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

Issued by the Chief Inspector

Name of designated centre:	Delvin Centre 2
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	18 March 2026
Centre ID:	OSV-0003956
Fieldwork ID:	MON-0044939

About the designated centre

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

Delvin Centre 2 is a designated centre operated by Muiríosa Foundation. The designated centre provides a full-time residential service to four adults, with a moderate intellectual disability, autism and behaviours that challenge. The centre comprises a large bungalow on its own grounds on the outskirts of a small town in Westmeath. Each resident has their own bedroom and there are suitable shower rooms, and bathrooms and communal facilities including sitting room, open plan kitchen and dining area. Wheelchair accessible vehicles are available to the designated centre to assist residents attend social activities and day services are provided from within the organisation. The centre is staffed by social care staff at all times when residents are present, with nursing oversight available as this is required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 18 March 2026	11:00hrs to 20:00hrs	Karena Butler	Lead

What residents told us and what inspectors observed

On the day of this unannounced monitoring inspection, while in the main good practice was observed and residents enjoyed a good quality of life, improvements were required to ensure the safety and care in the centre would be consistently met.

The inspector had the opportunity to meet and observe the four residents that were living in the centre. The four residents had alternative communication methods and three did not share their views with the inspector. They were instead observed in their home after they arrived back from their day service programmes. One resident went out for hot chocolate in the evening and the other three remained in the centre. Two of which spent a lot of time between their bedrooms and the kitchen area. All four residents appeared relaxed and comfortable in the presence of the staff on duty.

The fourth resident briefly communicated through gestures and facial expressions on two separate occasions with the inspector. They communicated that they were happy, that the staff were nice and they got choice in their daily life with regard to food and activities.

At one point when asked if they liked something, they gave a thumbs down but were smiling. The inspector asked if they were joking and the resident laughed and nodded that they were. They communicated through their facial expressions and body language that they didn't want to chat any further as they wanted to relax and watch television as a soccer match was on.

During the course of the inspection, the inspector had the opportunity to speak with the person in charge, and four staff members, two of which were on duty and the other two attended the centre for a team meeting.

Staff were observed to be calm and friendly in their interactions with residents. For example, staff were observed asking a resident if they still wanted to have their dinner in the sitting room and if so that they would bring it into them if they wanted to get settled in the sitting room.

The inspector had the opportunity to speak with one family representative on the day of this inspection and their feedback received was positive. They said they had no concerns at present and that if they were to have a concern they would feel comfortable raising it to staff or management. They felt that they would be listened to. They said that their family member was happy to return to the centre after family visits.

They said that staff were "lovely" and that 'they were very careful with their family member's health. That they were responsive and vigilant to any developing health

needs'. They communicated that the person in charge was "always so nice and easy to talk to."

The representative stated that the house was "nice" and that it was "a home from home" for their family member. The inspector observed the house to be tidy and in a good state of repair. The sitting room and some bedrooms had televisions for use. Each resident had their own bedroom. The bedrooms had adequate storage facilities for any personal belongings. There was a front and back garden. The front garden had an established lawn and had an area for parking. The back garden had a picnic table and seating that residents could use in times of good weather.

At the time of this inspection there were no visiting restrictions in place and no volunteers were used in the centre. There had been no complaints in 2025 to the time of this inspection. There were no vacancies.

In summary, the residents appeared to enjoy a pleasant quality of life in a homely environment where they were supported by a kind and familiar staff team.

However, while for the most part the day-to-day atmosphere was positive, the inspector found that the lack of clinical oversight and a failure to implement professional recommendations meant that the service was not consistently meeting the residents' assessed needs. Specifically, gaps in communication supports and safety measures were found to be impacting on the overall effectiveness of the care and service being provided.

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 as part of on-going monitoring of 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 provider's governance and management arrangements were found to require improvements in order to ensure the quality and safety of the service. The inspector found a number of regulations required action in order to provide a safe and effective service for residents.

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.

Staff had received training including refresher training that would facilitate them to safely support the residents in line with their assessed needs. For example, fire safety. However, some staff required training or refresher training, such as cardiac first response (CPR).

Improvements were required to the quality of some guidance plans and how records were maintained. For example, the inspector observed that additional information and guidance was required in one resident's behaviour support plan in order to appropriately guide staff.

