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:	Muinin
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Short Notice Announced
Date of inspection:	14 May 2025
Centre ID:	OSV-0007846
Fieldwork ID:	MON-0046451

About the designated centre

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

Muinin consists of four bungalow type residences located on a campus setting on the outskirts of a city. One of the bungalows can provide a home for five residents, one bungalow accommodates one resident, while the other two bungalows are both divided into two single-occupancy apartments. Overall the centre can provide full-time residential care for a maximum of ten residents over the age of 18 of both genders with intellectual disabilities. Each resident in the centre has their own bedroom and other facilities throughout the centre include bathrooms, dining/living areas and kitchens amongst others. Residents are supported by the person in charge, nursing staff and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 14 May 2025	10:30hrs to 18:45hrs	Deirdre Duggan	Lead
Wednesday 14 May 2025	10:30hrs to 18:45hrs	Lisa Redmond	Support

What residents told us and what inspectors observed

From what inspectors observed in this designated centre, residents in this centre were offered a safe and individualised service that took into account their individual needs and preferences. Residents were seen to be provided with opportunities to engage in activity within their local community and safeguarding arrangements were overall good. Some ongoing non compliance was present in relation to the premises and some improvements were required in relation to the identification and reporting of safeguarding concerns.

This centre accommodates ten adult residents and was fully occupied at the time of this inspection. All of the residents had lived in this centre or the campus for a number of years. All of the residents avail of full-time residential services. The centre comprises four bungalows located on a campus setting on the outskirts of a large city. One bungalow accommodates five adults, one bungalow accommodates one resident and the remaining two bungalows are subdivided into two single occupancy apartments each. All residents had their own bedrooms and each unit/apartment had separate kitchen, laundry and bathroom facilities.

Some areas of the centre were seen to be minimally decorated in line with residents' assessed needs, while in other areas, efforts had been made to personalise and decorate the centre in a homely manner and some residents told inspectors about how they had been involved in decorating their own apartments. An inspector was shown some improvements that had been made since the previous inspection, including a new fitted kitchen in one unit. However, as will be discussed further in this report, some areas of the premises remained dated and required attention and the house that accommodated five residents was observed to be small given the number and assessed needs of residents living there. Some fire safety works were outstanding also for this centre and the inspector was told that some refurbishments would not be taking place until those works had been completed first.

An inspector spent the morning of the inspection reviewing documentation and meeting with staff and residents in the larger unit and also visited all except one of the other units of the centre in the afternoon where she met with all of the residents living in these units. The remaining unit, a two bedroom apartment was visited by the second inspector. In total, inspectors met nine of the residents living in the centre and also met with nine staff and the person in charge of the centre.

Some residents were happy to show inspectors around their homes and all parts of the centre were observed during this inspection. Some of the units were seen to have pleasant back garden spaces and three residents in particular told inspectors that they enjoyed spending time in their garden areas. The larger unit had a covered area outside the back door with a table and seating that was used by one resident at lunchtime. There was also some vegetables observed growing in this space and the staff told the inspector that some residents enjoyed gardening. Another resident in a single occupancy apartment had access to their outdoor space

through a door in their bedroom and told the inspector that they loved spending time outside in their garden and had chosen the fence and garden décor themselves.

Aside from this this, residents also had access to a large campus with a number of green areas, a day service hub and a swimming pool. Transport was also provided for residents. Residents in the larger unit were provided with lunch from a main kitchen and prepared all other meals in their home. An inspector was present when lunch were delivered and served and staff told the inspector that residents had a choice of meals and that meals were prepared by the main kitchen in line with residents' specific dietary needs. These smelled and looked appetising and residents were seen to enjoy them. Residents in the smaller units were supported to cook their own meals in their homes and one resident was observed to be enjoying bacon and cabbage in their apartment when an inspector visited.

