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:	Mulberry Lodge
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Offaly
Type of inspection:	Unannounced
Date of inspection:	17 June 2025
Centre ID:	OSV-0007413
Fieldwork ID:	MON-0046955

About the designated centre

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

Mulberry Lodge is a designated centre run by Nua Healthcare Services Ltd. The centre can provide residential care for up to four male and female residents, who are over the age of 18 years and who have an intellectual disability. The centre can also cater for residents who require high behavioural support. The centre comprises of a main bungalow and four separate apartments. Each apartment provides residents with their own en-suite bedroom, living space and enclosed outdoor area. The main bungalow, comprises of a kitchen, staff office, bathroom, sunroom and hallway. Adjacent to the main bungalow, is a separate building comprising of laundry facilities and storage area. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 17 June 2025	09:00hrs to 17:30hrs	Anne Marie Byrne	Lead
Wednesday 18 June 2025	09:30hrs to 15:15hrs	Anne Marie Byrne	Lead
Tuesday 17 June 2025	09:00hrs to 17:30hrs	Ivan Cormican	Support
Wednesday 18 June 2025	09:30hrs to 15:15hrs	Ivan Cormican	Support

What residents told us and what inspectors observed

This was an unannounced inspection conducted to assess the actions taken by the provider to bring the centre back into compliance with the regulations, following the outcome of this centre's previous inspection in February 2025. That inspection found significant issues in relation to the provider's oversight and response to the high volume of restrictive practices that were being used in the centre, with failings also found in relation to aspects of behavioural support arrangements, risk management, and the provider's own governance and monitoring arrangements. Following on from that inspection, the provider submitted a timebound compliance plan to the Chief Inspector of Social Services, which outlined a number of specific actions that they planned to take to address the issues raised. Inspectors found that the provider had completed these, which were effective in addressing the specific issues relating to restrictive practices, with a marked reduction found in the use of these. However, the improvements that the provider made to their oversight arrangements were found to only have improved this aspect of the service, with little transfer of the learning from making these improvements in responding to, and proactively dealing with, other issues and risks that this centre was challenged with. The findings of this inspection again found that significant concerns remained in relation to the provider's role in the oversight of care, risk management, residents' assessment of need, and in the overall provision and review of behavioural interventions. These will be discussed in more detail later on in this report.

In light of the findings of the last inspection, and with due consideration of the complex care and support needs of the residents living in this centre, this was a very focused inspection that specifically looked at a small number of regulations, informed by very clear lines of enquiry. To inform these lines of enquiry, inspectors both conducted a review of the incidents that had occurred in this centre from March 2025 to the date of this inspection for two residents, where it was established that one of these residents in particular had been the subject of a large volume of incidents within that time period. The specific lines of enquiry from this incident review, resulted in a particular focus on the care and support arrangements for this resident, along with the oversight and response to their assessed risks, both at a local and senior management level.

On both days, the inspection was facilitated by the person in charge and the director of operations. Both were found to have a good understanding of the residents' individual and collective care needs, and it was clear that they were committed to promoting their welfare and well-being. Inspectors also got to meet with two of the residents, both of whom greeted the inspectors but didn't speak with them directly about the care and support they received. The two other residents were present at the centre, with one of them coming and going with staff over the course of the two days. The inspectors made two attempts to meet with the fourth resident, but on each occasion this resident was spending quiet time alone in their apartment. This centre was highly staffed both day and night, with inspectors getting to meet with eight staff over the course of the two days. Inspectors were able to speak with them

at various intervals around the care and support that these residents received, all of whom spoke very respectfully about the residents. Both management and staff were aware of the specific failings found upon the last inspection, and were all aware of the particular changes that were made to care practices, so as to improve these aspects of the service.

Four residents lived in this centre, each had their own apartment and were each assessed as requiring high levels of staff support both day and night. Some of them required two-to-one staffing, while others were assessed as requiring three-to-one staff, with a slight reduction in these staffing levels at night for some residents. These residents each had complex care and support needs, which primarily related to their assessed behavioural support needs, with some prescribed varying levels of environmental and physical restrictive practices, in response to this aspect of their care. Others had assessed mental health needs, some were identified with having a risk of leaving the centre without staff support, and others had identified risks relating to their environment and community access which posed threat to their personal safety. The general layout of the centre meant that these residents didn't have to interact with one another, as each had their own apartment, separate driveways, and transport. However, a few months prior to this inspection some incidents had occurred where negative interactions happened despite the spacious and individualised layout and design of this centre. Multiple incidents were still occurring where there was significant potential for these negative interactions to re-occur, which will be discussed further on in this section of the report.

