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:	Delvin Centre 1
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Announced
Date of inspection:	19 May 2026
Centre ID:	OSV-0003955
Fieldwork ID:	MON-0041762

About the designated centre

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

This designated centre comprises of three bungalows located in close proximity to the nearest small town. The centre offers a full time residential service to eleven adults with intellectual disabilities and there are no gender restrictions. The first house has five bedrooms with a kitchen / dining area, utility room, bathroom, shower room and toilet. There is a garden to the front and an outdoor seating area to the back. The second house has six bedrooms one which has an en suite bathroom, a kitchen / dining area, sitting room, a bathroom and a shower room. There are gardens to the rear and front of house. The third house has four bedrooms with a kitchen / dining room, a sitting room, a bathroom, shower room and lawns to the front and rear of the house. The three houses have transport available for the residents. There is a full-time person in charge in place for the designated centre.

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
Tuesday 19 May 2026	09:35hrs to 17:35hrs	Karena Butler	Lead
Wednesday 20 May 2026	09:30hrs to 17:40hrs	Karena Butler	Lead

What residents told us and what inspectors observed

The inspection findings of this two day announced inspection were, for the most part, positive. The inspector found that in a number of areas of service provision the centre was performing well, while others required some improvement. For example, areas requiring improvement related to training and some staff knowledge, risk and medicines arrangements, and ensuring all residents had access at all times to their money. These points are discussed in detail later in this report.

During the inspection, the inspector met all ten of the residents living in this centre. There was one vacancy at the time of this inspection. Four of the residents spoke to the inspector with support from staff. Some residents who used alternative communication methods did not share their views directly with the inspector. Instead they were observed at different times throughout the course of the inspection in their home. One resident chose not to engage with the inspector other than to smile and that choice was respected.

Five residents participated in a day service programme between Monday and Friday. Residents were observed engaging in community activities ranging from massages, walks in different locations, day service programmes, out for tea or coffee, and attending appointments. They were also observed moving freely around their homes, spending time in the kitchen, sitting room, and their bedrooms. They appeared content in their environment. For example, one resident was observed on both days on their return to their house to relax listening to music in their preferred chair. They were observed very content, nodding their head and bobbing their leg to the music. A resident in house one, communicated that they would like more choice with their daily food. It was confirmed that they chose their weekly meal plan at each of the weekly residents' meetings. However, the person in charge and local manager confirmed that going forward, they would encourage the staff team to check each day if the resident still wanted to eat the meal they had chosen or would they prefer something different.

As part of this inspection process residents' views were sought through questionnaires provided by the office of The Chief Inspector of Social Services (The Chief Inspector). Staff members supported residents to complete and return ten questionnaires. Feedback was positive and questions were ticked 'yes' for happy when asked about the service and care provided. One resident selected 'it could be better' in relation to feeling safe in their home. This was also linked to a conversation the inspector had with them using alternative communication methods. This is discussed further under Regulation 8: Protection.

Over the two days, residents appeared comfortable in the presence of their supporting staff. In addition to the person in charge and the local managers for each house, the inspector had the opportunity to speak with eleven staff members. For the most part, the person in charge, local managers, and staff members spoken with

demonstrated that they were familiar with the residents' support needs and likes. They were observed to interact with residents in a relaxed and respectful manner. For example, one staff member was observed asking a resident's preference if they wanted to wear a jumper and were overheard explaining the next steps that were going to happen to the resident in a calm and gentle manner.

The provider had arranged for staff to have training in human rights. One staff member explained how the training had improved their everyday practice. For example, when supporting residents with intimate care, they ensured they knocked, explained who they were and why they wanted to come in. They then paused before re-entering a bathroom, allowing the resident time to process the information.

