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:	Delta Evergreen
Name of provider:	Delta Centre CLG
Address of centre:	Carlow
Type of inspection:	Announced
Date of inspection:	17 August 2026
Centre ID:	OSV-0004708
Fieldwork ID:	MON-0042925

About the designated centre

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

Delta Evergreen is a residential designated centre for people with intellectual disabilities operated by Delta Centre Company Limited by Guarantee. The centre is situated in Carlow town. It comprises of two houses. All of the residents living within these community residential settings have daily access to Delta Centre Ltd campus in Carlow. Residents also have access to a wide range of community based social activities. The centre is managed by a person in charge and the staff team is made up of senior social care workers, social care workers and care assistants. Nursing care is also available when required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
Monday 17 August 2026	10:00hrs to 18:30hrs	Sarah Barry	Lead

What residents told us and what inspectors observed

This was an announced inspection, completed to monitor the provider's compliance with the regulations and to assist in informing the decision in relation to renewing the registration of the designated centre. It took place over one day and was carried out by one inspector. Using observations, engagement with the residents and staff and reviewing records pertaining to the care and support provided in this centre, the inspector observed that the residents were being provided with person centred care. Improvements were required under Regulation 6: Health care.

The designated centre comprised of two properties, located in a town in Co. Carlow. On the day of the inspection, the centre was home to eight people. Five residents lived in one of the properties, which consisted of a large dormer bungalow, and three residents lived in the second property which consisted of a two interconnected semi-detached houses.

The first house encompassed five residents' bedrooms, a staff sleepover room, two sitting rooms, a kitchen/dining room, three bathrooms and an utility room. The downstairs of the house was fully accessible to meet the mobility needs of the residents. The only room upstairs was the staff sleepover room. There was a patio/garden area with outdoor furniture, where residents could relax outside during the nice weather.

The second property was home to three people, at the time of this inspection. Residents' bedrooms were located upstairs in both of these adjacent houses and the downstairs of the houses were interconnected so that the three residents moved regularly between the two houses. There were two living rooms, two kitchen/dining rooms and a conservatory. There was also a staff sleepover room located upstairs in one of the houses. There was a garden to the rear of the house which residents accessed.

The inspector visited both locations over the course of the inspection. The houses were found to be well-maintained, homely and clean. One of the residents the inspector spoke with said there was nothing they would change about their home with the exception of the stairs up to their bedroom, which had impacted them last year when their mobility changed due to an injury.

The inspection was facilitated by two members of the provider's management team. On arrival to the first house in the centre, the inspector held an opening meeting with the members of the provider's management team. The residents were in various stages of starting their days. Four residents in this house were supported by staff from their home throughout the day. The inspector did not get the opportunity to meet the fifth resident who lived in this house as they were staying with family members at the time of the inspection.

The care and support needs and staffing levels were very different across the two houses in the designated centre. In the first house, four staff members worked in the centre during the day. The inspector met with the four staff members working in the house on the day of the inspection. All of the staff members knew the residents very well and were very knowledgeable of the resident's needs and the supports in place to meet those needs.

The inspector observed the staff members supporting the residents in a person-centred, professional and caring manner throughout the inspection. Residents in the house communicated in their own styles. The inspector was unable to receive verbal feedback from them about their lives in the centre and the care and support they received. One resident used their communication strategies to manually sign to the inspector that they were going for a drive to a local shopping area and this appeared to be something they were very happy about.

In the second house, there were no staff members rostered during the day, until the afternoon, when residents returned from their day service. The inspector met the staff member and two of the residents in the afternoon of the inspection. Both residents spoke very positively about their lives in the centre. One resident commented that "all staff are kind" and gave their consent to the inspector to include this quote in the inspection report.

Prior to the inspection, staff had supported residents to complete questionnaires regarding their feelings about their homes. The feedback in these questionnaires was very positive. One resident wrote "the staff are so helpful and kind and help us a lot". The inspector also met with some family members of a resident who were visiting their family member during the inspection. The resident had moved into their new home earlier in the year and the family members spoke about how they were happy with their family member's new home.

Residents spent their days engaged in activities in line with their interests. One resident had just returned from a break away with family. They spoke to the inspector about some historical sights they had visited and gave recommendations to the inspector for the area they had visited. Another resident had been to see a musical theatre show and recommended the show to the inspector. One of the residents competed in the recent Special Olympics Games. Four residents in the centre attended day service on a full time basis during the week and the other four residents were supported to engage in activities of their choice by staff throughout the day. A review of the daily notes demonstrated how staff respected the residents right to engage or not to engage in occupations of their choice and this was also reflected in conversations with staff members on the day of the inspection.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

The management structure in the centre was clearly defined with associated responsibilities and lines of authority. The person in charge had good oversight of the service and ensured that the staff team provided person-centred care.

