, selection and garda vetting did not provide clear direction in relation to the requirement for staff to be appropriately garda vetted. The section on garda vetting included the following:

- 'Re-vetting will be undertaken at intervals as close as possible to every three to five years dependent on resources to undertake administration of the process'.

This guidance was too vague to be meaningful, and did not address the requirement for the provider to ensure that the designated centre is adequately resourced.

Judgment: Not 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, although some review was required to ensure that the information was current, 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.

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, and staff were observed to manage an incident of behaviour of concern effectively and safely.

Improvements were required in the support offered to residents in managing their personal finances to ensure that they had control of their assets.

The practices in relation to PRN ('as required') medication was not sufficiently robust so as to ensure its safe administration, and records were not updated in a timely manner.

Regulation 10: Communication

The person in charge and staff members were familiar with the ways in which residents communicate. This was clear from the observations made by the inspectors during the course of the inspection and from discussions with staff. For example, one of the staff members spoke about the way in which a resident's non-verbal communication indicated their current mood.

There was a communication care plan in place for each resident and the inspectors reviewed both of these. The plans included information about some of the supports that would help communication with residents.. For example, the plan for one resident described how they might take time to respond, and also how they might request several things at once, until settling on the actual request.

There was also a communication dictionary' in place for each resident which included some information around the best ways in which staff should communicate with residents, but which was insufficient to be a clear guide. The PIC had already identified this as an issue, and had made referrals for both residents to the speech and language therapist.

It was clear that communication with residents was facilitated by consistent and familiar staff team, and that supporting documentation was kept under review with a view to improving the guidance for staff.

Judgment: Compliant

Regulation 12: Personal possessions

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

Both residents had their own bank accounts, however, their income was paid directly into a Patient Private Property Account held by the organisation. The

residents then received a weekly allowance. Residents were supported to have sufficient spending money at their disposal for their daily needs, however, if further cash was required, a request had to be made in writing, and the amount requested was then issued over the coming days.

Therefore the inspectors were 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 13: General welfare and development

There was an emphasis on ensuring that residents had a meaningful day, and that opportunities were made available to them in accordance with their preferences.

One resident had a preference for home-based activities, and while outings were continually made available to them, they were often not chosen by the resident. Those activities that were chosen by the resident included going out for a drive, although they would often choose not to get out of the car, but ask staff to make purchases for them. This was kept under constant review, and the efforts made by staff to encourage the resident to engage in the community were regularly documented.

The other resident was more interested in outings, and was involved in various activities with the support of staff so that it was clear that activities were supported in a person centred way.

Judgment: Compliant

Regulation 17: Premises

The premises were appropriate to meet the needs of the two residents currently living there. Each had their own room, and there were adequate communal areas, kitchen and laundry facilities. The premises appeared to be clean and tidy, and well maintained inside and out. Where there were some minor maintenance issues, these had been identified by the provider, and there were plans to rectify the issues. For example, both residents' bedrooms were due to be repainted.

The inspectors also found that there were plans to further improve the premises, especially in relation to the changing needs of residents. For example there were plans to renovate one of the bathrooms to create an easily accessible wet room.

The outside areas of the house were accessible to residents by means of ramps leading to all areas. There was nice, functional garden furniture including a swing and a gazebo. Residents were observed throughout the inspection to be utilising various areas of the house, including the garden areas.

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.

Individual risk management plans included plans in relation to accessing the community, the risk of falls, and the risk associated with the anxiety of a resident around the fire blanket. Each risk management plan included detailed control measures.

There was a risk assessment and management plan in relation to the safeguarding of residents which included information about training, recruitment and the role of the designated officer. The provider undertook to update this risk management plan if required following the completion of the investigation into allegations of abuse.

The inspectors were assured that the provider was responsive to changing risks.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had put in place structures and processes to ensure fire safety. There were self-closing fire doors throughout the centre and all equipment had been maintained. The inspectors noticed an issue with the outside lighting of the building, and this was addresses during the course of the inspection.

Regular fire drills had been undertaken, and there was an up-to-date personal evacuation plan in place for each resident, giving clear guidance to staff as to how to support each resident to evacuate. Where it was recommended that equipment be used to facilitate a swift evacuation, this equipment was in place. For example where it was recommended that a wheelchair be used in the event of an emergency, the wheelchair was present in the resident's room.

