



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

Issued by the Chief Inspector

Name of designated centre:	Mullingar Centre 7
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	14 January 2026
Centre ID:	OSV-0008491
Fieldwork ID:	MON-0049186

About the designated centre

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

Mullingar centre 7 can accommodate up to three individuals male or female in a single storey building on the outskirts of a town. Only residents aged 18 years and above will be accommodated in the centre. The residents are supported by a team of support workers managed by a person in charge. The person in charge manages three centres including this centre and splits their time evenly between the three centres.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3
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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 January 2026	09:45hrs to 18:35hrs	Karena Butler	Lead

What residents told us and what inspectors observed

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

While the service was performing well in many areas, the inspection did identify some areas for improvement to ensure the safety and care in the centre would be consistently met. One regulation was found to be not compliant as some of the records in the centre required a number of improvements to ensure they were adequately maintained. Without improvement in the oversight and accuracy of records, this could put the residents at risk of inconsistent care.

Despite the positive atmosphere, the inspector observed that the quality of life for residents was impacted by issues in relation to the back garden, and the follow-through on communication recommendations. For example, it was communicated to the inspector that a resident was observed to be disappointed that they could not use the swing in the back garden, which had been broken for a significant period. Additionally, governance systems required improvement, for example; ensuring staff training and records were accurately maintained. These points are discussed in detail later in this report.

The inspector had the opportunity to meet and observe the three residents that were living in the centre. They had alternative communication methods and did not share their views with the inspector. Instead, the inspector observed them in their home at different times during the inspection. They appeared relaxed and comfortable in the presence of the staff on duty.

One resident attended a salt room for a session in the morning with their support staff. In the afternoon all three residents went out for lunch. Afterwards, one resident went shopping and the other two residents went for a walk around a rugby pitch. Staff communicated that the residents had a nice day.

The inspector had the opportunity to speak with the four staff on duty, the person in charge, and the previous person in charge. The current person in charge took over the role in December 2025. Staff were observed to be calm and respectful in their interactions. For example, a staff member was observed to ask a resident if they wanted any help when the resident was going to the bathroom.

The provider had arranged for the majority of staff to have training in human rights. A staff member spoken with communicated how they had put that training into everyday practice. They felt that prior to having the training they may not have afforded residents much time on their own and possibly over supervised them. Now, since having the training they tried to be more conscious of residents' right to

privacy. They now had a better appreciation for the fact that the residents did not require eyes-on supervision at all times while in their home.

The inspector had the opportunity to speak with two residents' family representatives on the day of this inspection and feedback received was positive. The family representatives communicated that they felt their family members were safe and had their assessed needs met by the staff team. They said they had no concerns at present and that if they were to have a concern they would feel comfortable raising it with staff or management. They felt they would be listened to. Both felt that the staff team knew their family members well. One representative said that they felt the staff were 'responsive to all of their family member's health needs'. They said that 'the staff have great patience, were great with their family member and that their family member loved the staff'. Another family representative said their family member was 'blooming since moving into' the centre. They felt that staff were respectful of their family member and that staff were 'so pleasant'. They felt the house was very clean so that you could eat your dinner off the floor.

The inspector observed the house to be clean, tidy and it appeared homely. The sitting room and activity room had televisions for use.

Each resident had their own bedroom. The bedrooms had adequate storage facilities for any personal belongings. There were personal pictures displayed in bedrooms and in different areas of the house.

The bathroom had been renovated since the last inspection report, and the outside path had been repaved, both were completed as part of the providers compliance plan arising from the previous inspection of this centre. The works completed helped improve the aesthetic of the house as well as the suitability of the premises for the residents.

There was a front garden mainly used for parking. The back garden contained a table with benches, a gazebo, and a basketball net that residents could use in times of good weather. However, the garden was not fully suitable for the residents' interests and preferences at the time of this inspection and therefore improvements were required.

At the time of this inspection there were no visiting restrictions in place and there were no vacancies or recent admissions to the centre.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

This inspection was unannounced and was undertaken following the provider's application to renew the registration of the centre. This centre was last inspected in January 2024.