Regulation 15: Staffing

The inspector found that the centre had effective staffing arrangements in place to meet the needs of the residents. At the time of the inspection, there was a vacancy of one Whole Time Equivalent (WTE) on the staff team across the centre. The inspector reviewed the actual rosters from June 15, 2026 to the date of the inspection. This demonstrated that the vacancy on the staff team was being covered by members of the provider's wider staff team and a small amount of agency staff in one of the houses. For example, from mid-June to mid-July, six shifts were covered by six different agency staff members. Agency staff members never lone worked in the centre. In the second house, no agency staff was utilized and all shifts since mid-June were covered by the staff team or members of the provider's wider staff team.

As mentioned earlier in this report, staff arrangements were different across the two houses in the designated centre. Two residents in the second house were supported by one staff member on their return to the centre in afternoon during the week. The third resident was supported by their own staff member until night time. One sleepover staff supported the three residents at night. The staff team consisted of social care workers and health care assistants. There was also input from members of the provider's wider staff team that were nurses. One nurse completed two shifts in one of the houses each month to assist the staff team with the residents' healthcare needs.

Team meetings were taking place in each house in the centre, every three months. The inspector reviewed the minutes of the meetings which had taken place for the year to date. There was a set agenda for each meeting, which included health and safety, resident's weekly meetings, training and safeguarding.

The inspector reviewed the staff files of three staff members working in the centre. They contained all the requirements of Schedule 2. For example, all three staff members had been vetted with An Garda Síochána.

Judgment: Compliant

Regulation 16: Training and staff development

The provider and person in charge had effective systems in place to record and monitor staff training. There was a staff training matrix in place in the centre, which the person in charge used to monitor when staff were required to complete refresher training in each area.

The inspector reviewed the training matrix and found that all staff had completed and were up to date with the training deemed mandatory for staff to support residents with their assessed needs in this centre, with the exception of new staff which had commenced in the centre just prior to the inspection. Some staff required to complete the practical assessment following a training course. There were arrangements in place to ensure that this did not impact on residents. The training that staff had completed included training in safeguarding, epilepsy, dementia and fire safety.

The person in charge had responsibility for completing supervision meetings with the staff team. The inspector reviewed the last three supervision records of three staff members. These records showed that these staff members were up to date with their supervisions, which occurred every three months, as per the provider's policy. These records also demonstrated that there was a set format for supervisions.

Judgment: Compliant

Regulation 23: Governance and management

The provider had ensured that there was management systems in place to ensure that the service provided was safe, appropriate to residents' needs and was consistently and effectively monitored. There was a full time person in charge appointed to the centre. Staff spoken with all felt very supported in their roles by the person in charge and felt they could approach the person in charge with any concerns.

There was a clear commitment from the provider, person in charge and staff to continual quality improvement. Audits were taking place in the centre every three months. These were either unannounced provider audits or audits conducted by the person in charge. Additional audits were taking place in areas such as medication management, incidents and infection prevention control. There was evidence of actions from audits improving the quality and safety of care delivered to residents. For example, a medication management audit had identified an increase in

medication errors. The provider and person in charge had put in place a number of actions and this had lead to a reduction in incidences.

There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The staff team were very knowledgeable about the support needs of the resident.

Staff in one house raised concerns regarding the transport options available to residents. There was one accessible vehicle attached to this house, which had space for one resident. Staff advised that if all the residents were going out for a meal, for example, it could take an hour for everyone to utilise the vehicle. There was also concerns regarding the limited number of drivers on the staff team. The inspector raised this concern with members of the provider's senior management team at the meeting at the close of the inspection. The provider discussed some of the measures they had taken to address the concerns. These included offering an initiative to staff regarding covering the financial cost of driving lessons, providing access to other vehicles within the organisation, changing the age restrictions on their vehicle insurance policy and coordinating transport for residents for big events organised by the provider.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

Admissions to the centre took into account the services outlined in the statement of purpose and the residents living in the centre. The inspector reviewed the admission process in relation to one of the most recent admissions to the centre. This resident had moved from another centre operated by the registered provider. The resident's changing needs meant that their previous home could no longer meet their needs.

A transition plan was put in place prior to the resident's move. This identified the resident's changing needs and what supports would be required in their new home and the health and social care professionals whose input was required. The plan documented the resident's visits to their new home, prior to the move.

Once the resident had moved to the centre, a progress report was implemented to track how the resident's transition was going. This was updated for six months following the move and contained a final comment on the success of the transition for the resident.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had a statement of purpose in place which accurately outlined the service provided and met the requirements of the regulations. The provider had submitted the statement of purpose to the regulator as part of their application to renew the registration of the centre.

The inspector reviewed the statement of purpose and found that it described the model of care and support delivered to the resident in the service and the day-to-day operation of the designated centre.

In addition, a walk around of the designated centre confirmed that the statement of purpose accurately described the layout of the designated centre, which consisted of two properties.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed the incident log of incidents that had occurred in the centre since the beginning of year and found no incidents that should have been reported which had not been reported to the Chief Inspector of Social Services.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of the service for the people who accessed services in the designated centre. The people who used the service enjoyed a safe and quality service in this centre. However, improvements were required under Regulation 6: Health care.