Residents were observed to leave and return to their homes for activities such as swimming, shopping, walks and visiting the day service hub and going for a picnic. One resident visited a sensory room in a local library on the day of the inspection. Staff who supported another resident on a 2:1 ratio told an inspector that this resident was now taking part in activities that they would not have had the opportunity to take part in a few years ago such as visiting shopping centres. This resident loved trainers and the inspector saw that they had numerous pairs of stylish trainers to chose from each day. Staff confirmed that residents had access to transport for activities. In their homes, there was evidence that residents enjoyed activities such as board games, TV, music, gardening and arts and crafts. One resident was observed to spend most of the day sitting in a specific seat in their home. An inspector was told this was this resident's preference. They were observed to be offered table top activities and staff were seen to interact regularly with this resident, who appeared to be content on the day of the inspection.

Overall, the findings on this inspection indicated that residents were afforded a safe service and had a good quality of life in this centre and that there was ongoing progress with the provider's plan for this centre. 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 on the quality and safety of the service being delivered.

Capacity and capability

Bawnmore campus is made up of five registered designated centres. Out of the five centres registered there are four that currently have restrictive conditions attached. The Chief Inspector of Social Services attached these restrictive conditions to come into compliance based on the provider's time bound plan. The provider made these commitments in the plan they submitted to the Chief Inspector dated 5 December 2023.

The Chief Inspector carried out an inspection of all five centres on the one day and as part of this inspection process the overall plan for the five centres was reviewed.The provider was making good progress, for example, two houses were completed to a very high standard taking into account the individual needs of residents and one house being refurbished to the specification of each resident to support their individual needs. The provider had also purchased a house in the community to transition a resident and a new development of three units in the community had started.

It was also observed and noted on the day of inspection that residents were well supported and there was positive interactions from staff. Residents were also accessing their community on a more regular basis and this will be discussed in the individual inspection reports linked to the campus. The provider was seeking accreditation from an external body in relation to the providers on going work for quality improvement for residents.

There was good evidence of oversight, governance and commitment from the provider. A member of the senior management team spoke about each house on campus and the profile of each resident, she demonstrated a very good understanding of the changing needs of residents and spoke about the evolving culture moving towards a social model of support.

It was also evident from speaking with residents that they were involved in the decisions about their new homes. This will also be discussed in the individual reports. The provider has been afforded time to come into compliance as issues relating to fire and premises have been significant and it was evidenced that works are being carried out in accordance with the plan. The provider demonstrated commitment to enhancing the quality of life of residents and this was observed and noted in all centres on campus along with very good supports that were evident from staff and management. This was observed on the day of inspection by noting the smiles, gestures and interaction from residents.

In relation to Muinin specifically, this inspection found that governance and management systems were in place that contributed to an overall safe and good quality service for residents.

The centre is registered with a restrictive condition requiring the provider to comply with a specific plan by 30 June 2026. This plan related to the campus overall and was aimed at addressing long-standing premises and fire safety concerns. The annual review for the centre completed in March 2025 set out the progress the provider was making with this plan. Two units of this centre had the required fire works completed. Two residents in one unit were identified as requiring individualised services that were to be planned, and there were plans for one resident in the remaining unit to move out to a community house as part of the de-congregation plan for this service. The management of the centre told an inspector that further works were planned as part of the overall plan for this campus to address ongoing issues and bring all units into compliance with the regulations concerning fire precautions and premises.

This was a short-notice announced adult safeguarding inspection and focused on specific regulations. The previous inspection of this centre took place in October 2023. Documentation reviewed during the inspection included resident information, safeguarding documentation, the annual review, the report of the unannounced six-monthly provider visit, an audit schedule, incident reports and team meeting minutes. There was evidence that the provider was identifying issues and taking action in response to them and that ongoing consideration was being given to safeguarding residents in this centre. However, some safeguarding allegations not been reported in line with the provider's own policy, although it was seen that action was taken in relation to these matters.