Feedback received when speaking on the phone with two residents' family representatives from house two and three was positive. They told the inspector that they felt their family members were safe and had their assessed needs met by the staff team. Neither had concerns and if they did, they would feel comfortable raising them to a staff member or management. They both felt welcome to visit. One representative communicated that "It's a great service. The house is always warm and clean". They said the residents 'always seem well looked after, that they look clean, well dressed, and happy'. They said they always get an annual questionnaire from the provider to give their feedback. They said that 'staff were friendly, that they had nothing bad to say, and that everything was perfect'. While one family representative had wanted clarity on certain matters from a previous meeting with the provider, they were happy for the inspector to pass that information onto the person in charge, which the inspector did.

The house was observed to be homely, for example there were potted flowers at the front of the houses. The houses were found to be clean and tidy. There were accessible front and back gardens at each property.

At the time of this inspection there were no visiting restrictions in place other than for the comfort of one resident to receive notice in advance of receiving visitors in order for staff to help them prepare. There were no volunteers used, and there had been no complaints in 2025 or up to and including this inspection in May 2026.

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 announced and was undertaken over two days following the provider's application to renew the registration of the centre. This centre was last inspected in November 2025.

The findings of this inspection indicated that while some areas for improvement were identified, the provider had the capacity to operate the service within substantial compliance with the Health Act 2007 and associated regulations. The person in charge was operating the service in a manner which ensured the delivery of care was meeting the residents' needs.

Although there had been a number of unforeseen management changes in this centre over the last year, the inspector found the current arrangements to be effective. From speaking with the local managers for each house, they were aware of areas that they wanted to improve on or enhance.

There was a statement of purpose in place that was reviewed and updated on a regular basis.

The inspector reviewed staffing arrangements and found that safe staffing levels were maintained and where possible a consistent staff team was in place.

Staff were found to have access to a suite of training in order to carry out their roles safely. However, further improvements were required to ensure that all staff were adequately trained in all required areas, that there was appropriate oversight of staff training, and that all staff had the appropriate knowledge of residents' healthcare supports.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider submitted an application to renew the registration of the centre. The application contained the required information set out under this regulation and the related schedules. While some minor revisions were required to the statement of purpose and floor plans, they were completed and re-submitted the day after this inspection and found to be correct.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that adequate staffing arrangements were in place.

A review of a sample of rosters in house one and two across February to May 2026, demonstrated that there were planned and actual rosters in place. While there was

not a full staffing complement in house two, the person in charge and the local managers were maintaining safe staffing levels as well as in the other two houses. Where possible, temporary staffing used were consistent and familiar to the residents. This would facilitate continuity of care. The person in charge confirmed that house two should have a full staff complement by the end of June 2026 as there was one staff member due to join the staff team.

Staff personnel files were not reviewed at this inspection. However, the inspector reviewed a sample of four core staff members' and one agency staff member's Garda vetting certificates for staff who worked in house two and three. All were found to have been completed within the last three years, demonstrating that the provider was ensuring safe recruitment practices in line with best practice.

Judgment: Compliant

Regulation 16: Training and staff development

The staff team, for each house that made up this centre, had access to a suite of training in order to support the assessed needs of the residents. However, the inspector found that improvements were required in the management and oversight of staff training needs as there were gaps identified in several areas.

In house one, a staff member had completed catheterisation training; however, there was no evidence that they had completed the required competency assessment. The local manager confirmed that the staff member had undergone a competency; however, there was no evidence for this or to confirm how long ago they completed it. That staff member was scheduled to complete refresher training in June 2026.

In addition, it was not evident if three staff members had completed aseptic techniques training which was required to support one resident in house one. The local manager confirmed that all staff had completed that training and that they just could not find evidence of it as it would have been a number of years since they had last undertaken that training. They confirmed that they would ensure staff refreshed their training in this area as soon as possible.

Without evidence of up-to-date training and competency checks, the provider could not be assured that residents were receiving this specific care in line with best, safe practice.

Additionally, it was not evident if one agency staff member and one relief staff member had completed Cardiopulmonary resuscitation (CPR) training.

Furthermore, two staff members in house three required positive behaviour support training. Once this was brought to the attention of the person in charge, the two

staff members completed their training the day after this inspection with confirmation submitted post inspection.

