



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:	Announced
Date of inspection:	22 June 2026
Centre ID:	OSV-0002518
Fieldwork ID:	MON-0041979

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 five 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. 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
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How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 22 June 2026	12:15hrs to 17:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

The inspector found that good governance arrangements coupled with a high standard of care and support meant that residents living at Sliabh Glas were happy in their home and felt safe. This was a good quality service where 17 of 18 regulations reviewed were compliant with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013).

This was an announced inspection, the purpose of which was to monitor regulatory compliance and inform a registration renewal application. On arrival, the inspector met with the person in charge and a staff nurse. The person in charge facilitated the inspection.

The centre comprised a dormer bungalow and a separate flat. At the time of inspection, there were three residents living in the main house and one resident living in the flat. There was a vacant room in the main house as a resident had died in February 2026. When asked, the person in charge spoke of the impact of this on both the residents and the staff team. Throughout the inspection, the inspector observed, read and was told about both formal and informal arrangements in place to support the bereavement process. The resident's picture was displayed and if people were supported to speak about them if they wished to do so. Trips to their favourite places took place where residents could take a walk and tell stories of remembrance. In addition, the inspector saw a photograph of a fundraising presentation to the local hospice by the resident's family, their peers from Sliabh Glas and the staff team. This showed that good governance and support arrangements were in place at all times of a resident's life, including support with bereavement and loss.

The inspector visited the both the main house and the flat. The premises was in a quiet area close to the facilities of a busy town. There was sufficient parking spaces and a lovely garden. There was a gardening shed and raised beds where potatoes were growing. One resident told the inspector that they enjoyed gardening and had mowed the grass at the weekend. There was a basketball hoop at the side of the flat. The living accommodation in both the house and the flat was comfortable and welcoming. Both areas were well equipped with sufficient supplies of food and equipment. Transport was provided.

In the main, the accommodation provided met with residents assessed needs, however, there were ongoing issues regarding the changing needs of one resident who used a wheelchair. In addition, some works were required to the bathroom. This will be expanded on under Regulation 17: Premises later in this report.

The inspector observed that sufficient staff were employed. Those spoken with told the inspector that they enjoyed their work, they spoke about the rights of residents and of their active lives. They said that they were familiar with residents' family

members and visits to and from home were facilitated in line with each person's preference. When asked, they were aware of support strategies for residents that required help with expressive behaviours, were aware of fire evacuation procedures and knew what to do if a safeguarding concern arose.

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

Capacity and capability

The inspector found that the effective governance and management arrangements at the centre, coupled with a skilled and dedicated staff team meant that good quality care and support was provided.

Sufficient numbers of staff were employed and the roster arrangements were based on the needs of the residents. The person in charge was skilled, experienced and competent. The registered provider had good governance oversight of the service and the documentation systems were clear and comprehensive. Where required, statutory notifications were submitted for the attention of the Chief Inspector.

Example of compliance are provided under the regulations below.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider made an application to renew the registration of this centre in the form determined by the Chief Inspector of Social Services. This included the information set out in Schedule 2 of the regulations.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was employed full-time and had oversight of one designated centre at the time of this inspection. Therefore, they were regularly present and had a good knowledge of the residents, their family supports and their assessed needs.

They had the required qualifications and were assessed as a fit person in line with the Chief Inspector's guidance in this regard. They presented as calm and competent and had the skills required to lead the staff team.

Judgment: Compliant

Regulation 15: Staffing

A review of staffing arrangements at the centre completed by the inspector found that in the main, the number, qualifications and skill mix of staff employed was appropriate to the number and assessed needs of residents and size and layout of their homes.

The provider and the person in charge were proactive in monitoring staffing arrangements to ensure that they met with residents' needs. For example, at the time of this inspection, they had identified the need for an additional waking night staff. This was documented as an escalated risk, and a plan was in place to progress this.

The inspector reviewed the staff roster from 11 May 2026 to the date of inspection. This review found that the roster was well maintained with clear indications of who was on duty. Some changes were required to ensure that clarity of role for all staff was provided. This was addressed on the day of inspection.

Where additional staff were required, consistent and experienced agency staff were employed.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a range of mandatory and bespoke training modules as part of a professional development programme.

The inspector choose a sample of mandatory modules which were relevant to the centre. These included training in positive behaviour support, safeguarding vulnerable adults, fire safety and moving and handling. Dates of completion for staff including nurses, healthcare and assistants and agency staff were reviewed. This found that all modules were completed as required.

The provider had a staff supervision policy which was in date and provided guidance on the completion of personal achievement meetings. The person in charge had a

schedule for these meetings and the inspector reviewed completion dates for five of these.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had a contract of insurance which met with the requirements of this regulation.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the inspector was assured by the governance and management arrangements at Sliabh Glas. Additional work as outlined under Regulation 17 below with further strengthen compliance at this centre.

