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:	Unannounced
Date of inspection:	19 November 2025
Centre ID:	OSV-0003955
Fieldwork ID:	MON-0048281

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:	11

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 19 November 2025	15:15hrs to 20:45hrs	Karena Butler	Lead
Thursday 20 November 2025	09:30hrs to 18:10hrs	Karena Butler	Lead

What residents told us and what inspectors observed

This was an unannounced inspection conducted over two days with a specific focus on how residents were safeguarded in the centre. From what the inspector observed, it was evident that efforts were being made to promote a holistic safeguarding culture and to ensure residents were safeguarded in their home. However, the inspector found that improvements were required under four regulations, individual assessment and personal plan, training and staff development, governance and management, and risk management.

Examples of some areas identified related to, ensuring periodic servicing of residents' equipment as well as ensuring appropriate and timely follow up to issues identified in the servicing of the heating systems. In addition, some minor issues were identified relating to policies requiring review, ensuring personal plans and assessment of need documents contained all applicable information, and ensuring all staff have required training including refresher training. Those regulations and identified areas for improvement will be discussed further, later in this report.

The centre was made up of three houses within a short driving distance from one another. The inspector had the opportunity to meet the 11 residents living in the centre. In order to gather information for this inspection, the inspector spoke with one resident in detail, and spoke briefly with three other residents. The remaining seven residents with alternative communication methods, did not share their views with the inspector, and were observed throughout the course of the inspection at different times in their homes.

One resident spoke briefly to the inspector. However, they chose not to share their views on the service provided to them or with regard to their home other than to say they were happy and felt safe. They indicated that they did not want to speak anymore and that choice was respected by the inspector. Another resident spoke briefly about feeling happy with the staff that worked with them and liking their house and otherwise wanted to speak about topics of interest to them which included wanting to know more about the purpose of this inspection. A third resident communicated they were happy and the staff team were nice. They also said they felt safe. They communicated clearly that they did not want any further questions and preferred the inspector to stay in the staff office to review documents.

It was clear from speaking in more depth with one resident that they liked their home, they loved their room and how it was laid out, they liked their staff team, and felt that they had choices each day with regard to what they ate and what activities they engaged in. They said they felt safe in their home. They said they had no concerns and if they were to have any concerns that they would tell a staff member. They said that while they could have some issues with one housemate standing in the hallway outside of their room, they confirmed that their housemate never went into their room without permission since the staff explained to their housemate that

they wouldn't like that.

On the evening of day one of the inspection, some residents had attended an 80th birthday party, some residents attended a day service programme, others had attended a garden centre to buy flowers for their house, one resident went swimming, and another chose to go out for coffee. The following day, three residents in house one and two residents from house three, attended their day service programme. One resident went out for coffee and then attended horse riding. Two residents attended different hairdressers, one resident participated in a computer class, one resident went out for tea, and the last resident went to an appointment followed by dinner out and shopping. This demonstrated to the inspector that residents were being supported to engage in activities in the community and as per their interests.

The inspector observed interactions between some residents and staff, spoke with the person in charge and eight staff members, and reviewed documentation over the course of the inspection. From observations, it was evident that residents were comfortable in the presence of the staff members that supported them.

Staff were observed on different occasions to actively listen to residents, they gave them time to talk and did not rush them. For example, a staff in house one used hand tapping to support a resident who communicated non-verbally whether they wanted to spend time in their room or in the kitchen. They were observed repeatedly engaging with the resident to ensure they were comfortable and happy.

The provider had arranged for staff to have training in human rights. One staff member spoken with was asked about how they were putting this training into everyday practice to promote the rights of the residents. They explained, that prior to having the training they might have stuck more rigidly to planned schedules and since having the training they tried to ensure that they were ensuring that the resident still wanted to complete the scheduled activity or task. They explained that they wanted to ensure that they were giving choices to the individuals that they support with regard to decisions that affect their lives.

The inspector had the opportunity to speak with three family representatives, one from each house. The feedback received was very positive. All three representatives felt that their family members were safe and well taken care of. They had no concerns and confirmed that they would feel comfortable raising concerns if they had any. They believed that they would be listened to. All three were complimentary of the staff that supported their family members.