While this was a positive step, further oversight of training was required in order to ensure staff have all of the required training necessary to perform their roles effectively and ensure the safety of the residents.

Judgment: Substantially 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 and evidence of the insurance was submitted to the Chief Inspector.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the provider had adequate governance and management arrangements in place.

Unannounced provider-led visits were taking place every six months as required, which the inspector verified by reviewing the last two reports for each house. In addition, there were monthly audits completed in order to ensure the centre was effectively monitored and the service provided was safe for the residents. Areas included, health and safety, and the centre's vehicles. There were also arrangements in place for audits of residents' finances every two months.

The provider had arrangements in place for an annual review. The inspector reviewed the most recent version for 2025.

A review of the records of the team meeting minutes from January to April 2026 showed that incidents that occurred within the centre were reviewed for shared learning with the staff team to promote consistency of approach to facilitate better care for residents.

Judgment: 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 of 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). For example, it described the specific care and support needs that the provider intended to meet.

Judgment: Compliant

Quality and safety

The inspection found that residents were receiving a good service that met their needs. However, some improvements were required to aspects of risk and medicines management arrangements. Additionally, further improvements were required to ensure that all residents had full access to their money whenever they may need.

While residents had access to day-to-day funds, the process for accessing larger amounts of their own money was more restrictive and required review.

The inspector found that while there were risk management processes in place, further oversight was required with regard to risk assessments and their associated control measures in place to mitigate risk.

In addition, while there were many good medicines management systems in place, further oversight and adherence to safe medicines practices was required. For instance, a medicated cream was observed to be in use with no date of opening records. This was important as certain medications required to be discarded after being open for a certain length of time.

There was a residents' guide that contained the required information as set out in the regulations.

A review of the transition arrangements for one resident showed that the process was undertaken in a transparent manner with the resident's involvement.

Other key areas including healthcare, safeguarding, general welfare and development, premises, and fire precautions were examined and found to be compliant with regulatory requirements.

For example:

- residents had access to a general practitioner (GP)
- there was a safeguarding policy in place to guide staff
- residents had access to activities of interest to them

- each premises was found to be tidy and clean
- the provider ensured there were appropriate firefighting and detection systems in place in the case of an emergency.

Regulation 12: Personal possessions

The provider had ensured that residents retained control of their personal property. Residents had their own items in their homes and, from a sample of two files, these were recorded in a log of personal possessions. However, the inspector found that residents did not have full ownership of their own finances.

The majority of residents did not have financial accounts in their own name. Their finances were managed by the organisation. The inspector was informed that nine out of ten residents' monies were managed centrally in a provider account (Patient Private Property Account PPPA) and residents received sums of their own money at planned intervals. While the provider ensured residents had access to money when needed as residents could use the provider's house finance card for emergencies, their own money was not always readily available or accessible to them due to being in a central account. For example, if money was required, staff needed to apply to the manager for the amount needed and it was confirmed that it could take three days to receive the money.

From a conversation with the person in charge, they confirmed that financial institutions had not been engaged with in several years to attempt to open accounts for the residents in this centre. In addition, access to advocacy had not been sourced for the residents with regard to supporting them around this issue.

The person in charge confirmed that the residents in this centre were due to trial a particular finance card. However, no date could be provided for when that trial would commence and it wasn't due to commence for several months while logistics were being worked through.

Judgment: Substantially compliant

Regulation 13: General welfare and development

The inspector found that efforts were being made to encourage and support residents to engage in activities they enjoyed.

For example, from a review of a sample of four residents' activities across January to April 2026, residents participated in a range of activities. For example, eating out, coffee out, going on holidays, upcycling items as part of an art session, visiting friends and family, massages, bowling, and going swimming.

The inspector also found that social goals had been set for the residents. The inspector reviewed the goals in place for a sample of the four residents and found that staff were supporting residents to work on goals that may enhance their quality of life. While the tracking and trending of goals required further development to ensure there were no unnecessary delays, management had already highlighted this area for improvement.

