Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Glendonagh Residential Home
Name of provider:	Glendonagh Residential Home Limited
Address of centre:	Dungourney, Midleton, Cork
Type of inspection:	Unannounced
Date of inspection:	17 June 2025
Centre ID:	OSV-0000229
Fieldwork ID:	MON-0046797

About the designated centre

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

Glendonagh Residential Home is located near the village of Dungourney in East Cork. It is set on well maintained, extensive grounds. The centre is registered as a designated centre under the Health Act 2007 for the care of 42 residents with 24-hour nursing care available. The centre is registered to provide accommodation for 42 residents over two floors. There is a specific nine bedded dementia care unit for residents who required additional support called the Orchard unit. Care is provided by a team of nursing staff who are supported by care, catering, household and activity staff. Medical and allied healthcare professionals provide ongoing healthcare for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	36

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 17 June 2025	20:20hrs to 02:45hrs	Siobhan Bourke	Lead
Tuesday 17 June 2025	20:20hrs to 02:45hrs	Caroline Connelly	Support

What residents told us and what inspectors observed

This was an unannounced inspection at night, by two inspectors of social services. The inspectors met with many of the residents and spoke with eight residents in more detail to get feedback on their experience of living in Glendonagh Residential Care Home. Many of the residents told the inspectors that staff were kind and caring, some residents outlined how staffing levels during the day had improved, but that there was still some delays in answering call bells at night.

On arrival to the centre at 8.20pm, the inspectors followed the centre's signing in and hand hygiene procedures, and proceeded to the day room to meet with residents and staff. There were a number of residents watching television and others were chatting with each other. Care staff were assisting other residents to go to their rooms for the night. The inspectors observed that there was a calm atmosphere in the day room and there were no evident delays in providing assistance to residents. The inspectors saw that there were five staff on duty when they arrived to the centre, three care assistants and two registered nurses.

Glendonagh Residential Care Home is located on spacious, well maintained grounds, near the rural village of Dungourney. The centre has three floors, with accommodations for 31 residents on the ground floor and 11 residents on the first floor, in the Manor Wing. The laundry and storage areas are in the basement of the building. Resident accommodation is in three distinct units, namely the Orchard Unit, which is a secure unit for residents living with dementia, or other specific needs. This unit has seven single bedrooms and one twin bedroom for residents. The Courtyard Unit is on the ground floor and accommodates 14 residents in two twin bedrooms and 10 single bedrooms. The Manor Unit is over two floors with one triple bedroom on the ground floor, four twin bedrooms and eight single bedrooms. The centre had a number of well-maintained communal rooms and private spaces for residents' use, including a large day room and oratory, a large dining room, the Gold Room, used as a visiting room and the Green Room as a family room.

Following meeting some of the residents in the dayroom, the inspectors went on a walk around the centre to meet with residents who were already in their bedrooms. Residents were being assisted by staff in a respectful and unhurried manner. The care environment was observed to be clean and well-maintained. Residents' rooms were decorated and personalised with items of personal significance to the residents.

In the secure unit, the inspectors observed a resident, who was living with a significant cognitive impairment and advanced dementia, walking into another resident's room. Staff and other residents confirmed that this was a regular occurrence. The resident in the bedroom was heard calling out for the resident to leave their bedroom. Inspectors observed that there was no staff in the secure unit at this time and staff informed them there were other periods during the night when staff were not in this unit. The inspectors saw that there were a list of duties

allocated for care staff working in the secure unit that included assisting with hourly checks on residents in the Manor unit, assisting with comfort rounds during the night for residents, in all areas of the home and setting up the breakfast trays for the centre. This meant that the staff member had to leave the unit to complete these duties at intervals during the night,leaving this unit unsupervised.

The inspectors were informed that, approximately half the residents living in the centre, had been assessed as not being able to use call bells. The inspectors observed that these residents did not have call bells and did not have any other means of alerting staff, if they required assistance, such as sensor mats or other alarm systems. The inspectors saw that the remaining residents did have call bells within easy reach. Inspectors saw that there was a high use of bed rails in the centre. There were sixteen residents of the 36 residents living in the centre, with two bed rails and bed-bumpers in use. Inspectors saw that residents who were in bed appeared comfortable and content. The staff, after ensuring all residents were safely in bed, were seen to clean all the chairs in the day room and to wash floors in the corridor, the dining room and the sitting room as outlined in the night duty allocation lists.

