



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

Issued by the Chief Inspector

Name of designated centre:	Glenealy
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	05 November 2025
Centre ID:	OSV-0002385
Fieldwork ID:	MON-0039892

About the designated centre

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

Glenealy is a designated centre operated by St. Michael's House. The centre comprises a campus based seven bed-roomed bungalow located within the main St Michael's House complex in North Dublin. It is within walking distance of lots of local amenities which residents frequently use. The centre provides full-time residential care for seven residents. Residents are both male and female and over the age of 18 years with physical and intellectual disabilities with co-existing mental health concerns. It is a fully wheelchair accessible house. Residents present with a range of complex needs which were assessed on an individual basis. There is a small patio area to the rear of the centre for residents to use as they wish. Care and support is provided in the centre by a person in charge, deputy manager, registered staff nurses, social care workers and direct support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6
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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 5 November 2025	10:15hrs to 17:30hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This was an announced inspection, completed to monitor the provider's compliance with the regulations and to inform the decision in relation to renewing the registration of the designated centre.

The inspector found that there had been a lot of improvements in the designated centre since the last inspection in 2023 and overall, good levels of compliance were found on the day. The inspector observed that the care and support provided to the residents was person-centred and the provider and person in charge were endeavouring to promote an inclusive environment where each of the residents' needs and wishes were taken into account.

The inspection was facilitated by the person in charge for the duration of the inspection. The inspector used observations and engagements with residents, a review of documentation and conversations with staff and management to inform judgments on the residents' quality of life. Residents living in the centre used non-verbal forms of communication and where appropriate, their views were relayed through staff advocating on their behalf. Resident's views were also taken from the designated centre's annual review, Health Information and Quality Authority's (HIQA) residents' survey and various other records that endeavoured to voice each resident's opinion.

This designated centre provided full-time residential care and support to seven residents with intellectual disabilities. At the time of inspection there was one vacancy in the centre. During the inspection, the inspector got the opportunity to meet and briefly chat with all six residents that lived in the centre.

The provider and person in charge had put a variety of systems in place to ensure that residents and their families were consulted in the running of the centre and played an active role in the decision making within the centre. Families played an important part in the residents' lives and the person in charge and staff acknowledged and supported these. The person in charge and staff facilitated family visits for residents during the week and at weekends. On review of one resident's personal plan, the inspector saw that, maintaining family contact, was one of their current goals.

On walking around the residents home, the inspector observed lots of pictures, photographs and soft furnishing which provided a homely atmosphere to the house. The house was clean and tidy and there had been a number of improvement to the internal parts of the premises and in particular, the provision of enhanced storage arrangements.

There were new storage units in the hallway and living room areas of the house. In addition, new in-built wardrobes as well as TV units that included storage shelves

and drawers had been provided in two residents' bedrooms. The new units provided a clutter-free and spacious feel to these areas.

Each resident was provided with their own individual bedroom which was decorated to their unique style and preference. Each resident was consulted as well as being part of the decision making about the décor and layout of their rooms. Bedrooms included individualised soft furnishings, memorabilia, pictures, family photographs, all of which were in line with each resident's likes and choice.

One resident was recently supported to move to another larger bedroom which better met their needs, in particular their medical equipment needs. For example, the inspector observed that while there was ample space to allow for all the resident's medical and assistive equipment there was also sufficient space for the resident's belongings, soft furnishings and memorabilia. The inspector observed that the room was a homely, welcoming and overall, provided a relaxing environment for the resident. On meeting with the resident and their staff member, the staff informed the inspector that the resident really enjoyed spending time in their new room.

In the large hallway of the house there was a jukebox style compact disk (CD) player and a collection of CD's. One resident in particular liked to sit in this area and listen to music. The person in charge told the inspector that the jukebox had belonged to another resident who had passed away in late 2024 and that their family member had donated it to the centre. From speaking with staff and on review of documentation the inspector saw that residents were supported to remember their housemate, through an annual remembrance mass, that was held in the house at the end of October this year.

Residents living in this designated centre required considerable supports in relation to their manual handling and healthcare needs. The provider had ensured the centre was supplied with a comprehensive scope of manual handling aids and devices to support residents' mobility and manual handling requirements. The inspector observed a large assisted bath in the main bathroom as well as a new shower trolley, and other assistive equipment to support residents during personal care. The inspector observed all the equipment to be clean and in good repair. Since the last inspection, a new cleaning schedule had been implemented to ensure appropriate service and cleaning of the equipment and from observations made during the inspection, this cleaning schedule was effective.