There was a clear management structure present and there was evidence that the management of this centre were maintaining good oversight and maintained a strong presence in the centre. Front-line staff and a Clinical Nurse Manager 1 (CNM1) supported the person in charge with day-to-day oversight in the centre. The person in charge and night CNM2 reported to an assistant director of nursing (ADON), who in turn reported to the Head of Integrated Services. This individual reported to a regional director of services, who in turn reported to a Chief Executive Officer and a National Board. Three of these individuals were also named persons participating in the management of the centre (PPIMs).

There had been a change in the local management of the centre since the previous inspection and a new person in charge had been appointed. This individual had remit over this designated centre only and was available to meet with an inspector on the afternoon of the inspection and the inspection was also facilitated by the CNM1 who was on duty in the centre on the day of the inspection. Both of these individuals were seen to be very familiar with the assessed needs of residents and knowledgeable about the care and support residents required.

The local management team and staff spoken with reported that they received good supports from the management structures in place and the person in charge told the inspector about the arrangements to provider had in place to support them in their role.

The centre was seen to be adequately resourced and staffing levels and competencies were seen to provide for a good quality and personalised service for residents. The training needs of staff were being appropriately considered and all staff had completed training in the area of safeguarding.

In summary, this inspection found that there was evidence of good compliance with the regulations in this centre and the findings of this inspection indicated that residents were being afforded safe and person centred services. The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

An inspector reviewed the rosters for a two week period for night and day in each unit and saw that staffing levels were in line with the statement of purpose for the centre and were sufficient to provide for a safe service for residents. The number and skill mix of staff was appropriate to meet the needs of residents. The staff team consisted of health care assistants and nursing staff. Nursing supports were rostered in the centre on a 24 hour basis. Two residents received 2:1 supports by day and 1:1 supports at night while two residents received 1:1 supports by day with shared staff supports at night. All of these residents lived in single occupancy apartments and these supports were seen to be provided on the day of the inspection. In the five bed unit generally two to three staff supported by day and one staff supported at night. Rosters indicated that staffing levels were maintained at these levels. As detailed under Regulation 5, additional staffing was put in place if required to meet the assessed needs of residents.

On the day of this inspection a member of cleaning staff was also observed in the larger unit in the centre and this meant that the staff team assigned to residents could focus on providing a person-centred service to the residents living there. Staff and local management in the centre reported that staffing levels were always maintained at safe levels. There was one vacancy reported by the person in charge at the time of this inspection and this was covered by regular relief staff. An overall low turnover was reported among the staff team and some staff had worked in the centre or on the campus for a long number of years. No agency staff were reported to be in use at the time of this inspection. Relief or unfamiliar staff member always worked alongside familiar staff and this promoted consistency of care for residents. One relief staff member working in the centre on the day of the inspection had recently commenced this role and told the inspector that they had received a good induction and were well supported in their role. The inspector observed that this staff member was rostered to work alongside the CNM1 and other regular staff and was familiar with the care and support needs of the residents that they were supporting.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training, as part of a continuous professional development programme. Staff were being provided with training appropriate to their roles and the person in charge was maintaining oversight of the training needs of staff.

The inspector reviewed records related to training for 34 staff that were also named on the centre roster. The records viewed indicated that staff had access to and had completed training in keys areas to provide for safe care and support for residents. This included training in safeguarding, manual handling, fire safety, and training to support staff in managing behaviours that challenge. Staff were also seen to have access to refresher training as required. The person in charge had also arranged

training in wheelchair clamping for some staff to support a resident who was temporarily confined to a wheelchair following an injury.

Staff spoken with confirmed that they had taken part in performance management meetings as per the provider's policy and that they were well supported by the management in the centre.

Judgment: Compliant

Regulation 23: Governance and management

This inspection found that the provider was ensuring that this designated centre was overall adequately resourced to provide for the effective delivery of care and support in accordance with the statement of purpose. For example, ongoing works were being completed to bring the centre into compliance with the regulations and residents living in the centre had access to good multidisciplinary supports.