The inspectors saw that there were five staff on duty until 10.30 pm when the twilight nurse's shift was finished. The nursing staff told the inspectors that this newly rostered shift had helped them immensely as they could conduct the medication rounds for residents, without interruption and assist care staff with residents care in a timely manner. The three care staff who spoke with the inspectors also confirmed that the additional nurse had greatly improved the care provided to residents during this time-frame. However, when staffing levels reduced after 11.30 pm to one nurse and two carers, the carer assigned to the secure unit had to assist with hourly safety checks and comfort rounds until the day staff arrived, leaving the secure unit unattended for periods during the night. This finding is actioned under Regulation 15; Staffing.

Residents who spoke with the inspectors outlined that the majority of staff working in the centre were kind and caring. Three residents told the inspectors that the physiotherapist attending the centre had greatly improved their mobility. Residents gave positive feedback on the food and drinks available to them and said there was always choice offered.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to review the action taken by the registered

provider to address issues of non-compliance identified during inspections of the centre in April and December 2024.

The inspection of the centre in December 2024 found non compliance with Regulation 15; Staffing, Regulation 16; Training and staff development, Regulation 23; Governance and management, Regulation 3; Notification of incidents, Regulation 27; Infection control, Regulation 5; Individual assessment and care plan, Regulation 7; Managing behaviour that is challenging and Regulation 9; Residents Rights. The inspectors found on this inspection that some action had been taken with regard to training and staff development, individual assessment and care plan, infection control and managing responsive behaviour. Furthermore, the findings of this inspection, were that although the provider had improved the staffing levels in the centre since the previous inspection, the governance and management arrangements in place required urgent action to ensure the quality and safety of services for residents. Significant action was also required in relation to, notification of incidents, complaints management, protection and residents rights. These will be discussed further under their respective regulations.

The registered provider for Glendonagh Residential Home is Glendonagh Residential Home Ltd. The registered provider company has two directors, one of whom is actively involved in the management of the centre and is the nominated person representing the provider. The designated centre also had a full time administration manager and receptionist.

The person in charge was full time in their role, however two clinical nurse managers had resigned from the centre in the months prior to the inspection, leaving a gap in the management structure. The provider assured the inspectors, that recruitment of a clinical nurse manager was in progress, with a person expected to commence in the centre in the coming weeks. To fill the gap left by these vacancies, a senior staff nurse was scheduled to support the director of nursing with their role one day every two weeks and a person, who previously worked in the centre as a director of nursing, was onsite two days a week in a managerial capacity.

The inspectors saw that the numbers of nursing and care staff had increased since the previous inspection and an extra nurse was rostered seven days a week from 7.30pm to 10.30 pm to support the one night nurse with administering the night medications round and assisting care staff when residents were going to bed. However, the number of care staff rostered from 11.30 pm remained a concern. Inspectors were not assured there were an adequate number of staff rostered for the remaining hours of the night, taking into account the size and layout of the centre, to ensure residents were appropriately supervised in the secure unit, as outlined under Regulation 15; Staffing.

The provider had sought the support from a nurse consultant to support the nursing team with updating policies and practices in the centre, and this programme of work was ongoing at the time of the inspection. This person was also assisting with face-to-face training on safeguarding vulnerable adults in the centre. From a review of the training matrix provided, mandatory training such as fire safety, manual

handling, and managing responsive behaviour was up to date for staff. However, from speaking with staff and from review of records of incidents maintained in the centre, it was evident to inspectors, that further training was required, on safeguarding for staff as outlined under Regulation 16; Training and staff development.

On review of the provider's monitoring systems, inspectors were not assured that a number of the managements systems in place were effective, in ensuring the service was safe, consistent and effectively monitored. The provider had a schedule of audits in place that included care planning, medication management, wound care management and audits of call bells. For example, the provider had completed an audit of call bell response times in March and June 2025 and from a review of the findings of these audits, response times showed some significant delays with some residents waiting for assistance for up to 20 minutes. However, there was no evidence of these findings being actioned appropriately as there was no evidence of improvement seen between the audits. These and further findings are outlined under Regulation 23;Governance and management.