Examples of goals included, attending a music festival, finding the location of a grave of a loved one and visiting the grave to pay their respects, and re-commencing swimming.

In summary, the inspector found that the staff team were taking steps to support the residents in achieving their goals, doing so in a manner that respected the residents' wishes and maintained their safety.

Judgment: Compliant

Regulation 17: Premises

The layout and design of each of the premises met the residents' current needs and the houses were observed to be tidy and in a good state of repair.

The facilities of Schedule 6 of the regulations were available for residents' use. For example, there was access to cooking and laundry facilities.

While a minor amount of mildew was observed in house one and two, this was addressed by the maintenance department during this inspection.

Each resident had their own bedroom with sufficient space for their belongings and bedrooms were observed to be individually decorated.

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 mops and buckets in place.

Judgment: Compliant

Regulation 20: Information for residents

There was a residents' guide that contained the required information as set out in the regulations. For example, it explained to residents how to access inspection report, and what the arrangements for visiting were to the centre.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

A review of documentation found that a transition of one resident from this centre to another of the provider's centres was planned and ensured continuity of care for residents. Transition arrangements ensured that the resident's preferences were considered and upheld in the move from the centre. The resident had the opportunity to visit their new home on several occasions prior to moving in.

From speaking with the person in charge and a staff member that used to work with the resident in this centre, they both confirmed that the move was successful and was completed in a manner that involved the resident. Both confirmed the resident was happy in their new living arrangement and that the resident had already known the people they moved in with. The new living arrangement better suited the resident's needs and afforded them more space in their environment.

Judgment: Compliant

Regulation 26: Risk management procedures

There were arrangements in place to manage risk, and generally, risks were well controlled. However, there were improvements required to one process used to support a resident. Other improvements were required in the documentation of risk management, as well as ensuring all control measures were in place to ensure effective oversight and monitoring.

A tray used for supporting a resident for an aseptic technique was stored in a bathroom and observed to be dirty. Although staff cleaned it once the inspector highlighted the issue, it had not been cleaned immediately after its last use. This required review to protect the resident from the risk of a healthcare-associated infection.

The inspector reviewed a sample of centre specific and individual residents' risk assessments for house one and two. While they were linked to residents' care plans and needs assessments, and the control measures were proportionate to the level of risk, some control measurements required further oversight to ensure they were in place and being utilised.

For example, in house two, a control measure in place to ensure residents' safety was that all staff have training in CPR. As discussed under Regulation 16: Training and staff development, on review of the training matrix and discussions with the person in charge, not all staff had this training.

A risk assessment for one resident, in house one, had not been updated in light of changes in their care, despite the change occurring a month prior. While this information was known to the staff member on duty, inaccurate information had the potential to put the resident at increased risk, particularly from temporary staff, of receiving care not in line with their assessed needs.

Some other minor changes were required to some risk assessments in house one which were discussed with the local manager and person in charge on the day. For instance, one risk assessment was scored incorrectly. Another risk assessment listed a training course as a control measure that the organisation no longer used.

One resident's eating and drinking plan had not been formally reviewed since 2022 by a speech and language therapist despite it being recorded on the recommendations that it should be reviewed annually. While the local manager reported that there had been no changes to the resident's presentation, this still required review to ensure all supports were up to date and applicable for the resident.

The inspector found that, upon reviewing the adverse incidents since January 2026 for house one and two, there were low levels of incidents occurring and they were being reported as required. Learning was then shared with the staff team to promote consistency of care for the residents.

On review of other arrangements in place to meet the requirements of this regulation, it was noted that from a sample of two of the centre's vehicles they were taxed, insured, serviced within the last year, and had an up-to-date national car test (NCT).

Judgment: Substantially compliant

Regulation 28: Fire precautions

The inspector reviewed the fire safety measures in place and found that they were appropriate in safeguarding the residents from the risk of fire. For example, staff had received appropriate fire safety training.

