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:	Glasthule
Name of provider:	St John of God Community Services CLG
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	25 June 2025
Centre ID:	OSV-0004136
Fieldwork ID:	MON-0038827

About the designated centre

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

Glasthule is a designated centre operated by St John of God Community Services CLG. Glasthule is located in a suburban area of South County Dublin and is comprised of two individual houses. It provides 24 hour residential care to persons with intellectual disabilities and has capacity for supporting 9 individuals. One of the houses is a three-storey house and consists of a kitchen, dining room and sitting room on the ground floor. There are four residents' bedrooms, three on the first floor and one on the ground floor. There is also a shower and toilet facility and separate toilet facility on the ground floor as well as a laundry room. One of the resident's bedrooms on the first floor includes and en-suite shower room. There is also a communal bath and toilet facility on this floor. On the third floor there was an staff office and spare room. The other house consisted of a kitchen, dining-room and sitting-room on the ground floor as well as a resident's bedroom. There is also a toilet on this floor. On the first floor there are four bedrooms and a bathroom with toilet facilities and a separate shower facility. The centre is managed by a person in charge who divides their time between this centre and two other designated centres. They are supported in their role by a social care leader and a staff team of social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 25 June 2025	09:30hrs to 17:00hrs	Jacqueline Joynt	Lead
Thursday 26 June 2025	09:15hrs to 15:00hrs	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 inspection was facilitated by the person in charge and supervisor for the duration of the inspection. During the inspection, the inspector spoke with four staff and six residents. Residents living in the centre used different forms of communication and where appropriate, their views were relayed through staff advocating on their behalf. Residents' views were also taken from the designated centre's annual review, Health Information and Quality Authority's (HIQA) residents' surveys and various other records that endeavoured to voice residents' opinions.

Overall, the inspector found good levels of compliance with the regulations. The quality of care and support provided to residents was good, resulting in positive outcomes for residents. The provider was endeavouring to bring Regulation 17 back into compliance by ensuring residents accessibly needs were met at all times. There was a plan for residents to move out of one of the premises in the centre to different alternative accommodations so that they would better met their health, mobility and changing needs. This is discussed in greater detail under Regulation 17 and Regulation 23.

This was a centre that ensured service delivery was person-centred and included a rights-based focus. There were eight residents living in the centre, four residents in one premises and four residents in the other premises. During the inspection, the inspector got the opportunity to meet and briefly talk with most of the residents however, two residents, were not available at the time to meet with the inspector.

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 relationships and in particular, made strong efforts to facilitate and enable residents to keep regular contact with their families.

The designated centre was made up of two premises which were within the same locality. One of the houses comprised of a three-storey house within a small housing estate. The house consisted of a kitchen, dining room and sitting room and toilet down stairs. There were four residents bedrooms, three on the first floor and one on the ground floor. On the third floor there was an staff office and spare room. Throughout were lots of pictures, photographs and easy-to-read signage in the house in line with residents needs, preferences and likes. There was a very large planning board in the residents' dining room that included photographs of staff and what days and nights they were working, a weekly menu plan, a weekly activity plan and other information that was important to note that week. Overall, the house was

in good upkeep and repair and presented as bright, homely and welcoming. However, some improvement was needed to the upkeep of two shower facilities.

The other house consisted of a kitchen, dining-room and sitting-room on the ground floor. There was also a bathroom and shower and toilet facility on the ground floor. Residents' bedrooms were laid out and designed in line with their likes and preferences and were personal to each resident. The inspector observed 'vision boards' displayed on the walls of residents' bedrooms. The boards had been designed and created by residents with the support of their staff members. The vision boards relayed information about the residents and in particular, pictures and photographs related to their current goals. Since the last inspection, there had been some work completed in the house to improve accessibly however, it had not been sufficient enough to be able to meet the current and changing needs of all residents. There was a lot of upkeep and repair needed to the kitchen in the house which overall, was impacting on the effectiveness of the infection prevention and control measures in place.