The inspectors reviewed the incident records maintained in the centre and saw that not all required notifications were submitted to the office of the Chief Inspector as required under Regulation 31 notification of Incidents. This is a repeated finding.

The complaints procedure was displayed in the centre and met the requirements of the regulation. From a review of complaints records maintained in the centre, it was evident that written responses outlining whether the complaint was upheld and any recommendations arising from the investigation of the complaint were not provided to complainants, as required under Regulation 34 Complaints procedure.

Regulation 15: Staffing

While the number and skill mix of staff was appropriate to meet the assessed needs of the 36 residents living in the centre on the night of inspection, there was not enough care staff rostered after 11.30pm at night, to ensure that a carer was assigned to supervise residents living in the secure unit at all times. As mentioned earlier in this report, many residents living in this unit did not have the capacity to use the call bell facilities and they required enhanced supervision due to a cognitive impairment.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspectors found that training was not appropriate in relation to safeguarding, as evidenced by the following;

- From discussions with staff, inspectors found that staff knowledge on what constituted safeguarding of vulnerable adults was not adequate to ensure residents were protected at all times, as outlined under Regulation 8; Protection.

Judgment: Substantially compliant

Regulation 23: Governance and management

Significant concerns remained with regards the governance and management of the service and the registered provider's ability to ensure that the service provided was safe.

- There was a gap in the management structure arising from the resignation of both clinical nurse managers since the previous inspection.
- There was inadequate resources available to ensure residents living in the secure unit were supervised by staff at all times.

Management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. This was evidenced by the following:

- There was a lack of oversight of legally mandated notifications: these were not submitted as required to the Chief inspector with regard to allegations or incidents of abuse of residents and other required notifications as outlined under Regulation 31;Notification of incidents. This is a repeat finding.
- Management systems in place to ensure complaints were recorded and investigated and managed in line with the Regulation 34; Complaints procedure required action.
- The oversight of systems to ensure residents were protected while living in the centre required action, as evidenced under Regulation 8; Protection
- While there was a schedule of audits in place, repeated poor response times were found between call bell audits indicating that appropriate action had not been taken between the audits to address the findings.

Judgment: Not compliant

Regulation 31: Notification of incidents

From a review of a log of incidents and complaints maintained in the centre, and from speaking with residents, it was evident that required notifications were not

consistently submitted as required to the office of the Chief Inspector as evidenced by the following;

- A number of allegations or incidents relating to safeguarding of residents had not been notified to the Chief inspector as required.This is a repeat finding.
- A sudden death in the centre had not been notified as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

The system in place for the management of complaints in the centre was not effective. Complaints management required action to comply with the requirements of regulations, as follows:

- The inspectors found that not all required records of complaints were maintained in the centre. For example, there was no record of a complaint a resident raised with the inspectors, whereby they experienced delay with personal care delivery and had reported it to staff.
- There was no records of a written response to a complainant outlining the outcome of the investigation, the learnings made or the procedure to follow if a review of the complaint was required.

These are required to meet the regulation and to ensure that complaints are fully investigated and recommendations actioned to improve the service for residents.

Judgment: Not compliant

Quality and safety

The inspectors found that some action had been taken by the provider, following the previous inspection, with regard to the quality and safety of care provided to residents. However, the ineffective governance and management arrangements outlined in the capacity and capability section of this report, impacted the quality and safety of care for residents with regard to protection, managing behaviour that is challenging and ensuring residents' rights were promoted at all times.

The inspectors reviewed a sample of five care plans and found that residents had good access to local GP services and there was evidence of regular review. A physiotherapist attended the centre every week and residents and relatives spoke very positively regarding the impact this had on residents' mobility and well being.

All residents had a care plan developed within 48 hours of admission and it was evident that validated assessment tools were used to assess risks to residents. From a review of a sample of care plans, many of the records were person-centred and sufficiently detailed, to direct care. However, residents with wounds did not have a validated wound assessment tool completed consistently and a resident with a wound over a pressure area did not have this detailed in their care plan; these and other findings are outlined under Regulation 5; Individual assessment and care plan.

