Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Sliabh Glas
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	15 July 2025
Centre ID:	OSV-0002518
Fieldwork ID:	MON-0047503

About the designated centre

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

Sliabh Glas is a designated centre run by the Health Service Executive (HSE) in Community Healthcare Organisation 1 (CHO1). Sliabh Glas provides a full-time residential service, with 24 hour support, to six adults with an intellectual disability. The centre comprises a dormer style bungalow and separate annex, and is located on the outskirts of a large town. The centre has access to it's own bus to facilitate community based outings and activities. Each resident has their own bedroom. Within the main house residents share communal areas which include the kitchen, utility room and sitting-room. Residents also have access to two bathrooms, one with a bath and one with a walk-in shower. The separate annex flat provides accommodation for one resident, and has an open plan kitchen and living area as well as two bedrooms and a shared bathroom. Residents also have access to a mature, private garden.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 15 July 2025	15:10hrs to 18:40hrs	Angela McCormack	Lead
Wednesday 16 July 2025	09:30hrs to 13:30hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

Overall, this inspection found that residents living in Sliabh Glas designated centre were receiving a safe and person-centred service. Some improvements were required to ensure full compliance with the regulations, which would further enhance the good care provided. This will be discussed later in the report.

This inspection was an unannounced inspection which focused on safeguarding. The Chief Inspector of Social Services issued a regulatory notice to providers in June 2024 outlining a plan to launch a regulatory adult safeguarding programme for inspections of designated centres. This inspection was completed as part of this programme.

This inspection was completed over two half days; one evening and the following morning. The inspector provided a document called 'Nice to Meet You' that inspectors use to support residents to understand about why they are visiting their home. The inspector met and spoke with five residents, three staff members and members of the local management team.

There were six residents living in the centre at the time of inspection. One resident was at home with their family at the time of the inspection, therefore they were not met with. Residents spent their days as they wished. For example, residents attended a day service, had employment or engaged in an outreach programme during the week. One resident was supported to take part in activities from their home.

On arrival to the centre the inspector met with a staff member who had commenced working in the centre over the previous few weeks. All residents were out at the time doing their usual weekday activities. Shortly after, residents began to return home and were met with by the inspector. The inspector initially met with one resident. They spoke with the inspector about their day, their family and where they were from. They conversed with the inspector in Gaelige (Irish) at times. They agreed to show the inspector their bedroom. With staff support, they made their way to the bedroom. They spoke about their interests, about the photographs on display and about their family.

Other residents were met with during the course of the evening at a time that suited them .Throughout the inspection, residents were observed relaxing in their home, watching television and listening to music. Residents were observed freely moving around their home, with the exception of one resident who required staff support in moving around their home. This will be discussed further under Regulation 17: Premises. All residents appeared comfortable with the staff supporting them and with each other. There was a friendly and relaxed atmosphere in the house, with light banter observed between residents and staff.

From a walk around of the house, garden and apartment, the inspector observed a

clean and well-maintained service. Residents' bedrooms seen by the inspector, were nicely decorated and reflected their individual personalities and interests such as favorite football teams.

Residents had individual person-centred plans (PCPs) which were found to be kept under review to monitor the progress of personal goals that were set. Residents enjoyed a wide variety of activities such as; gardening, playing pool, playing darts, going to the cinema, going bowling, eating out and going on overnight breaks. One resident showed the inspector photographs of a recent trip that they had gone on to Co. Cork. Another resident spoke about their travel to another country last year and about how they got their passport and their thoughts on flying in an airplane. There were easy-to-read notices and pictures to support residents in making choices in their day-to-day lives.

Residents were consulted about the running of the centre and their views were sought through regular meetings where their choices and preferences for the week ahead were discussed. These meetings also provided a forum for the 'easy-to- read documents' to be discussed. This meant that staff were regularly checking with residents if they had any concerns and supporting them in how to raise concerns. Residents spoken with said they would go to staff members, the person in charge and the designated officers if they were worried about anything. Residents that the inspector spoke with said that they liked living in the centre, were friends with their housemates and said that they felt safe.

The inspector spoke with three staff members. Staff members were found to be knowledgeable about the needs of residents, their individual communication preferences and the supports required. Observations by the inspector included that staff members were supporting residents in line with their support plans and in a caring and respectful manner. Staff members were aware of the safeguarding procedures and about how to support residents in line with safeguarding plans.