The inspector conducted a walkabout of each of three houses which made up this centre. While residents were comfortable, observations showed that some areas of their homes required maintenance to ensure they were free from mildew and ensure heating systems were appropriately maintained as per professional recommendations. The inspector did find that the houses were well maintained and tidy other than what was previously mentioned. There was an accessible front and back garden for each house. There were mature plants in the gardens which provided a welcoming look for the properties.

The inspector reviewed the complaints log for one house as well as speaking with the person in charge, and found that there were no complaints in 2025.

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 an unannounced inspection with a focus to review the arrangements the provider had in place to ensure 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) and the National Standards for Adult Safeguarding (2019). It followed a regulatory notice issued by the Chief Inspector of Social Services (The Chief Inspector) in June 2024 in which the safeguarding of residents was outlined as one of the most important responsibilities of a designated centre and fundamental to the provision of high quality care and support. Furthermore, that safeguarding was more than the prevention of abuse, but a holistic approach that promoted people's human rights and empowered them to exercise choice and control over their lives.

Overall, it was apparent that any concerns or allegations were taken seriously, appropriate actions and investigations were undertaken as required, and safeguarding was given high priority by the provider, the management team, and the staff team. However, some improvements were required to aspects of governance and management as well as training and staff development.

From a review of the provider's governance and management arrangements, the inspector found that, while there were many appropriate systems in place in order to ensure the quality and safety of the service some improvements were required, for example as some policies required review.

There were adequate staffing levels available to safely support the residents. From a review of staff training, for the most part staff had the required skills to meet the assessed needs of residents. It was not evident if agency staff had training in epilepsy, and some staff required refresher training in some areas related to infection, prevention, and control (IPC).

Regulation 15: Staffing

On the day of the unannounced inspection, the registered provider ensured that there were sufficient staffing levels to meet the assessed needs of the residents.

The inspector reviewed a sample of rosters of three months September to November in 2025. This review demonstrated to the inspector that there were adequate staff to meet the needs of residents during the day and night.

While there was not a full complement of staff for the centre, the person in charge was using a number of regular consistent relief and agency staff in order to fill the roster. This facilitated continuity of care and ensured familiar staff worked with the residents to meet their assessed needs and to promote a safe environment.

Interactions between staff and residents were observed to be kind and respectful. The inspector spoke with the person in charge and six staff members during the course of the inspection, and found them to be knowledgeable about the support needs and any safeguarding requirements for the residents. Staff members spoken with were familiar with the residents' care plans and preferences in respect of their care.

The inspector observed six staff member's Garda Síochána (police) vetting (GV) certificate for a mixture of support workers, relief staff, and agency staff. In addition, the inspector observed the provider also ensured they had sought a police clearance certificate for one staff member. This demonstrated that the provider had arrangements for safe recruitment practices.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector viewed the staff training matrix and found that there were improvements in the oversight and maintenance of records since the last inspection of this centre. The inspector also reviewed a sample of training certification across five training areas, for example fire safety. This review demonstrated that staff had received a suite of training in key areas in order to ensure staff knew how to support the residents in line with their assessed needs, as well as to safeguard and protect them. However, some refresher training was required in the area of IPC, and it was not clear if agency staff had all of the required training to work in house two.

While staff completed a number of trainings related to IPC, the inspector found that refresher training was required.

For example:

- the personal protective equipment (PPE) training for five staff had expired
- one staff required refresher training in standard and transmission based precautions
- one staff required refresher training in cough etiquette and respiratory hygiene.

Those trainings would support staff to have the necessary skills and up-to-date

knowledge in key areas of IPC. This in turn would facilitate residents being safeguarded from the risk of developing healthcare associated infections and manage infection control risks should they occur. In the absence of those training courses, this had the potential to put the residents at increased risk.

Training provided to staff included:

- safeguarding of vulnerable adults
- children first
- catheter training
- aseptic techniques
- cardiac first response
- medication management
- feeding, eating, and drinking.