The inspectors saw that staff engaged in a respectful manner, when residents presented with responsive behaviour during the inspection. Care plans included assessments of antecedents to responsive behaviours to direct staff. A number of residents had alternatives to bed rails such as low beds and crash mats which was an improvement since the previous inspection. However, the rate of bed rail usage remained high in the centre as outlined under Regulation 7; Managing behaviour that is challenging.

The provider had ensured that staff were provided with training on safeguarding vulnerable adults, however, inspectors were not assured that where safeguarding concerns arose, they were consistently recognised, reported and investigated as required. These findings are outlined under Regulation 8; Protection.

Improvements were seen with regard to ensuring residents were consulted on the running of the service through residents' meetings. However, inspectors remained concerned regarding how residents could alert staff when they required assistance. An assessment of residents' capacity to use a call bell resulted in only half the residents in the centre being provided with a call bell. While inspectors saw that these residents had a call bell within easy reach, the remaining residents did not and had no other means of calling for assistance as outlined under Regulation 9 Residents' rights.

Improvements were seen in a number of aspects of infection prevention and control and the centre was found to be clean and odour free on the night of inspection.

Regulation 27: Infection control

The inspectors followed up on the findings of the previous inspection with regard to infection control and found that residents' equipment that the inspectors observed was noted to be visibly clean. Equipment from the bedpan washer was clean. There were no malodours evident on the night of inspection.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

From a review of a sample of nursing care records, it was evident to inspectors that there were some improvements since the previous inspection, however the following required action;

- Wound assessments were not being consistently completed to ensure that improvements or deterioration in wounds could be detected
- A care plan reviewed, did not include sufficient detail on a wound over a pressure area to direct care.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to medical services from local GPs and there was evidence of regular medical review. Residents had access to allied social and health care professionals such as speech and language therapists, dietitian and physiotherapy and were referred when required. A number of residents told the inspectors that the recent appointment of a physiotherapist who attended the centre on a weekly basis had a very positive impact on their mobility and well being.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

While it was noted that action had been taken by the provider to provide alternatives to bed rails such as low beds and crash mats, the number of bedrails in use remained high with over 40% of residents using these.

Judgment: Substantially compliant

Regulation 8: Protection

Based on findings and observation of practice over the inspection, the inspectors were not assured that all reasonable measures to protect residents from abuse had been taken by the registered provider as evidenced by the following;

- Inspectors found that a number of allegations and incidents with regard to safeguarding of residents were not appropriately investigated and managed to ensure that residents were protected.

- A number of incidents were not recognised as safeguarding incidents and were therefore not reported nor managed in line with the regulations.
- The inspectors saw that where a safeguarding allegation was raised, nursing staff who had responsibility for supervision of care staff and residents were not informed by the management team so that they could ensure staff were appropriately supervised.
- residents in the secure unit had no way of alerting staff when another resident entered their bedrooms uninvited, when staff were not in the unit and therefore these residents were not appropriately protected.

Judgment: Not compliant

Regulation 9: Residents' rights

Notwithstanding that the provider had actioned some of findings with regards to residents rights since the previous inspection, the following required action to ensure residents' rights were upheld in the centre.

- Inspectors saw that half the residents, living in the centre, had been assessed as not being able to use call bells. Therefore, did not have a call bell available to them. There was no evidence of any alternative way of calling for assistance or alerting staff, for these residents and therefore they relied on hourly checks by staff during the night to seek assistance.
- From a review of audits of call bell response times completed by the provider in March 2025 and June 2025, there was evidence of delays in response times for up to 20 minutes in some call bells audited. This continued between the two audits with no improvements seen. This finding was supported on receipt of feedback from three residents who told the inspectors, that there was delays with responses times to their call bells, especially at night.