The inspector reviewed the fire safety management documentation for the three houses and found evidence that fire detection, emergency lighting, and firefighting equipment had been regularly serviced, ensuring that the systems remained in good working order.

There were fire containment doors in place fitted with self-closing devices. While one door in house two would not close fully by itself and another door was observed to have a larger than recommended gap, this was addressed by the maintenance department during the inspection.

Records of eight fire practice drills, across house two and three, confirmed that both residents and staff could be safely evacuated during daytime and hours of darkness scenarios. The inspector reviewed the personal emergency evacuation plans (PEEPS) for the seven residents, these plans provided adequate information to ensure residents could be evacuated safely.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

While there were many appropriate arrangements in place with regard to medicines management, the inspector observed that the internal checks designed to catch mistakes, prior to administration of medication, required improvement to ensure the system for checking and verifying incoming medicines was robust.

For example, from a review of four residents' files across house one and two, the medication stock count form for medicines received from a pharmacy did not prompt staff to check for pharmacy labels, compare the labels to the prescription, or verify that all requested medications were received.

Pictures and some descriptions were available to help staff identify medications arriving in blister packs. However, some pictures were unclear, and some medications lacked descriptions. This meant staff could not always independently verify that the contents of the blister packs matched the prescriptions. While a sample check showed no actual errors had occurred, this gap weakened the checking system and increased the risk of pharmacy errors going unnoticed.

The inspector also observed a documentation recording error, whereby a staff member had twice incorrectly recorded the code used for recording when a cream was applied instead of their nebulizer. Three more staff members had followed suit; however, subsequent staff members had identified their errors and corrected the documentation. Further oversight was required to ensure that staff independently ensured they only used the prescriber's signed document for reference when recording medications administered and not to copy what other staff members recorded.

The arrangements for storage of out of date or medicines to be returned to the pharmacy in house one required review to ensure that they were segregated from active medications stock. For example, the inspector found that two medications due to be returned to the pharmacy; however, they had not been identified as such and were stored alongside current medications. The inspector did observe that when a medication had been returned previously, that a record of the returned medications was kept and it was signed as received by the pharmacy.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector found that the health needs of the residents had been appropriately assessed, and appropriate healthcare supports were in place.

From a review of four residents' healthcare information, there were care plans in place for any identified assessed needs. For example, there was an epilepsy plan and associated epilepsy emergency medication protocol, and an eating, drinking, and swallowing plan in place for residents that required support in that area. Of the plans reviewed, they were found to appropriately guide staff.

For the most part, staff members spoken with were very knowledgeable with regard to care and support needs. While one staff member's knowledge of certain healthcare supports required improvement, this was addressed under Regulation 16: training and staff development.

There was evidence that residents had access to allied health professionals and were supported in attending appointments with GPs when required. For example, residents had access to a neurologist, physiotherapist, occupational therapist (OT), and a dentist.

While it was not evident when the residents in house two last received an eye test, once this was brought to the attention of the person in charge, all three residents were booked in to receive a test.

At the time of the inspection, the residents were in good health, and efforts were being made to maintain this status.

Judgment: Compliant

Regulation 8: Protection

From a review of the systems in place to protect residents from the risk of abuse, the inspector found that appropriate safeguarding measures were in place.

From speaking with a member of staff from each of the three staff houses, they demonstrated appropriate safeguarding knowledge with regard to if they witnessed a peer-to-peer incident or an unwitnessed disclosure was made to them.

The provider had responded to any arising safeguarding concerns and concerns were notified to the relevant external agencies. When required there were safeguarding plans in place with control measures to help mitigate the chances of reoccurrence. For example, after an incident in house one in November 2025, the provider's behaviour therapist reviewed the guidance to staff in relation to the

resident who impacted another resident. The behaviour therapist also attended one of the staff meetings to ensure staff were clear on the guidance.

Two family representatives and the eleven staff members spoken with all confirmed they would feel comfortable raising concerns if they had any.