To give context to the size, scale and layout of this centre, it comprised of one main building, and had four separate apartments. Two of these apartments had connecting doors into the main building which were routinely locked and their only intended purpose was to provide an additional fire exit from these apartments, if it was needed. The third apartment was adjacent to the main building also, but there was no access point in or out of there from the main house. The fourth apartment was located on separate grounds to the main building and other apartments. There was also an external laundry, storage and staff area available. The main house comprised of a kitchen and dining area, sunroom, staff office and bathroom. Two of the residents had supervised access to this area of the centre, and the two other residents did not have access to this area. Each apartment comprised of a bedroom, bathroom, small hallway, and living area. There was a variance in the furnishings provided within each apartment, which was derived from various risks that these residents individually presented with. Each apartment did have a number of environmental restrictions in place, to include, keypad locks, window restrictors, heavy duty furniture, some items were bolted to the floor, and each apartment was surrounded by high fencing. Most of the residents also had restrictive practices in relation to the provision of kitchen appliances in their apartment, with staff in the process of introducing some of these to one resident's apartment, following the outcome of a recent multi-disciplinary assessment that was completed.

Upon the inspectors' arrival, some residents were up and about, while staff were supporting the others to get ready to start their day. There was a very pleasant and calm feel about the centre, and all interactions between staff and the residents that inspectors had the opportunity to observe, were warm and friendly. There was very

little change in the care and support arrangements for these residents since the last inspection; however, one resident had spent time in hospital after becoming unwell in recent months, but were reported to be recovering well since their discharge home. During their walk-around of the centre, inspectors first visited the apartment of the resident who resided independent of the main building. This resident required full-time staff supervision, and were supported by three staff who were present in this apartment. This resident had celebrated their birthday a few days before this inspection, and had kept some of the balloons from the celebrations in their living area. They greeted both inspectors, but didn't engage with them for very long. This particular resident had identified risks, whereby, their apartment was required to be minimally furnished, their environment included various restrictions such as keypad access doors and window restrictors, and the perimeter of their apartment was surrounded by high fencing. Following on from the last inspection, the provider did remove some restrictions from this resident's environment, however, in response to incidents that occurred following their removal, it was re-assessed that these restrictions required to be re-installed. This resident loved action figures and the fence which surrounded their apartment was recently painted with various illustrations of these. Inspectors then visited another apartment; however, the resident was gone out with staff at the time they were there. In response to the assessed needs of this particular resident, their apartment was also very minimally furnished, and mainly contained heavy duty tables and chairs, their television was enclosed by protective casing, and some of the walls had a padded covering in place. Their apartment also was surrounded by high fencing, and entry in and out of this area was via key-pad lock system. Inspectors did attempt to visit the third apartment, however; due to the presentation of the resident at the time of the visit, they were unable to enter this apartment. This resident did however regularly come into the main building on both days, where one of the inspectors had the opportunity to briefly meet with them. They spoke with the person in charge during this time, and appeared to have a very friendly and pleasant relationship with them.

When inspectors visited the fourth apartment, they didn't enter the actual apartment area as they were informed that the resident was spending some time alone. Due to the assessed needs of this resident, and associated risks relating to their care, they were also supported by three staff, who took time to speak with the inspectors in the resident's outdoor area. This was the apartment that featured largely in the findings of the last inspection report, due to the 13ft high fence that it was surrounded by that the resident loved to climb, which was initially installed in response to an assessed absconsion risk. However, since their admission in August 2024, no incidents occurred of them attempting to abscond from the centre when they successfully climbed over this fence. Instead, they made their way towards the main building, which they had restrictive access to, and was an area of the centre that had fuelled their curiosity since their admission. This fence had also become an integral part of the provider's measures in safeguarding other residents from this resident gaining access to the main building and potentially negatively interacting with them. From a review of incidents that was later conducted by the inspectors, it was clear that this resident still regularly managed to successfully climb and scale this fence so as to gain access to the main building. When this occurred, staff were vigilant in ensuring no other resident was in the vicinity of the main house at the time, which had prevented further negative interaction between this residents and

their peers from occurring. However, the multiple incidents of where this resident still successfully was able to gain access to this main building, was of concern to inspectors in relation to the potential likelihood for negative peer-to-peer related incidents to re-occur.

Since the last inspection, the height of this fence was further increased by an industrial style pipe that was fitted to the top of this fence. The rationale for the provider's decision to install this additional piping was in an effort to deter the resident from being able to scale and climb over this fence. However, this measure was ineffective in doing so, as incidents were still happening where the resident did continue to do so, with staff having to place a crash mat at the base of the fence to prevent an injury to the resident when they jumped from this height. Staff who were present spoke about how the resident continued to attempt to climb and scale this fence at each and every opportunity that they could. They explained how they used specific distraction techniques to deter the resident from doing so, which were only effective some of the time. This fence when at 13ft, already posed a considerable falls risk and potential risk of serious injury to the resident, which was now at an even greater height, further increasing this risk.