Judgment: Not 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 Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Glendonagh Residential Home OSV-0000229

Inspection ID: MON-0046797

Date of inspection: 17/06/2025

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 Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Glendonagh is a 42-bed facility, including a dedicated 9-bed secure unit, the Orchard, which provides additional support for residents experiencing cognitive symptoms due to their diagnosed health conditions. We welcome and appreciate the positive feedback provided by the inspection team, particularly in relation to our overall staffing levels and skill mix. We are committed to continuously improving our practices and see this as an opportunity to further strengthen how we deliver care and supervision within the Orchard. Following the inspection, a full review of our night-time staffing allocations was undertaken. As a result, a revised staffing model has now been implemented, ensuring that a designated member of the care team is consistently assigned to remain within the Orchard for the entire night shift (7:30pm to 7:30am). This enhancement provides continuous, proactive supervision and ensures that residents receive responsive support at all times. Our current night-time staffing comprises three full-time team members supported by two twilight staff. To further strengthen supervision, we are transitioning to a consistent four full-time night staff structure. While the new Orchard allocations are already in place, we recognise the need to expand the team to sustain this model. Recruitment is being prioritised to support this model with an initial focus on additional carers hours, followed by the longer-term move towards a two-nurse, two-carer structure. The revised allocations are clearly reflected in the night duty roster, and adherence is being actively monitored through regular spot checks by the lead Night Nurse, supported by weekly oversight from the Person in Charge to ensure consistency and accountability. Staff have been fully briefed on the updated supervision protocols, with an emphasis on maintaining a visible and continuous presence within the Orchard at all times. In addition, all supervision activities, observations, and resident interactions are now recorded using an Orchard-specific digital log within the TouchCare system. These logs are reviewed daily during handovers and form part of our monthly audits, providing a robust framework for monitoring staff presence and resident engagement. The transition to the revised staffing model has been carefully planned in line with workforce capacity and recruitment timelines to ensure sustainability. Initially, the model	

will focus on 3 full time carers (target 31 Oct 2025) with the phased progression to two nurses and two carers (31 Dec 2025) this is designed to further enhance clinical oversight and strengthen the quality of resident care as recruitment is completed.
Ongoing compliance will continue to be monitored through our established governance and quality management systems. Monthly audits, weekly management reviews, and quarterly governance oversight will assess the effectiveness of the revised model and ensure it remains responsive to the evolving needs of residents.
We are confident that these measures address the findings raised under Regulation 15 and demonstrate Glendonagh's commitment to providing safe, high-quality, person-centred care. By enhancing supervision protocols, investing in recruitment, and strengthening monitoring systems, we are ensuring that residents within the Orchard — and across the wider facility — continue to receive the highest standards of care and support.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
All members of the Glendonagh team are currently up to date with mandatory and complementary training requirements, including safeguarding. However, following the inspection, we recognise the need to strengthen staff understanding of what constitutes safeguarding in practice, and how to apply this knowledge confidently and consistently in day-to-day care. While staff have completed safeguarding training, it was identified that their ability to articulate or demonstrate safeguarding awareness in discussion did not meet the expected standard.
To address this, we have placed a renewed emphasis on safeguarding education through the delivery of enhanced, scenario-based training sessions focused specifically on recognising, preventing, and responding to all forms of abuse. These will be delivered in small groups to encourage discussion and ensure that learning is meaningful and retained.
In addition, supplementary safeguarding training has been delivered to members of the management team to ensure they are equipped to lead confidently in this area and provide support or guidance to colleagues as needed. Resources have also been developed for families and are being made available to support a wider culture of awareness and shared responsibility for resident protection.
Glendonagh is committed to fostering a culture of safety, openness, and continuous learning. We believe these additional measures will ensure staff not only meet but exceed the requirements set out under Regulation 16 and Regulation 8, offering residents the highest standard of protection and care.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

Glendonagh acknowledges the areas of non-compliance identified under Regulation 23: Governance and Management. We are committed to ensuring the service provided is safe, consistent, and effectively monitored at all times. The resignation of our Clinical Nurse Managers (CNMs) since the previous inspection did result in a temporary gap in the management structure. However, Glendonagh immediately engaged both a senior management support person with extensive industry experience as well as internal knowledge and an external consultant to provide continuity during the recruitment process. The consultant supported policy and training reviews while an experienced senior nurse was also allocated dedicated office time each week to oversee internal systems and ensure essential day-to-day operational tasks were completed. HIQA was kept informed throughout, and every effort was made to minimise disruption and maintain high standards of care and oversight during the transitionary period of 6 weeks with the new recruited CNM joining the team 16th July 2025.