No evidence was presented to the inspector if agency staff working in house two had training in epilepsy, and the administration of emergency epilepsy medication. This would put residents who had a diagnoses of epilepsy at risk if they were to have a seizure when no trained staff were supporting them.

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

Judgment: Substantially compliant

Regulation 23: Governance and management

There were many sufficient management systems in place for oversight of the safety of the residents in the centre. For example, there was a clearly defined management structure in place and a staff member spoken with was able to confirm the reporting structure to the inspector. Six staff explained they would be comfortable reporting any concern to management if one arose. However, improvement was required to ensure up-to-date policies were in place in order to effectively guide staff practice, to ensure defined time frames for reporting concerns to external bodies were met, and to ensure that staff receive timely refresher training in areas deemed mandatory prior to their training expired.

The inspector found that, further oversight of training was required. For example, two staff members had gaps of three to six months between their safeguarding training expiring and the completion of their refresher course. This would put residents at increased risk of staff not being knowledgeable in their roles and responsibilities with regard to safeguarding.

The inspector found in one case, that while an external agency responsible for safeguarding was informed in relation to one potential safeguarding concern, the provider had not ensured that the concern was reported within prescribed time

frames having been reported nearly two months later instead of within three days. While the reporting system was evident for other concerns raised, and this was found to be a specific lapse, improvement was required to ensure the provider always meets their mandated time frames.

The inspector reviewed the organisation's Schedule 5 policy folder. The regulatory requirement is that Schedule 5 policies were required to be in place, were to be made available to staff and were to be reviewed every three years or sooner if needed. All required policies where found to be available for staff; however, not all policies were found to be reviewed within the prescribed review period. In the absence of up-to-date policies staff may not be appropriately guided in line with best practice on how to support and keep residents safe, and safeguarding them from inappropriate practices.

Policies found to be outside of the three year review period were:

- provision of behavioural support, which was due for review June 2024
- the use of restrictive procedures and physical, chemical and environmental restraint, which was due for review June 2024
- residents' personal property, personal finances and possessions, which was due for review September 2025
- staff training and development, which was due for review September 2025
- the policy related to the handling and investigating of complaints, which was due for review February 2025.

There were different monitoring and oversight processes in place in relation to the safeguarding of residents. For example, unannounced six-month provider-led visits were conducted and regular audits covering topics, such as health and safety, fire safety, the vehicle, medication, and finances.

Monthly staff meetings were held and from a review of the minutes of two meetings in each house, safeguarding was a standing item at each of these meetings. Other topics for discussion included, health and safety, complaints, finances, and restrictive practices. Incidents were also reviewed at meetings and any learning that arose was shared and discussed with the staff team for learning and to ensure consistency of approach.

Judgment: Substantially compliant

Quality and safety

This inspection found that this centre was ensuring that residents were treated with respect and dignity and that their human rights, including the right to be safe from abuse, were being upheld. However, a number of improvements were required in relation to risk management. Additionally, some improvements were required in

relation to individual assessment and personal plan.

While there were many appropriate systems in place for risk management to ensure that risks were identified and monitored, some significant areas for improvement were required and they will be discussed further under the specific regulation. For example, it was not evident that required recommendations for adjustments to the heating systems were followed up or completed. This meant the provider could not fully assure that residents were living in a safe environment or that their homes would remain adequately heated.

The provider had assessed the needs of residents and support plans were developed as deemed applicable, to help guide staff on how to support the residents in the safest and most appropriate way. However, some areas were identified as requiring improvement. For example, ensuring all applicable information is recorded and to ensure consistency of approach when supporting the residents.

The inspector observed that the premises was suitable in providing a safe environment for the residents to live in. For example, the houses were tidy and exit points were free from obstruction.

The provider was facilitating appropriate positive behaviour support in the centre which supported residents to be safeguarded, as far as possible, from any negative consequences of their behaviour towards themselves or others.

While there were restrictive practices in place, for example a lap belt on a wheelchair, they were observed to be in place for the safety of those residents.

There were adequate systems in place with regard to protection of residents. The inspector found that concerns or allegations of potential abuse were investigated and reported to relevant agencies.