In advance of the inspection, residents had been provided with Health Information and Quality Authority (HIQA) surveys. These surveys sought information and residents' feedback about what it was like to live in this designated centre. Eight surveys had been completed by residents with the support of their staff members. The residents' feedback was very positive and indicated satisfaction with the service provided to them in the centre, including, activities, trips and events, premises, staff support and food. Where there was a plan for residents to move to alternative accommodation, residents noted in their survey that they were happy to be moving to their new home and that they were able to bring all their belongings to their new home. Another resident noted that they had visited their new home every week. Another resident noted that they were able to see their new house before moving in to it. Residents also relayed other positive comments about staff support such as, staff members supported them to visit their family at Christmas time, staff listened to what they had to say and that they could go to staff when they had a concern.

On speaking with the person in charge, supervisor and staff members, the inspector found that they were familiar with residents' assessed needs and supports in place to meet those needs. On observing residents interacting and engaging with staff, using different styles of communication, it was obvious that staff interpreted what was being communicated. It was clear that they were aware of each resident's likes and dislikes. It was evident that residents felt very much at home in the centre and were able to live their lives and pursue their interests as they chose. Staff supported and encouraged residents to find goals that were meaningful to them. Residents were supported by staff members to process their goals at a pace that was in line with their needs, and in a way that was very achievable.

Through observations and a review of menu plans, the inspector saw that residents were provided with a choice of healthy meal, beverage and snack options. Where residents required assistance with eating or drinking, there was a sufficient number of appropriately trained staff available to support residents during mealtimes and were consistent with the residents' individual dietary needs and preferences as laid

out in their personal plan.

The inspector found that the service was operated through a human rights-based approach to care and support, and residents were being supported to live their lives in a manner that was in line with their needs, wishes and personal preferences. For example, residents were aware of the plan in place for them to move to alternative accommodation. Residents and where appropriate their families, had been consulted from the beginning about the transitions. Some residents had visited their new home or had met for coffee with residents who lived in their new home. The person in charge and staff were following the organisation's policies and procedures for transitioning residents to a new home, so that the safety and wellbeing of all residents was taken in to account at all stages.

In summary, the inspector found that each resident's wellbeing 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 and that overall, the person in charge and staff were endeavouring to continuously promote residents' independence as much as they were capable of.

Improvements were needed to one of the houses within the centre's premises. There was a plan in place, however the plan was at the initial stages. In addition, some improvements were needed to protection, restrictive practices, staffing levels, infection prevention and control and protection. 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 the provider's compliance with the regulations and to inform the decision in relation to renewing the registration of the designated centre.

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.

Residents living in this designated centre were in receipt of a good quality and safe service, with good local governance and management supports in place. For the most part, there was good levels of compliance found on the inspection however, improvements were needed to the centre's premises, which had also been found non-compliant on the previous inspection. The timeliness of the provider to bring Regulation 17 back in to compliance was not satisfactory and was impacting negatively on the lived experience of residents in one of the houses. The provider,

had recently put a new plan in place to bring premises back into compliance however, the plan was at the initial stages and. There were also some improvements needed to staffing, positive behaviour supports and protection.

On the day of the inspection the inspector found that there was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre.

The service was led by a capable person in charge, who was knowledgeable about the support needs of the residents living in the centre. The person in charge was full-time and responsible for this and two other designated centres. They were supported in their role in this centre by a supervisor and a person participating in management.

The registered provider and person in charge had implemented satisfactory management systems to monitor the quality and safety of service provided to residents. Overall, the governance and management systems in place were found to operate to a good standard in this centre.

Six-monthly unannounced visits of the centre were taking place to review the quality and safety of care and support provided to residents. The review included an action plan to address any concerns regarding the standard of care and support provided.

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

The registered provider had ensured the skill-mix and staffing levels allocated to the centre were in accordance with residents' current assessed needs. There were two social care staff vacancies at the time of inspection and recruitment was underway to back fill these vacancies. The person in charge was endeavouring to provide continuity of care. Where possible, permanent staff filled the gaps on the roster. Where agency staff were required, the person in charge was endeavouring to employ the same agency staff members as much as possible, so that they were familiar to residents and their support needs however, this was not always possible.

Throughout the day the inspector observed positive and caring interactions between staff and residents and it was evident that residents' needs were known to staff, the supervisor and the person in charge. The inspector observed that residents appeared very comfortable and happy in their home and relaxed in the company of staff.

The education and training provided to staff enabled them to provide care that reflected up-to-date, evidence-based practice. The training needs of staff were regularly monitored and addressed to ensure the delivery of quality, safe and effective services for residents.