Management systems were in place to ensure that the service provided was appropriate to residents' needs and took into consideration safeguarding practices. Such management systems also aimed to ensure the service's approach to safeguarding was appropriate, consistent and effectively monitored. There was a clear governance structure in place that set out the lines of accountability within the service. The provider had appointed a designated officer to promote and manage safeguarding within the service. This individual's details were displayed prominently in the service and all staff spoken with were aware of safeguarding procedures and how to raise a concern if needed.

Documentation reviewed by an inspector during the inspection such as provider audits, team meeting minutes, the annual review, and the provider's report of the most recent six monthly unannounced inspection, showed that the provider was maintaining good oversight of the service provided in this centre and that governance and management arrangements in the centre were effective.

An annual review had been completed in respect of the centre in March 2025 and the inspector reviewed this document. Unannounced six-monthly visits were being conducted by a representative of the provider and a report on the most recent of these visits was also reviewed. Both of these included evidence of consultation with residents and their family members and it was noted that this feedback was overall very positive. Action plans arising from these reviews were in place and there was evidence of completion of some of the identified actions.

Staff members spoken to in the centre reported that the person in charge was very supportive to the staff team and that they would be comfortable to raise any concerns to any of the management team.

Judgment: Compliant

Quality and safety

Safe and good quality supports were being provided to the ten residents that availed of residential services in this centre. The wellbeing and welfare of residents in this centre was maintained by a very good standard of care and support, provided by a consistent and committed core staff team. A good level of compliance with the regulations was found during this inspection, with ongoing non-compliance being addressed through the provider's plan. However, some issues in relation to reporting of allegations of abuse were found during this inspection and are discussed under Regulation 8. Also, some ongoing issues in relation to resident finances are discussed under Regulation 9.

Ongoing progress was being made so that residents would benefit from a premises that provided a good standard of accommodation and continued to meet their assessed needs in relation to their environment. Residents were participating in a variety of community and campus based activities of their own choosing. There were indications of a good staff culture that promoted safeguarding and rights in the centre. Safeguarding was discussed regularly with residents while individualised personal plans and positive behaviour support plans were in place that provided clear guidance to staff about how to support residents in a manner that promoted their safety and wellbeing.

Inspectors saw that on the day of this inspection residents were comfortable, content and happy in their home. Residents were offered choices and were being well supported by the staff team present. Risk management systems were in place that balanced the need to keep residents safe, while respecting the choices that residents made for themselves.

Records provided indicated that all staff working in the centre had completed training in safeguarding and underwent Garda Síochána (police) vetting. House meeting minutes and staff meeting minutes were viewed that indicated that topics such as safeguarding, complaints and rights were regularly discussed with residents and staff. Overall, staff spoken with during this inspection demonstrated knowledge of safeguarding procedures and complaints procedures while also presenting as being aware of these topics and how to manage any issues, should they arise.

Regulation 10: Communication

The registered provider was ensuring that residents were assisted and supported to communicate in accordance with their needs and wishes. Staff were observed to be very familiar with and respectful of residents' communication methods and styles.

Inspectors reviewed communication guidance in residents' personal plans and saw that relevant guidance was available to staff in relation to supporting residents to communicate.

From the sample of files reviewed it was seen that residents had communication passports in place which included information about their likes, dislikes and how they communicate. Easy-to-read guides and information were viewed in residents' files. Some of these were seen to be person specific, tailored for the individual based on their individual needs.