The person in charge facilitated this inspection competently. They were skilled and experienced and had a good knowledge of the residents, the staff and the service. This impacted positively on the quality of care and support provided.

The provider had an audit schedule for the service which included a range of weekly, monthly, quarterly and annual reviews. A review of the arrangements for a six-monthly provider-led audit found that it was completed in March 2026. The annual review of care and support was completed in September 2025. Actions identified were documented on a quality improvement plan which was reviewed and updated by the person in charge monthly.

Staff meetings were taking place on a regular basis, including a meeting scheduled for the day following the inspection. Discussions included a review of the quality improvement plan, safeguarding, and training completion. Staff were facilitated to raise concerns at these meetings if required or on a one-to-one basis with the person in charge. The inspector noted that there were concerns raised recently in relation to costs incurred by staff when supporting residents with holiday plans. While this did not impact on the quality of life of residents at the time of inspection, there was risk that it may in the future. While staff said they found this matter challenging, overall, they spoke highly of the support provided to them in their role and said that they were happy at work.

Judgment: Compliant

Regulation 3: Statement of purpose

The inspector read the statement of purpose for the service which was also available in accessible format for residents' use.

It was updated on 22 April 2026 and provided an accurate reflection of the services and facilities at this centre. It met with the requirements of Schedule 2 of this regulation.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of incidents arising at the centre from 1 January 2026 to the date of inspection found that if required, matters arising were reported to the Chief Inspector of Social Services in line with the requirements of this regulation

Judgment: Compliant

Regulation 34: Complaints procedure

The inspector reviewed the complaints policy for residents at the centre and found that it was subject to review in line with the provider's policy. It was available in easy-to-read format for residents' use which was displayed on the notice board.

There were no open complaints from residents at the time of inspection. Residents were supported to understand the process as it was discussed at residents' meetings.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had a folder where the Schedule 5 policies and procedures were available to guide staff. A review completed by the inspector found that they were subject to regular review and were linked with national policy and relevant legislation where required.

Judgment: Compliant

Quality and safety

The care and support provided at this centre was of good quality and ensured that people were safe. A review of the premises provided to ensure that it met with the assessed needs of all residents would further strengthen compliance under this section of the report.

Residents support needs were subject to ongoing review to ensure that the standard of care met with changing needs if required. Where required, support plans and guidance for staff was provided. Staff spoken with were familiar with residents' communication needs and this had a positive impact on their day to day life at the centre and their ability to make decisions. Easy-to-read information and social stories were provided.

Overall, this was a very pleasant inspection, where a good quality and safe service was provided for residents.

Regulation 13: General welfare and development

This centre adopted a rights-based approach to residents' welfare and development. Each person was supported to make decisions about how they wished to live their lives. This meant that the service implemented care based on residents' strengths and encouraged connection with their families and participation with their local community.

All residents were provided with access to facilities for occupation and recreation, with most residents attending a day service which they were reported to enjoy. In the evenings and weekends, residents participated in a range of home and community-based activities. As outlined, a summer holiday was planned later this year.

Judgment: Compliant

Regulation 17: Premises

A review of the properties comprising this designated centre found that some work was required to strengthen compliance under this regulation.

As outlined, there were some risks relating to the changing needs of a resident as outlined at the last inspection. However, the inspector found that the provider was aware of this. They scheduled a multi-disciplinary team review which took place recently (2 June 2026). The inspector reviewed the minutes which documented the attendance of the resident's family and members of their multidisciplinary team. At provider level, the quality, patient safety and risk specialist was involved and furthermore, the resident had access to an independent advocate through the National Advocacy Service.

A tour of the centre found some repairs were required to the upstairs bathroom in the main property. This had a bath which was not used and showed signs of aging. Furthermore, the floor covering was lifting from the floor. While residents were reported to prefer to shower, this meant that they were required to go downstairs. This arrangement required review.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The inspector found that there were a range of risks which required monitoring at this centre. A review of the arrangements found that the provider and the person in charge had effective arrangements in place at the time of this inspection.

The inspector reviewed the risk management folder which held provider level, service level and centre level safety statements. Several safety representatives were identified, and their details were clearly provided.

A review of the risk register found that it was updated prior to this inspection. There were two risk assessments with a red risk rating. The first related to the placement of a resident with high support mobility needs. This was ongoing as outlined under Regulation 17 in this report. The second related to supporting staff who attended holiday with residents. The person in charge told the inspector a discussion was planned with the provider later that week.

The inspector also read the emergency evacuation plan and when spoken with staff were aware of the process to follow and of the emergency evacuation location for each premises. The risk management and emergency planning policy was available to guide staff and subject to regular review.

Each resident had a risk screening assessment. This provided information on how to manage risks identified and if a care plan, nursing intervention or risk assessment was required.