The findings of this inspection indicated that the provider had the capacity to operate the service within substantial compliance with the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations). The management team, which included the person in charge, was operating the service in a manner which ensured the delivery of care was meeting the residents' needs.

The inspector reviewed the provider's governance and management arrangements and found that while systems were in place, oversight was inconsistent in some areas, specifically regarding staff training and the maintenance of records. Notwithstanding that, staff were found to be in receipt of training that would facilitate them to effectively support the residents, for example medication management.

From a review of a sample of rosters across three months, the inspector found that there was adequate staffing in place to meet the assessed needs of the residents.

The provider ensured that the centre was sufficiently insured against risk to the residents. In addition, there was a statement of purpose completed and made available in the centre that contained prescribed information as required by the regulations.

Registration Regulation 5: Application for registration or renewal of registration

As required by the registration regulations, the provider had submitted an application to renew the registration of the centre. This included submission of required prescribed documents. For example, the provider had arranged for a revised statement of purpose, and residents' guide to be submitted for review.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was employed in a full-time capacity and had the necessary experience and qualifications to fulfil the role. For example, they held a qualification in social care. They demonstrated a good understanding of the residents and their needs, for example what healthcare and behavioural support needs the residents required support with.

They were also found to be aware of their legal remit to the regulations and were responsive to the inspection process. For instance, they were aware that it was their responsibility to ensure the reporting of any adverse incidents that occurred to the Chief Inspector.

They were responsible for this designated centre along with additional responsibilities as area leader for the provider. They attended the centre regularly to provide oversight and provide informal supervision for staff. They were supported in this role by a team leader.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that the staffing arrangements in the centre were effective in meeting residents' assessed needs.

The inspector reviewed a sample of rosters over a three-month period from November 2025 to January 2026. The review demonstrated that planned and actual rosters were being maintained. While the centre did not have a full staffing complement and required two staff posts to be filled, one of which was a recent resignation, cover for those shifts was undertaken by familiar consistent relief or agency staff. The provider was actively recruiting to fill the positions. In the interim, the person in charge had arranged for a regular relief staff member to be block booked exclusively for this centre while recruitment was on-going. This arrangement supported continuity of care for the residents and reduce the risk of them receiving inconsistent support from unfamiliar staff.

The staff on duty on the day of the inspection were observed to be gentle and respectful towards the residents. One family representative stated that 'staff treated their family member very nicely. That they have a trust relationship with their family member and that all staff were brilliant with their family member.'

Staff personnel files were not reviewed at this inspection. However, the inspector reviewed a sample of three staff members' Garda Síochána (police) vetting (GV) certificates as well as one police clearance certificate. Two staff members' GV were completed within the last year and the third staff had applied recently for re-vetting. This demonstrated that the provider had arrangements for safe recruitment practices.

Judgment: Compliant

Regulation 16: Training and staff development

The provider provided staff with opportunities to access a suite of training and meet the requirements of this regulation. While some improvement was required with the oversight of staff training, this is being actioned under Regulation 23: Governance and management.

A review of certification of three training courses for all staff that worked in the centre demonstrated to the inspector that staff received training in areas determined by the provider to be mandatory as well as refresher training. Staff had also received training in additional areas specific to residents' assessed needs.

Examples of the training staff had completed included:

- safeguarding vulnerable adults
- medication management
- feeding, eating, and drinking
- epilepsy awareness and emergency epilepsy medication administration
- hand hygiene
- Autism awareness
- fire safety.

The person in charge had reviewed training needs for 2026 and had a plan in place to address deficits found.

Staff had received additional training to support residents. For example, staff had received training in human rights. Further details on this have been included in the 'what residents told us and what inspectors observed' section of the report.

From a review of two staff members' files, this confirmed to the inspector that supervision was occurring as per the minimum frequency decided by the provider and that it was an opportunity to raise concerns if any. The new person in charge had a schedule in place for 2026 that would ensure that staff received supervision on a more frequent basis. This would facilitate more opportunities for staff to raise concerns they may have

Judgment: Compliant

Regulation 21: Records

This inspection found that although the majority of records were accessible, improvements were required to ensure records were accurate and up to date.