Rosters reviewed showed that familiar staff were allocated to the centre on an ongoing basis that would be familiar with residents' communication styles. Residents had access to media such as television, newspapers and radio.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had a risk management policy in place that provided for the identification, assessment and review of risk in the centre. The same policy also outlined control measures for specific risks as required including self-harm and accidental injury. Individualised risk assessments were viewed in residents' files and a local risk register was in also in place and reviewed by an inspector in one unit. Risk assessments were seen to be subject to regular monitoring and updating. Where risk was identified, efforts had been taken to reduce or mitigate the impact of this on residents. A risk assessment was seen to have been put in place following a recent incident where a resident had suffered an injury.

From a sample of risk assessments reviewed, the measures outlined to mitigate against risk in the centre had been put in place. For example, one resident presented with a very specific risk that could impact on themselves or others. To reduce the risk to other residents, this resident was supported to live in their own single occupancy apartment. There was clear measures outlined in this risk assessment to protect both the resident themselves and other residents. Guidance was available to staff to effectively support them to manage this risk and the measures outlined were observed to be in place on the day of the inspection. There was some evidence of positive risk taking also, with staff telling the inspector that they were now taking a resident to new places and trying out new things and some residents reporting that they had recently enjoyed a helicopter ride.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The registered provider was ensuring that arrangements were in place in the centre to meet the assessed needs of the residents using the centre. Ongoing consideration was being given to resident numbers to ensure a safe service could be provided to all residents, and staffing levels were considered based on the assessed needs of each resident and were seen to be appropriate to meet the needs of residents. The number of residents accommodated in the individual units that made up this centre had decreased over a number of years and all residents now had their own bedrooms. Inspectors were told about plans to enhance some parts of the centre to ensure it could meet the ongoing needs of residents with changing needs. The centre was suited for the purpose of residents aging in place and this would provide for consistency of care and support for residents.

The person in charge had ensured that the centre was suitable for the purposes of meeting the assessed needs of each resident. A number of residents were supported on a 1:1 basis and two residents were supported on a 2:1 basis. One resident had recently sustained an accidental fracture and additional staffing had been put in place temporarily to ensure that their needs could be fully met while they were recovering. The inspector saw that individualised plans were in place for residents. A sample of four residents' personal plans and files were reviewed during this inspection. Plans in place outlined residents' assessed needs and there was clear evidence of substantial multi-disciplinary input. Plans were being appropriately reviewed and updated to reflect changing circumstances and support needs while weekly review meetings were documented that outlined any changes. Support plans were in place that provided good guidance to staff about how best to meet residents' assessed needs. This meant that the care and support offered to residents was evidence based and person-centred.

There was some evidence that residents were provided with opportunities to participate in the person-centred planning process and some residents were able to tell inspectors about their goals and things they had achieved in the previous year. There was evidence that residents had been supported to set and achieve goals as part of the person-centred planning process within the previous year and there was evidence of progression, completion and ongoing review of goals. For example, residents had set goals that included getting a goldfish, taking the train to Dublin Zoo, going on a boat trip, working on cooking skills etc. Some residents had set a goal to take a helicopter ride and had achieved this. Progress with goals was documented during weekly review meetings for each resident.

Goals were identified based on residents' assessed needs and preferences. Where residents communication skills impacted their ability to set goals for themselves, consideration was given to residents' preferences and capacities when setting goals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Overall, the evidence found on this inspection showed that positive behaviour support was well managed in this centre. This meant that residents could be supported in a manner that met their assessed needs and were provided with appropriate care and support to safeguard themselves and others from the impact of behaviours of concern.

The person in charge had ensured that staff had up-to-date knowledge and skills to respond to behaviours of concern and support residents to manage their behaviour. When reviewing residents' information, it was seen that guidance was included within this on how to support residents to engage in positive behaviour. Positive behaviour support plans and practice protocols were in place where required to guide staff. This guidance included particular strategies to adopt with residents if required. Incident records reviewed in the centre, indicated that such guidance and strategies were being followed in practice.