In advance of the inspection, residents were each provided with a Health Information and Quality Authority (HIQA) survey. Residents' were supported by their staff when completing them. Overall, the survey relayed positive feedback regarding the quality of care and support provided to the residents.

Information within the surveys relayed residents happiness at going on holidays and enjoyment of going to the cinema, concerts and many activities in their local community. Three surveys noted while the centre had no designated visitors room residents could meet with their family or friends in the sitting room or in private, in their own bedroom. One resident's survey noted that they would like a relaxation

room in their home where they could "chill and listen to music". Some surveys referred to the residents' weekly household meetings where they made choices as well as making decisions.

The provider's 2024 annual review had also ensured that residents and their family and representatives were consulted with and given the opportunity to express their views on the service provided in the designated centre. The review noted that all family members said that they felt very welcome in the centre and were very happy with the care provided to their family member. One family commented that there was a great consistency in the staff team and that 'staff had a great attitude'. Another family member commented that they were "100% happy with the care provided in the centre".

On the morning of the inspection, the inspector met with two residents who were getting ready to head off on their holidays to a spa hotel in county Wicklow. The inspector observed an atmosphere of excitement amongst the residents and their staff members as they got ready to head off in the bus for their holiday.

Two residents' day services were closed for the day due to a staff meeting in the day service. The two residents chose to go for walk with staff to the local park. On return the staff told the inspector that the residents had enjoyed their activity and in particular, enjoyed their lunch out in a café close by. One resident was unable to attend their day service as there was no transport to facilitate their return from the day service. This person in charge advised the inspector that this was a rare occurrence and that there was normally adequate transport in place for the resident to attend their days service.

Overall, while there was a calm atmosphere in the house, residents and staff were observed coming and going to different activities throughout the day. Residents also enjoyed listening to music in their rooms and communal areas. The inspector observed a resident relaxing on the couch in the main sitting room. For some of the time they listened to music on their headphones, they watched some television programmes and afterward the inspector heard their staff member read them a story form one of their books.

Residents were provided with weekly household meetings, where matters that were important to them were discussed and decisions made. There was easy-to-read information as well as pictures available for staff to use at the meetings. This was to support residents understand matters in a way that was in line with their communication needs. Meetings included topics such as weekly menu plan, activities, fire safety, restrictive practice, health and safety, residents' news but to mention a few topics. However, some improvements were needed to ensure that the meetings were meaningful, effective and consistent at all times. This is discussed further in the report.

As mentioned above, residents living in the centre did not use verbal communication. On observing staff engaging with residents it was evident that staff knew what residents were relying to them and that residents understood what was been said to them. Staff were supported through residents' communication support

plans as well as communication passports to guide them with residents different facial expressions and body language as part of their communication methods. One staff member told the inspector that there were cards in one resident's bedroom that explained the resident's own form of verbal language and what each verbalisation meant. This guided staff in how to support and communicate with the resident in a way that was meaningful and effective.

The person in charge spoke about the care and support provided to residents and how they were endeavouring to ensure each resident's wellbeing and welfare was maintained in a person-centred way. The person in charge spoke about the good standard of care provided to residents and of ensuring that changes in residents' needs were addressed and potential future changes were also reviewed. Through observations and speaking with staff, as well as a review of the documentation, the inspector found that there was suitable evidence to support this.

One staff member showed the inspector the medication cupboard and went through in detail the safe medication management systems in place. The inspector observed the cupboard to be neat and tidy and clearly laid out with each resident's medication. The inspector found the staff member to be very knowledgeable in this area and was aware of each resident's medication needs and the specific ways their medication was administered. There had been additional protocols put in place since the last inspection which the staff member, as well as other staff spoken to, were aware and knowledgeable of.

In summary, the inspector found that each resident's well-being and welfare was maintained to a good standard and that there was a strong and visible person-centred culture within the designated centre. The inspector found that there were systems in place to ensure residents were safe and in receipt of good quality care and support. Through speaking with staff, through observations and a review of documentation, it was evident that staff and the local management team were striving to ensure that residents lived in a supportive and caring environment.

There were improvements needed to aspects of the centre's premises, as well as some improvements to the area of staffing, communication and health. These are discussed further in the next two sections of the report which present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations and, to contribute to the decision-making process for the renewal of the centre's registration. This section of the report sets out the findings of the inspection

in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

Overall, the findings of this announced inspection were that residents were in receipt of a good quality and safe service, with good local governance and management supports in place. Since the last inspection, the provider had made improvements that had resulted in positive outcomes for residents in particular, in relation to staffing arrangements, storage facilities in the premise, medication management and infection prevention and control arrangements.