In relation to supervision in the secure unit, a review of night-time staffing allocations has been completed and a revised model is now in place to further strengthen supervision within the Orchard. A dedicated staff member remains within the unit throughout the night shift, ensuring continuous and proactive resident support. Recruitment is underway to transition from the current structure of three full-time staff and two twilight members to a consistent four full-time night staff, enhancing overall coverage and resilience. This phased plan prioritises appointing additional carer first, followed by nursing staff to support the longer-term move towards a two-nurse, two-carer model.

Adherence to the updated allocation is monitored through spot checks and weekly oversight by the Person in Charge. All supervision and engagement are logged digitally via TouchCare, reviewed daily and audited monthly, ensuring robust governance and sustained compliance with Regulation 15.

We also recognise the findings in relation to oversight and reporting systems, particularly with regard to mandatory notifications and complaints management. In early 2025, we engaged an external safeguarding consultant who has been working closely with management to audit and strengthen all safeguarding-related practices. This includes updated training for staff and management, clearer pathways for incident reporting, and a robust internal system to ensure that all allegations or suspicions of abuse are promptly escalated, logged, and reported to HIQA in accordance with Regulation 31. A designatedlead now monitors all mandatory notifications to ensure compliance and prevent recurrence of previous delays or omissions.

Our complaints process has also been revised, with a new internal complaint's tracker implemented to document, follow up and resolve all concerns in line with Regulation 34. Training has been delivered to ensure staff are confident in recognising and reporting informal concerns as well as formal complaints. The complaints log is reviewed weekly at our management meeting and audited monthly for compliance.

With regard to restrictive practice, a comprehensive review is currently underway to

ensure all measures in place reflect best practice. Staff have received enhanced training in this area, with a strong focus on minimising the use of chemical restraints and bedrails. Clear multidisciplinary protocols have been implemented in consultation with our GP, physiotherapist, and families, placing resident wellbeing at the centre of all decision-making. All restrictions are now subject to regular review, and any new application of restraint is documented and justified in line with national policy.
Finally, we have undertaken a full review of our nurse call system, including updated risk assessments and a reassessment of suitable alternatives. Quarterly audits have now been increased to monthly, with the addition of unannounced spot checks to ensure responsiveness is monitored in real-time. Enhanced staff training has also been delivered to improve the quality and consistency of audit findings. Each audit now includes specific, documented actions, and outcomes are discussed at team meetings with all staff informed of changes and improvements.
These actions form part of our overall commitment to strengthening governance at Glendonagh. They are being implemented within realistic and clearly defined timeframes, with regular internal oversight and scheduled external review to ensure sustained improvement and full compliance with Regulation 23.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Glendonagh acknowledges the findings under Regulation 31 and fully accepts the importance of timely and accurate notifications to the Chief Inspector. While these instances were addressed and managed appropriately at local level, we recognise that the regulatory requirement to notify HIQA was not met in every case. We take this matter seriously and are committed to ensuring that such oversights do not recur.
As part of our wider governance enhancement in early 2025, we proactively engaged an external safeguarding consultant to support us in strengthening our incident management and notification processes. This collaboration has already yielded meaningful improvements. Clearer internal pathways for incident escalation have been developed, and all relevant staff have received updated training to reinforce their understanding of what constitutes a notifiable event under Regulation 31, and the importance of timely reporting.
To embed this learning, we've implemented a new internal notification tracking system, led by a designated compliance lead. This individual oversees all incident and complaints logs, ensuring every potential notification is reviewed, actioned, and submitted in accordance with HIQA guidelines. A monthly governance meeting now includes a standing agenda item to review any recent incidents, safeguarding concerns, or deaths, with a view to ensuring nothing has been overlooked. We have also updated our documentation to include a mandatory prompt for the Person in Charge to consider if a HIQA notification is required when reviewing each incident or complaint.
Further assurance is provided through a quarterly audit of all notifications, matched against our internal records. This allows us to continuously monitor our compliance and

address any emerging issues quickly. These changes have already begun to foster a stronger culture of awareness, accountability, and proactive communication throughout the team.
We are confident that the measures now in place provide a much more robust and responsive system for managing notifiable events. Our commitment to transparency and resident safety is unwavering, and we are determined to ensure full and sustained compliance with Regulation 31 going forward