The inspector observed that, the individual choices and preferences of the residents were promoted and supported by staff. Communication was promoted in relation to safeguarding as well as all aspects of daily life. For example, referrals submitted for some residents for speech and language therapy to see if there was any further support that could be provided for their communication.

Regulation 10: Communication

On the day of the inspection, there were adequate arrangements in place to promote communication.

The three staff members spoken with demonstrated a clear understanding of the residents' communication methods and how staff should communicate with them. One staff provided examples to the inspector, such as if a resident repeated information, that you don't interrupt them or try to reassure them. They explained the resident needed time to process the information that had just been said before

the conversation could be moved on.

The inspector saw staff interact with the residents in a dignified and person-centered manner. For example, a staff member was observed taking their time communicating information and asking the resident to use hand taps for 'yes' or 'no' answers. The resident was observed to respond effectively using this method.

In addition, a number of staff were found to have been trained in how to use a simplified manual sign language.

The inspector found that one resident had received speech and language therapy (SALT) input in the past so as to maximise effective communication. Recent referrals for the residents in this designated centre for review of their communication from SALT had been submitted.

From a review of two residents' files, one the inspector observed that there were communication dictionaries in place which detailed residents' preferred style of communication and how best to support them to communicate their needs. For example, "what I do, what this might mean, and what you should do". Some further information was required in order to ensure all staff understood how the residents may communicate. A familiar staff member updated the information on the day of the inspection.

Information was available for residents in an easy-to-read format in order to promote their understanding. For example, there was information on making a will, keeping you safe, Autism, preventing constipation.

In addition, residents had access to a television, radio, and the Internet which provided different sources of information to them.

Judgment: Compliant

Regulation 17: Premises

The inspector found that the premises were suitable for the assessed needs of the residents. This demonstrated that the safeguarding of residents included providing a safe living environment. For example, each house was a single storey which suited the mobility requirements of some residents and ensured that all of their home was accessible for them.

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

The houses were kept in a good state of repair and were found to be tidy. For the most part they were found to be clean. Although some mildew was observed in house two the majority of which was cleaned prior to the end of the inspection, this

issue is being actioned under Regulation 26: Risk management.

From observation of the residents' bedrooms, the inspector found them to be individually decorated and arranged to suit each resident's assessed needs and preferences.

Judgment: Compliant

Regulation 26: Risk management procedures

While some appropriate risk processes were in place, a number of risks were identified regarding the maintenance of essential heating systems, infection control, and the servicing of equipment used to support residents.

While the boilers in all three houses were serviced in May 2025, not all identified faults had been addressed. The person in charge communicated that the identified works for one house had been completed. They were unsure as to works in relation to house two which required an oil filter. The works identified for house three, which included the location of the boiler not being appropriate and a new drain pipe required, were still in progress with quotes received although no set dates for completion.

In two houses, there was no evidence to suggest that equipment used to support the residents had been serviced since May 2024 in order to ensure they were fit for purpose for the residents.

The inspector observed that in two houses that there was inappropriate storage of the colour coded mops and buckets that were in place in order to prevent cross contamination. Therefore, inappropriate storage and usage of this equipment could increase the chances of residents contracting a healthcare related illness.

In addition, mildew was observed around the back and side door of house two. While the majority of this was cleaned by day two of this inspection, this issue had been identified on a previous inspection for this centre demonstrating that this was an on-going issue for this house. Mildew had the potential to negatively impact on a person's respiratory health.

The inspector reviewed accidents and incidents, for two of the houses, which had occurred in the centre since January 2025. They were found to be reviewed by the person in charge and learning from adverse incidents was shared with the staff at team meetings. For example, as a result of a medication error one staff received refresher training for medicines management in order to ensure that they had the right information and competency to safely administer medication to the residents.

The inspector reviewed the fire safety arrangements in place to safeguard residents from the risk or fire and found that fire safety arrangements were appropriate. This included servicing of firefighting equipment, emergency lighting, and detection.

Regular fire practice drills were completed to assure the provider that residents could be evacuated for all areas of the houses and included drills during hours of darkness and with minimum staffing levels with maximum residents participating.