Efforts were made to ensure staff were familiar with the plans in place. Good practice was noted that would contribute to staff awareness of the plans in place. For example, new staff working in the centre would always be rostered alongside a familiar staff member. This provided for consistency of care and ensured that all staff working in the centre were familiar with how best to support residents in line with their specific assessed needs, thereby reducing the likelihood and potential impact of residents presenting with behaviours of concern. Training records indicated that staff had access to and had completed training in this area also. Records of regular safety intervention practice drills were also viewed that showed that staff regularly practiced the practical skills learned during this training. Restrictive practices in place were also reviewed by staff during the weekly review meetings documented for each resident.

There were a number of restrictions in place in all units of the centre. Most of these were in place to safeguard residents from specific risks. A sample of restrictive practice logs were viewed in two units and these were seen to be reviewed regularly by a multidisciplinary team.

Judgment: Compliant

Regulation 8: Protection

The findings of this inspection indicated that the registered provider had appropriate measures in place to protect residents from abuse. The person in charge had ensured that all staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. The provider had a system in place to respond to and notify relevant bodies of any concerns raised. However, the person in charge had not initiated and put in place an investigation in relation to all allegations of abuse in line with the providers' policies.

A review of incident reports for a six month period and a further review of a residents' documentation found that two incidents had occurred where a resident had made what appeared to be unfounded allegations of a safeguarding nature towards a staff member. The evidence reviewed showed that these allegations had been reported by staff to management and showed action was taken to support the resident with accessing mental health supports in response to these. However, these allegations had not been reported to the designated officer in line with the provider's policy. This meant that these allegations were not fully investigated or screened out and were also not reported to the Chief Inspector or the Health Service Executive Safeguarding and Protection Team as required. While safeguarding was a regular topic for discussion on team meeting agenda's and staff presented with an overall awareness of the reporting procedures in place, some further improvements were needed to ensure that all of the staff and management working in the centre were fully aware of what constitutes a safeguarding concern and how to respond to this in line with the provider's policies and the regulations.

Aside from this, there was evidence that overall there was good practice occurring in this centre in relation to safeguarding residents. Guidance on supporting residents with intimate personal care was contained within residents' personal plans. Safeguarding plans were in place where safeguarding risks had been identified while a forensic risk assessment and plan was in place for one resident. Safeguarding measures in place in the centre included the provision 1:1 or 2:1 staffing for residents that required this support. Staff rotas reviewed, observations on the day of this inspection, and discussions with staff indicated that this was in place at all times as required. A number of residents lived in single occupancy apartments in line with their assessed needs. Staff working in the centre had completed relevant safeguarding training. Staff and management spoken with during the inspection reported that residents were safe and well protected in the centre. Residents spoken with also told the inspector that they felt safe in their home.

There was evidence viewed in a sample of residents' documentation that demonstrated that they were provided with information and education for self-care and protection. Regular house meetings were documented as taking place and the minutes of these included details of discussion around safeguarding matters and rights.

From documentation reviewed in the centre including incident reports, and speaking to residents, staff and management, the inspector saw that incidents that occurred were responded to and ongoing learning following any incidents or near misses that occurred in the centre. Assurances were provided by the provider that all staff working in the centre had been Garda vetted.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Overall, residents were seen to be treated with dignity and respect in their homes. Staff interactions were observed to be kind and respectful and take into account residents communication preferences. Residents were seen to have choices in relation to the activities that they took part in. For example, a resident showed the inspector an activity schedule board that they used to plan their week and told the inspector that they had chosen not to take part in a specific activity listed for the day of the inspection because they were tired following a trip to Knock the previous day.

Residents were observed to leave and return to their homes for activities such as swimming, shopping and walks and residents and staff and residents told inspectors about some of the activities that they enjoyed. There was also evidence in residents' personal plans and other documentation that residents were being provided with regular opportunities to take part in activities and achieve personal goals in accordance with their wishes.