For example, a healthcare plan was found to contain outdated information guiding staff to support a resident to have an incorrect maximum dosage of liquid in a day when it had been significantly reduced months prior to the review of this plan. In addition, the plan guided staff to complete weekly blood pressure checks on the resident; however, this had been reduced to every six months and the plan did not reflect this change. This created a risk that a resident would not be provided with

consistent care in line with their assessed needs. While staff on duty were familiar with the most up-to-date information, residents were at an increased risk as part-time staff supported the residents on a more infrequent basis.

A resident's personal emergency evacuation plan (PEEP) had not been updated to reflect that they refused to evacuate during an hours of darkness drill with minimum staffing levels on. This could put the resident more at risk in the event of an emergency if staff were not familiar with this information and how best to encourage them to leave in the event of a fire. While the plan had only been recently updated, the update did not involve all relevant information or the learning from that refusal from August 2025. This did not assure the inspector that reviews of residents' support plans were always thorough or an accurate reflection of each resident's current support needs. Although the PEEPs were updated during the inspection, they contained generic guidance on refusal to evacuate applied to all residents, rather than specific guidance related to the resident who had actually refused. This risked misleading staff regarding the other residents' evacuation histories.

In addition, the records of fire drills required improvement. While the previous person in charge communicated to the inspector that an evacuation was practiced using an alternative route to the front door, the drill records only evidenced the use of the front door. The records did not demonstrate that all escape routes could be used safely. Furthermore, while the provider submitted, post inspection, evidence that the fire alarm coverage was suitable for the centre, the inspector found conflicting evidence in the centre. Therefore, more attention was required to the oversight of records that related to fire safety to ensure accuracy of information provided.

One resident's positive behaviour support plan did not include information on how to support them with their sensory seeking behaviours which often resulted in them receiving minor injuries. While the information had been explored with the behaviour therapist and staff were familiar with the information, it was not included in the guidance plan to staff. Therefore, this had the potential for inconsistent care being provided to the resident especially when they were being supported by some part-time staff.

Maintenance of safeguarding records required improvement. For example, evidence that a safeguarding plan had been completed and that the incident was closed by the external agency was not contained within the designated safeguarding folder. Consequently, the person in charge had to source this information from multiple different locations during the inspection.

From the review of a sample of rosters, they were not fully maintained with all applicable information as they did not always contain the full names for part time staff. The inspector observed that an agency staff member was only recorded by their first name and a relief staff had their first name along with the first letter of their second name recorded. This would make it more difficult to ascertain who worked what shifts in the event of an investigation.

Overall, while the majority of records were easily accessible for the inspector to review, other information was more difficult to source and involved the person in charge and the previous person in charge searching for information to produce as evidence. Additionally, while all support plans had been reviewed recently as per the requirements of the regulations, the inspector was not assured by the quality of those reviews due to inaccurate or missing information, which increased the risk of residents receiving inappropriate support.

Judgment: Not compliant

Regulation 22: Insurance

As per the requirements of the regulations, the provider had ensured that the centre was adequately insured against risks to residents, as well as the building and contents were insured. Evidence of the insurance was submitted to the Chief Inspector.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that while the provider had governance and management arrangements in place, oversight was inconsistent in some areas. For example, improvement was required with regard to oversight of staff training, and that audit actions, such as those related to boiler servicing and spot checks, were completed in a timely manner.

There were clear lines of authority and accountability in this service. The centre had a clearly defined management structure in place which was led by the person in charge. A staff member spoken with was familiar with the reporting structure, and the on-call system for out of normal working hours support.

However, improvement was required of the provider's oversight of staff training. For instance one staff member's fire safety training expired in July 2025. This was highlighted by the previous person in charge to the training department in September 2025; however, by that time the staff member's training had been expired nearly two months. In addition, there was a delay in the staff member receiving their training once identified as they did not complete their refresher training until January 2026.

Furthermore, the inspector noted that the staff member's infection prevention and control (IPC) training was expired since July 2025 and they had never completed required IPC training related to standard and transmission-based precautions. The

new person in charge had already identified the gaps in staff training and the staff member was scheduled to complete the required training within the coming days of this inspection. In relation to one staff member who engaged in some lone working shifts, their basic first aid training was expired since September 2025 with no scheduled date for when they would complete this training. The absence of up-to-date training in fire safety and basic first aid increased the potential risk to residents in the event of an emergency. The absence of up-to-date IPC training would increase the risk to residents of developing a healthcare-related illness.