This resident was admitted to this service in August 2024, with a reported 187 incidents involving them since their admission, 58 of these occurring within the time period that was reviewed by inspectors. This resident was subject to regular multi-disciplinary reviews, had a behaviour support plan in place, and there had also been recent changes to staffing arrangements and updates made to staff training, in response to the assessed needs of this resident. Despite this, the incidents which were reviewed by inspectors gave very clear accounts of the very challenging circumstances that staff often had to respond to, aswell as the distress displayed by the resident when they were deterred from climbing their fence, and/or from not being able to gain entry into the main building. Many of these incidents escalated to where the resident engaged in self-injurious behaviour, was very physically aggressive towards staff, who as a last resort measure had to implement a physical restraint. Staff were often subject to physical assault, with one staff member off duty at the time of this inspection due an injury they sustained from this resident. This wasn't an isolated incident, as a further review of documentation later showed that this was the fourth time a staff member was subject to this level of injury since this resident's admission. Furthermore, due to the reported strength and heightened presentation of the resident, it was happening more and more often where staff were unable to sustain the physical hold, or where the effectiveness of the hold was compromised. When this happened, staff had to release and re-attempt again, or swap in and out with other staff members from the centre so as to maintain their own safety. Again, there were multiple incidents of this found to have occurred.

During this incident review, both inspectors individually spent time with the person in charge and director of operations to discuss the response to the escalating incidents of physical aggression towards staff, as well as the management of the increasing falls risk from climbing their fence. Both were very aware of each and every individual incident that the inspectors had reviewed, and both had been concerned in relation to the increased frequency and severity of some of the incidents, particularly in relation to the exhibit of physical aggression towards staff.

Maintaining staff safety was their main priority, and they had an external person come to the centre and make observations and recommendations on how staff could increase their own personal safety when supporting this resident. They had also made additional PPE available to staff, and in more recent weeks had established a core staff team that were specifically rostered to care for this resident, so as to further promote continuity of care in an effort to reduce the number of incidents where the resident had targeted their aggression towards specific staff members. Since the last inspection, the person in charge spent a lot of time conducting debriefing sessions with staff when incidents occurred, and also was carrying out regular on-the-floor mentoring to provide additional support to staff. Both the person in charge and director of operations had also sought a meeting with the agency that were responsible for the admission of this resident into this centre, which was scheduled to occur the week after this inspection. In relation to the falls risk that the fence in this resident's outdoor area continued to present, local management were responding to, and managing this by placing huge emphasis on the reiteration to staff to adhere to supervision arrangements, distraction techniques to deter them from climbing the fence, and in the vigilance of the use of crash mats. Although this had resulted in preventing injury to the resident when they jumped from this fence, there remained a considerable falls risk to this resident with their continued desire to climb and scale this fence at every opportunity, irrespective of it now being fitted with industrial piping.

It is also important to note, that what was also obvious to inspectors from the review of these incidents was the improved implementation of alternative measures in response to challenging behavioural related incidents, resulting in fewer physical holds being used. Incidents had occurred where some behavioural incidents lasted for extensive periods of time, some of which throughout the entire night, and had required significant input and interventions from staff in order to bring this resident back to baseline, which they done so successfully. The commitment of staff and local management in adhering to the provider's action plan requires particular mention, as they still were presented with very difficult incidents that they had up-skilled and debriefed upon, so as to therapeutically manage these incidents without the use of additional physical restrictions, only when required as last resort.

Despite the efforts of local management and staff to respond to the level of incidents occurring, and increasing risks posed by these, this centre was still presented with significant risks beyond the capacity and scope of local management to be able to fully respond fully to. Based on the evidence which was readily available to the inspectors, there are serious considerations for the provider to give, to assure themselves as to whether this designated centre can meet the needs of all residents living in the current environment and its design. This inspection also highlighted significant deficits in the initial assessment of need informing a resident's admission, which was not informed with up-to-date information about this resident's needs, prior to their transition. Despite the high number of incidents that were being reported in relation to this resident since their admission, this hadn't prompted the provider to complete a full review of the appropriateness of this resident's placement, or to give due consideration to the impact of restrictions and high level interventions needed to support these four residents to live in such close proximity to each other. The provider was failing to appreciate that the operation of the centre

in its current format was not promoting safe or quality care to the residents, and that the level of risks to residents and staff clearly indicated by context of incidents that had happened, required comprehensive assessment, review, management and robust monitoring, at a senior management level, so as to mitigate against the fundamental issue of the appropriateness and suitability of these residents to be sharing this designated centre.

The specific findings of this inspection will now be discussed in the next two sections of this report.

Capacity and capability

Overall, inspectors found that the provider had placed significant action in addressing and overseeing the use of physical restraint in their centre, which had resulted in a considerable decline in the use of these, and better oversight of when they were required to be used. The action taken by the provider since the last inspection in order to do so, included, provision of additional staff training, improvements were made incident reporting and incident risk-rating systems were reviewed, policy and procedure updates were completed, staff de-briefing sessions were occurring, there were increased incident and restrictive practice reviews, staff mentoring and incident root cause analysis had commenced, and there was also increased multi-disciplinary involvement. Key to all of this was the retention of staff since the last inspection, which afforded good consistency in the implementation of these actions, as well as continuity of care for the residents. There also was good oversight maintained by the director of operations in conjunction with the person in charge, who regularly met to ensure that they were completing all actions as specified by the provider in the compliance plan response that was submitted to the Chief Inspector. As well as this, both managers maintain rigid oversight of the use of restrictive practices since the last inspection, and used the learning from this to inform on-the-floor mentoring and de-briefing sessions with staff.