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Glendonagh acknowledges the importance of a robust, transparent, and resident-focused complaints process. We take all feedback seriously and are committed to ensuring that any concerns raised, formal or informal, are listened to, addressed promptly, and used as an opportunity to continuously improve the quality of care we provide. Following the inspection findings, we have taken immediate steps to strengthen our complaints management system to meet the full requirements of Regulation 34.
A revised complaints process has now been implemented, supported by the introduction of a comprehensive internal complaint's tracker. This new system ensures that every complaint, regardless of how it is raised, is formally recorded, followed up, and closed out with a clear written response. The response outlines the outcome of any investigation, the actions taken, and the right to request a review, in full alignment with the regulation. All documentation is centrally stored to allow for easy audit and oversight.
To support this, targeted training has been delivered to all staff to help them confidently identify and escalate concerns, whether expressed casually during conversation or more formally. This ensures that informal feedback is not missed or underestimated, and that all residents feel heard. Staff have also been reminded of their responsibility to document complaints accurately and to notify the Person in Charge where appropriate.
The complaints log is now reviewed monthly as part of our senior management governance meeting, ensuring real-time oversight and timely resolution. Additionally, complaints are reviewed to verify that responses are appropriately documented, timelines are met, and any necessary service improvements are actioned.
We are confident that these measures will ensure full compliance with Regulation 34 and foster a more transparent, responsive culture where all residents and their families feel confident to raise concerns, knowing they will be listened to, respected, and acted upon.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: Glendonagh welcomes the recognition of improvements made in our individual assessment and care planning processes since the previous inspection, and we are committed to building on this progress to achieve full compliance with Regulation 5. We acknowledge that further action is required in relation to the consistency and detail of wound assessments and care planning to ensure optimal outcomes for residents. To address the identified gaps, we have enhanced our wound care documentation protocols to ensure that all wounds are assessed and recorded using a standardised and evidence-based approach. This includes clear guidance on assessing wound size, appearance, and healing progress. Nursing staff have been reminded of the importance of regular and consistent documentation, particularly for pressure-related wounds, to ensure early detection of any deterioration or improvement. In addition, targeted refresher training on wound care assessment and documentation has been delivered to all nursing staff. This training focused on both clinical best practice and the regulatory expectations surrounding care planning. Particular attention was given to the development of person-centred wound care plans that include specific interventions, monitoring frequency, and escalation protocols. To support implementation, the CNM Will carry out a weekly review of all residents with wounds, ensuring that care plans are reviewed and updated regularly, with appropriate clinical oversight. Updates are provided at each handover. In addition, a monthly audit of wound care records is also in place, and findings are shared at governance meetings to promote learning and consistency. These measures are aimed at strengthening the quality and accuracy of our clinical documentation while ensuring residents receive individualised, high-quality care based on timely and accurate assessments. We are confident that these changes will close the remaining compliance gap under Regulation 5 and support continued improvement in resident outcomes.	
Regulation 7: Managing behaviour that is challenging	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging: Glendonagh acknowledges the findings under Regulation 7 and welcomes the recognition that positive steps have already been taken to reduce restrictive practices. While we are pleased that the centre is substantially compliant, we recognise that the number of bedrails in use remains higher than ideal and are committed to further reducing this in line with national policy and best practice. A full review of all current bedrail use has been undertaken, led by the PIC in collaboration with the wider multidisciplinary team. Each resident using bedrails now has a clearly documented assessment, with justification based on clinical need, risk minimisation and personal preference. We have also strengthened our consent processes	