The centre had a clearly defined management structure in place which was led by a capable person in charge. They were supported in their role by a CMN I and a person participating in management. The person in charge was an experienced, qualified professional and demonstrated their knowledge of the residents' assessed needs.

The governance systems in place ensured that service delivery was safe and effective through the ongoing auditing and monitoring of its performance resulting in a thorough and effective quality assurance system in place. The person in charge carried out a schedule of local audits throughout the year and followed up promptly on any actions arising from the audits. These audits assisted the person in charge ensure that the operational management and administration of centre resulted in safe and effective service delivery.

There were clear lines of accountability at individual, team and organisational level so that all staff working in the centre were aware of their responsibilities and who they were accountable to. There was one staff vacancy in the centre. This vacancy was being covered by members of the current staff team as well as relief and agency staff who were familiar to residents. There was a monthly staff roster system in place however, some improvements were needed to ensure it was appropriately maintained.

The inspector reviewed a sample of staff files and found that for the most part they included all Schedule 2 requirements. Some improvements were needed to the monitoring and oversight systems in place for agency staff Garda vetting. The inspector spoke with two staff members in detail during the inspection and found that they were aware and knowledgeable of the support needs of residents living in the centre. On the day of the inspection, the inspector observed kind, caring and respectful interactions between staff and residents throughout the day.

There was a training schedule in place for all staff working in the centre and this was regularly reviewed by the person in charge and the inspector found that all staff were provided with appropriate training. This ensured that staff were provided with the necessary skills and training to the delivery quality, safe and effective services that catered for each resident's assessed needs.

There was a schedule in place for staff one-to-one supervision and performance management meetings to support staff perform their duties to the best of their ability.

Incidents were appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. There was appropriate information governance arrangements in place to ensure that the designated centre complied with all notification requirements.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Registration Regulation 5: Application for registration or renewal of registration

The application for registration renewal and all required information was submitted to the Chief Inspector of Social Services within the required time-frame.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full-time in this centre. The person in charge was ensuring effective governance, operational management and administration of the designated centre. The person in charge was supported by a clinical nurse manager (CNMI) and a person participating in management.

Documentation submitted to the Chief Inspector, demonstrated that the person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives.

The inspector found that the person in charge had a clear understanding and vision of the service to be provided and, supported by the provider, fostered a culture that promoted the individual and collective rights of residents living in this centre.

Staff who spoke with the inspector informed them that the person in charge was supportive, approachable and available to them when they needed them.

Judgment: Compliant

Regulation 15: Staffing

Staff who spoke with the inspector demonstrated good understanding of the residents' support needs and were knowledgeable of policies and procedures which related to the general welfare and protection of residents living in the centre.

Since the last inspection there had been improvements to the staffing arrangements in the centre. Two full time nurses, one part-time nurse, one full-time social care worker and one direct support worker had been recruited and employed to work in the centre. On the day of the inspection there remained one full-time social care worker vacancy.

For the most part, on review of the roster for the past three months, the inspector saw that management were endeavouring to ensure that continuity of care was provided to residents. The inspector saw that while there were four to five agency staff included on the roster, primarily the same two agency and relief staff were employed on a consistent basis.

On review of the staff roster from August to November 2025, the inspector found that improvements were needed to ensure that the rosters were maintained appropriately. For example, the inspector observed there to be a lot of notes, scribbles and unclear markings on the rosters. This made it difficult to ascertain some of the handwriting and initials on the document to clearly identify what staff were working each day. In one case, a staff shift 9am to 9pm, had been recorded on the actual roster but there was no detail of the name of the staff member who completed the shift. On the day, the person in charge looked through other documents and records to try find the name of the person who worked the shift however, by the end of the inspection it remained unclear.

The person in charge had arranged for staff files to be brought to the centre for review. All staff files were reviewed and for the most part were found to meet the requirements of Schedule 2 of the Regulations. The provider's Garda vetting policy stated that all staff will undergo Garda Síochána vetting every three years. On review of the files, the inspector saw that, for the most part, this was in place. However, three staff members' Garda vetting was due for renewal in June, September and October 2025. The inspector was informed on the day, that these were in process.

The inspector found that improvement was needed to the monitoring and oversight of the vetting system in place for agency staff members. This was to ensure that the provider and person in charge were in line with the organisation's own Garda vetting policy but also to ensure the safety of residents at all times. For example, evidence of Garda vetting for two regular agency staff members, had only been received by the service the day before the inspection. In addition, for one agency staff member, their Garda vetting information was limited and only included the person's name and date the vetting was completed. Overall, the inspector found that a review of the systems in place for monitoring pertinent information and records for agency staff was needed.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Overall, the inspector found that there had been a number of improvements to the systems in place for monitoring and providing training to staff members, since the last inspection. .