Regulation 15: Staffing

The inspector found that there were sufficient staff available, with the required skills to meet the assessed needs of residents.

The inspector reviewed a sample of rosters over a three-month period from January to March 2026 and found that planned and actual rosters were being maintained. While the centre did not have a full staffing complement and required one staff post to be filled, the inspector was informed that one post was filled and the candidate was undergoing pre-employment checks and was due to commence their role in Mid April 2026.

In the meantime, one consistent relief staff commenced the week prior to this inspection to fill any required shifts on the roster. This arrangement facilitated continuity of care. Safe staffing levels, that were determined by the provider, were found to be maintained in the centre.

While full staff personnel files were not reviewed, the inspector did review a sample of four staff members' Garda Síochána (police) vetting (GV) certificates. Three of the GV certificates were completed within the last three years which facilitated safe recruitment practices in line with best practice. However, one staff member was last vetted in 2019 and had not received re-vetting in line with the provider's policy or best practice. This is addressed under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 16: Training and staff development

Staff received training in areas determined by the provider to be mandatory, such as safeguarding and fire safety. The inspector found that some staff required training and some refresher training was overdue.

The inspector reviewed the certification of eight training courses for core staff that worked in the centre as well as the training oversight document.

Examples of other training staff had completed included:

- training related to positive behaviour supports that included de-escalation techniques
- medication management
- epilepsy awareness and emergency epilepsy medication administration
- Autism awareness
- human rights
- augmentative alternative communication (AAC).

However, the inspector found that there was no evidence to suggest that one of the core staff members had completed CPR training, and two staff required refresher training since 2024. This put the residents at risk as staff worked lone working at night in this centre.

Additionally, training was due in the following areas:

- three staff members' fire safety training expired between January to 6 March 2026
- one staff member's hand hygiene expired in March 2025
- there was no record of one staff member completing standard and transmission based precautions or personal protective equipment (PPE)
- two staff required refresher training in cough etiquette and respiratory hygiene.

A review of three staff members' files confirmed that supervision took place as per the minimum frequency required by the provider's policy. From speaking with a staff member and the person in charge, they confirmed that supervision was an opportunity to raise concerns if they had any.

Judgment: Substantially compliant

Regulation 21: Records

The inspector had concerns with regard to the information governance arrangements and records were not always appropriately maintained or available for review .

While regular team meetings were occurring in the centre, as confirmed by the person in charge, many of the minutes of the meetings were not available for review. This was either due to them being missing or that they had not been typed by the time of this inspection. Missing or not typed minutes related to meetings in August, October and November 2025, and January and February 2026. The issue of

team meeting minutes not being available on site was also self-identified on the provider's last unannounced visit to the centre in November 2025.

Outdated information was contained in some residents' documents. For example, with regard to some goals that were identified several years ago for one resident to work towards were still present in their file as if they were the current goals being progressed which they weren't.

In addition, while updated information was available as to one resident's eating and drinking plan, their file contained old outdated information with regard to what way their food was to be prepared as part of their speech and language therapist (SLT) assessment. While a staff member spoke with was familiar as to the resident's requirements in this area, outdated information still available had the potential for the resident to receive inappropriate care, particularly from temporary or less familiar staff.

While a behaviour support meeting had taken place within the last year to review a resident's supports, it was not evident if their behaviour support plan was reviewed since March 2024. While the person in charge believed it was reviewed since then, the more up-to-date plan was not available for review by the inspector. Therefore, it was difficult to ascertain if the information guiding staff that was present in the centre was the most up to date and if it was still relevant.

An SLT report was not made available in the centre in order to ensure all recommendations were being appropriately followed through on. The person in charge communicated that the report was stored in the resident's day service.

The person in charge confirmed that they completed regular spot check audits in the centre; however, the inspector was only able to review the records of one of those audits from January 2026. They communicated that they did not have the time to maintain the records of the audits.

While the person in charge communicated that they had spoken to staff on the matter, the inspector observed that there were regular gaps in the cleaning schedule document. It was difficult to ascertain if the cleaning was completed on those days or whether it was a documentation issue.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector reviewed the provider's governance and management arrangements and found that they required improvement to ensure the service was effectively monitored and that the care to residents was being provided in line with allied healthcare professionals' recommendations.