In addition, a review of the boiler service record from 16 December 2025 noted that the professional could not access the oil tank. There was no evidence that this was known or followed up on by the current or previous person in charge. Therefore, the inspector was not assured that there was appropriate oversight over servicing records to ensure any actions would be followed up within a timely manner.

In addition, as previously stated, the inspector identified that a PEEP failed to accurately guide staff following the resident's refusal to evacuate during a practice drill. While the PEEP was amended on the day of this inspection, further oversight of fire safety documentation was required to ensure appropriate fire safety practices were in place and were effective.

There were many audits being completed on different aspects of the service to facilitate a safe and effective service. For example, the provider had arrangements in place for an annual review, of which the inspector reviewed the 2024 version and the 2025 version was due for completion at the end of January 2026. There were arrangements for unannounced provider led visits every six months and the inspector found that they were taking place as required, evidenced by a review of the reports from May and November 2025. In addition, there were a number of monthly audits completed by staff members on medication management, finances, vehicle checks, and health and safety. The person in charge completed spot checks on different topics and identified actions for completion. However, it was not evident from review of a sample of two of those spot checks if all actions were completed.

The inspector observed from a review of the records of the team meeting minutes that they were occurring monthly. A review of five team meeting minutes, February, July, November, December 2025, and January 2026, demonstrated that any incidents that occurred within the centre were reviewed for shared learning with the staff team. Other examples of topics discussed at the meetings included, a discussion on the residents, safeguarding, and IPC.

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

Overall, while there were many appropriate systems in place further improvements were required to aspects of oversight to ensure the residents were provided a quality, safe service.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider prepared a statement of purpose which was up to date, accurately described the service provided and contained all of the information as required by Schedule 1.

For example, it contained information on the organisational structure, and fire precaution arrangements in the centre.

Judgment: Compliant

Quality and safety

Overall, this inspection found that the residents living in this service were supported in line with their assessed needs. However, some improvements were required in relation to communication, and the premises.

While staff were familiar with how residents communicated, improvements were required to ensure staff themselves were being effective communication partners and following through on all professional recommendations.

The inspector observed the house to be clean and tidy which also facilitated the arrangements for good infection prevention and control (IPC). However, improvements were required to the garden to ensure it was appropriate and suitable for residents' use.

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

There was a residents' guide available in the centre that contained all of the required information as prescribed by the regulations.

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

For example, staff were familiar with residents' healthcare support needs and were providing care in line with their assessed needs. Where required, residents were supported by a behaviour therapist to help support them and guide staff should the resident be experiencing periods of distress. There was a safeguarding policy in place to guide staff should they have any safeguarding concerns. Residents were

supported to have access to their personal possessions and their possessions were safeguarded. The inspector found that the residents appeared to engage in regular community access in line with their preferences.

Regulation 10: Communication

For the most part, communication was facilitated for residents in accordance with their needs, preferences and assessed needs. Some improvement was required to ensure that recommendations from assessments were fully followed through on. In addition, to ensure that visual aids are used consistently and appropriately. Therefore, this regulation was found to be substantially compliant.

A referral had been made for the three residents to be re-assessed by a speech and language therapist (SLT) to ensure they were receiving appropriate supports with their communication. The residents had previously received assessments by an SLT with recommendations made. For instance, to use visuals when communicating with the residents, and to use some core words from a simplified manual sign language. One assessment had recommended this since 2015 and again upon re-assessment in 2024. However, while two staff spoken with were familiar with some of the recommended core signs they were not familiar with the remainder. Therefore, it was not evident that all staff were made familiar with or implementing all recommendations to promote the residents' understanding.

The provider had arranged for some staff to have training in this manual sign language.

From a review of two residents' files they had documented communication needs in a communication dictionary as well as in other documents to guide staff as to what they may be trying to communicate and support effective communication. For example, the inspector found guidance information with regard to communication in the residents' hospital passports as well as a "Disability Distress Assessment Tool" assessment to assess how the residents express contentment or how to know when they were distressed.