A supervision schedule and supervision records of all staff were maintained in the designated centre. The inspector saw that staff were in receipt of regular, quality

supervision, which covered topics relevant to service provision and professional development.

The registered provider had prepared a written statement of purpose that contained the information set out in Schedule 1. The statement of purpose had been recently reviewed and was available to residents and their representatives to view.

The provider had suitable arrangements in place for the management of complaints and an accessible complaints procedure was available for residents in a prominent place in the 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 was employed full-time. They divided their role between this centre and two other designated centres. The inspector found that the person in charge was ensuring effective governance, operational management and administration of the designated centres concerned.

The person in charge was supported by a supervisor in this centre. The supervisor supported the inspector manage the service within both houses in the centre. The person in charge was supported by two other supervisors in the other centres they were responsible for. They were also supported by 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 person in charge was familiar with residents' support needs and was endeavouring to ensure that they were met in practice. 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, person participating in management and supervisor, fostered a culture that promoted the individual and collective rights of residents living in this centre.

Judgment: Compliant

Regulation 15: Staffing

The provider and person in charge were endeavouring to ensure that there were sufficient staffing levels with the appropriate skills, qualifications and experience to meet the assessed needs of residents at all times, in accordance with the statement of purpose and the size and layout of the designated centre.

The staff team consisted of the person in charge, a supervisor and social care workers. On the day of the inspection there were two social care worker vacancies in the designated centre.

The person in charge was endeavouring to ensure continuity of care and promote the development and maintenance of trusting relations. On review of the roster between March 2025 and June 2025 the inspector saw that, for one house, ten different agency staff had been employed over that period. For the most part, the same five agency staff, as well as one relief staff member, were primarily employed to cover shifts. There had been a decrease in the use of agency staff in June. Permanent staff members were also covering shifts which meant that residents were being supported and cared for by staff who were familiar to them. The inspector found that overall, and in line with residents assessed needs for familiar staff, continuity of care could not be ensured at all times while the staff vacancies remained in place.

During the inspection, the inspector spoke with and observed a number of staff members on duty and their interactions with residents; The inspector spoke in detail with four staff members and found that they were very knowledgeable about residents' support needs and their responsibilities in providing care. The inspector observed that where residents had specific communication needs, that staff members understood what residents were relaying to them. On speaking with key-working staff members, the inspector found that they were enthusiastic and energetic about supporting residents' progress their goals and of residents' goal achievements to date.

The person in charge, with the support from the supervisor, appropriately maintained both planned and actual staff rosters. The rosters clearly reflected the staffing arrangements in the centre, including the full names of staff on duty during both day and night shifts. The working hours of the person in charge and deputy manager were also noted on the roster and incorporated times when the person in charge worked on-site in both houses of the designated centre.

On review of a sample of four staff files, the inspector found that they contained all the required information as per Schedule 2. Overall, the inspector found that the staff team was well qualified, and dedicated to delivering care that upheld residents' rights and ensured their safety.

Judgment: Substantially compliant

Regulation 16: Training and staff development

On the day of the inspection, the inspector saw that the person in charge had good systems in place to evaluate staff training needs and to ensure that adequate training levels were maintained.

On review of the staff training records, the inspector saw that staff had completed or were scheduled to complete the organisation's mandatory training as well as training specific to the needs of residents. Staff were provided guidance and support relating to dementia-care from members of the provider's multi-disciplinary team which was tailored specifically to residents with this diagnosis.

Some of the training provided to staff included:

- manual handling,
- safeguarding vulnerable adults,
- human rights,
- fire safety,
- feeding, eating, drinking and swallow (FEDS),
- infection and prevention and control
- catheter care training
- triple C communication training
- first aid
- positive behaviour supports

The person in charge had ensured that one-to-one supervision meetings and performance management reviews, that support staff in their role when providing care and support to residents, were scheduled for all staff. The supervisor had completed staff supervision meetings in line with the schedule in place for 2025. Staff who spoke with the inspector said that they found the supervision meetings to be supportive and beneficial to their practice. They informed the inspector that they found the person in charge and supervisor very approachable and were available to support them when needed.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residents in the designated centre. The directory had elements of the information specified in paragraph three of Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

Records required and requested were made available to the inspector. The inspector found that records were appropriately maintained. The sample of records reviewed on inspection reflected practices in place.