There was a staff training record in place that supported the person in charge to monitor, review and address the training needs of staff to ensure the delivery of quality, safe and effective service for the residents. Overall, staff training was up-to-date including refresher training.

On a review of the training records, the inspector saw that, staff were provided with training in, safeguarding and protection of vulnerable adults, fire safety, managing behaviours that challenge, safe medicine practices, epilepsy, food hygiene, feeding, eating and drinking (FED), infection prevention and control, but to mention a few.

Staff who spoke with the inspector were found to be knowledgeable of policies and procedures which related to the general welfare and protection of residents living in this centre.

Supervision and performance appraisal meetings were provided for staff to support them perform their duties to the best of their ability.

There was a supervision schedule in place and the inspector saw that all staff one to one supervision meetings were up-to-date with more meetings planned for October and November 2025.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had valid insurance cover for the centre, in line with the requirements of the Regulation.

The service was adequately insured in the event of an accident or incident. The required documentation in relation to insurance was submitted as part of the application to renew the registration of the centre.

The inspector reviewed the insurance submitted to the Chief Inspector and found that it ensured that the building and all contents, including residents' property, were appropriately insured. In addition, the insurance in place also covered against risks in the centre, including injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management systems in place were found to operate to a good standard in this centre. Overall, there was a clearly defined management structure that identified the lines of authority and accountability and staff had specific roles and responsibilities in relation to the day-to-day running of the centre; The person in charge was assisted by a clinical nurse manager to support them ensure effective governance, operational management and administration of the designated centre

The provider had completed an annual report in January 2025 of the quality and safety of care and support in the designated centre during 2024 and there was evidence to demonstrate that the residents and their families were consulted about the review.

In addition the provider had completed an unannounced review of the quality of care and support in the centre in May 2025. The review included an action plan which was followed up and progressed by the person in charge. On review of the action plan, the inspector saw that many of the actions had been completed.

Monthly data reports, that were used at management meetings between the person in charge and service manager to review issues arising and actions required, were being completed with the most recent completed in September 2025. Some of the areas reviewed by the report included monitoring of residents' goal progress, quality and safety checks, money audits, safeguarding referrals, complaints and complements, fire drills and environmental risks.

The most recent staff team meeting had taken place in mid-October 2025. This was to provide staff an opportunity for reflection and shared learning. On review of the minutes of the meeting, the inspector saw that topics such as the appointment of the new senior service manager, the HIQA inspection, infection prevention and control, safeguarding, key working and medicine and drug audits were discussed. Shared information and updates on the support needs of residents was also discussed in detail.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had submitted a statement of purpose which outlined the service provided and met the requirements of the regulations.

The statement of purpose described the model of care and support delivered to residents in the service and the day-to-day operation of the designated centre. The statement of purpose was available to residents and their representatives.

In addition, a walk around of the designated centre confirmed that the statement of purpose accurately described the facilities available, including room function.

The person in charge was aware of their legal remit to review and update the statement of purpose on an annual basis, or sooner, as required by 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).

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that there were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

Adverse incidents and accidents in the designated centre, required to be notified to the Chief Inspector of social services, had been notified and within the required time frames as required by S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

The inspector found that incidents were managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of the service for the residents who lived in the designated centre.

The inspector found that the designated centre was well run and provided a homely and pleasant environment for residents. Each of the resident's well-being and welfare was maintained by a good standard of evidence-based care and support. It was evident that the person in charge and staff were aware of residents' needs and knowledgeable in the person-centred care practices required to meet those needs. Care and support provided to residents was of good quality. However, to ensure

positive outcomes for residents at all times, some improvements were needed to the following areas; Premises, communication and healthcare.

Overall, the design and layout of the premises of the designated centre were in line with the statement of purpose and met the needs of residents living in the centre. The house was observed to be clean and tidy and in good upkeep and repair. However, improvements were needed to ensure that the decorative upkeep of the house, for example the inspector observed a number of walls in the centre were grubby in areas and required refurbishment.

The person in charge was ensuring that an assessment of need was completed for each resident on an annual basis and in consultation with each resident, their family, representatives and where appropriate included multi-disciplinary input. Where appropriate, there was an accessible version of the plan available to residents.