While the registered provider had ensured that residents had access to appropriate healthcare, there wasn't a comprehensive system in place to ensure that updates regarding the residents healthcare needs were communicated to the staff team.

The provider had a robust process in place for the oversight and management of restrictive practices.

Regulation 11: Visits

The registered provider and staff team had ensured the residents were supported to maintain links with important people in their lives.

A review of daily notes demonstrated that residents frequently received visits from family members. There was an open door policy to visiting in the centre, with family members dropping by without having to make prior arrangements. Residents spoke to the inspector about their families and how important spending time with them was.

Judgment: Compliant

Regulation 17: Premises

The centre was found to be clean, warm and welcoming on the day of the inspection. Each resident had their own bedroom and these were decorated with their personal items. There were multiple areas in both premises for residents to spend time and relax in.

One house was designed to be appropriately accessible for residents with additional mobility needs. This included additional equipment in the bathrooms and wide hallways. This was meeting the needs of the residents at the time of the inspection.

The centre met the requirements of Schedule 6, under the regulations. The houses were located on the outskirts of an urban area where residents could access local shops and amenities. They were also close to the day service that some of the residents attended.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had mitigated against the risk of fire by implementing suitable fire prevention and oversight measures. Fire drills had been completed in each house, with the highest and lowest staffing levels. Learning from drills were being implemented in the centre.

There was fire safety equipment in place in the centre and this included fire detection and alarm system, emergency lighting and fire extinguishers. The inspector reviewed the servicing records for this equipment in one of the houses in the designated centre. These records demonstrated that the equipment had been serviced by competent fire personnel, for example, the fire alarm and fire detection systems had been serviced in July 2026 and the fire extinguishers had been serviced in January 2026.

Staff in the centre completed weekly checks on the fire doors, fire blankets, the fire panel and fire exits.

Judgment: Compliant

Regulation 6: Health care

The registered provider had provided appropriate healthcare for each resident. However, improvements were required to the provider's systems to ensure that any changes to residents' healthcare needs were communicated effectively to the staff team. A resident had recently been admitted to hospital and during their hospital stay, there had been changes made to one of their medications. However, upon return to the centre, there was no formal system in place to communicate this change to staff. This change would be reflected in the relevant support plan, however, there was no system in place to communicate this change, while the support plan was being updated by the relevant medical professionals. A member of the provider's management team sent an email to staff during the inspection to address this gap.

Residents were in receipt of care from a range of medical and health and social care professionals. These included opticians, audiologists, general practitioners (GPs) and behavioural therapists. Where residents had an identified healthcare need, there was a support plan in place to support and guide staff to support the residents. The provider's nursing team were also available to support residents and a staff completed two shifts per month in one of the houses to support with the residents healthcare needs.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

At the time of this inspection, there were a number of restrictive practices applied in the centre. The person in charge had notified all of the restrictive practices to the Chief Inspector of Social Services, as required by the regulations.

The provider had a robust process in place for the oversight and management of restrictive practices. There was a restraint register in place and this had last been updated in August 2026. Each restrictive practice was reviewed quarterly, with a full review taking place annually. This annual review involved examining if there were less restrictive alternatives available and if any required clinical supports were in place. Each restrictive practice also had a corresponding risk assessment. There was also accessible information in place for residents in relation to restrictive practices

that impacted on them. For example, there was an easy-to-read support plan in place for residents regarding their finances, which staff supported them to manage.

Where residents had an identified need regarding positive behaviour support, there was a support plan in place. The inspector reviewed the positive behaviour support plan in place for one resident. This plan had been completed by a relevant health and social care professional. It had been updated within the last 12 months and contained detailed guidance for staff to support the resident with their needs in this area.

Judgment: Compliant

Regulation 8: Protection

The service had put in place safeguarding measures to promote and protect people who use the service and their health and wellbeing, as well as empowering people to protect themselves.

At the time of this inspection, there were no open safeguarding concerns in the centre. The inspector reviewed a previous safeguarding incident and found that the provider's policy in relation to safeguarding incidents had been followed. In addition, a debrief form had been completed with the resident affected. This was done in an accessible format with the resident given the opportunity to describe what happened, either in a written or pictorial format. When addressing how the resident felt at the time and how they felt following the incident, the format utilised popular emojis to facilitate the resident to communicate their feelings. The form also asked the resident if there was anything that the provider should do if something were to occur again, to further support the resident.

The inspector reviewed the support plan in place to support one resident with their personal and intimate care needs. This contained guidance for staff to protect the resident's dignity and privacy.

All staff had completed training in safeguarding and the staff spoken to were knowledgeable about the processes in place to protect residents.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Delta Evergreen OSV-0004708

Inspection ID: MON-0042925

Date of inspection: 17/08/2026

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 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: The Person in Charge has established a dedicated staff team group email to communicate important updates relating to changes to residents' medication, healthcare needs, changes in care arrangements, risk management and any relevant protocols. The staff communication/handovers system will be maintained to ensure that important information is communicated between shifts and that relevant updates are not dependent solely on verbal communication.	

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 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	21/09/2026