On the day of the inspection, the person in charge organised for staff records to be made available to the inspector in the provider's head office for review. On review of a sample of four staff files, the inspector found that they contained all the required information as per Schedule 2.

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

Overall, the governance and management systems in place were of a good standard in this centre. 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 supported by a supervisor to carry out their role in the designated centre.

The provider had completed an annual review of the quality and safety of care and support in the designated centre between 1 January to 1 December 2024. There

was evidence to demonstrate that residents and their families had been consulted in the review. In addition to the annual review, unannounced six monthly reviews had been completed in January 2025 and July 2024. This was to review the quality and safety of care and the support provided to residents every six months and included an action plan with allocated responsibilities and time scales was in place.

There was a schedule of peer to peer audits in place. The peer to peer audits were carried out by the three supervisors that supported the person in charge for the centres they were responsible for. The audits ensured good oversight and shared learning between the three designated centres the person in charge was responsible for.

Supported by the person in charge, the supervisor carried out regular team meetings with staff. The person in charge regularly attended the meetings. Overall, the inspector found that the meetings promoted shared learning and supported an environment where staff could raise concerns and talk about the quality and safety of the care and support provided to residents.

However, in relation to the provider's responsibility of ensuring the designated centre was appropriate to residents' needs, the inspector found that improvement was needed. For example, the provider had failed to bring Regulation 17, Premises, back into compliance in a timely way so as to lessen the impact on residents.

While a number of actions were completed that improved the levels of accessibility in one of the houses overall, it had not been sufficient to fully meet the changing needs of all residents living in the house. The inspector was informed that there had been extensive work completed to ascertain how to make the house accessible however, due to the layout of the premises it was not possible.

As an alternative, the provider put a new plan in place to support each resident relocate to an alternative location that was of preference to them, and would better meet their assessed needs, however, as of the day of the inspection, the plan was at the initial stages. Further detail can be found under regulation 17.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The was a written policy, prepared by the provider, on the referral, admissions, transition and discharge of residents.

There were contracts of care in place for all residents. The inspector reviewed a sample of four contracts of care and found that residents had been supported to understand the contents of the contracts and in a way that was in line with their communication needs.

The contracts of care were written in plain language and in easy-to-read format.

Terms and conditions of the contracts were clear and transparent and included what residents were expected to pay for and what this included in relation to service provision.

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

There were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

The person in charge had ensured that all 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 timeframes 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. Where there had been incidents of concern, the incident and learning from the incident, had been discussed at staff team meetings.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had established and implemented effective complaint handling processes. For example, there was a complaints and compliments policy in place and it was up-to-date. In addition, staff were provided with the appropriate skills and resources to deal with a complaint and had a full understanding of the complaint's policy.

The inspector observed that the complaints procedure was accessible to residents and in a format that they could understand. Residents were supported to make complaints, and had access to an advocate when making a complaint or raising a concern.

On the day of the inspection, the inspector was informed that there were no open complaints.

Judgment: Compliant

Quality and safety

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

The person in charge, supervisor and staff members 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 better outcomes for residents at all times, improvements were required in relation to the premise, positive behavioural supports, infection prevention and control, and protection.

On a walk around of both houses within the centre, the inspector observed the houses to be clean and tidy. Overall, the houses presented as warm and welcoming with a homely feel to them. Residents appeared comfortable in their environment and were consulted in the layout and design of their bedrooms. However, the design and layout of one of the houses was not meeting the current or changing needs of all residents. There was a plan in place to support all residents transition to alternative accommodation that would better meet their needs. The issue of accessibly had been a finding on the previous inspection, and while the provider had made some structural improvements to the house in the interim overall, it was not

satisfactory or timely in fully meeting residents' assessed needs.

There were infection, prevention and control measures and arrangements to protect residents from the risk of infection however, some improvements were required to meet optimum standards. For the most part, the inspector found that the infection, prevention and control measures were effective and efficiently managed to ensure the safety of residents. However, to ensure all areas of the centre could be cleaned effectively, improvements were needed to the upkeep and repair of some areas in both houses.

The inspector reviewed a sample of residents' personal plans. The person in charge ensured that there was a comprehensive assessment for each resident, taking into account their changing needs. The assessment informed residents' personal plans which guided the staff team in supporting residents with identified needs and supports. Plans were reviewed annually, in consultation with each resident, and more regularly if required. Residents were provided an accessible version of their plan in the form of a 'vision board'.