Four fire containment doors across the three houses would not close fully by themselves. This could impact on the containment of smoke and fire in the event of an emergency. One emergency light was found not to be working. Both the lighting and the doors were fixed on the day of the inspection.

The provider had ensured a risk management policy was in place to guide staff on risk management procedures. The policy was subject to periodic review and was not due again for review until June 2026.

There was a risk register and associated risk assessments in place for identified risks both centre specific and risk assessments for individuals as required. Risk assessments contained control measures that were for the most part found to be in place in order to minimise or prevent the likelihood of the risk occurring and reduce the impact on individuals. For example, there was a risk assessment in place for slips, trips and falls with control measures in place to mitigate the chances of occurrence, such as bed rails were in use.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

While the provider had systems in place for the assessment of residents' needs and ensured that personal plans were in place as required, the inspector observed some areas that required improvement.

The inspector reviewed a sample of four residents' assessment of need documents and personal plans. While the assessment of need document contained a lot of important and clear information in order to ensure residents' social and financial needs were assessed, some topics were not covered by the assessment. For example, it was not evident if areas related to healthcare, mental health, dietary requirements or independence in the home and community as well as road safety were assessed. This was important in order to ensure the correct supports were in place to safeguard residents, and in order to facilitate residents' independence.

There were personal plans in place for people who required support in specific areas.

Examples of plans included:

- feeding, eating and drinking
- managing a safe environment
- epilepsy
- catheterisation

- hospital passports to guide hospital staff should a resident require to be admitted.

All plans reviewed by the inspector had received a review date within the last year to ensure information provided to staff was accurate. Two residents' had protocols in place as to when to administer emergency medication should they have a seizure. However, there was no evidence that the guidance with regard to time frames for when to administer the emergency medication, was directed by the prescribing professional. The separate document signed by the prescribing professional had not described any specific time frames of when to administer this medication, just the dosage that could be administered within a 24 hour period.

Two staff spoken with confidently informed the inspector as to when the residents should receive their doses of this medication which was in line with the residents' protocols.

From a sample of the other plans reviewed, the guidance provided for staff in order to support the residents was found to be clear. Discrepancies were noted between digital and printed personal plans. For example, a printed intimate care plan lacked specific guidance found in the digital version regarding a resident's preference to lie down after hair washing. This inconsistency posed a risk that staff might miss current care guidance. In addition, it was recommended in a safeguarding plan, following some safeguarding incidents in house three, that behaviour support advice would be sought for one resident. However, it was not evident that this had been followed through on. This meant that staff may not be in receipt of pertinent information and advice in order to appropriately support the resident.

Notwithstanding, staff spoken with could explain their role in ensuring the safety of residents in areas requiring support. For example, staff were able to discuss what supports were required in relation to minimising the potential of safeguarding incidents from occurring, preventing a choking episode, or in relation to the steps for catheterisation.

The inspector observed that residents were supported to make and achieve goals. While it was evident some goals were being supported, it was not evident if all goals were being progressed. For instance, one resident in house one was afraid of cats and dogs and there was a recorded goal to help them with this fear; however, there was no evidence of any supports having been provided and staff member spoken with was not familiar with this goal. In house two, again there was no evidence of some goals had been supported that were mentioned in a meeting in October 2024, such as to re-introduce swimming. While the goal to re-introduce horse riding was occurring, the steps in order to achieve this were not recorded in order to guide staff appropriately. From speaking with the local manager for this house, this appeared to be more of a documentation issue as they were able to speak in detail as to the step-by-step approach that was adopted in order to promote a successful return to that activity. The inspector also observed that an annual meeting was overdue for that resident to review their goals. The meeting had been due in Oct 2025. In the absence of appropriate tracking of residents' goals it was difficult to ascertain if residents were being supported appropriately to achieve their goals in

order to enhance their quality of life.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents had access to the necessary support to manage behaviours that may cause distress to themselves or others and in turn provide appropriate safeguards.

Residents had access to a behaviour support specialist and senior clinical psychologist. From a review of two residents' files, annual or sooner if required, behaviour support meetings were held in relation to some residents to discuss supports they may require or to review existing supports to ensure appropriateness and effectiveness.