All the required checks had been regularly completed, including quarterly checks of fire detectors, weekly checks of the alarm system and daily checks of the fire panel and fire exits. There was an emergency plan in place which outlined the steps to be taken in the event of a major emergency. .

Staff were all in receipt of fire safety training and could describe the actions they would take in the event of an emergency, including the support each resident would require. The inspectors were assured that all residents could be evacuated in the event of an emergency.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

All staff had received training in the safe administration of medications. This training took place over two days and was followed by three competency assessments undertaken by a registered nurse. Refreshers were undertaken at least every three years. The inspectors reviewed the content of this training and found it to be comprehensive and evidence based.

Where residents were prescribed PRN (as required) medications there were protocols in place which outlined the circumstances under which a decision would be made to administer the medication. However, one of the protocols lacked clarity as to the reason for administration, in that it was not clear whether the identified behaviour should be sustained for a certain period of time before the decision would be made to administer the medication.

Records were maintained of the administration of the medication and the reason for the decision, however some of these records referred to the resident being 'anxious' but did not describe their presentation, so that it could not be ascertained whether the protocol had been followed.

There was conflicting information in different documents relating to the dosage of a medication that was given as a regular medication as well as being prescribed for use 'as required' so that the inspectors were concerned that the maximum dose for the day could be exceeded. It was unclear initially as to where the latest prescription had originated, and it was over an hour before staff could locate the relevant information from the prescriber. There was no record of the appointment in the resident's documentation, and the care plan had not been updated.

An audit of medication management had taken place, however it was a self-audit undertaken by staff, and was a tick-box form that staff completed. This audit had not identified any of the issues described above.

The inspectors were not satisfied that PRN medications were safely and effectively managed or monitored.

Judgment: Not 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, although not all the reviews were meaningful.

There were sections in the care plans relating to healthcare needs including mental health, to maintaining safety in the environment and to intimate and personal care for each resident. While the care plans had been marked as having been reviewed, there were several instances of out of date information remaining in the care plans. For example, one care plan referred to glasses which the resident no longer wears, and another referred to a positive behaviour support plan which had been discontinued.

However, where the care plans were current, they included sufficient detail as to guide staff in the delivery of care and support. Staff were aware of the guidance in the care plans, and could describe their role in the implementation of them. The inspectors observed the implementation of aspects of the care plans throughout the inspection, for example in the support in mobilising and communicating.

Each resident also had a person-centred plan including goals for achievement. Goals included home-based activities, maintaining independent mobilising, and accessing new activities in the community. Each person centred plan was individualised, and related to the needs and preferences of each resident.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where a resident required positive behaviour support, there was a detailed plan in place, based on a comprehensive assessment of needs. There was only one such plan in place which was reviewed by the inspector.

The plan included proactive strategies, for example allowing time to process information and allowing personal space, and reactive strategies such as redirection, returning home to the centre and advice that the staff should remove themselves from the situation. As outlined under Regulation 5: Individualised assessment and personal plan of this report, some outdated information had not been removed, for example there was a recommendation from some years ago that the resident might benefit from an individualised service, but this was no longer recommended.

There was an associated risk assessment and management plan which included guidance including the management of visitors, travelling and community access. Staff were all aware of the guidance in these documents and could describe their role in managing behaviour of concern. Staff had all received training in the management of behaviours of concern, and could discuss their learning from this training.

The inspectors observed, form a distance, the management of such behaviours during the second day of the inspection, and saw that staff managed the situation safely and effectively.

There were no restrictive practices in place in the designated centre, and the inspectors were assured that behaviours of concern were well managed in the least restrictive ways.

Judgment: Compliant

Regulation 8: Protection

There was a clear safeguarding policy in place which had been regularly reviewed. Areas addressed in this policy included the following:

- reporting of accidents and incidents and near misses
- rights of residents
- presumption of capacity
- prevention of abuse and risk management
- common themes known to contribute to the risk of abuse
- culture
- early detection
- responsibilities of staff.

A series of allegations of abuse had been made two days before the inspection, mostly relating to concerns about incidents that were alleged to have occurred over the previous six months. These allegations were not made to the provider at the time of the alleged incidents. The provider did, however, notify the Office of the Chief Inspector immediately that they were made aware of the allegations.

The immediate steps taken to safeguard residents, and the quality improvement plan developed by the provider in response to the allegations were discussed in detail under regulation 23: governance and management of this report.