While good information was available, the person in charge had identified that communication plans required a thorough review and further elaboration. This was necessary to ensure staff could act as effective communication partners and support residents to communicate their needs effectively.

The inspector observed there were visuals available in the centre to aid residents' understanding and promote choice of their daily routine and food choices. There was a visual roster on the notice board to support the residents to understand what staff would be working in their home on that day. However, the meal and activity planners for the day were blank apart from the breakfast entry. As the residents in this centre did not communicate verbally, a SLT had recommended the use of

visuals for the residents. However, they were not being used consistently to support effective communication and understanding.

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

Judgment: Substantially compliant

Regulation 12: Personal possessions

Residents had access to their personal belongings and there were systems in place to support their personal possessions to be safeguarded.

The inspector found that the residents in this centre had personal financial accounts. Two residents were trialling a deposit card system to facilitate easier access to their funds. The third resident had a bank account in their own name with a bank card to ensure that they always had access to their money when they needed it.

A review of one resident's inventory list demonstrated that a record of all the resident's belongings was maintained in the centre. This included a picture of each of the items to provide clarity of what items were being recorded. This helped ensure residents' personal possessions were safeguarded and for their use only.

From a review of the audits completed in the centre in 2025, the inspector observed that financial audits were completed every second month of the residents' finances. This was to ensure their money was accurately accounted for and to assess the systems in place to safeguard their money to ensure that they were working.

The inspector found, from a review of two residents' finance records from the first to the 14th January 2026, that staff were completing daily balance checks to ensure the residents' money was safeguarded. The inspector counted one resident's money in the presence of a staff member and found that it matched the amount recorded on the finance recording sheet. This assured the inspector that residents' finances were safeguarded.

Judgment: Compliant

Regulation 13: General welfare and development

This inspection found that the residents were supported to participate in activities of interest in their home and in the community. In addition, they were supported to maintain relationships with family.

Both family representatives spoken with said they felt welcome to visit the centre. One family representative stated that 'staff go out of their way to bring their family member to visit weekly'.

From a review of the two residents' files over a two-week period in January 2026 and from speaking with staff on duty, the inspector observed that residents were being offered activities that interested them. Ranging from reflexology, trips to the cinema, going for walks, visiting family, and horse riding.

Residents were supported to set and achieve personal goals to enhance their quality of life. For example, from a review of a sample of two residents' goals, they were undertaking goals related to planning individual holidays for 2026 and one resident was being supported to arrange and attend lunch out alone with their brother which was very important to the resident. A trial of this arrangement towards the end of 2025 had been successful.

Judgment: Compliant

Regulation 17: Premises

The layout and design of the premises was appropriate to meet residents' needs. The premises internally was found to be in a state of good repair and was observed to be tidy. The facilities of Schedule 6 of the regulations were available for residents' use. For example, there was access to cooking and laundry facilities. However, improvements were required to the back garden to ensure it was fully accessible for residents and that recreational equipment provided was in working order. Therefore, this regulation was found to be substantially compliant.

Some areas were observed by the inspector to have developed minor patches of mildew; however, the person in charge arranged for this to be cleaned and treated on the day. While some internal painting was required, this was self-identified by the provider and had commenced the day of this inspection with expected completion within days of the inspection.

From observations, staff discussions, and a review of residents' feedback questionnaires, the inspector found that some work was required to the back garden to ensure that it was suitable for the residents' preferences. One resident liked to walk a particular route in the garden; however, they had not been able to do that during the damper weather as the route was not paved and the ground was too muddy.

Another resident liked to use the swing; however, it was broken for over a year and was not due to be repaired until after the provider completed renovations on the back garden. The resident was reported to enjoy using the swing and it appeared to relax them. There was no set date for when the renovation works would be

completed. It was reported to the inspector that one resident regularly went out to the garden to see if they could use it and appeared sad when they could not.

There were facilities in place to support hand hygiene, such as hand wash and disposable towels. There was a colour-coded system in place for the cleaning of the centre to minimise the chances of residents receiving a healthcare-related illness. For example, there were colour-coded cloths, mops and buckets in place. A recent internal audit had identified the storage location of the mops and buckets as an area for review, to ensure compliance with infection prevention and control (IPC). This demonstrated that appropriate oversight and consideration was given to oversee IPC in the centre.