Where required, residents had a positive behavioural support plan in place which was reviewed by a behaviour specialist. From a review of one resident's plan they had documented proactive and reactive de-escalation strategies that were incorporated as part of their behaviour support planning. The plan also included post incident guidance to staff. While the inspector noted that not all listed behaviours that the person may display had a staff response, such as self-injurious behaviour, this was actioned under Regulation 5: Individual assessment and personal plan

Staff had received training related to positive behaviour support. The person in charge and two staff members spoken with, were knowledgeable as to how to respond to residents with proactive strategies, how a resident may present when distressed and what responses were appropriate under the circumstances.

While there were some restrictive practices in place, such as bed rails, and a monitor at night for alerting staff if a resident had a seizure, they were in place to ensure the safety of the residents. Any restrictive intervention had been assessed to ensure its use was in line with best practice and they were subject to periodic review by organisation's restrictive practice committee. Where restrictive practices were deemed no longer required, they were discontinued in order to ensure that residents were not being unnecessarily restricted.

Judgment: Compliant

Regulation 8: Protection

The arrangements in the centre promoted residents' safety and protection from the risk of abuse.

There was a clear reporting structure in place for reporting any potential

safeguarding concerns to the line manager and designated officer. Concerns were found to be reviewed and where required safeguarding plans were developed to ensure they were effective. It was evident that, any safeguarding concerns or allegations were responded to appropriately and in a transparent manner. Concerns were observed to be reported to the relevant statutory agencies. In one instance the inspector observed a concern was notified to a statutory body outside of prescribed time frames. While the resident was immediately safeguarded, the administrative reporting to the agency was delayed and therefore this was actioned under Regulation 23: Governance and management.

Staff had received safeguarding vulnerable adults training, and the majority of staff had training in communicating effectively through open disclosures, which would facilitate residents being safeguarded in their home.

Three staff spoken with were able to explain about their role and responsibilities in ensuring the safety of residents. They were aware of various types of abuse, the signs of abuse that might be of concern, and their role in responding to any concerns. All eight staff spoken with confirmed that they would feel comfortable reporting any concerns they may have. No staff member had any concerns at the time of this inspection.

'Lets talk about safeguarding' posters were displayed in the houses to alert people to national safeguarding day 14 November 2025. The provider had asked people to send entries in of what safeguarding means to you.

Residents' finances were safeguarded through the various checks and audits completed. For example, from a review of two residents' money balance sheet for October to November 2025, the inspector observed that staff completed regular balance checks and the sheet was signed off by staff. The inspector reviewed the money balance for one resident and found that their money balance sheet matched the amount of money in place. This demonstrated to the inspector that there was appropriate safeguards and oversight of residents' finances.

The inspector reviewed three intimate care plans across the three houses and found they adequately guided staff as to supports residents required in that area. This ensured they were afforded the correct supports in the right manner to promote independence, dignity, and their safety. For example, one resident prefers a cooling moisturiser for under their arms after shaving. While one resident's plan required more information and ensuring that the information matched that contained in the soft copy versus hard copy plan, this was actioned under Regulation 5: individual assessment and personal plan.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that there were adequate arrangements in order to uphold and

promote the rights of residents.

The inspector spoke with one resident, the person in charge, and three staff members regarding rights and choices about everyday life choices. The inspector found that residents were supported to make their own decisions and choices about their daily lives. For example, what they wanted to eat and how they wanted to spend their day.

Residents were also supported to have visitors or visit family. A family representative communicated that they felt welcome to visit and confirmed that their family member was supported to visit them. The person in charge and the family representative communicated that a meeting to discuss the resident's support needs was being organised for the week after the inspection at a location that suited the family representative. This was due to them not being able to travel at present and therefore ensuring they could be present at the meeting, which was in line with the resident's wishes.

There were weekly residents' meetings taking place. From a more in depth review of the minutes from the meetings held during October 2025 in house two, the minutes demonstrated to the inspector that different topics were discussed in order to keep residents informed and aware of areas that may impact them. Topics included, to plan their weekly menus and activities, complaints, restrictive practices, and rights.