Overall, appropriate healthcare was made available to residents having regard to their personal plan. Residents were supported to live healthily and were provided with choice around activities, meals and beverages that promoted healthy living. Residents' healthcare plans demonstrated that each resident had access to allied health professionals including access to a medical practitioner. However, some improvement was needed to ensure that all residents, where appropriate, were facilitated to be aware of and attend national screening programmes.

For the most part, the person in charge and staff team were endeavouring to ensure that residents could receive information in a way that they could understand. Each resident was provided with a communication support plan and a personal communication passport. However, some improvements were needed to residents household meetings so that they were meaningful and effective in supporting residents choice and decision-making.

Overall, the inspector found that the provider and person in charge promoted a positive approach in responding to behaviours that challenge. Where restrictive procedure were being used, they were based on centre and national policies. Where applied, the restrictive practices were clearly documented and were subject to review by the appropriate professionals involved in the assessment and interventions with the individual.

The provider had ensured that the risk management policy met the requirements as set out in the regulations. There were systems in place to manage and mitigate risks and keep residents and staff members safe in the centre.

Residents living in the designated centre were protected by appropriate safeguarding arrangements. Staff were provided with appropriate training relating to keeping residents safeguarded. The person in charge and staff demonstrated good levels of understanding of the need to ensure each resident's safety. There was an appropriate level of oversight to ensure that safeguarding arrangements ensured residents' safety and welfare.

There were infection, prevention and control (IPC), measures and arrangements to protect residents from the risk of infection. From a review of documentation, from

observations in the centre and from speaking with staff, the inspector found that the infection, prevention and control measures were effective and efficiently managed to ensure the safety of residents.

The inspectors found that the systems in place for the prevention and detection of fire were observed to be satisfactory. There was suitable fire safety equipment in place and systems in place to ensure it was serviced and maintained. There was emergency lighting and illuminated signage at fire exit doors. Local fire safety checks took place regularly and were recorded and fire drills were taking place at suitable intervals.

Regulation 10: Communication

Residents living in the centre presented with a variety of communication support needs. For the most part, residents were assisted and supported to communicate in accordance with their needs and wishes.

On speaking with staff members, the inspector found that they were knowledgeable of residents' communication support needs. One staff member talked with the inspector about how they could identify if a resident was upset or unhappy. They said that one resident expressed their emotions through facial expressions and that another resident expressed their upset through a specific type of vocalisation.

Another staff member told the inspector that when they administered medication to one of the residents, who was sight impaired, they would always talk to the resident first and explain to them about the medication and let them know exactly when they were about to administer it.

Residents' files contained communication care plans which detailed how best to support each resident in this area. Residents were also provided communication passports which guided staff to know how each resident preferred to be communicated with, how they liked to communicate with people and how they made choices. For example, one resident's communication passport noted that when the resident provided their meal, they express their dislike of the food by turning their head away and not opening their mouth.

Throughout the duration of the inspection, the inspector observed residents expressing themselves, receiving information and being communicated with in the best way that met their assessed needs. The inspector found that residents were cared for by staff who understood their communication needs and could respond accordingly.

However some improvements were needed to some areas of communication. For example, residents were supported to attend a weekly household meeting that enabled them communicate their choices and make decisions. The household meeting agenda included items such as the weekly menu plan, weekly activities, residents' news, health and safety, fire precautions and restrictive practices. There

was a selection of easy-to-read documents to support understanding on some of the agenda items. However, on review of a sample of meetings minutes from August to November 2025, the inspector observed that not all areas of the meetings had been discussed. In addition, there were gaps in records of minutes, and for some weeks, there were no minutes of meetings at all. This meant that it was difficult to ascertain if the meetings took place, as well as what was discussed and what decisions were made.

Overall, a review of the residents' household meetings and agenda was needed to ensure that it provided meaningful and effective engagement for residents when they were communicating their choices and making decisions on matters that were important and relevant to them.

Judgment: Substantially compliant

Regulation 17: Premises

The physical environment of the house was clean and for the most part, in good decorative and structural repair. The design and layout of the premises ensured that each resident could enjoy living in an accessible, safe, comfortable and homely environment. This enabled the promotion of recreation and leisure and enabled a good quality of life for the residents living in the centre.

The house was found to be suitable to meet residents' individual and collective needs in a comfortable and homely way. The inspector observed that the walls of the premises included photographs of residents, framed pictures and a large framed activity and meal planner that was in a format in line with residents' communication needs and preference. Ceiling hoists and assistive equipment were also provided in most of the residents' bedrooms and bathrooms to support their safe movement.