The person in charge managed two designated centres and managed another house that was part of a third designated centre. The four staff and the family representative spoken with found the person in charge was approachable, that they would feel comfortable raising any concerns they may have, and that they felt they would be listened to. However, the inspector found that their extended remit was impacting on their ability to provide appropriate oversight of this centre. For example, in completion of their administration work and on how the documentation in the centre was being maintained. Therefore, that arrangement was not sustainable.

The last annual review of the quality and safety of care and support in the centre was not available for review for the inspector as requested. The person in charge confirmed that it was done; however, they were unable to access it on the day of this inspection. Therefore, the inspector was unable to assess if it was an adequate review of the service and whether it contained resident and family consultation as required.

As discussed under the relevant regulations, the inspector found that improved oversight was required to ensure that recommendations made as part of the on-going assessed needs of the residents were made known to staff and followed through on. This will be further discussed under Regulation 5: assessment of need and personal plan and Regulation 10: Communication.

As previously stated, one staff member was last vetted in 2019 and had not received re-vetting in line with the provider's policy or best practice in order to ensure safe recruitment practices.

There were arrangements in place for the completion of the unannounced provider-led visit reports that were occurring every six months as per the requirements of the regulations. The inspector found that they took place in May and November 2025. The inspector observed that some similar areas for improvement were being identified in both visit reports meaning that either changes were not always being consistently implemented or able to be sustained.

The inspector observed that some areas of the house required a more thorough clean and while they were addressed on the day of this inspection further oversight was required to ensure that the premises was maintained to the most optimum standard. For example, some sinks had dark residue and staining on them which had built up over time, and the base of the kettle holder, that promoted one resident's independence using the kettle, was found to be dirty.

Judgment: Not compliant

Quality and safety

Overall, while the inspection found that the residents living in this service were supported by a caring staff team a number of improvements were required in relation to assuring residents' were supported in line with their assessed recommendations, and that there were sufficient and effective fire precautions in place. In addition, that residents' goals were appropriately supported and followed through on.

Care plans required review to ensure all applicable information was contained and that staff were consistently following through on allied healthcare professionals' recommendations in order to enhance the residents' lives.

The inspector found that improvements were required to how communication was facilitated in the centre to ensure it was in line with residents' assessed needs, for example through consistent use of a resident's communication device.

While there were a number of adequate systems in place to safeguard residents, such as there was a safeguarding policy in place, one resident's behaviour was negatively impacting on their peers on occasion.

The inspector found that residents were supported to engage in activities of their interest. However, it was not evident if residents were getting out in the community at a frequency of their choice. Further oversight was also required to ensure meaningful goals set for the residents were supported and their progress tracked.

There were many appropriate and suitable fire safety management systems in place, such as arrangements for regular servicing of detection and alert systems. However, the inspector noted that improvements were required with regard to fire evacuation to ensure that all residents could be safely evacuated and from all areas of the house if required.

The inspector observed the house to be clean and tidy which also facilitated in the arrangements for good infection prevention and control (IPC).

Regulation 10: Communication

This inspection found that communication had not been adequately accommodated within the centre.

One resident was devised a programme of functional communication training in June 2025 to be completed with them by staff. It included practicing different scenarios to teach the resident what way they could react in a situation that may frustrate them and for staff to role play with them. From speaking with a staff member and the person in charge, the inspector found that the recommendations from that functional communication programme were not being followed through on. The staff member communicated that they felt some of the negative behaviours that the resident could display could be due to boredom or trying to get their peers to follow

certain rules. Due to this resident negatively impacting on their peers on occasion, the functional communication training was important to practice with the resident to potentially give them more effective ways of communicating their frustrations or needs. In the absence of the training, it meant that residents remained at risk of being impacted by their peer's frustrations, which may be related to potential distress in not being able to communicate their needs effectively.

From a review of the minutes of a behaviour support meeting for that resident in February 2025, staff had expressed a need for training in simplified sign language as they communicated that they couldn't understand what the resident was telling them and that it could cause distress for the resident. That resident had information on how they communicated in a document called "about me". The information stated that the resident likes people to use simplified sign language when speaking with them. In addition, it was recorded that another resident recognised four sign language signs and while this was recorded in their communication information, those signs were not familiar to the two staff on duty. While staff had since received training on augmentative alternative communication, at the time of this inspection only one of the core staff was trained in sign language.