Every effort had been made to ensure that residents could receive information in a way that they could understand. Each resident was provided with a communication support plan that had been developed from a comprehensive individual communication assessment. The support plans were reviewed on a yearly basis or sooner if required.

The provider had ensured that temporary absences of residents, transitions between or within services and discharges of residents were planned and managed in partnership with the resident using a rights-based approach. The provider had ensured that there was effective leadership in place that identified responsibilities for the transition process and discharge of residents.

The provider had ensured that the risk management policy met the requirements as set out in the regulations. Residents were supported to partake in activities they liked in an enjoyable but safe way through innovative and creative considerations in place. There were systems in place to manage and mitigate risks and keep residents and staff members safe in the centre.

Staff were provided with appropriate training relating to keeping residents safeguarded. The provider, person in charge and staff demonstrated a high-level of understanding of the need to ensure each resident's safety. Overall, residents living in the designated centre were protected by appropriate safeguarding arrangements however, in some instances, improvement was needed to the recording and screening of alleged incidents.

The provider and person in charge promoted a positive approach in responding to behaviours that challenge and ensured evidence-based specialist and therapeutic interventions were implemented. Systems were in place to ensure that where behavioural support practices were being used that they were clearly documented and reviewed by the appropriate professionals. The restrictive practices used were clearly documented and were supported by appropriate risk assessments which were reviewed on a regular basis. However, an improvement was needed to ensure

that environmental and rights restrictions were subject to review by an appropriate professional.

Suitable fire equipment was provided and serviced as required including the fire alarm, emergency lighting and fire fighting equipment. There were suitable means of escape and an up-to-date fire evacuation plan. Staff were trained in fire prevention and suitable fire drills were completed.

Regulation 10: Communication

Residents living in the centre presented with a variety of communication support needs. Communication access was facilitated for residents in this centre in a number of ways in accordance with their needs and wishes.

In documentation related to residents, there was an emphasis on how best to support residents to understand information.

Every effort had been made to ensure that residents could receive information in a way that they could understand. Information for residents was provided in easy-to-read format, pictures, photographs. For one resident there was a 'yes and no' sign language visual in place in their bedroom and in the kitchen. The sign language was specific to the resident as they had created the signs. The visual was used to support the resident make choices and also as a guide for staff on how to perform the options in the resident's own sign language.

All residents had been provided a communication assessment using the Triple C format and the outcome of the assessments then informed the support plan required for each resident. The plan guided staff in how to best understand and communicate with residents in line with the outcome of the assessments' symbolic established level. Residents were supported to engage in household meetings on a group or one to one basis. At the meetings residents made choices and decisions about their meals, activities and matters that were important to the. The meetings took in to account residents different communication abilities and levels and where appropriate were adapted to take in to consider each resident's Triple C communication level. Residents ticked or signed if they had participated and understood the meeting.

On speaking with staff members it was evident that they were aware of the communication supports that residents required and were knowledgeable on how to communicate with residents. The inspector found that staff knew each resident's communication format and were flexible and adaptable with the communication strategies used.

Judgment: Compliant

Regulation 17: Premises

One of the houses in the designated centre was not meeting the current and changing needs of all residents living in it. This was impacting on the quality of life for residents and posed a safety risk in terms of infection, prevention and control.

The inspector was provided with a detailed plan for the transition of the four residents living in the house to move to four separate locations. There were three stages within the plan and within stage one, there were three steps. The first step in stage one saw the provider's residential planning group committee identify vacancies across the entire service. Committee members included multi-disciplinary professionals representing areas such as occupation therapy, social work, psychology and physiotherapy as well as person in charges and day service managers. The committee was responsible for identifying any potential barriers before residents moved to the compatibility stage of transitioning to their new home.

Stage one of the provider's plan also included communicating with residents and their families about the move and commencing the compatibility process with all residents involved. As of the day of the inspection, all residents were engaging in the compatibility process. Most residents had meet their future housemates and had visited their potential new homes. The provider had estimated that all residents will have transitioned into their alternative accommodations by early October 2025.

Stage two and three, related to the transition of other residents in to the house (on a temporary basis) and associated registration applications. However, there was no date in place for the overall completion date of their final stage.