Residents expressed themselves through their personalised living spaces. The residents were consulted in the décor of their rooms which included family photographs, paintings and memorabilia that were of interest to them. New wardrobes had been installed in two residents' bedrooms. The style and design of the wardrobes provided additional storage as well a homely and warm aesthetic to the bedroom.

Overall, the inspector observed that, since the last inspection, there had been significant improvement to the provision of adequate storage in all areas of the premises. In addition to the new wardrobes, new large storage units had been installed in the main hallway and in the sitting room. This meant that there was ample space for medical equipment and residents' files and records which had previously been stored in boxes in open communal spaces in the house.

However, there were some improvements needed to the premises and in particular, to the paintwork in the internal areas of the house. One of the provider's 2024 annual report actions included painting the internal areas of the centre by December

2025. On review of the progress of the action, the inspector saw that this was at quotation stage. A request had been previously submitted to the organisation's maintenance department to have the house painted back in 2024. This meant that the provider was not addressing the decorative upkeep of the residents' home in a timely manner.

In addition, there were some other improvements identified on the day, for example;

The rubber seal at the bottom of a double door exit in a resident's bedroom required repair. The door was also used as a fire exit door. This posed a potential trip or fall hazard when staff or residents exited through the doors.

Furthermore, on opening the double doors, the inspector observed a large pile of leaves gathered up against the door which would likely hinder the speed of evacuation from the door. On the day of the inspection, the person in charge advised the inspector that they would notify their maintenance team to address both issues.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had prepared a guide for residents which met the requirements of regulation 20.

On review of the residents' guide, the inspector saw that information in the guide aligned with the requirements of associated regulations, specifically the statement of purpose, residents' rights, communication, visits, admissions and contract for the provision of services, and the complaints procedure.

The guide was written in easy to read language and was available to everyone in the designated centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector reviewed the centre's integrated risk management policy and found that the provider had ensured that the policy met the requirements as set out in the regulations. The policy, had been reviewed and updated in June 2023.

Where there were identified risks in the centre, the person in charge ensured appropriate control measures were in place to reduce or mitigate any potential risks.

For example, the person in charge had completed a range of risk assessments with appropriate control measures that were specific to residents' individual health, safety and personal support needs. There were also centre-related risk assessments completed with appropriate control measures in place.

There was good oversight of risks in the centre. The person in charge carried out regular reviews and updates on the risk register and associated risk assessments.

Judgment: Compliant

Regulation 27: Protection against infection

The organisation's infection prevention and control policy was reviewed and updated in 2025.

The inspector observed that the centre was visibly clean and tidy on the day of the inspection. The person in charge had ensured that appropriate infection prevention and control measures and practices were in place for including laundry management and a color-coded mop systems. There had been improvements to the laundry area with a new safer ventilation system installed since the last inspection.

On review of residents' personal plans, the inspector saw that all residents were been provided with influenza support plans. In addition, all residents had been supported to received their flu vaccine in October 2025.

There were cleaning schedules in place, which were supporting the ongoing maintenance of a clean and safe environment for residents. Risk assessments were in place for infection prevention and control specific risks and provided appropriate measures to mitigate risk. Since the last inspection of the centre, improvements had been made to the cleaning schedules so that cleaning of residents' mobility and medical equipment was included on the schedules.

The inspector reviewed training schedules which demonstrated that, staff had completed specific training in relation to infection, prevention and control (IPC) and overall, refresher training was up-to-date.

There were flushing checks in place for water outlets that were not used on a frequent basis. There were clear guidance and instruction for staff how to carry out the flushing checks in line with policy and best practice.

The centre's infection prevention and control preparedness plan was reviewed and updated in May 2025. There was a monthly infection prevention and control checklist in place with the most recent checklist completed in October 2025. This audit monitored and ensured the effectiveness of the infection prevention and

control measures in place. Furthermore, a hygiene inspection checklist had been completed in August 2025, which had considered matters relating to safe catering.

Judgment: Compliant

Regulation 28: Fire precautions

Overall, the registered provider had ensured that there was effective fire safety management systems in the centre that ensured the safety of residents in the event of a fire.

Staff had completed fire safety training and were knowledgeable in how to support residents evacuate the premises, in the event of a fire.

Staff completed daily, monthly and quarterly fire checks. The emergency lights, fire alarms, blankets and extinguishers were serviced by an external company within the required time frame. However, on the day of the inspection there was no satisfactory record of the number, type and maintenance of the fire-fighting equipment, as required by schedule 4 of Regulation 21. Subsequent to the inspection, a copy of the most recent fire alarm system inspection as well as a fire-fighting equipment service record, was submitted to the Health Information Quality Authority.