Three of the four residents had not received an SLT input in order to assess their communication and potentially provide recommendations for staff to follow in order to enhance communication. The person in charge confirmed that they were referred for SLT in 2025 and awaiting their assessments. The fourth resident had received SLT input, was recommended a communication device which they received, and staff were provided with training in relation to the device. However, from speaking with a staff member, the device was not consistently being used by staff to support the resident with their communication in their home. Therefore, the inspector was not assured that the resident was being supported in line with their assessed needs, meaning that staff were not being effective communication partners as recommended by the SLT, and a behaviour therapist in order to fully support and promote the resident's communication.

In addition, the first resident's communication information explained that they may initially give a thumbs down but will often change this response after thinking about the information. However, it was not recorded that the resident could also give a thumbs down as a joke, which the inspector observed.

In some cases the inspector had to review several documents to gather a more complete picture of the the residents communicated or how staff should communicate with them. Each document did not signpost the reader to additional documents to read in order to have all applicable information. This increased the risk that pertinent information may not be known to all staff, particularly temporary staff.

While there was a visual staff roster in the kitchen, it was found not to be in use. This was also identified at the last two six-monthly provider unannounced visits.

The inspector also found that there were no visuals available of daily activities or activities on offer in order to support a resident's understanding of the choices that

were on offer. While there were pictures of food choices available, it was unclear if they were in consistent use and they were not being displayed to alert the residents as to what was for dinner each day.

The inspector observed that residents had access to televisions, the radio, and the Internet while in the centre which would support their communication.

Judgment: Not compliant

Regulation 13: General welfare and development

The person in charge had ensured that residents had access to opportunities for leisure and recreation. Residents engaged in activities in their home and community. However, the frequency of which residents participated in external activities in their home could be improved and improvements were required to ensure residents' goals were progressed in line with their interests.

Residents were supported to attend day service programmes Monday to Friday. The inspector found that residents had went on individual hotel breaks in different locations in 2025. One resident already had plans in place to celebrate their upcoming birthday with a hotel break and a trip to a theme park.

A review of the three residents' daily notes over a one-week period in March 2026, and from reviewing pictures of their engagement in some community activities showed that residents were being offered activities based on their interests. For example, dinner out, horse riding, shopping, attending the barbers, swimming, a specific social club, and having a hot chocolate out.

From speaking with two staff members and a family representative, they believed that while residents did engage in some external activities further opportunities for participation in community access and recreation activities would be beneficial. Staff members felt that due to supervision levels required in order to ensure appropriate safeguarding measures so that one resident did not negatively impact on their peers, meant that on occasion some residents may not have the opportunity to participate in community activities as often as they may like.

Residents were supported to set and achieve personal goals in order to enhance their quality of life. For example, from a review of a sample of two different residents' goals, they were undertaking goals related to increasing their exercise or participating in a flight experience in a small airport. However, the inspector found that two goals for one resident that were set a number of years prior had not been progressed. They related to a resident exploring a particular profession that may interest them, and joining a local club with the future aim of independently participating without staff support. From reviewing documentation and speaking with a staff member on duty and the person in charge, it was unclear why the goals were not progressed.

Judgment: Substantially compliant

Regulation 17: Premises

The layout and design of the premises met the residents' needs and the house 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.

Each resident had their own bedroom with adequate space for their belongings. One family representative stated that their family member's home was 'nice'.

There was a sitting room and a separate kitchen with a dining space. Residents were found to make use of both of those spaces.

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.

As previously stated, while three patches of black residue were observed on two bathroom sinks, a television, and a kettle holder were observed to be dirty, they were cleaned prior to the end of the inspection. Further oversight requirements in this area were addressed under Regulations 23: Governance and Management.

Judgment: Compliant

Regulation 28: Fire precautions

While there were a number of suitable fire safety practices in place which included staff having received training in fire safety, and there was appropriate emergency lighting installed, the inspector identified improvements that required review regarding ensuring safe evacuation for all residents.