There was evidence that residents were consulted with in the centre. For example, regular resident meetings were documented and easy-to-read consent forms in relation were viewed in the sample of residents' files reviewed. Efforts had been made to consult with and educate a resident about a particular restriction in place for health reasons and to provide the resident with the autonomy to decide if they wished to adhere to this restriction. For example, the resident had an easy-to-read plan in place around this and showed and told an inspector about this. Staff were seen to refer the resident back to this document frequently, while also reminding the resident that it was their choice to adhere to this plan or not.

However, some ongoing issues continued to impact on residents rights:

- Institutional type features such as perspex viewing panels from the kitchen to communal areas were still present in three of the bungalows. This did not fully protect the privacy and dignity of residents.
- During the October 2023 inspection, it was identified that residents in this designated centre had bank accounts with the one banking organisation and that there was no evidence to support that the residents were involved to select a bank of their choosing, were consulted and had the freedom to exercise control in relation to this. The provider had implemented actions outlined in the compliance plan response sent to the Chief Inspector following the October 2023 inspection. This included ensuring residents' bank statements were scanned and retained in the personal financial file of the relevant residents. The provider also made available to the Chief Inspector following this most recent inspection communication and other records which demonstrated that the provider had raised issues related to residents' bank accounts to other bodies since the October 2023 inspection. During the current inspection, it was indicated that matters related to residents' bank accounts remained unchanged and that this had been identified as being a restriction on residents. The provider had completed a review of the "Policy on the handling of the personal assets of adults supported by the services". This review included the addition of a restrictive practice decision making record within the policy which acknowledged aspects of the policy are

restrictive for residents. However, the policy also referenced that restrictions were being kept to a minimum while endeavouring to ensure adequate arrangements were in place to protect resident's finances.
- The person in charge told the an inspector that the issues highlighted in the previous inspection in relation to one resident having access to their own finances remained unresolved and the resident was still not in receipt of their own disability allowance. The person in charge told the inspector that this resident always had access to money as required and that there was no significant day-to-day impact on the resident due to the arrangements in place.

Judgment: Substantially compliant

Regulation 17: Premises

Previous inspections of this centre have found non-compliance in relation to premises and as mentioned in the opening section of this report, the provider has a time-bound plan in place to address this non-compliance and has been afforded time to come into compliance. It was evidenced that works are being carried out in accordance with the plan and some works had been completed such as an upgraded kitchen and bathroom area. An inspector was also told by staff in the centre about upcoming works that were planned for some areas. Notwithstanding this, the registered provider had not yet ensured the premises of the designated centre was designed and laid out to meet the number and needs of residents nor kept in a good state of repair internally. The provider had also not yet fully ensured that matters set out in Schedule 6 of the regulations had been provided for. Specific issues identified during the inspection included:

- A number of items of furniture throughout the centre were seen to be worn, chipped, and dated.
- Paintwork was chipped and peeling in a number of areas of the centre
- Some areas of the centre were seen to be cluttered and lacking adequate storage. One unit accommodated five residents. Often three staff would also be present. Bedrooms were small and the small visitors room was seen to be used to store mobility equipment and continence wear. This meant it was not readily available to residents to use or enjoy as intended or as an additional communal area. The kitchens in all units were seen to have restrictions to access in place for various reasons. For these residents, the main communal area was often the only place they could spend time in. Although this room was large, given the number of residents and staff, this would not always provide for a peaceful and relaxing environment for residents. Also, resident files, medications and office equipment were seen to be stored in a small utility/laundry room that was accessed by keypad. This meant that residents were restricted in accessing laundry facilities independently and also presented some risks. For example, due to the type of electrical equipment in this room this would be a higher risk area for an outbreak of fire which would

be harder to control given the amount of flammable materials present due to paperwork being stored in this room.
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 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 17: Premises	Not compliant