For example, and as outlined, some residents at this centre required support with responsive behaviours. Their risk assessed was reviewed and updated in June 2026. Control measures were documented and these dove-tailed with the resident's positive behaviour support protocols. Risk ratings were in line with the provider's policy. A second resident with a history of significant risk behaviours had their risk assessment reviewed in January 2026. The person in charge outlined that this was a low rated risk at the time of inspection. This indicated that the risk management processes used were effective.

Judgment: Compliant

Regulation 28: Fire precautions

The inspector found that the provider had effective fire safety management systems in place at the time of this inspection. A review of the systems to detect, contain and extinguish fires found that they were subject to regular assessment by a competent fire safety professional.

All residents had a personal emergency evacuation plan which subject to regular review. Staff spoken with were aware of how to evacuate residents if required. Fire drills were taking place using both day and nighttime scenarios.

The provider's fire safety policy was in date; evacuation plans were clear and staff had up-to-date training.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector held discussions with residents, completed a tour of the centre and reviewed documentation. They found that the centre met with the assessed needs of residents and good arrangements were in place to support the needs identified.

A keyworker support system was used to support residents. All residents had individual personal plans which provided good information on residents' circles of support and preferred activities and goals. For example, some residents enjoyed seaside and woodland walks, train trips, football and eating out. Three residents were looking forward to an overnight summer holiday which they were planning together.

Overall, residents were provided with person-centred assessments and personal plans which respected the unique likes and dislikes of each person. The provider and

the staff team supported the autonomy of each person and positive risk-taking was considered part of fulfilled life.

Judgment: Compliant

Regulation 6: Health care

Residents at Sliabh Glas had the support of a general practitioner (GP), pharmacist and allied health professional in line with their assessed needs. A review of the arrangements completed by the inspector, found that where possible, residents participated in choices about their care and support and these were respected.

In addition, residents had support of allied health professionals such as occupational, speech and language and physiotherapy as required. Chiropody appointments were scheduled regularly. If required, access to consultant-led care was provided.

As outlined, a resident living at this centre passed away in February 2026. This was discussed with the person in charge and the staff nurse who spoke respectfully and with knowledge of the importance of end-of-life care which is informed by a palliative care philosophy. Furthermore, they recognised that the role of bereavement support for other residents living at this centre and had arrangements in place to provided this.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector reviewed the arrangements to support residents with responsive behaviours and behaviours of concern and found compliance with the regulation.

The policy on positive behaviour support was available to guide staff and staff had access to training. Those spoken with had a good understanding of a rights-based focus to behaviour support.

Where required the support of a behaviour support specialist was provided and residents had behaviour support protocols or plans. A review of two plans completed found that they provided clear strategies to guide staff. The inspector observed that advice provided was followed. For example, when residents returned to the centre in the evening, this noted as a typically busy time of day. However, staff maintained a low-arousal and calm environment. This meant that there was a clam and structured atmosphere during a potentially challenging period of the day.

The restrictive practice protocol was updated since the last inspection. This reflected the removal of a practice used at nighttime. This was no longer required as waking nighttime staff were on duty to provide support if required. Restrictive practices were subject to quarterly review and access to a human rights committee was provided.

Judgment: Compliant

Regulation 8: Protection

From a review of documentation and from conversations held, the inspector found that residents were assisted and supported to develop safeguarding skills and to stay safe.

The provider had a policy on safeguarding of vulnerable adults and if required residents had safeguarding plans. There were no open plans at the time of this inspection. A safeguarding audit tool was completed quarterly with the most recent in April 2026.

In addition, staff were provided with training in safeguarding and protection and all residents had an intimate care plan, which was subject to regular review.

Staff spoken with had a good understanding of safeguarding risks and of the actions to be taken if required. They were aware of the identity of the designated safeguarding officer.

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	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
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Sliabh Glas OSV-0002518

Inspection ID: MON-0041979

Date of inspection: 22/06/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	
To ensure compliance with Regulation 17: Premises the following actions have been/will be undertaken	
17(1)(b)	
• The PIC met with the landlord on 23/06/2026 to discuss the required upgrade for the bathroom. An agreement was reached for the HSE to upgrade the bathroom with conditions of appropriate wall and floor preparations, removal of bath and installation of a shower in the upstairs bathroom. Completion date:23-06-2026 • The HSE maintenance department have developed a scope of works and issued same for tender process. • Pending approval of the costings for the upgrade required the works will be completed by the 31-12-2026.	
17(5)	
• An MDT took place on 02/06/2026 to discuss the future accommodation plan for the resident with input from National advocacy, the resident, and their representative. Completion date: 02-06-2026 • A follow up MDT is scheduled for 22/09/2026. Completion date: 22-09-2026 • The advocate will continue to meet with the resident to ascertain their will and preference which will inform future accommodation. • Alternative accommodation will be required within the next 1-2 years.	

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(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	31/12/2026
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	31/12/2028