The inspector found from a review of the four personal emergency evacuation plans (PEEPs), that they outlined the residents' support requirements during an emergency. However, while one did state that a resident may refuse to evacuate, it did not state that they had refused to evacuate on several occasions. Their PEEP guided staff to use an evacuation box that was stored in the hall in the event they declined to evacuate. However, the box was found not to contain the items that were stated should be there. Therefore, the inspector was not assured as to the effectiveness of the box to ensure a safe evacuation for the resident in the event of an emergency.

A review of six fire practice drills demonstrated that regular fire evacuation drills were being completed in order to familiarise the residents with safe evacuation in the event of an emergency. One drill was completed during hours of darkness as required. However, there was no evidence to suggest, from speaking with a staff member or from a review of the practice drill documentation, that alternative evacuation routes were being practiced in order to ensure that residents could be evacuated from all areas of their home.

One resident had refused to evacuate during a drill in January 2026. While the provider's fire officer had reviewed the outcome of the drill and provided recommendations, those recommendations had not yet been trialled to see whether they would be effective in supporting the resident to evacuate.

Additionally, three of the four residents required supervision during an evacuation, with two of the three being described as requiring constant supervision in case they wandered or re-entered the house in the event of a fire. While staff were alerted to this in the residents' PEEPs and staff were advised to ensure the front gate was closed over, there was no evidence to suggest that this arrangement would be sufficient in ensuring everyone's safety especially as staff were lone working at night.

Furthermore, while the fire alert and detection system in place was found to be regularly serviced as required, the inspector sought clarification regarding the fire alarm system coverage as it did not appear to be meet the regulatory requirements.

There were fire containment doors in place fitted with self-closing devices, heat protection strips and cold smoke seals. Three of the fire containment doors were tested and found to not close properly themselves. Another door was found to have a larger than recommended gap between the door and the frame which could allow for fire to spread more easily through the building in the event of an emergency. However, the person in charge arranged for a member of the maintenance team to call to fix all of the identified doors prior to the end of the inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

While residents' needs were assessed and there were care plans in place as required to guide support, not all recommendations from allied healthcare professionals were being followed through on. In addition, further information was required in the behaviour support plan that guided staff as to how to best support one particular resident. As a result, oversight of clinical recommendations was insufficient to ensure residents received care tailored to their assessed needs.

From a review of the one resident's file, the inspector observed that the resident had a positive behavioural support plan to facilitate staff when supporting them. The

plan was created by a behaviour specialist to ensure that the resident was receiving appropriate supports.

As previous described, it was not evident if the most up-to-date behaviour support plan was present in the centre to guide staff. The behaviour support plan presented was found to outline guidance that staff needed to follow to support the resident with proactive and reactive strategies for some behaviours that the resident may present with. However, not all applicable information was contained. For instance, it did not describe the risk of the resident grabbing at other residents or moving their personal belongings and what proactive and reactive strategies staff should follow for those risks. This meant that other residents could be placed at increased risk from their peer's behaviour if staff were not appropriately guided. Notwithstanding that, a staff member spoken with appeared familiar with the resident's support needs in this area.

From a review of three residents' occupational therapy assessment reports, the inspector found that a number of recommendations were made in order to enhance residents' quality of life in certain areas. However, the inspector observed that the majority of the recommendations had not been followed through on in the centre for all three residents.

Some examples of recommendations made that were found not to be occurring included:

- the use of a yoga mat and floor time activities for one resident
- involvement in music and dance sessions, the person in charge said that as far as they were aware it was occurring in the resident's day service programme but not in their home
- to trial a monitor under another resident's mattress or on the floor in case they were up at night
- a handrail was recommended in a bathroom for one resident and a shower gel holder and they were found not to be in place
- while the resident was found to have infrequent foot massages, they were recommended to have face, foot, hand, and body massage
- the use of a rocking chair, trampoline or swing were recommended and found not to be in place for another resident
- supporting a resident with improving their tolerance for groups and social interaction skills by involvement in group activities and games initially as a passive observer with staff, for example play a musical instrument.

From speaking with the person in charge and a staff member on duty, the majority of the recommendations made by the OT, for the three residents, were not familiar to them. Therefore, significant improvements were required in this area in order to ensure that residents were receiving all recommended care and support that had the potential to improve their quality of life.