However, despite this, there was still considerable improvement required in how the provider was overseeing other incidents that continued to occur, and using this information to inform the action needed to be taken in this centre so as to respond to these with the same robustness and oversight, as they showed in their oversight and response to the use of physical restrictions. In addition to this, there were also significant concerns raised in the provider's ability to recognise the requirement for a comprehensive review of one particular resident's assessment of need, at a senior management level, in light of the volume and severity of incidents that had occurred since their admission, to ensure that their placement in this designated centre was appropriate and suitable for them.

A large number of incidents were repeatedly occurring which were placing local management in a very challenging position to sustain a safe and suitable service for residents, and for the staff that supported them. The provider's own weekly

governance meetings were provided with the information around these incidents, however; the way in which they were being reviewed needed to be reconsidered by the provider to ensure this weekly oversight system was fit for purpose, in being able to highlight where action needed to be taken to address the specific and on-going issues and risks in this particular centre, that these incidents were clearly indicating. Improvements were also required to how the provider was monitoring effective and positive change in this centre, with much of the focus of internal reviews and audits being on the completion of the provider's compliance plan actions, rather than assessing for the overall effectiveness of them improving fundamental systems and arrangements that governed how this centre operated.

The fundamental failing on this inspection was in relation to the provider's failure to recognise the requirement for them, as the provider, to review the suitability and capacity of their service, to provide all residents with an appropriate, suitable and good quality of service, based on the nature and context of the incidents that were happening.

Regulation 15: Staffing

The provider ensured that the centre was well resourced in terms of staffing. Residents who used this service had high support needs and each required a certain level of staff both day and night to support them with their assessed needs. For instance, some of them required two-to-one staffing, while others were assessed as requiring three-to-one staff, with a slight reduction in these staffing levels at night for some residents. In response to one resident's behavioural support needs, the person in charge had established a core staff team to support this individual. This was in the early stages of being implemented at the time of this inspection, but was reported to be working well so far. Due to the complex care and support required by the residents in this centre, staffing levels were maintained under very regular review by the person in charge. Since the last inspection, there was good staff retention, which resulted in consistently of care for these residents.

Along with additional training, following on from the last inspection, local management had also consistently provided on-the-floor mentoring and debriefing sessions with staff in the last number of months, so as to promote a culture of learning and responsive care in relation to incidents that had occurred. Staff who met with the inspector each spoke confidently about the complexity of the care and support arrangements that were in place for some residents, and were very aware of the incidents that had been happening in this centre, and of the local control measures that were in place in response to these

The person in charge maintained an actual and planned rota which demonstrated that residents were supported by a staff team who were familiar to them, that clearly outlined the full name of each staff member and their start and finish times worked.

Judgment: Compliant

Regulation 23: Governance and management

Weekly governance meetings continued to be a fundamental aspect of how this provider monitored all of their designated centres. These meetings were attended by the director of operations on behalf of Mulberry Lodge, and a report was prepared by the person in charge ahead of each meeting, to inform on the incidents that had occurred the previous week. This report largely focused on the trending of the number of notifiable incidents to HIQA, medication errors and near misses, staff retention levels, occasions of physical restraint, and specific internal levels of non-compliance that had been identified through internal quality reviews. Incidents that did not fit this criteria were provided separately in narrative format, and were not included as part of the overall weekly trending analysis. Although these meetings monitored the areas of service that the provider had deemed they wanted weekly oversight of, for the particular incidents and issues that were being experienced within Mulberry Lodge, this review and oversight process alone, was not effective in recognising the impact these incidents were having on the quality and safety of care in this centre. The narrative format in which these incidents were reviewed under, significantly diluted the frequency and severity of their occurrence that was indicating increased safety risks for both residents and staff. The provider had failed to recognise that the repeated reporting of these incidents, warranted significant oversight, action, robust monitoring, and specific review at these governance meetings, so that they could effectively ensure the quality and safety of care in this service.

In the case of this centre, a review of incidents that had happened in this centre pertaining to two residents from March 2025 to the date of this inspection which was conducted by inspectors. As earlier mention, one resident was the subject of a high volume of these incidents, which resulted in a review of their care and support arrangements informing alot of the lines of enquiry into this inspection. These incidents were the same ones that were provided weekly to senior management, and highlighted very significant concerns regarding the very challenging incidents that staff had to respond to, some of which resulted in significant risk to staff and resident safety. These incidents were happening more and more often, and inspectors found that local management were reactive to the risks posed by these incidents, but they were limited by their roles in terms of larger operational decisions. Inspectors found that those delegated at a senior management provider level were not proactively examining these incidents this in the context of the overall quality of the service which all residents received, in light of the following:

- the frequency and intensity of incidents which placed residents and staff at risk of harm
- there was lack of due consideration for the level and extent of restrictions that were continually required for these four residents to live together, to include, the 13ft fence that had repeatedly failed to effectively mitigate against the potential for further safeguarding incidents to re-occur, with multiple occasions reported each

month where a resident with restricted access to the main house, gained access to this area of the centre by climbing and scaling this fence
- despite increased behavioural support input, interventions had failed to eliminate or effectively reduce the resident's continued curiosity with regards entering the centre's main house
- recorded incidents of challenging behaviour highlighted multiple failed attempts of physical holds which placed the resident and staff at significant risk of harm. Furthermore, four staff sustained significant injuries since August 2024 which warranted their leave, as a direct result from incidents of behaviours of concern
- in light of the incidents that were occurring, the failure to recognise the requirement for a full and comprehensive review to be completed, at a senior management level, of the suitability of this designated centre, so the provider could assure themselves and clearly demonstrate, that this service could meet the individual and collective needs of residents

In addition, there were also failings found in relation to the provider's other monitoring systems. Following on from the last inspection in February 2025, the provider conducted their own six monthly provider-led visit of this service in March 2025. Despite the findings of the inspection a month previous highlighting significant failings, many of the same areas that were subject for review as part of this visit were found to be substantially compliant. This visit failed to consider the impact, oversight, response and management of significant incidents that had happened in the weeks around and prior to this visit, some of which were significantly challenging for staff to respond to, and lasting for 14 and 15 minutes at a time. As well as this visit, the provider was also using a further review and monitoring system to maintain oversight of the completion of the actions they had committed to in their compliance plan to the Chief Inspector. However, the emphasis of this was solely on the completion of these actions, and not on the overall effectiveness they had on improving the safety and quality of care across key areas such as risk management and oversight arrangements relating to this service.

Judgment: Not compliant

Quality and safety

The previous inspection of this centre highlighted significant issues in relation to risk and incident management, which were directly linked with behavioural support and the associated use of restrictive practices. Since then, there had been a marked reduction in the use of these practices and records reviewed by inspectors demonstrated that this had been sustained. Although this was a positive change, concerns remained in relation to other significant incidents and issues in this service that were placing residents and staff at risk of harm, which the provider was failing to recognise and robustly respond to, in the same manner in which they had

addressed issues around the use of restrictive practices. Furthermore, fundamental failings were also found in relation to the comprehensive re-assessment of a resident's needs, at a senior management level, which hadn't been prompted by the volume of repeated incidents that were occurring in this centre.

The person in charge and director of operations took on board the findings of the last inspection, and had worked closely with staff in improving how they were reporting incidents of physical restrictions, which now clearly described these events in better detail. The last inspection found that incidents relating to the implementation of physical holds failed to include, the body part that was held, by which staff member, and the specific duration it was held for. Significant emphasis had been placed by local management in addressing this, with many incident reports reviewed by inspectors were found to now contain this level of information, which was being kept under on-going review by the person in charge. Improvements had also been made to how these incidents were being risk-rated, which were previously only calculated on the presentation of an injury or property damage, but were now risk-rated based on the likelihood and impact of occurrence. At the time of this inspection, due to the software updates that were underway to migrate the new risk-rating process over to the provider's electronic incident report system, this aspect of the system wasn’t available to inspectors to review. However, those facilitating the inspection informed that it had been a welcomed development, and had allowed them to provide a more accurate risk-rating calculation of the incident being reported.

Due to the nature and context of the incidents that were reviewed by inspectors, the assessment of need of the resident who was subject to a large volume of these incidents was reviewed as part of this inspection. Since their admission in August 2024, 187 incidents had occurred involving this resident, and repeatedly pertained to incidents of self-injurious behaviour and physical aggression, falls risks, and the accessing of the same area of the centre that they were restricted from due to previous negative interactions with their peers. There was strong linkage observed by the inspectors between these incidents which led to the resident becoming quite distressed and subsequently engaging in self-injurious behaviours, which then led to increased episodes of physical aggression, then leading to times where situations could only be managed by staff implementing last resort physical restrictions. Of concern to inspectors was that the presentation of this information at governance meetings, had not made any difference to safety arrangements for this resident, the other residents, and for the staff in this centre. It also again raised concerns in the provider's ability to recognise and respond to safety concerns, even though the same fundamental issues with regards the oversight, response, and management of incidents were clearly highlighted in the last inspection.

Another fundamental issue in this centre was the level of restrictions placed upon one resident in order for them to live in a designated centre within close proximity to other residents, which were not effective. The resident's garden and car park area was enclosed by a 13ft high fence, and they were supported by three-to-one staffing at all hours of the day and night. Despite this level of supervision and environmental restriction of this 13ft fence, this resident still frequently gained access to the main area of the centre, where other residents living areas were

located, placing them at risk of harm, and potentially being subjected to similar negative interactions with this resident, that they had experienced a few months previous.

Overall, this inspection found significant failings with regards to process for assessing residents' needs, risk management, and behavioural support arrangements. There were clear deficits in the comprehensive re-assessment of this resident's needs, and in the response to the incidents that had subsequently occurred since their admission. The repetitious volume and severity of some these incidents that had been reported, had not led in the provider identifying at a senior management level, that local managements' efforts alone were beyond what was required in this centre, and that action was required to be taken by them, the provider, to review the suitability of this resident's placement at this centre.