The inspector observed residents coming and going to their home during the days of inspection. Observations by the inspector included that residents were supported to take part in their preferred activities when they chose to and that they were supported and facilitated to attend appointments. Furthermore it was noted that residents' decisions about interventions to support their health were respected. For example, residents were given information about various health and wellbeing topics that affected them, and their decisions about whether to access healthcare interventions were respected.

Overall, the inspector found that Sliabh Glas provided person-centred care where residents' individuality and choices about how they lived their lives were found to be respected.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and describes how governance and management affect the quality and safety of the service provided.

Capacity and capability

This inspection found that there were good arrangements for the management and monitoring of the service provided. The service was found to be in good compliance with the regulations overall.

There was a clear management structure in place which promoted good leadership and oversight. The person in charge had recently returned from a period of planned leave. Arrangements during their absence were found to be effective in ensuring that monitoring of the service continued in line with the provider's audit schedule.

An annual audit schedule was in place and covered topics such as safeguarding, complaints, restrictive practices, finances and medication. This also covered a monthly review and analysis of incidents. This promoted good oversight of the centre.

The skill-mix in the centre included nurses and health care assistants. The staffing needs were under review at the time of inspection. In the interim the centre used a number of regular agency staff, which helped to ensure continuity of care.

Regulation 16: Training and staff development

The provider had good arrangements in place for staffing training and development.

The inspector reviewed the training records and matrix for the staff team. These included both permanent staff and agency staff that worked in the centre. The records reviewed showed that all staff members had the mandatory training completed as required, which included behaviour management, safeguarding and Children First. In addition, site-specific training modules were identified for the service, such as human rights and supporting residents with sexuality. Where training was due (two staff members required behaviour management training), dates had been set for September 2025.

The inspector also reviewed the plan for supervision meetings between staff and their line manager. These were mostly completed in line with the provider's policy, with two meetings overdue due to leave arrangements. The person in charge was aware of this and had plans to address this.

Judgment: Compliant

Regulation 23: Governance and management

The management team was found to have the capacity and capability to ensure that a safe and high-quality service was provided to residents. The centre was found to be resourced with the numbers and skill mix of staff to meet residents' needs at this time. The centre was responsive to the changing needs of residents. For example, waking night-time staff had been implemented following a review of residents' changing needs. In addition, the inspector was informed that there was a further review of the staffing needs planned to ensure that any future changing needs would be met.

This inspection found that there were good oversight and monitoring systems in place that included a schedule of various audits carried out by the local management team. The inspector reviewed the audits for 2025 where it could be seen that these audits were carried out as outlined in the schedule. This included regular auditing of incidents, safeguarding, residents' finances, personal plans, restrictive practices, medication, and complaints. The audits were found to be effective in identifying actions to help ensure that a person-centred and safe service was provided.

In addition, the provider ensured that unannounced visits were completed every six months as required in the regulations. Actions from the audits were then collated into a quality improvement plan which was monitored regularly to ensure completion of actions. The provider also ensured that an annual review of the quality and safety of care in the service was undertaken. In addition, the provider ensured that there were up-to-date policies and procedures in place to guide staff and which promoted residents' rights, safety and protection.

Judgment: Compliant

Quality and safety

The inspector found that residents living in Sliabh Glas received person-centred care and support. However, improvements in the review of restrictive practices, risk documentation and access to appropriate aids were required. This would enhance the quality and safety of care provided.

Residents' health, wellbeing and protection were found to be kept under ongoing review. Needs were assessed and care plans were developed, where required. Residents' review meetings demonstrated a partnership approach to protection and safety with the participation of residents, their representatives and the multidisciplinary team (MDT). Residents were empowered to make choices in their lives. They were provided with information in a manner that supported their communication and understanding.

Residents' rights were found to be promoted in the centre. There was one open complaint at the time of inspection. This related to one resident and a complaint

about an aspect of the service being provided to them. In addition, they were supported to submit a referral to the national advocacy service. This demonstrated a rights based culture, where residents' voices were heard.

In summary, the inspector found that the service promoted a holistic approach to care that strived to protect residents and ensure their safety and wellbeing.

Regulation 10: Communication

The centre promoted a total communication approach and supported residents with their communication preferences.

The inspector reviewed three residents' communication plans that were based on an assessment of their needs. The plans provided guidance to staff on how to support residents with their communication preferences. Staff could be seen communicating with residents in line with their care plans. Residents had access to MDT supports, such as speech and language therapists, to further support with communication.

Various methods of communication were used with residents in line with their assessed needs. These included verbal communication, the use of a picture board, visual schedules, social stories and the use of applications on a technological device. Residents were supported to understand various topics through the use of easy-to-read documents that were discussed with them at weekly residents' meetings. Minutes of the meetings also included links to YouTube clips that provided further information about topics.