Staff had all been in receipt of training in relation to protecting vulnerable adults from abuse, and all staff could describe their learning from this training, including the types of abuse, the signs of abuse and their responsibility should they have concerns that any abuse had taken place.

The provider had taken the appropriate steps to ensure that all residents were safeguarded from abuse following the allegations, including immediately increasing supervision levels, discontinuing lone working in the designated centre and providing support to staff in relation to reporting any concerns. However, given the lack of supervision of staff on a daily basis, the failure of the provider to ensure that staff were appropriately garda-vetted, and the failure of staff to report concerns relating to abuse in accordance with the organisation's policy, there was insufficient evidence that, prior to the allegations, the provider had safeguarded residents from all forms of abuse,
Judgment: Not 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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Mullaghmeen Centre 4 OSV-0005479

Inspection ID: MON-0047606

Date of inspection: 10/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
• All staff working in the centre are now fully garda vetted.
• All staff identification documents on file are in date.
• All CV's have been reviewed and any gaps notified to the relevant staff member with a request to submit an up-to-date CV ASAP.
• From 09/10/2025 each six-monthly unannounced visit to the designated centre, the auditor will contact the HR link person for the area and request the Garda Vetting status of each staff member associated to the centre.

Going forward all new staff being recruited to the organisation will be garda vetted prior to commencing in post.
• As per the amendments to the Muiriosa Recruitment, Selection and Garda Vetting Policy & Procedure, The Muiríosa Foundation has in place a programme for staff to undertake Garda re-vetting. Those staff who are three years or more since being vetted, are selected for the re-vetting process each year.
• Relevant Area Directors will be informed of the names of staff requested to complete Garda Vetting, and any staff member who has not responded to and/or complied with the request. All current staff members to be re-vetted are required to present in person to the Regional Office for validation of documentation.
• From 09/10/2025 each six-monthly unannounced visit to the designated centre, the auditor will contact the HR link person for the area and request the Garda Vetting status of each staff member associated to the centre. The vetting status for each staff member will be forwarded to the PIC of the centre. The PIC will follow up with individual staff to ensure re-vetting is completed.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• All staff in the centre have completed again the HSELand training on the safeguarding of vulnerable adults.
• All new staff to the centre will be required to complete this training prior to commencing on shift.
• All staff are required to attend in person safeguarding training facilitated by the organisations Designated Officer.
• The safeguarding of vulnerable adults is a standing agenda item on all team meetings and 1:1 support meetings with the PIC.
• As per the Quality Improvement Plan the PIC has scheduled monthly individual support meetings with all staff. However the PIC links in on an informal basis with all staff at least once weekly to check in on their wellbeing and to identify any concerns/ issues arising. The frequency of these meetings will be reviewed on the 30/09/2025.
• There is a monthly scheduled staff team meeting with a standing agenda including (but not limited to) safeguarding/ training & development/ health & safety/ risk management. The frequency of these meetings will be reviewed on the 30/09/2025.
• As identified in the Quality Improvement Plan the area director has scheduled individual support meetings with the PIC every 4 weeks. However the PIC and area director communicate daily on an informal basis. The frequency of the scheduled support meetings will be reviewed on 30/09/2025.
• The PIC has access to peer support informally on a daily basis from their PIC colleagues. There is also a quarterly day & residential governance meeting where all PICs and day service managers attend.
• The PIC works Mon to Fri 9am to 5pm in a supernumery capacity. Outside these hours there is an on call rota to ensure PIC / manager oversight 24hrs/ day, 7 x days per week. As part of the Quality Improvement Plan the PIC's workload was reviewed and reduced for a period of 3mths to allow them to focus fully on the improvements required in the centre. This arrangement will be reviewed on 31/10/2025. In addition to the PIC an experienced nurse was re-deployed into the centre.
• From the 31/10/2025 the PIC will be required to take on another designated centre. However, as part of the Quality Improvement Plan and ongoing governance in both locations, the PIC will ensure they are onsite daily in each location. In addition to this there is an identified team lead in each location.
• The PIC maintains a record of meetings with staff/ with residents and their families/ and has developed a log capturing progress on all identified actions.
• The area director visits the centre in a scheduled manner when meeting the PIC and in an unscheduled manner for ad hoc governance and support.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: • A multi-disciplinary MDT meeting was held on 30/07/2025 with attendance by Psychology/ Behavioural Support/ Area Director/ Person in charge/ Area Leader/ Staff Nurse/ Physiotherapy / Occupational Therapy/ Speech & Language. A three-month action plan was developed for review by the full MDT on 29/10/25. • A Quality Improvement Plan QIP is in place with a clear SMART action plan. The Person in Charge/ Area Leader/ Head of Quality Safety & Risk are owners of the plan and ensure all actions are being implemented within identified timelines. • An experienced staff nurse has been re-deployed into the team in a supernumerary capacity for a three-month period, to assist the Person in Charge in reviewing all care plans/ medication management/ infection prevention & control plans. They will also be supporting by liaising with external medical / health support for both residents. This arrangement will be reviewed on 31/10/2025. • The Area Director has increased onsite presence in the Centre; in a scheduled manner through meeting the PIC and in an unscheduled manner through ad hoc visits. • The PIC works Mon to Fri 9am to 5pm in a supernumery capacity. Outside these hours there is an on call rota to ensure PIC / manager oversight 24hrs/ day, 7 x days per week. For a three month period the PIC is being facilitated to focus fully on this centre. • From the 31/10/2025 the PIC will be required to take on another designated centre. However, as part of the Quality Improvement Plan and ongoing governance in both locations, the PIC will ensure they are onsite daily Mon to Fri in each location.	
Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: The current Muiriosa Recruitment, Selection and Garda Vetting Policy & Procedure was reviewed and updated in Oct 2024. It is due for further review in Sept 2026 or sooner depending on legislative or process changes. The current Policy will be amended with the following wording to ensure that services are appropriately and adequately resourced; • The Muiríosa Foundation has in place a programme for staff to undertake Garda re-vetting. Those staff who are three years or more since being vetted, are selected for the re-vetting process each year. • Relevant Area Directors will be informed of the names of staff requested to complete Garda Vetting, and any staff member who has not responded to and/or complied with the request. All current staff members to be re-vetted are required to present in person to the Regional Office for validation of documentation • From 09/10/2025 each six-monthly unannounced visit to the designated centre, the auditor will contact the HR link person for the area and request the Garda Vetting status of each staff member associated to the centre. The vetting status for each staff member	