Regulation 26: Risk management procedures

This was a centre that experienced a high volume of incidents and for the purpose of this inspection, inspectors reviewed incidents which had occurred relating to two particular residents, one of whom had 187 recorded incidents since their admission in August 2024. Inspectors reviewed incidents that had occurred for this resident from March 2025 to the date of this inspection, with 58 recorded incidents having been reported within this timeframe for this resident alone. Most of these incidents were behavioural related, some of which were in relation to incidents of property damage and incidents while on transport; however, more concerning to inspectors from their review was in relation to the following:

- 18 of these incidents related to where this resident was physically aggressive and/or had physically assaulted staff, with one staff member recently sustaining an injury from one of these incidents and was on leave at the time of this inspection. From other records reviewed, this was the fourth time a staff member had to take leave following injury from behavioural incidents involving this resident since their admission. These incidents detailed incidents of where staff were often charged at, cornered, kicked, pinched, were pulled and head butted. There was a clear escalation in the occurrence of these incidents, with 10 of them occurring in May 2025, in comparison to previous months, with five incidents having been reported in April 2025 and three having been reported in March 2025.

- Although there was a marked decline in the number of incidents where this resident was physically restrained, when it did occur, it was clear from the records available that these were in direct response to last resort measures to protect the safety of the resident, or the safety of the staff supporting them. However, there was a significant increase in the amount of times staff were unable to attempt or sustain physical restraint, with staff unsuccessfully able to do so 22 times over this period of incident review, due to the reported strength and heightened presentation of the resident at the time. There was also an escalation in how often this was

happening, with eight incidents of this already been recorded for June 2025, in comparison to three occasions in May 2025, and four occasions in April 2025.

- There had also been 10 recorded incidents of where this resident gained access into the main building by climbing and scaling their fence or by forcing mag-locks open. There were also 12 other incidents of where this resident attempted to climb their fence, but had been unsuccessful in doing so. Due to the falls risk and potential risk of injury posed to this resident from the 13ft fence that surrounded their apartment, information recorded within a number of these incidents informed of how staff were required to place a crash mat at the foot of the fence so as to break the resident's fall. In addition to this, within the aforementioned 12 incidents, it was reported on numerous occasions where the resident engaged in self-injurious behaviour when deterred from continuing to climb the fence. When this happened, this often led to these incidents then significantly escalating into physical aggression towards staff, resulting in physical restraint having to be deployed by staff so as to maintain either their safety, or the safety of the resident.

Local management were aware of these aforementioned incidents and recognised the increased threat to staff safety, and had taken action by seeking an external person to come to the centre to review staff personal safety arrangements, had provided additional PPE, and had also more recently established a core staff team to maintain continuity of care. The person in charge continued to conduct de-brief sessions with staff following incidents of physical restraint, to include the incidents of where restraint had been unsuccessful due to the heightened presentation of the resident. There was full recognition from local management with regards to the continued falls risk presented to this resident by their 13ft fence, and through their robust oversight of this risk, they had ensured complete staff adherence to falls management measures, which had kept this resident safe from injury, despite the number of times they continued to climb and scale this fence.

However, at provider level, a similar response to these incidents had not occurred. It was clear from the review of these incidents that there was a significant risk posed to staff safety, to the safety of the resident, and for the potential of further negative peer-to-peer interactions which was beyond the scope and capacity of local management to continue to effectively manage. However, no comprehensive review had been completed by the provider of all the incidents that were occurring, to establish the capacity and safety of staff and local management to continue to encounter and sustain their response to these escalating risks, withstanding the collective volume, nature and severity of some of the incidents that had occurred.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

This inspection found that considerable improvements was required with regards the

comprehensive review of a resident's assessed needs, at a senior management level, to ensure Mulberry Lodge was an appropriate service to meet their assessed needs.

The incident review conducted by inspectors relating to this resident, clearly outlined where some of these had caused quite significant distress to the resident, which led to many of the behavioural related incidents that then occurred, some of which couldn't always be therapeutically managed. Although the person in charge maintained regular oversight to ensure that this resident's comprehensive assessment of need was regularly updated, this was to of no avail without intervention at senior management level, to take action on the information gathered from the incidents that had happened involving this resident since their admission, to ensure this centre was an appropriate and suitable placement for this resident.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Since the last inspection, there was increased input from a behaviour support specialist in the review of all behaviour support plans, who also met regularly with the person in charge to review all incidents of physical restraint. However, inspectors did find that further review of behaviour support plans were required, particularly with regards to ensuring better guidance was provided to staff around the implementation of last resort physical restraint. For example, the behaviour support plan for a resident that was reviewed by inspectors listed a number of different types of last resort physical holds that were prescribed for them, with staff advised to conduct a dynamic risk assessment to determine the level of risk posed, before implementing one of these restrictive practice options. However, the information in the behaviour support plan failed to provide adequate guidance to staff in relation to the considerations they needed to include as part of this dynamic risk assessment, or as to how the outcome of this assessment informed which physical hold was the one that was appropriate to implement. In addition, given the increased number of incidents that had happened where physical restraint was unsuccessful due to the heightened presentation of the resident, the behaviour support plan didn't include guidance for staff on what to do when these incidents occurred.