Overall, the inspector found, that while the provider was endeavouring to meet the assessed needs and preferences of all residents, the timeliness to bring Regulation 17 back in to compliance was not satisfactory. The delay was impacting on residents' rights to live in a home that met their needs and promoted their independence, in terms of accessibility. It was also impacting on their safety in terms of poor upkeep and repair impacting on the effectiveness of the infection prevention and control measures in place.

Judgment: Not compliant

Regulation 20: Information for residents

The registered provider had prepared a guide for residents which met the requirements of Regulation 20. For example, on review of the guide, the inspector saw that information in the residents' 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 25: Temporary absence, transition and discharge of residents

The inspector found that there was good leadership and oversight from the person in charge, the supervisor as well as the provider's residential planning group committee over the plan to move four residents to alternative accommodation. There were planned stages, and steps within the stages, that ensured the residents' transition were safe, at a pace that met their needs and successful.

The person in charge and supervisor were endeavouring to ensure that moves between services were person-centred, provided continuity in each resident's life and meet their assessed needs. For example, the planned transition to alternative accommodation had taken in to account residents' accessibility needs as well as continuity of residents' current day service. It also considered maintaining social relationships and a sense of connection with appropriate support networks for the residents. Furthermore, some of the new locations were within close reach of residents' current home which meant that local shops and services, that were familiar to residents, remained available to them.

The transition plan had also ensured that staff and team members within and between services had clearly defined responsibilities to assist residents who require support from more than one service and there were arrangements in place to support inter-agency working, communication and information sharing to minimise the risk of harm to the resident. On the day of the inspection, the compatibility process of stage one of the plan had commenced. On speaking with staff and residents, and on review of documentation, the inspector saw that social visits had been arranged between a number of residents and other residents who lived in their potential new home and there had been occasions where residents' families had visit the new home also.

Where a discharge had taken plan for one resident in January 2025 to move to a centre that better met their healthcare needs, the person in charge had ensured that the resident was consulted throughout the process. They were supported through a transition plan that had oversight by the person in charge, multi-disciplinary teams and dementia care team. This was to ensure that appropriate supports were available for the resident to deal with adjustment to their new environment, both emotionally and physically.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector reviewed the centre's 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 with an addendum in September 2022.

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. Risk were discussed at meetings between the person participating in management and person in charge on a quarterly basis.

Judgment: Compliant

Regulation 27: Protection against infection

In the main, the premises was observed to be clean and tidy however, upkeep and repairs were needed in a number of instances to ensure that all areas of the house, including some fixtures and fittings, could be clean effectively, in terms of infection prevention and control.

For example, the inspector observed the following when walking around the centre;

In one house the two accessible shower facilities required upkeep and deep cleaning. The inspector observed black ingrained grime and marks inside the shower doors. There were also some cracked and missing grout among the lower layer of wall and floor tiles within the shower.

In both houses, there were a number of doors, door frames and walls with chipped or peeling paint and warranted upkeep.

There was rust observed in a radiator in one of the bedrooms. there was rust observed on the bottom of a shower chair.

In another house there was mould observed on a number of window frames. The provided had noted on their quality enhancement plan about a mould issue in this house and work had been completed to remove it in February. However, as the

ventilation remained an issue, the mould had returned again and was visible on the day.

In one of the houses the carpet on the stairs leading to the third floor was observed as grubby and worn. In another house, the walls in the staff bedroom required painting.

The counter tops in the kitchen in one house were in poor repair and the timber was peeling off cupboards under the oven.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The centre had appropriate fire management systems in place. This included containment systems, fire detection systems, emergency lighting, and fire fighting equipment. These were all subject to regular checks and servicing with a fire specialist. The inspector saw that emergency lights, fire alarms, blankets and extinguishers were serviced by an external company within the required time frame.

The inspector observed that fire exits were easily accessible, kept clear, and well sign posted. All staff had completed fire safety training. Staff who spoke with the inspector on the day were knowledgeable in how to support residents to evacuate the premises in the event of a fire.

The person in charge had prepared fire evacuation plans and resident personal evacuation plans for staff to follow in the event of an evacuation. These were reviewed for their effectiveness during fire drills and reviews.