Judgment: Not compliant

Regulation 6: Health care

The residents' health needs were assessed and known to the staff supporting them.

As previously stated, a family representative spoken with communicated that staff were 'very responsive to their family member's health needs'.

The residents had access to a range of allied healthcare professionals for example:

- general practitioner (GP)
- behaviour therapist (BT)
- ophthalmologist
- OT
- physiotherapist
- SLT
- Dietitian.

One resident was also receiving specialist care and supervision regarding their recently diagnosed condition.

There were healthcare plans completed to support residents with their assessed healthcare needs. For example, an epilepsy care plan, a hospital passport should a resident require a hospital stay, and an eating, drinking and swallowing plan. A staff member spoken with was familiar as to the residents' support needs in those areas.

While improvements were required to ensure recommendations from multi-disciplinary professionals were consistently followed through in the centre, this was addressed under Regulation 5: Assessment of need and personal plan.

Judgment: Compliant

Regulation 8: Protection

While there were a number of suitable arrangements in place to safeguard the residents, due to compatibility issues between some of the residents, on occasions there were incidents when one resident was negatively impacting on their peers.

The registered provider had a policy in place to guide staff as to how to safeguard the residents and all staff had been provided with training in safeguarding vulnerable adults.

One staff spoken with explained to the inspector what actions they would take if they observed an abusive interaction occurring or if a disclosure was made. For example, they explained in the case of an unwitnessed disclosure that they would

gather the facts while being mindful not to ask leading questions to the person. They would report the incident and complete the necessary incident forms.

However, there were a number of occasions whereby the behaviours of one resident was negatively impacting on others living in the centre. For example, some incidents involved the resident physically attacking staff in the presence of other residents, pulling items out of their peers' hands or moving their peers' belongings while they were in use.

The provider had increased staffing levels in the centre in order to better ensure suitable staff supervision levels of residents and facilitate in mitigating potential safeguarding risks. While this was a positive step the safeguarding risk still remained and required a lot of staff supervision to ensure residents were not negatively impacted. The person in charge communicated that the resident was on the list for alternative accommodation should a suitable location become available.

The family representative and the four staff spoken with communicated that they felt comfortable raising concerns. At the time of this inspection, two staff members spoken with had concerns related to safeguarding in the centre. The current arrangements meant that staffing attention could be diverted away from improving quality of life or providing intimate care due to supervision requirements.

The inspector reviewed a sample of safeguarding incidents that occurred since January 2025 and found that potential safeguarding risks were escalated, reviewed, and reported to the relevant statutory agencies.

The inspector also found, from a review of one resident's finance records over March 2026, that staff were completing daily balance checks to ensure the residents' money was safeguarded. The person in charge completed a count of the money in the presence of the inspector and the count was found to be accurate. This demonstrated that the current oversight systems for safeguarding residents' finances was working as required.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Delvin Centre 2 OSV-0003956

Inspection ID: MON-0044939

Date of inspection: 18/03/2026

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 completed a comprehensive review of all training requirements for the Centre to ensure they align with residents assessed needs and service requirements.
• The Person in Charge has liaised with the training department and a structured schedule is now in place for all outstanding training needs identified in this report to be completed.
• Two additional training sessions in LAMH and Augmentative Alternative Communication have been scheduled to enhance staff competence and ensure residents are supported effectively by the staff team.

Regulation Heading	Judgment
Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• The Person in Charge has typed up the missing team meeting minutes and are now available in the designated centre. The Person in Charge has a schedule of monthly team meetings for the year and this has been shared with the staff team. Team meeting minutes will be typed after each meeting is completed.

• The Person in Charge has removed all outdated clinical information/reports/assessments from residents' files and only the most current in date documentation remain in the resident's folders to reduce the risk of residents receiving

inappropriate care this includes:

1. The most recent Speech and Language report for 1 resident.

2. Occupational Therapy reports for 4 residents.

3. A Behaviour Support Plan for 1 resident.

• The Person in Charge has ensured that the most recent Behaviour support meeting minutes and documentation is present for one resident. Also, a review of the Behaviour Support plan is scheduled for May 2026 to ensure the effectiveness of the Behaviour Support Plan.