The person in charge had prepared fire evacuation plans and resident personal evacuation plans. These were in place for staff to follow in the event of an evacuation. The plans provided clear guidance to staff to ensure a timely evacuation in the case of fire. As an additional safety measure, the person in charge implemented a colour coded system for each resident's bedroom door. The system allowed for staff to be quickly informed as to the levels of mobility support required by each resident during an evacuation.

Daytime and night time fire drills, to test the effectiveness of the fire evacuation plans, had been carried out in June and August 2025 with another day time drill to take place mid-November. On review of the drill records, the inspector saw that no issues were identified and residents were evacuated in a timely manner.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Overall, on the day of the inspection, the inspector found that the person in charge had ensured that appropriate systems were in place for the ordering, receipt, prescribing, storing, disposal and administration of medicines and that there were satisfactory safe medical systems in place that included robust oversight systems.

There was a 'safe medication management systems' policy in place which had been reviewed in April 2025.

Staff spoken with on the day were knowledgeable on medicine management procedures and on the reasons medicines were prescribed. A review of medication administration records also indicated that medications were administered as prescribed.

The inspector found that there had been significant improvements in practice since the last inspection. For example, there were improvements to the labelling of medication, which saw all medicines appropriately labelled on the day and a robust system in place for labelling. In addition, the checking of labels was now included on the centre's medication audit. A new medication protocol had been implemented to ensure the safe transfer of medication to residents' days service as well as home visits. All medications sent to the residents' day service were now recorded and audited through the drug audit record.

There were appropriate oversight systems in place to ensure safe medication practices and to ensure their effectiveness. The person in charge carried out a number of checks and audits that ensured that each resident's medication was administered and monitored according to best practice as individually and clinically indicated to increase the quality of each resident's life.

A full medication audit was carried out in the centre following the deficits identified on the last inspection with all actions completed. The most recent medication audit was completed in January 2025. The person in charge also carried out spot audits in October 2024, January 2025, May 2025 and September 2025. This was to monitor practice, ensure compliance and identify if improvements required, had been completed.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured assessments of residents' needs were completed and informed the development of personal plans. On the day of the inspection, the inspector reviewed a sample of three residents' personal plans.

Within each plan there was a comprehensive assessment of need in place for residents, which identified their healthcare, personal and social care needs. These assessments were used to inform detailed plans of care, and there were arrangements in place to carry out reviews of the effectiveness of plans.

Residents' personal plans were regularly reviewed to take into account the revised assessed needs of residents. Multidisciplinary reviews were effective and took into account changes in circumstances and new developments in residents' lives.

On an annual basis, each resident was provided a 'wellbeing meeting' that included a review of their personal plan. Residents, and where appropriate their family members, were consulted in the planning and review process of their personal plans.

On speaking with a new staff member, they told the inspector about one resident's 'wellbeing meeting' they had attended. The said that it was very person-centred and the resident was at the forefront of the meeting. Photographs of the resident enjoying activities and achieving their goals were used at the meeting. This was to better support engagement with the resident in line with their communication support needs. The staff member told the inspector that they could see the resident's face light up when the photographs were shown and events regarding the photograph were talked about.

Residents' personal plans included assessable information that provided support in helping residents understanding what was contained within their plan and in a format they understood. The inspector observed in one resident's bedroom their personal plan displayed in their bedroom in a framed collage-type poster. The poster included photographs of the resident enjoying meaningful activities in the community and their home that were related to their goals.

Judgment: Compliant

Regulation 6: Health care

Overall, the inspector found that appropriate healthcare was made available to all residents having regard to their personal plan. Plans were regularly reviewed in line with the residents' assessed needs and required supports.

There were an array of healthcare support plans in place to support staff in their practice when supporting the resident with their health. For example there were support plans relating to residents' general health, epilepsy, hay fever, sleep care, constipation, feeding eating and drinking, but to mention a few.

In addition, residents' health and wellbeing was promoted and supported in a variety of ways including through diet, nutrition, recreation, exercise and physical activities. On review of residents' menu plans, the inspector found that the choice of food, beverage and snacks offered to residents was varied, nutritious and in line with each resident's likes and tastes.

The designated centre provided a range of specialised supports to residents. Access to these supports was through an assessment and referral process utilising a multidisciplinary clinical support team (MDT). On review of residents' support plans the inspector saw that regular clinical support was provided in the centre and access to specialist clinicians and consultants as was provided as required.