One resident, in house one, communicated through alternative means that sometimes they felt safe in their home as they answered "yes and no" through their communication method. While incidents in this centre had reduced significantly in the last number of years, this resident had on occasion been subjected to negative interactions by one of their peers. That resident had also indicated, with staff support, that 'it could be better' when asked on their feedback questionnaire if they felt safe in their home.

The person in charge confirmed that the resident's feelings on this would be explored with them. They confirmed on day two of this inspection that they had contacted the speech and language therapist to help support this exploration.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Delvin Centre 1 OSV-0003955

Inspection ID: MON-0041762

Date of inspection: 20/05/2026

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person in Charge has conducted a review of catheterisation training and updated staff personnel files to include completed competency records. • The Person in Charge has reviewed aseptic technique training for all staff in the centre, and all staff have completed the required aseptic technique refresher training. • CPR training has been scheduled for one staff member and is due to be completed on 26/06/2026. • The Area Director has requested that all agency staff supporting the centre have up-to-date CPR training completed and that this is reflected within their training compliance records. • The Person in Charge has completed a review of Behaviour Support training, confirming that all staff in the centre have completed the required training. • The Person in Charge has implemented quarterly training reviews to monitor compliance and ensure that all staff maintain completion of the mandatory training requirements for the centre.	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: • Residents' finances are appropriately managed and audited to ensure that residents' funds are safeguarded. However, despite ongoing efforts, there have been difficulties in opening individual bank accounts for each resident. The Person in Charge has engaged with the independent advocate to support residents in opening personal bank accounts, enabling greater independence and easier access to their finances. Ongoing engagement with financial institutions will continue to progress with the opening of individual accounts. • A risk assessment has been developed to address the risk associated with residents	

who currently use Patient Private Property Accounts (PPPA) and may not have immediate access to their personal funds. The risk assessment outlines the existing control measures in place to safeguard residents' finances and details additional controls to be implemented by the Person in Charge to further mitigate identified risks.
• The registered provider is also exploring alternative methods for residents to access their personal funds, including the introduction of a finance card that can be topped up as required and used for ATM withdrawals and online purchases. This option aims to promote greater autonomy and timely access to personal finances while maintaining appropriate financial safeguards.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Person in Charge has completed a review of the storage arrangements for all aseptic technique equipment to ensure that equipment is stored in a designated clean storage area. A cleaning protocol has been implemented requiring all equipment to be cleaned, checked, and documented following each use. All staff have completed the required aseptic technique training.
• The Person in Charge has completed a review of all centre-specific risk assessments and individual residents' risk assessments to ensure that identified control measures are consistent with and aligned to the recommendations outlined within residents' care plans.
• The Person in Charge has reviewed staff training records and has scheduled CPR training for staff members where required. Agency staff supporting the centre have also been requested to complete CPR training to ensure that all recommended control measures can be effectively implemented.
• The Person in Charge has completed a review of residents' Eating and Drinking Care Plans to ensure that all recommendations are current, accurate, and fully implemented. An annual review of Eating and Drinking Care Plans will be undertaken, or sooner where required in response to changes in residents' assessed needs

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• The Person in Charge has implemented a Medication Management Protocol that requires staff to verify medication labels upon receipt against the corresponding prescription to ensure accuracy. The protocol also outlines the process for managing medication returns, including the use of a designated storage system for returned medications until collection can be facilitated. All medication returns are documented and recorded upon completion.
• The Person in Charge has addressed medication documentation errors with the staff team and provided guidance to ensure staff are directed by the prescriber's instructions and documentation when administering medications. This will support accurate recording of medication administration details and promote safe medication management practices.
• The Person in Charge has scheduled a meeting with the centre's pharmacy provider to discuss enhancements to the blister pack system, including the introduction of clearer

medication images and descriptions to further support safe medication administration and reduce the risk of error.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	31/12/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/06/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the	Substantially Compliant	Yellow	31/07/2026

	designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	30/08/2026
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is	Substantially Compliant	Yellow	30/08/2026

	segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.			