will be forwarded to the PIC of the centre. The PIC will follow up with individual staff to ensure re-vetting is completed.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
To ensure compliance with Regulation 12 and to promote a more person-centred approach, the following actions will be undertaken:

A risk assessment has been developed to manage the risk of individuals with Patient Private Property Accounts (PPPA) not having immediate access to their own private funds. This risk assessment details all current controls in place to manage this risk for both residents and includes additional controls that will be put in place by the PIC. These additional controls include;
• Exploring alternative options to cash for individuals to access their private funds, including the use of pre-paid debit cards, which via electronic transfer can be credited with a person's funds from the PPPA and can be used to pay for transactions in person and online.
• The Person in Charge (PIC) will support both residents with individual person specific guidance and education on the process of opening and managing a personal bank account/ their own money. This guidance and education will include information on the Patient Private Property Account and will allow each individual to make an informed choice as per the HSE National Consent Policy [2024]. This support will include accessible information for residents to understand the options open to them regarding decision making support arrangements.
• Individuals choosing to keep their money in an alternative financial institution (bank/ credit union) will be supported by staff to open an account/ access their funds.
• Through this process where it is identified that an Individual does not have capacity to decide, regarding the management of their personal funds, the PIC will ensure they are supported to access a decision-making representative who will make decisions on their behalf in relation to their finances.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

• An experienced staff nurse has been re-deployed into the team for a three-month period, in a supernumerary capacity to assist the Person in Charge in reviewing all care plans/ medication management/ infection prevention & control plans. They will also be supporting by liaising with external medical / health support for both residents. This arrangement will be reviewed on 31/10/2025.
• The PIC and staff nurse will liaise with relevant healthcare practitioners both internally and externally to the organisation, to ensure local guidance is fully comprehensive/ up to date & effective in guiding practice.
• All PRN (as required) documentation will be reviewed by the PIC, staff nurse, relevant healthcare practitioner, to ensure local guidance is fully comprehensive/ up to date & effective in guiding practice.
The Area Leader & staff nurse conducted a self assessment tool to Assess Compliance with the National Standards for Safer Better Healthcare in July 2025 which includes the area of medication safety. A comprehensive action plan was developed as a result and has been incorporated into the overall Quality Improvement Plan for the centre.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• A Quality Improvement Plan QIP is in place with a clear SMART action plan. The Person in Charge/ Area Leader/ Head of Quality Safety & Risk are owners of the plan and ensure all actions are being implemented within identified timelines.
• An experienced staff nurse has been re-deployed into the team in to assist the Person in Charge in reviewing all care plans/ medication management/ infection prevention & control plans. They will also be supporting by liaising with external medical / health support for both residents.
• As part of the Quality Improvement Plan the PIC's workload was reviewed and reduced for a period of 3mths to allow them to focus fully on the improvements required in the centre. This arrangement will be reviewed on 31/10/2025.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• All staff in the centre have completed again the HSELand training on the safeguarding of vulnerable adults.
• All new staff to the centre will be required to complete this training prior to commencing on shift.