Regular fire drills were taking place, including drills with the most amount of residents and the least amount of staff on duty, as well as different scenarios. This was to provide assurances that residents could be safely and promptly evacuated and to ensure the effectiveness of the fire evacuation plans. On a review of records, the inspector saw that a deep sleep drill that included four residents and one staff member had taken place on 18 June 2025 with no issues detected. Where the drill time in another house had been slower than a previous drill, this had been reported to the person in charge who was following up with the appropriate health professional.

On review of the centre's fire safety folder, the inspector saw that the person in charge had ensured that daily and weekly fire checks were completed of the precautions in place to ensure their effectiveness in keeping residents safe in the event of a fire. The person in charge also completed a fire safety register audit on a quarterly basis. The audit reviewed matters related to staff training, drills, staff fire safety checklists, inspection of fire fighting equipment, emergency light, fire detection system staff induction, guidelines in residents' emergency evacuation

plans and fire exits.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of five residents' personal plans and saw that they included an 'All about me' assessment which included areas such as communication, sensory, behaviour, feeding eating and drinking, health and nursing supports, mobility, skin, personal care and dressing, physical skills, money support, transport support and sleeping.

Residents personal plans also included risk assessments, financial passports, rights assessment, personal evacuation plans and financial passports. In addition, residents were provided with a 'using your environment' assessment, which detailed the level of independence each resident had and identified areas where they would like more independence in.

Following on from assessments, care plan supports were put in place for each residents to maximised each resident's personal development in accordance to their wishes, individual needs and choices.

The plans were regularly reviewed to take into account the revised assessed need 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 a provided a 'circle of friends' meeting. Residents, and where appropriate their family members, were consulted in the planning and review process of their personal plans.

Residents' personal plans included assessable information that was important them and provided support in helping residents understanding what was contained within their plan and in a format they understood and was of preference to them. Residents were also supported to create an annual 'vision board' that included their likes and preferences, people who were important to them and the goals they hoped to achieve. During the inspection, three residents pointed out their vision board to the inspector and appeared happy and proud when showing it and in particular, where goals had been achieved.

Residents were supported to choose goals that were meaningful to them, included them in their community and were in line with each of their likes and preferences. Residents were supported to progress their goals through key working sessions with their staff members and residents were involved and consulted through the process.

On speaking with staff on the day, the inspector found that staff were enthusiastic and excited about supporting residents to achieve their goals. Some of the goals achieved by residents who liked to travel included, a trip to see the sound of music in Austria, a trip to Disneyland in Paris and an overnight stay in a spa hotel in

Ireland.

Judgment: Compliant

Regulation 6: Health care

The inspector found that 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. On review of residents' personal goal, some included attending a yoga class, fitness programmes and going for relaxing massages. On observing food in residents' fridges, the inspector saw that there was a lot of fresh healthy foods available to residents.

Residents' healthcare plans demonstrated that each resident had access to allied health professionals including access to their general practitioner (GP). Residents were supported and encourage to attend annual health check-ups and to avail of national screening programmes that were available to them. Staff support residents with their healthcare and GP and hospital services were provided in the community or with the organisations' multi-disciplinary team. Overall, the provider and person in charge promoted the rights of residents in relation to making choices around their healthcare and support needs in this area.

For example, during the inspection, a resident told the inspector that they were unhappy with their bed as it was too high off the ground and they were afraid of falling when sitting on the bed. The person in charge provided emails and referral forms to demonstrated that the resident's voice and concerns had been heard. The organisation's occupational therapist and physiotherapist had visited the resident in their home and reviewed their bed in May 2025. In addition, the occupational therapist wrote a letter to resident, (in easy-to-read format), advising the resident that they were aware of their concern and would submit a referral for a new bed that would better met their needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector found that there were arrangements in place to provide positive behaviour supports to residents with an assessed need in this area. On review of a resident's positive behaviour support plan, the inspector saw that it was detailed, comprehensive and developed by an appropriately qualified person. In addition, the plan included proactive and preventive strategies in order to reduce the risk of

behaviours of concern from occurring.

The person in charge ensured that staff had received training in the management of behaviour that is challenging and received regular refresher training in line with best practice. Staff spoken with were knowledgeable of support plans in place and the inspector observed positive communications and interactions throughout the inspection between residents and staff.