Residents were supported to maintain contact with their family and friends. Many residents enjoyed visits home to their families or met them for social meet-ups. Residents had access to televisions, technological devices, mobile phones and the Internet in line with their preferences. One resident was reported to enjoy buying and reading the local paper to keep updated with the local news.

Judgment: Compliant

Regulation 17: Premises

Overall, the centre was found to meet the needs of residents. However the following was found:

- One resident's mobility aid did not support their full capabilities and independence. This meant that they were reliant on staff members to support them to move around their home, where they previously could do this independently. While it was clear that efforts were made to address this issue and the resident was supported to voice their dissatisfaction about this, this

required further review. This would help to ensure that the balance of protecting the resident's physical health with their rights and choices about being able to move independently was reviewed with them.

The homes and garden were clean, well maintained and nicely decorated, creating a homely atmosphere. Residents had individual bedrooms which they decorated in line with their individual preferences and where they could store their personal belongings safely.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The inspector found that overall there were good systems in place for the assessment and ongoing monitoring of risks that could impact on residents' wellbeing and protection. This could be seen through the inspector's review of the incidents, risk management policy, risk assessment documentation and management audits. In addition, the inspector reviewed four residents' assessments of needs and associated care plans which included an assessment of individual risks that could impact on their safety and wellbeing.

For the most part, risks were found to be identified promptly and assessed, and included control measures to reduce the risk of harm to resident and others as relevant. However the following was found and required review:

- The documentation in relation to one risk required review to ensure that it contained clear information about the risk of harm, following a moderate rated incident that occurred when a resident was on a social outing. While the information included on the assessment form mentioned a potential risk, the information was not fully clear about what could happen and what the outcome could potentially be based on the previous incident and the impact that had on the resident and others. Improvements in this documentation would ensure that there are no gaps in information that could impact on staff members' knowledge about risks that could occur.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There were good arrangements in place for the assessment, monitoring and review of residents' needs and care plans.

The inspector reviewed four residents' assessments of needs, care plans and minutes of annual review meetings. A collaborative approach to care was evident,

where residents, members of the MDT and residents' representatives were involved in the review meetings, as relevant.

Residents' needs, various care plans and risks to their wellbeing and protection were kept under ongoing review. Care and support plans provided clear guidance on how to best support residents. Staff spoken with were knowledgeable about residents' preferences, needs, communications and how to best to support them. Residents were supported to identify goals for the future if they so wished. These goals were then reviewed regularly to ensure that they were completed in a timely manner.

Judgment: Compliant

Regulation 7: Positive behavioural support

Overall, there were good arrangements in place for supporting residents with behaviours of concern. However, the following required further review to ensure that the measures were proportionate to the risk:

- One restrictive practice required further review with the resident affected, to assess whether this practice was still required as there was waking night staff in place which would appear to mitigate one of the risks that was identified when the restriction was originally put in place. This would ensure that the least restrictive option for the shortest duration was in use.

The inspector reviewed the policies and procedures that the provider had for behaviour management and for restrictive practices. These were up to date and available to staff in the centre. They provided clear guidance about the roles and responsibilities of staff members, management and the MDT.

The inspector reviewed two residents' behaviour support plans. These were found to be comprehensive and provided clear guidance to staff members about how to support residents with behaviours, while ensuring their rights were upheld. This was evident through the language in the plans, which outlined the FREDA principles of fairness, respect, equality, dignity and autonomy.

Staff spoken with were knowledgeable about the behaviour support needs of residents. Support plans were developed with input from the relevant MDT and were kept under ongoing review. It was clear to the inspector through a review of the support plans and through discussions with staff members, that every effort was made to establish the causes of behaviours displayed by residents. Some residents were referred for speech and language therapy to support with communication. This showed how the staff team strived to support residents to communicate effectively, and promoted an individualised approach to care that recognised the individual feelings, and challenges with communication, that residents may experience.

Restrictive practices used in the centre were found to be assessed, kept under ongoing review and included MDT input. Trends in use were regularly monitored

also, which showed how the management team strived to ensure that restrictive practices were used as a last resort. The protocols and assessments included clear rationales for their use and included consultation with residents and their representatives. One resident spoke with the inspector about a practice that was in place for their safety, and they said that they didn't mind that it was there.

Judgment: Substantially compliant

Regulation 8: Protection

The centre was found to promote and uphold the protection of residents.