While the inspector found some personal protective equipment stored inappropriately on the concrete floor of the hot press, the team leader for the centre arranged for it to be moved during the inspection to a more appropriate location.

Each resident had their own bedroom individually decorated with sufficient space for their belongings.

Judgment: Substantially compliant

Regulation 20: Information for residents

There was a residents' guide available in the hall of the centre that contained the required information as set out in the regulations. For example, it explained to residents where they would find details on the terms and conditions related to residency, and where they might access inspection reports.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable fire safety practices in place which included staff having received training in fire safety.

From a review of three fire practice drills, the inspector found that monthly fire evacuation drills were being completed in order to familiarise the residents with safe evacuation in the event of an emergency.

During the most recent hours of darkness drill with minimum staffing arrangements in August 2025, one resident refused to leave the centre. The inspector found that the resident's PEEP was not updated to include this information or to guide staff on how to respond should the resident refuse again. This was despite the plan being reviewed in January 2026. However, the plan was amended on the day of this

inspection to include the majority of information required and therefore this was actioned under Regulation 21: Records and Regulation 23: Governance and management.

There were fire containment doors in place fitted with self-closing devices. The majority of fire containment doors were tested to see if they closed properly and of the five doors tested all closed effectively which would support fire containment in the event of an emergency.

The inspector found that there were detection and alert systems, emergency lighting and firefighting equipment in place, each of which was regularly serviced.

The inspector sought clarification regarding the fire alarm system coverage. Post-inspection evidence confirmed the coverage was appropriate. However, as the records held in the centre on the day of inspection were inaccurate, this issue was actioned under Regulation 21: Records.

Judgment: Compliant

Regulation 6: Health care

Residents were supported in line with their healthcare needs and had access to allied health professionals when required.

Two staff spoken with were knowledgeable with regard to required healthcare supports for residents.

Where applicable, there were healthcare plans in place to guide staff as to what supports residents required, for example an eating, drinking and swallowing plan, and epilepsy care plans and associated emergency epilepsy medication administration protocol. The protocols were signed off by each resident's general practitioner (GP).

One resident required the fluid intake to be limited and the inspector found that staff were familiar with this and there was a recording system in place to track the resident's fluid intake to ensure it was in line with their assessed needs.

While one plan required some minor amendments to ensure information was up to date, this was actioned under Regulation 21: Records as some information recorded was incorrect; however, it was known by staff.

Based on a review of two residents' files, they were found to have access to a range of allied healthcare services, such as a GP, dermatologist, and a physiotherapist when required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported to experience best possible mental health. Where required they had access to the support of a behaviour support therapist.

From a review of one resident's file, the inspector observed that where required, residents had a positive behavioural support plan in place which was reviewed by the behaviour specialist. It was found to have been reviewed in January 2026 to ensure accuracy of the information provided to staff. This in turn ensured that the resident was receiving up-to-date appropriate supports. While further information was required in the plan, this was actioned under Regulation 21: Records due to some applicable information that was known to staff not being evident to the inspector in the plan itself.

The behaviour support plan was found to outline strategies that staff needed to follow to support the residents in times of distress.

For example:

- responses to when the resident is becoming anxious or experiencing behaviour that may cause distress to themselves or others
- the response to be taken and what it may look like when the resident is returning to baseline.

In addition, the person in charge had arranged for a positive behavioural supports workshop to take place in February for the staff team with the behaviour therapist to ensure the staff are appropriately guided and being consistent in their approach.

The inspector found that previous restrictive practices that were in place, such as a locked chemical press, were no longer in use as deemed not applicable for the residents living in this centre. This assured the inspector that restrictive practices were only being used when needed and for the shortest duration.

Judgment: Compliant

Regulation 8: Protection

There were suitable arrangements in place to protect the residents from the risk of abuse. For example:

- there was an organisational safeguarding policy in place
- staff had received training in safeguarding vulnerable adults
- there was a reporting system in place with a designated officer (DO) nominated for the organisation

- two staff spoken with were able to identify who the DO was to the inspector, and the identity of the DO was displayed in the hall.