Compliance Plan for Muinin OSV-0007846

Inspection ID: MON-0046451

Date of inspection: 14/05/2025

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 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • Following the inspection, a meeting was held on 15/05/2025 with the Designated Officer, Assistant Director of Nursing, Head of Integrated Services and the Person in Charge. • A retrospective CP1 was completed at this meeting in relation to the two incidents identified in the report. These incidents relates to the staff member. • 16/05/2025 Designated officer met with the resident who made the allegation • Preliminary screening carried out, sent to the Safeguarding and Protection team, and concluded no grounds for concern. • The resident's behaviour support plan has been updated on 11/06/2025.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • MDT to be arranged to discuss the use of viewing panels and to determine if they are required on an ongoing basis. • The BOCSILR Policy on the Handling of the Personal Assets of Adults Supported by the Services includes a permission form which supports people to opt in or opt out of support from the BOCSILR in the management of their personal assets. • No resident is restricted from managing their own personal assets if they choose to opt out of support from the BOCSILR. Residents may choose to manage their personal assets independently, with a decision supporter or another person outside of the services should they choose to. • In order to support people to make an informed decision information is provided to them regarding the nature of the support that the BOCSILR can offer to them in terms of the management of their personal assets.	

• At present the BOCSILR have identified one suitable deposit account and one suitable current account through which support can be offered in a safe manner both for the person supported and for staff.
• The BOCSILR Policy on the Handling of the Personal Assets of Adults Supported by the Services clearly sets out the limitations on direct access to personal assets inherent in the use of this type of account in order to ensure full transparency when a person is choosing to opt in or opt out of support.
• Every effort is made to mitigate the impact of the restrictions on direct access to personal assets inherent in the use of this type of account and these are set out in the policy.
• Limitations on direct access to personal assets inherent in the use of this type of account as well as those in place to minimize the vulnerability to misappropriation of funds are not notified to the regulator as restrictions as each person support has the right to opt in or opt out of support.
• The BOCSILR is committed to exploring all alternative accounts that may facilitate less restrictive direct access to personal assets for people supported who opt in to support from the BOCSILR. In this regard the engagement with the assisted decision making department with the HSE seeking guidance in assisting residents in relation to banking arrangements was commenced on 11/11/2024. Engagement with banking institutions has also been perused to identify possible suitable banking products that would be a less restrictive alternative for residents within the service.
• One resident who is not in receipt of her disability allowance is supported by Social worker and Person In Charge who advocate regularly with the family. The family however do make a contribution to meet the resident's needs.
• Risk assessment completed on 11/06/2025. This determined that there is greater benefit to person supported having positive family engagement over access to finances. The consistent and regular contact and visits with family is of utmost importance to the resident.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Maintenance meeting held with facilities on 9/06/2025 to prioritise minor maintenance to be completed in the context of the overall Bawnmore plan. This included a walkabout of the Designated centre with the ADON to inform this discussion.
• Progress on the plan submitted to HIQA in respect of Fire safety, building upgrade and Decongregation.
• We are working towards full compliance, if there are delays outside of our control we will be engaging with the Chief Inspector to find a solution.
• The intention is that all residents in this designated centre will reside in high quality homes once this plan is fully realised.
• New bathroom is currently been upgraded in a fire compliant bungalow which will provide storage for incontinence wear.
• Head of Integrated Services to meet with Facilities to explore the possibility of

developing an outdoor area to be purchased for utility and laundry facilities.
• Laundry and utility would then be converted to an office space for storage of documentation. In the meantime files will be removed from the laundry. This is reflected in the risk assessment on risk of fire in utility.
• The intention is to reduce the number of residents living in this bungalow and one resident is on the waiting list for an appropriate vacancy when it arises.

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Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/06/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/06/2026
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/06/2026
Regulation 08(3)	The person in charge shall initiate and put in place an	Substantially Compliant	Yellow	11/06/2025

	Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	31/12/2026
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Substantially Compliant	Yellow	31/12/2026
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care,	Substantially Compliant	Yellow	31/12/2026

	professional consultations and personal information.			