The inspector reviewed the policies and procedures that the provider had in place for safeguarding vulnerable adults and for the provision of intimate and personal care. These were available to staff in the centre and found to be up to date. Posters, information leaflets and notices about safeguarding and advocacy were observed on display in the home.

Training records reviewed by the inspector showed that all staff received training in safeguarding. The induction programme for new staff included safeguarding arrangements. The inspector spoke with three staff members about safeguarding arrangements. Staff spoken with were aware of the safeguarding procedures and what to do in the event of protection concerns. Staff members said that they could raise any concerns that they had about the residents' care and safety with the management team. Where incidents of possible protection concerns occurred, the procedures were followed in line with the provider’s policy.

The management team monitored staff members' knowledge about safeguarding through 'safeguarding awareness audits' that were completed each month. The inspector saw records for 2025 that were included in the audit folder. In addition, the inspector reviewed various meeting notes such as team meetings and person in charge meetings held during 2025, where it could be seen that discussions on safeguarding were held.

Safeguarding of residents was promoted through regular review of incidents and through discussions about safeguarding at various meetings. Residents spoken with told the inspector what they would do if they had any concern about their protection. Discussions at meetings included discussing scenarios with residents to further support their knowledge in how to self-protect. Residents' protection was also promoted through person-centred care plans for the provision of personal care, three of which were reviewed by the inspector.

Judgment: Compliant

Regulation 9: Residents' rights

A human rights-based approach to care was evident in the centre. This could be seen through the language used in care plans and from the discussions with staff members and residents. The inspector observed that individualised person-centred care was provided by staff members, that showed respect for residents' choices about how they lived their life. Through a review of documentation, the inspector could see that residents' voting rights and the right to practice their faith were discussed with them.

The inspector reviewed a sample of seven residents' meeting notes for 2025, where it could be seen that residents were consulted and empowered to make choices in their day-to-day lives. Residents' individual interests were promoted and residents were also consulted about their care and support through the personal planning and review meetings process.

In addition, residents were supported to understand their rights through regular discussions at residents' meetings and through the use of accessible information. Residents were supported to make complaints and where made, complaints were found to be taken seriously. For example, one resident was supported to make a complaint about a mobility aid that they received which impacted on their freedom of movement. This complaint was kept under ongoing review and remained open with the resident kept informed and updated regularly. In addition, a resident was supported to seek the services of an independent advocate to support them with an issue that they had. This was in progress at the time of inspection.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Sliabh Glas OSV-0002518

Inspection ID: MON-0047503

Date of inspection: 16/07/2025

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 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: To ensure compliance with regulation 17: Premises following action will be undertaken • One resident who had received a mobility aid and was dissatisfied with same has been supported to make a complaint. Completion date: 20-03-2024 • The resident was also supported to complete a referral to the National advocacy Service to support them with the complaint made. Completion date: 30-04-2024 • The Occupational Therapist was made aware of the complaint. As per the Occupational Therapist the resident required this piece of equipment due to the deterioration in the residents care needs. • The National Advocacy Service met with the resident and the complaint was closed to the resident's satisfaction. Completion date: 26-07-2025 • The National Advocacy Service continues to work with the resident to establish his will and preference around alternative accommodation as his current accommodation is not meeting his current needs. Completion date: 31-12-2025 • Once the residents will and preference regarding future accommodation is completed the PIC in conjunction with the resident will schedule an MDT to discuss future planning.	
Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: To ensure compliance with regulation 26: Risk Management the following action will be undertaken • The PIC has reviewed and updated the risk assessment for one resident pertaining to social outings to ensure all controls are in place to mitigate the risks and that all staff are aware of same. Completion date: 31/07/2025	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: To ensure compliance with regulation 7: Positive behavioural support the following actions has been undertaken • The named nurse and resident discussed the use of the two motion sensor mats as documented in the residents personal plan. A decision was made to cease the use of one of the motion sensor mats due to an increase in staffing levels in the centre. For the motion sensory mat that continues to be in use the resident has provided consent for the use of same. Completion date: 22-07-2025 • The PIC has updated the environmental restrictive practice protocol to reflect the reduction in the use of restrictive practices. Completion date: 23-07-2025 • All staff have read and signed the update environmental restrictive practice protocol. Completion date: 20-08-2025 • The environmental restrictive practice protocol will be reviewed by the PIC on a quarterly basis. Completion date: every three months	

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 17(5)	The registered provider shall ensure that the premises of the designated centre are equipped, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.	Substantially Compliant	Yellow	31/12/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/07/2025
Regulation 07(5)(c)	The person in charge shall ensure that, where	Substantially Compliant	Yellow	23/07/2025

	a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			