• The PPIM- Area Director will deliver staff training specific to the requirement of developing maintaining and recording goals with residents with the full staff team to ensure that each resident has live and actional goals to work towards in line with their will and preference- This is scheduled for 03/06/2026.

• The Person in Charge has introduced a staff schedule for the completion of monthly audits. The Person in Charge will review these audits monthly. Also, a daily communication handover has been introduced to ensure that daily/ weekly and monthly documentation is being completed and all relevant information to ensure the care and support of each resident is maintained.

• The Person in Charge has updated the daily cleaning schedule and will review this schedule on a weekly basis to address gaps in recording or incomplete tasks. Regular IPC spot checks will be carried out by the Person in Charge, and an internal IPC audit has been completed since the date of the inspection with an action plan developed.

• The Person in Charge will submit a monthly report to the Area Director and a review of the compliance plan actions will be added to the agenda.

• The PPIM- Area Director has scheduled a meeting with the staff team in relation to record keeping and maintaining documentation within the Centre, with a specific focus on reviewing all current clinical guidance in place for all residents and assurance that all staff are aware of same.

• A monthly audit with a section for an action plan has been developed for the PIC to take handwritten notes. This will be discussed with the PPIM at monthly PIC and PPIM review.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: • The registered provider has reviewed the governance responsibilities of the Person in Charge and reduced their oversight from three locations to two. This change ensures the Person in Charge has sufficient capacity and oversight to effectively carry out administrative duties and adequate time to dedicate to each centre. The PPIM- Area Director will review this arrangement with the Person in Charge on a quarterly basis to assess the effectiveness of governance and management. • On the day of the inspection the Annual Review was not readily available to the inspector. This Annual Review has been completed and is now readily available and accessible in the Centre. A soft copy is also available should this be required going forward. • An Assessment of Need document has been introduced to capture all aspects of changing needs and recommendations by the multi-disciplinary teams involved in the Centre. These recommendations will be reflected in the Residents care plans. Only the most up to date information will be kept in the residents' folders and older/outdated information has been removed/archived. • One staff member as stated in the report had not been re-vetted since 2019. The vetting process has now started with this staff member. Garda vetting checks are now part of the provider led audit which will be completed every 6 months to ensure adequate monitoring of the vetting process. • The Regional Director has issued a communication to all Area Directors and Area Leads to ensure that Garda vetting audits for each designated centre are up to date. A report will be issued to the Regional Director on 30/04/2026. • Provider led audits that had been completed in May and November 2025 had shown similar actions in both audits. The person in Charge will submit the completed action plan to the Area Director for review after each audit to ensure these actions are addressed in the timeframes set out by the auditor. • The cleaning schedule has been adapted to ensure all areas of the Centre are appropriately cleaned and meet Infection Control standards. The Person in Charge will conduct weekly spot checks in the Centre and has also scheduled an Infection Control audit to be completed by an internal IPC auditor. • The PPIM-Area Director has scheduled monthly visits to the designated centre to review implantation of the compliance plan and all actions associated with it. • The PPIM-Area Director has scheduled monthly meetings with the PIC to review implantation of the compliance plan and all actions associated with it. • The PPIM-Area Director will update the regional Director monthly on the implantation of the compliance plan and all actions associated with it.	
Regulation 10: Communication	Not Compliant
Outline how you are going to come into compliance with Regulation 10: Communication:	

• Speech and Language reassessments have been requested to ensure each resident has their communication preferences and abilities documented so that they can communicate effectively.

• The Functional Communication programme and training developed in June 2025, is now implemented.

• Two training dates have been scheduled in relation to augmentative alternative communication and Lámh/sign language to ensure each resident can communicate effectively and that when they communicate their likes and preferences and frustrations, staff will be able to understand their communication and respond accordingly.

• Documentation relating to Speech and language therapy reports and communication has been reviewed and only the most up to date relevant information is now kept in the residents' care plan. All older documentation has been archived.

• The following picture schedules are being developed for each resident including:

- Daily menu picture schedule

- Daily staff roster picture schedule

-Daily Schedule of activities for each resident.