The last inspection also identified that some environmental restrictive practices required attention from the provider, in particular the 13ft fence that surrounded one resident's apartment. This was still in place upon this inspection, and had increased further in height due to the installation of an industrial style pipe that was fitted to the top, in an effort to deter the resident from being able to climb and scale the top of the fence. As described under regulation 26, an extensive review of incidents involving this resident since March 2025 was conducted by the inspectors, found multiple incidents were still continuing to occur in this centre where the resident climbed this fence, successfully and sometimes unsuccessfully, in an effort to gain access to the main building. This fence still had an impact on their

immediate environment and continued to present a considerable falls risk and risk of serious injury to the resident. Due to the number of times the resident successfully still scaled and climbed over this fence, the effectiveness of its intended restrictive purpose hadn't been reviewed by the provider. As was highlighted by inspectors within the last inspection report, this fence still required review by the provider to recognise the extensive restrictive practice measures that were required to be imposed upon this resident, so that they could reside in this centre within close proximity to other residents.
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 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Mulberry Lodge OSV-0007413

Inspection ID: MON-0046955

Date of inspection: 18/06/2025

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

1. A Governance Improvement Plan shall be implemented in the Centre and will be overseen by the PIC and Director of Operations.

Completed: 28 July 2025

2. A Key Event Schedule (KES) linked to the Governance Improvement Plan will be implemented to monitor all actions and assigned responsibilities.

Completed: 31 July 2025

3. A meeting is to be held with the Centre's Management Team by the Director of Operations about Centre Management's Key Task List, Roles, and Responsibilities and Governance Driven Improvement Plan.

Completed: 28 July 2025

4. Director of Operations to schedule weekly meetings for 12 weeks with PIC, Quality Assurance Officer, Behavioural Specialist, and Administration Manager regarding weekly trends (incidents, restrictive practices, learning & development, Personal Plans effectiveness).

Due Date: 30 September 2025

5. A full re-assessment of Individuals Comprehensive Needs shall be completed and undertaken by the Person in Charge in conjunction with the Centre's Behavioural Specialist.

Due Date: 31 August 2025

6. PIC will ensure Supervision schedule is in place and maintained in the Centre.

Due Date: 30 September 2025

7. Quality Assurance Audits shall be completed on a bi-weekly basis at the Centre during the Governance Improvement Plan and actions within KES.

Due Date: 30 September 2025

8. Person in Charge, Director of Operations and Deputy COO will meet weekly to review the progress of the Governance Improvement Plan and identify areas for further improvement, if they arise.

Due Date: 30 September 2025

9. Conduct a review of weekly trends for a period of 12-weeks including incidents, accidents, restrictive practices, staff learning and development, effectiveness of Personal Plans, led by Director of Operations with PIC, QA Officer, Behavioral Specialist, Administration Manager.

Due Date: 30 September 2025

10. Director of Operations to provide a weekly update on Governance Improvement Plan progress at the weekly Governance Meeting and present on current and emerging trends within the Centre for discussion and action where relevant.

Due Date: 30 September 2025

11. Fortnightly Team meetings during the Governance Improvement Plan period to respond to emerging needs.

Due Date: 30 September 2025

12. Conduct test-of-knowledge assessments actioned by Behavioral Specialist and overseen by Centre Management to ensure staff understanding and application of Behavioral and Risk Management Plans.

Due Date: 30 September 2025

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. Person in Charge (PIC)/Centre Management to ensure all Personal Plans and

Individual Risk Management Plans (IRMPs) are up to date and reflective of assessed risks.

Completed: 10 August 2025

2. PIC & Director of Operations (DOO) to review IRMPs ensuring risks are accurately documented and consistent approach is adhered to through on-the-floor supervision, handovers, and supervisions.
Due Date: 31 August 2025

3. Conduct a review of weekly trends for a period of 12-weeks including incidents, accidents, restrictive practices, staff learning and development, effectiveness of Personal Plans, led by Director of Operations with PIC, QA Officer, Behavioural Specialist, Administration Manager.

Due Date: 31 August 2025

4. Director of Operations to provide weekly update on Governance Improvement Plan progress in ID Services' weekly Governance Meeting and present on current and emerging trends within the Centre for discussion and action where relevant.

Due Date: 31 August 2025

5. If any action is ineffective, Centre Management must immediately inform DOO and take corrective action. If DOO cannot support, escalate immediately to Senior DOO/DCOO.

Due Date: 31 August 2025

6. Agenda of Team meetings to include Team Member Key Task Lists and roles and responsibilities based on findings.

Due Date: 31 August 2025

7. Fortnightly Team meetings during the Governance Improvement Plan period to respond to emerging needs.

Due Date: 31 August 2025

8. Conduct test-of-knowledge assessments enforced by the Behavioral Specialist and overseen by management to ensure staff understanding and application of Behavioral and risk management plans.