• All staff are required to attend in person safeguarding training facilitated by the organisations Designated Officer.
• The safeguarding of vulnerable adults is a standing agenda item on all team meetings and 1:1 support meetings with the PIC.
• As per the Quality Improvement Plan the PIC has scheduled monthly individual support meetings with all staff. However the PIC links in on an informal basis with all staff at least once weekly to check in on their wellbeing and to identify any concerns/ issues arising. The frequency of these meetings will be reviewed on the 30/09/2025.
• There is a monthly scheduled staff team meeting with a standing agenda including (but not limited to) safeguarding/ training & development/ health & safety/ risk management. The frequency of these meetings will be reviewed on the 30/09/2025.
• As identified in the Quality Improvement Plan the area director has scheduled individual support meetings with the PIC every 4 weeks. However the PIC and area director communicate daily on an informal basis. The frequency of the scheduled support meetings will be reviewed on 30/09/2025.
• The PIC has access to peer support informally on a daily basis from their PIC colleagues. There is also a quarterly day & residential governance meeting where all PICs and day service managers attend.
• The PIC works Mon to Fri 9am to 5pm in a supernumery capacity. Outside these hours there is an on call rota to ensure PIC / manager oversight 24hrs/ day, 7 x days per week. As part of the Quality Improvement Plan the PIC's workload was reviewed and reduced for a period of 3mths to allow them to focus fully on the improvements required in the centre. This arrangement will be reviewed on 31/10/2025.
• From the 31/10/2025 the PIC will be required to take on another designated centre. However, as part of the Quality Improvement Plan and ongoing governance in both locations, the PIC will ensure they are onsite in each location daily Mon to Fri. In addition to this there is an identified team lead in each location.
• The PIC mantains a record of meetings with staff/ with residents and their families/ and has developed a log capturing progress on all identified actions.
• The area director visits the centre in a scheduled manner when meeting the PIC and in an unscheduled manner for ad hoc governance and support.
• All staff working in the centre are now fully garda vetted.
• All staff identification documents on file are in date.
• All CV's of existing centre staff have been reviewed and any gaps notified to the relevant staff member with a request to submit an up-to-date CV ASAP.
• The Muiriosa Recruitment, Selection and Garda Vetting Policy & Procedure, has been amended as follows;
• The Muiríosa Foundation has in place a programme for staff to undertake Garda re-vetting. Those staff who are three years or more since being vetted, are selected for the re-vetting process each year.
• Relevant Area Directors will be informed of the names of staff requested to complete Garda Vetting, and any staff member who has not responded to and/or complied with the request. All current staff members to be re-vetted are required to present in person to the Regional Office for validation of documentation.
• From 09/10/2025 each six-monthly unannounced visit to the designated centre, the auditor will contact the HR link person for the area and request the Garda Vetting status of each staff member associated to the centre. The vetting status for each staff member will be forwarded to the PIC of the centre. The PIC will follow up with individual staff to ensure re-vetting is completed.

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(4)(b)	The registered provider shall ensure that he or she, or any staff member, shall not pay money belonging to any resident into an account held in a financial institution unless the account is in the name of the resident to which the money belongs.	Not Compliant	Orange	30/09/2025
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.	Not Compliant	Orange	10/10/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/10/2025
Regulation 23(1)(c)	The registered provider shall	Not Compliant	Orange	31/10/2025

	ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	31/10/2025
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	10/10/2025
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	Substantially Compliant	Yellow	31/10/2025

	frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 05(6)(d)	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 take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	31/10/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	10/10/2025