• The Person in Charge will monitor the resident's communication preferences and this will be on the agenda for monthly team meetings also for staff feedback.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

• The Person in Charge will review each individual's activity schedule with keyworkers to ensure each person can participate in their preferred interests. A weekly planner has been introduced so that staff can plan activities/goals effectively and this will add more structure to planning events.

• The Person in Charge has begun roster planning reviews to ensure that staffing is scheduled to meet the needs of residents availing of social opportunities.

• The Area Director has planned a Inservice training day for all staff to specifically y focus on person centered planning for all staff to attend to ensure that goals that are identified are documented and acted upon. Goal planning will be structured in SMART Goal format and reviewed monthly by the Person in Charge. A monthly goal activity

record will be discussed at team meetings by each resident's keyworker.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Personal Evacuation plans have been reviewed and updated to reflect each resident's required support to evacuate the Centre safely. Residents are evacuated to the assembly point at the front of the house. Personal evacuation plans have been updated to reflect that residents have not tried to re-enter the house or leave the assembly area during the evacuation drill to date
• Evacuation drills will involve evacuating from each of the three exits of the Centre and not just one exit to ensure residents and staff are aware of how to exit safely and what challenges may present during an evacuation.
• A new PEEP has been developed for one resident who has experienced difficulty participating in evacuation drills- advice has been sought from the Organisation's Fire Officer, and this is currently being trialed at present.
• On the day of the inspection, it was not clear whether the Fire Alarm system met regulatory requirements. It was confirmed by the Organisation's Fire Officer (Competent Fire Person) following the inspection that the Fire alarm system did meet the regulatory requirements.
• The Person in Charge will complete the monthly Fire audit and report the findings to the Fire Officer. The staff team complete daily/weekly and monthly checks regarding fire safety and report any issues to the Person in Charge.

• The Person in Charge and Fire Officer will complete a bi-annual review of the Fire Precautions in the Centre.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• One resident is supported by the Behaviour support team; on the day of the inspection the minutes of the most recent Behaviour support meeting were not present. These minutes are now in place that have clear reactive and proactive strategies documenting how to support the residents in stressful situations. A risk assessment is in place in relation to safeguarding of peers and how staff can be guided to support all residents

and reduce the risk to other residents. • A Behaviour Support meeting is scheduled for May 2026. • The Person in Charge has scheduled a full review of Occupational health and Physio recommendations is scheduled to ensure that all recommendations have been actioned in both the home and in day services provided. • The Person in Charge and Area Director will review the actions from this review and ensure that the staff team are adequately trained and that all recommendations are being adhered to. • The Area Director has scheduled a bi-annual review with the MDTmembers to review Occupational Therapy and Physiotherapy needs of the Centre.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: • As outlined in the report, the registered provider has increased staffing levels to ensure there is an increased presence in the Centre. • A Behaviour Support review is scheduled for one resident to ensure that a Positive Behaviour support plan is in place to protect residents from peer-to-peer abuse and guide to dealing with stressful situations. This will include reactive and proactive strategies for when the resident becomes stressed and guide staff on how to manage these situations and also identify possible triggers for behavioural incidents. The Safeguarding Designated Officer has also been invited to this meeting. This is scheduled for 27/05/2026. • Staff will be trained in augmentative communication and sign language to ensure they can communicate effectively with the residents. • All staff are trained in Safety Intervention Techniques. • All Safeguarding incidents are recorded and reported to the Person in Charge,The designated Safeguarding officer and regulatory bodies such as HIQA and the National Safeguarding Team. • The Person in Charge monitors Safeguarding incidents and Learning Outcomes are shared with the staff team. • The Designated Officer is available to the Person in Charge to discuss implementation of Safeguarding plans and to review them.

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.	Not Compliant	Orange	30/07/2026
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.	Not Compliant	Orange	30/07/2026
Regulation 10(3)(c)	The registered provider shall ensure that where required residents are supported to use assistive technology and aids and appliances.	Not Compliant	Orange	30/07/2026

Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	28/08/2026
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	30/07/2026
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	Yellow	31/05/2026
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	Not Compliant	Orange	30/07/2026

	and effectively monitored.			
Regulation 23(1)(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the chief inspector.	Not Compliant	Orange	30/07/2026
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	30/08/2026
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Not Compliant	Orange	30/08/2026
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Not Compliant	Orange	30/08/2026

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/06/2026