Due Date: 31 August 2025

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
1. Review Comprehensive Needs Assessment (CNA) for ID483 in full: Any identified changes in need or circumstances will be reflected in the CNA with appropriate actions planned and documented.

Completed: 31 July 2025

2. Conduct a review of all Individuals Comprehensive Assessment and update and prepare all Personal Plans and Individual Risk Management Plans (IRMPs) for every resident at the Centre.

Completed: 08 August 2025

3. All Team Members to sign off on updated Personal Plans and IRMPs to confirm understanding and implementation.

Due Date: 22 August 2025

4. Finalise and implement discharge plan for ID483: A discharge notice has been issued to HSE due to the placement and potential impacts they may have on others caused by presenting behaviours and risks. The discharge plan will be completed collaboratively by the PIC and Transitions and Discharge Director, with ongoing support provided until a new appropriate placement is secured.

Due Date: 31 December 2025

5. Given the complexity of Individuals in the Centre, PIC to conduct formal reviews of care plans (at least every four months or sooner with any change), ensuring that all updates are scheduled, documented, and communicated.

Due Date: 31 October 2025

6. Conduct staff competency assessments focusing on knowledge of Regulation 5, care plan contents, and escalation procedures.

Due Date: 31 October 2025

7. Review residents' Personal Plans alongside daily and weekly activity planners to ensure access to activities matches assessed needs and preferences.

Due Date: 31 October 2025

8. Immediately address and escalate any gaps or ineffective care plans or implementation issues to DOO and Senior Management, ensuring timely corrective action.

Due Date: 31 October 2025

9. Update policies, procedures, and training programs as necessary based on audit findings, feedback, and evolving care requirements.

Due Date: 31 October 2025

10. If any action is ineffective, Centre Management must immediately inform DOO and take corrective action. If DOO cannot support, escalate immediately to Senior DOO/DCOO.

Due Date: 31 October 2025

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

1. Person in Charge (PIC) and Director of Operations (DOO) to conduct a comprehensive review of all Team Members' current knowledge and skills related to responding to challenging behaviors and supporting residents accordingly. Identify any gaps in knowledge or skills needing targeted training.

Due Date: 31 August 2025

2. PIC and Behavioral Specialist to establish/reconfirm a monthly review schedule for restrictive practices. Ensure reviews confirm all restrictive procedures are applied strictly according to national policy and evidence-based best practice.
Due Date: 31 August 2025

3. Based on the training needs review, roll out additional training sessions for Team Members identified as requiring skill/knowledge enhancement in supporting individuals with challenging behavior. Include up-to-date methods, de-escalation, positive behavior support, and restrictive practice policy adherence.

Due Date: 31 August 2025

4. Ensure ongoing fortnightly attendance of the Behavioral Specialist to review Behavioral Support Plans, conduct on-floor mentoring, and guide practice improvements with staff.

Due Date: 31 August 2025

5. Complete training for all Team Members on incident report writing to improve documentation and risk management around challenging behaviors and restrictive interventions.

Due Date: 31 August 2025

6. Train two Team Members and the PIC as Subject Matter Experts (SMEs) in Safety Intervention Techniques to ensure safe physical intervention is only used as a last resort.

Due Date: 31 August 2025

7. Confirm that monthly restrictive practice reviews are performed with documentation and feedback to PIC and DOO, verifying alignment with national policy and evidence.

Due Date: 31 August 2025

8. Ensure Behavioural Specialist attends at least two team meetings, providing feedback, discussing learnings, and reviewing incident trends related to behaviour support.

Due Date: 31 August 2025

9. Escalate Ineffective Actions Immediately. If any action—training, behaviour support, restrictive practice or environment reviews are found ineffective, Centre Management will notify DOO immediately and propose corrective actions. If unresolved, escalate to Senior DOO/DCOO without delay.

Due Date: 31 August 2025

10. Continue to ensure all Personal Plans and Individual Risk Management Plans remain current, accurately reflecting assessed needs and support strategies relevant to behaviors and restrictive practice.
Completed: 08 August 2025

11. Guidance to be included in the Multi-Element Behaviour Support Plan (MEBSP) developed by the Safety Intervention Officers, Behaviour Specialist and Risk Management Team on:
a. How to dynamically risk assess behaviours of concern for ID483.
b. Decision-making guidance to be outlined for ID483's behaviours of concern, including information on least restrictive to most restrictive behavioural strategies, and appropriate considerations for Team Members to take around physical restraint.

Due Date: 31 August 2025

12. MEBSP to be reviewed by the Behaviour Specialist and Senior Behaviour Specialist following the inclusion of this guidance to ensure reactive strategies are clear and understandable.

Due Date: 31 August 2025

13. Updated guidance to be communicated with staff through MEBSP training and attendance at team meetings.

Due Date: 30 September 2025

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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/09/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/08/2025
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive	Not Compliant	Orange	31/12/2025

	assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/09/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/09/2025