Residents' healthcare plans demonstrated that each resident had access to allied health professionals including access to their general practitioner (GP). However, some improvements were needed to ensure that, where appropriate, residents were facilitated and supported to register for health screenings. While two residents had been supported to register and access bowel screening services, other health screenings, that were applicable for one other resident, had not been followed up on and required action.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspector found that there were arrangements in place to provide positive behaviour support to residents with an assessed need in this area. Residents' positive behaviour support plans were observed to be detailed, comprehensive and developed by an appropriately qualified person. In addition, plans included proactive strategies in order to reduce the risk of behaviours of concern from recurring. Where there were changes in residents' behavioural needs, the person in charge communicated these changes to the appropriate clinician to ensure plans were updated in a timely manner and overall, effective.

The provider ensured that staff had received training positive behaviour supports and received regular refresher training in line with best practice. .

There were a number restrictive practices implemented in the centre. For example, the use of night checks, lap-belts, bed-rails, monitoring systems, sleep systems and storage of residents' finances. All restriction had been approved, or were in the process of approval, by the organisation's positive approach management group.

The rationale for restrictions in place were clear and deemed to be least restrictive option. All details of restrictive practices, as well as approvals, were contained within each resident's personal plan and reviewed on a yearly basis or sooner if required.

Judgment: Compliant

Regulation 8: Protection

Overall, the inspector found that the provider and person in charge had ensured that there were appropriate systems in place to ensure residents were safeguarded from abuse.

The training matrix demonstrated that all staff had been provided training in safeguarding of vulnerable adults and all was up-to-date.

From reviewing all staff files with regard to schedule 2 of the Regulations, all core staff team members had appropriate Garda vetting in place. Where there are improvements needed regarding agency staff records, these are addressed under Regulation 15.

There was an up-to-date safeguarding policy in the centre which had been reviewed in February 2025 it was made available for staff to review.

Information on how to contact the designated officer was on display in the centre and on the day of the inspection, the complaints officer information was also displayed in the residents' dining room.

The inspector spoke with two staff members and found that they were knowledgeable about safeguarding procedures. Staff understood their role in adult protection and were knowledgeable of the appropriate procedures that needed to be put into practice when necessary. They told the inspector that they would report a concern to the person in charge or senior management if they had one and were aware of the policies and procedures in place relating to safeguarding.

Residents' personal plans included person-centred and up-to-date personal care plans. The plans detailed the supports required to protect each resident's autonomy and dignity in delivering personal care.

There were appropriate local auditing and monitoring systems in place to ensure the safety of residents' finances and monthly updates on residents' finances were included in the centres' monthly data report.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Glenealy OSV-0002385

Inspection ID: MON-0039892

Date of inspection: 05/11/2025

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 15: Staffing	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <ul style="list-style-type: none"> • A new working roster has been implemented featuring a separate page for relief, additional hours, overtime and agency staff. This sheet will ensure accurate and trackable documenting of staff working in the home. Commenced on the 9th November 2025 • SMH are working on a formalised process for verification of Garda vetting with agencies. Due to be completed 31st March 2026. In the interim, overtime, relief panel staff and Tier 1 and 2 HSE approved agencies will be prioritised when filling vacant shifts. • Targeted recruitment evenings for social care workers are ongoing in SMH. Three recruitment evenings have taken place and an external recruitment company engaged to fill these vacancies. Expected recruitment by 31st March 2026. 	
Regulation 10: Communication	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 10: Communication:</p> <ul style="list-style-type: none"> • A new revised format for residents’ weekly meeting has been implemented. • All weekly meetings will have minutes recorded. Photographs and accessible information will be available to support resident’s to understand information discussed. Commenced on 29th November 2025. 	

Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <ul style="list-style-type: none"> • Rubber seal at the bottom of a double door exit in a resident bedroom is sealed and repaired on the 13th November 2025. • Large pile of leaves gathered up against the door were removed on the 11th November 2025. • Outstanding painting works on the maintenance workplan for completion by 31st March 2026 	
Regulation 6: Health care	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 6: Health care:</p> <ul style="list-style-type: none"> • Information has been sourced in a format that will be used to support the resident to understand breast and cervical screening. This has also been discussed with the individual's family to help support her understanding. Following this work around building capacity and whether she consents to the screening an appointment will be made with the SMH doctor for consultation 14th February 2026. 	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	29/11/2025
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/03/2026
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the	Substantially Compliant	Yellow	14/02/2026

	assessed needs of residents, it is provided.			
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/03/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/03/2026
Regulation 06(2)(e)	The person in charge shall ensure that residents are supported to access appropriate health information both within the residential service and as available within the wider community.	Substantially Compliant	Yellow	14/02/2026