One resident had communicated through their behaviour that they were unhappy with too many people in their home at any one time. In response, a visitors' protocol had been put in place to ensure that the resident could get notice of visits and make other arrangements if they did not want to be present at the time when others were having visitors.

In addition to receiving training on human rights, staff had received training around the Assisted Decision-Making (Capacity) Act. Those trainings would facilitate a supportive culture and promote residents' rights.

This demonstrated to the inspector that residents' known and expressed wishes were respected and supported in this centre.

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	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Delvin Centre 1 OSV-0003955

Inspection ID: MON-0048281

Date of inspection: 20/11/2025

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 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 and PPIM have reviewed the staff training records and have scheduled staffs for all outstanding Refresher Training in relation to IPC – this training facilitates residents being safeguarded from the risk of developing healthcare associated infections and manage infection control risks should they occur. • Refresher Training scheduled for PPE, Standard and Transmission based Precautions and Cough Etiquette and Respiratory Hygiene, scheduled for full completion on 31/12/2025 • On the day following the inspection the Person in Charge received the up-to-date training records for the two-agency staff identified in the report. Both staff were adequately trained in Epilepsy and Epilepsy medication administration. This training record was requested and is and is on file for the locations within Delvin Centre 1 as a requirement when agency staff are deployed.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The registered provided is in the process of reviewing the Policies outlined in the report that were past the 3-year review date. This will ensure that staff will be guided in line with best practice on how to support and keep the residents safe and safeguarding them from inappropriate practices. All reviews are scheduled for completion on 12/01/2026. • A full training review has taken place and staff have been scheduled to attend refresher training in Infection, Prevention and Control. • The registered provider will ensure that all Safeguarding concerns are reported to	

external bodies within the prescribed timeframes as situations arise. All agency staff receive an induction from the PIC or nominated staff which outline recognizing and reporting responsibilities in line with the national Safeguarding of Vulnerable Adults policy.
• The Person in Charge has reviewed staff Safeguarding Training to ensure all staff are up to date and training is delivered within the timeframes recommended, all training is now completed.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

• All three locations within the Centre had boiler service records available on the day of the inspection. However, on the day it was not clear whether actions identified had been addressed following the service. The Person in Charge has requested an update on progress of the actions and requested prompt action be taken in completing the tasks identified.
• The Person in Charge has requested and obtained maintenance records of equipment used to support the residents in 2025. These are kept on site for future audits/inspections.
• The Person in Charge has reviewed the cleaning schedule and Infection Control guidance to ensure that storage of Mop Buckets and colour coded mop heads are stored in line with best practice to reduce the risk of infection and healthcare related illness- a communication has been issued to all staff from the PIC on this matter.
• The Person in Charge has requested and completed a deep clean and seal of the surfaces where mildew was present in one location. The cleaning schedule has been updated to ensure that this issue is resolved therefore reducing the risk of respiratory health issues for the residents.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• The Person in Charge has introduced a new Assessment of Needs document that will capture all areas of specific care requirements including healthcare, mental health, dietary requirements, safe environment and levels of independence for each resident.
• A review of PRN protocols by a prescribing professional for Epilepsy medication to include identifying specific timeframes for administration and maximum dosage in a 24hr period has been completed.
• The Person in Charge has removed printed versions of Care plans and the up-to-date digital version is in place to ensure consistency in care guidance and support for residents. Personal plans will be reviewed at least annually or sooner if required. A multi-disciplinary approach will be taken upon any review taken.
• The Person in Charge has organized a Behaviour Support review for one resident as

advised following a review of Safeguarding incidents in one location.
• The Person in Charge reviews set goals monthly to ensure those identified are completed or in the process of completion depending on the identified goal. A monthly review template is in place to ensure and monitor progress of each individual's set goals.

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 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	31/12/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	12/01/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Not Compliant	Orange	01/04/2026

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	11/12/2025
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	01/05/2026
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there	Substantially Compliant	Yellow	01/05/2026

	is a change in needs or circumstances, which review shall be multidisciplinary.			