The inspector reviewed safeguarding incidents for the last year and found that any potential safeguarding risks were escalated, reviewed, and reported to the relevant statutory agencies. There were safeguarding plans in place to minimise the chances of recurrence of incidents. For example, one resident was reviewed as part of the safeguarding plan by a behaviour support therapist to see if further advice could be provided on how to better support one resident with their sensory seeking behaviours.

The two family representatives and the four staff spoken with felt comfortable raising concerns. At the time of this inspection, neither the family representatives nor the staff members spoken with had any concerns.

Two staff members spoken with were familiar with the steps to take should a safeguarding concern arise including a witnessed peer-to-peer incident or an unwitnessed disclosure. For example, the staff members explained that they would ensure the safety of the resident impacted by a peer-to-peer incident, check for any injuries, and report to their manager and the designated officer.

From a review of the two residents' files, the inspector observed that there were care plans in place that outlined residents' support needs and preferences with regard to the provision of intimate care. These plans promoted dignified care practices and reflected residents' preferences. For instance, it described how one resident preferred to have a bath rather than a shower.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Mullingar Centre 7 OSV-0008491

Inspection ID: MON-0049186

Date of inspection: 14/01/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 21: Records	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:</p> <p>Actions Taken:</p> <ul style="list-style-type: none"> -All care plans have been reviewed to ensure that the documents reflect current allied health professionals' guidance and recommendations and accurately reflect assessed needs to reduce the risk of inconsistent care. -All PEEPs have been updated with strategies to provide additional support to individuals during emergency evacuation. A nighttime drill was completed by staff 16/01/26 to ensure strategies were supportive of the individual's needs during emergency evacuation. Evacuation routes are now rotated in evacuation drills going forward to ensure that all exits are practiced. Fire safety records now accurately evidence compliance and demonstrate safe use of all escape routes. -The Person in Charge has completed an accident/ incident review of minor injuries and has requested MDT support to develop plans to support specific individual's sensory needs. -The Person in Charge has completed a review of safeguarding documentation and implemented an updated filing system where all documentation is filed in a centralized folder so that all information is accessible when required. Safeguarding records are complete, accessible, and compliant with regulatory requirements. -The PIC has reviewed and updated the rostering template to ensure full names of all staff are included. Staffing records are comprehensive and support accountability and traceability. 	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p>	

- The Person in Charge has reviewed all staff training requirements for the designated centre. Outstanding training has been completed, and scheduling of future training requirements is in place.
- A review of the boiler service has been requested to the servicing company awaiting date of service from the company.
- A review of all open actions from previous spot checks and audits has been completed and status updated and documented.
- All PEEPs have been and updated with strategies to provide additional support to individuals during emergency evacuation. A nighttime drill was completed by staff on 16/01/26 to ensure strategies were supportive of the individual's needs during emergency evacuation.

Evacuation routes are now rotated in evacuation drills going forward to ensure that all exits are practiced.

- The PIC will strengthen oversight through review and tracking of all action plans, and routine monitoring of training and maintenance to ensure sustained compliance.

Regulation 10: Communication	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 10: Communication:
 The PIC has sourced training for individuals identified communication needs. Staff are scheduled to attend.

- Up to date Clinical recommendations are now available to staff to ensure effective and consistent support. SLT recommendations relating to individuals' communication needs were discussed at a team meeting on 9.2.26, picture schedules and menu planning tools were discussed.
- A review of current support plans has been completed to include additional information on individuals chosen communication.

Regulation 17: Premises	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:
 A review of the back garden has been completed by the Person in Charge, Area Director, Regional Director and the Property maintenance department. A plan of works has been developed to improve accessibility, including the installation of appropriate paving along the preferred walking route of one individual to ensure safe, year-round access. Funding for this project work has been approved by the Regional Director. The Facilities manager is liaising with contractors on the scope of the required works. A project timeline has now been established, with works scheduled to be completed 30/06/26. A new accessible swing will be installed in the garden as part of the agreed works being completed.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	30/03/2026
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	30/03/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair	Substantially Compliant	Yellow	30/06/2026

	externally and internally.			
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	30/04/2026
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	30/04/2026
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.	Substantially Compliant	Yellow	28/02/2026