to ensure that residents and their families are actively involved in these decisions, with clear documentation outlining discussions and rationale.
To support the reduction of bedrail usage, additional non-restrictive alternatives are being introduced. These include further investment in low-low beds and sensor mats. Ongoing education for staff is also in place, with regular training sessions focusing on the principles of positive behaviour support and the safe management of responsive behaviours. These sessions also cover regulatory guidance on the use of restraint, the importance of least-restrictive practice, and the development of person-centred care strategies.
All uses of bedrails are now subject to a multidisciplinary review, with oversight from the Person in Charge. These reviews aim to identify where alternatives can be trialed safely and phased in gradually. A quarterly restrictive practice audit is also carried out, with findings reviewed at our governance meetings to track progress and inform further quality improvements.
We are confident that this proactive and resident-centred approach will lead to a continued reduction in bedrail usage and support full compliance with Regulation 7, while prioritising the dignity, safety, and independence of each resident.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Glendonagh acknowledges the findings under Regulation 8 and takes the protection of residents extremely seriously. While all staff had completed full safeguarding training in accordance with mandatory requirements prior to the inspection, we recognise that further action was needed to strengthen practical application and day-to-day awareness. As a result, we have introduced ongoing bite-sized safeguarding sessions across all departments. These short, focused sessions are delivered on-site in small groups and are designed to reinforce key safeguarding principles, improve confidence in recognising subtle or complex safeguarding concerns, and ensure immediate and appropriate escalation in every instance. These sessions are scenario-based and encourage open discussion, helping staff to apply theoretical knowledge in real-time situations.
In addition, we have trained and appointed a safeguarding Officer, PIC, along with our CNM whom will undertake the Designated Officer training. This will ensure continuous oversight and support for both staff and residents. We have also implemented a centralised incident tracker to monitor concerns from initial report through to resolution. To improve communication, a clear protocol has been introduced to ensure all relevant members of the care team—particularly supervising nurses—are informed of any safeguarding concern without delay. These improvements, combined with revised staffing allocations in the secure unit and exploration of discreet alert systems, represent a proactive and sustainable approach to ensuring the safety and protection of all residents in Glendonagh.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Upholding residents' rights to dignity, safety, and responsive care is a priority at Glendonagh. All resident rooms across the facility are equipped with a fully serviced wall-mounted call bell system, which forms part of a centrally maintained nurse call infrastructure, subject to quarterly servicing. This system enables residents with cognitive and physical ability, as well as staff or visiting family, to summon assistance when needed. However, at the time of inspection, a number of call bell leads had been removed following individual risk assessments for residents with significant cognitive impairment.

These risk assessments, carried out by the care team, determined that for some residents, the presence of a call bell lead posed a greater risk than benefit, either due to the inability to use it meaningfully or a risk of entanglement or distress. In such cases, care plans were adjusted to reflect elevated safety measures, including increased night-time supervision with scheduled half-hourly checks. However, following the inspection, a review of this practice has taken place. While alternative alert systems are currently under evaluation, all wall-mounted call bell leads have been reinstated for residents, even where cognitive capacity is limited. The existing regular checks continue without interruption and are now clearly documented and monitored by the PIC on a monthly basis to ensure consistency.

To address concerns regarding delays in response to call bells, we have strengthened our audit processes. In addition to our existing quarterly audits, monthly audits are now in place, with a particular focus on night-time response times. These are supplemented by unannounced spot checks to identify any emerging issues in real time. Any instance of a response delay exceeding five minutes is flagged and reviewed immediately, with follow-up action taken through staff supervision or additional training as required. Resident feedback on call bell response is also gathered as part of our quality assurance process, and discussed at weekly governance meetings. All staff have received refresher training highlighting the importance of prompt responses, especially in relation to vulnerable or non-verbal residents. Handovers include a specific focus on residents who may not be able to independently call for help, ensuring their supervision needs remain a visible and shared responsibility.

These combined actions—reinstatement of all call bell leads, reinforcement of regular checks, enhanced audit oversight and staff training are designed to ensure residents' rights to safety, communication and dignity are upheld in full. We are confident that these proactive measures will support Glendonagh in achieving full and sustained compliance with Regulation 9.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/12/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/09/2025
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details	Not Compliant	Orange	16/07/2025

	responsibilities for all areas of care provision.			
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/09/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	30/09/2025
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Not Compliant	Orange	30/09/2025
Regulation 34(6)(a)	The registered provider shall ensure that all complaints	Not Compliant	Orange	30/09/2025

	received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/08/2025
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	30/09/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in	Substantially Compliant	Yellow	30/09/2025

	a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/06/2025
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	31/12/2025
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	30/06/2025
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Not Compliant	Orange	30/09/2025