There were a small number restrictive practices implemented in the centre. All restriction had been approved by the organisation equality human rights committee. The rationale for restrictions in place were clear and deemed to be least restrictive option. On review of residents personal plan the inspector saw that residents were supported to understand and give consent for restrictive practices in use. On speaking with staff members the inspector was told about efforts to minimise the use of restrictions, for example, a locked front door in one of the premises had recently been removed.

The inspector saw there where restrictive procedure were being used, they were reviewed on a regular basis by the person in charge, the supervisor and staff members however, improvements were needed to ensure that all environmental and rights restrictive practices were subject to review by an appropriate professional that was involved in the original assessment and implementation of the restriction.

Judgment: Substantially compliant

Regulation 8: Protection

There was a clear policy in place with supporting procedures, which clearly directed staff on what to do in the event of a safeguarding concern. All staff had completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. The inspector spoke with four staff members in detail during the inspection and found that they were knowledgeable about their safeguarding remit and aware of how to support residents keep safe. On review of staff files, the inspector saw that all staff members had been through the appropriate vetting system.

The provider and person in charge had put in place safeguarding measures to ensure that staff providing personal intimate care to residents, who required such assistance, did so in line with each resident's personal plan and in a manner that respected each resident's dignity and bodily integrity.

The inspector found that some improvements were needed to ensure that, in all cases, incidents of a potential safeguarding nature were appropriately followed up.

For example:

A resident was provided with a dementia care support plan and it included guidance

for staff on how to support the resident should they make an allegation about another resident or a staff member. The designated officer and the resident's health professionals were informed of these types of incidents.

On speaking with a staff member, the inspector was informed that in most instances, where the resident made allegations about other residents or staff members, there was sufficient evidence to demonstrate that no incident had occurred. However, the inspector found that there were other times, where it was not so evident and where this had been the case, the allegation was followed up through verbal enquiry.

On day of the inspection the person in charge put additional protocols, guidance and a tracking system in place to ensure that verbal enquiry and follow up on such incidents were appropriately recorded and tracked. However, further improvements were needed to ensure that, where necessary, these incidents were screened and reported in accordance with national policy and regulatory requirements.

Judgment: Substantially 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 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Glasthule OSV-0004136

Inspection ID: MON-0038827

Date of inspection: 26/06/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and 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
Outline how you are going to come into compliance with Regulation 15: Staffing: There is a plan in place to fill the following two vacancies by the end of November 2025. One WTE is currently being filled by an agency staff who are in the process of getting her permanent contract with SJOG. Awaiting finalized paperwork. This will ensure continuity of care for the residents as this staff member has already been working in the location in an agency capacity. The second vacancy will be filled by 0.5 staff that are transferring from another DC. This is due to commence in September 2025; the second 0.5 will be filled by a staff member transferring from another location. This will be completed by the end of November 2025.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The plan submitted is progressing. Residents are moving to alternative locations in line with their assessed needs and preferences. When all residents are transitioned out to alternative homes, building works will commence November 2025.	
Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: The plan submitted is progressing. Residents are moving to alternative locations in line with their assessed needs and preferences. The remedial work required will be addressed more thoroughly as part of the long-term plan. When all residents are transitioned out to alternative homes, building works will commence November 2025.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection: The two accessible shower facilities have been scheduled for a deep clean. This will be completed by 17th of August 2025. The missing grout in the downstairs bathroom has been highlighted to the maintenance team who have assessed, and remedial works will be completed by the end of August 2025. The chipped paint on the doors, door frames and walls had previously been sent for completion and an agreed date for this is the end of October 2025. The rust on the radiator was cleaned on the day. The rust on the shower chair has been reported to OT and a new shower chair has been requested. This will be completed by the end of September 2025. The mould on the window frames has since been removed. This will be addressed more thoroughly as part of the long-term plan. Building works will commence in November 2025 when all residents have transitioned to their alternative homes. A request has been sent for approval of the replacement of the carpet on the stairs of the third floor. This will be completed by the end of November 2025. The counter tops and the timber peeling off the doors in the kitchen will be addressed when the kitchen is replaced as part of the long-term plan. Building works will commence in November 2025 when all residents have transitioned to their alternative homes.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: A committee has been set up in DSE to review the service approach to environmental restrictive practices. There are representatives from both day and residential services, as well as clinical representatives on this committee. The committee will be chaired by the Programme Manager. Actions from these meetings will be put in place in line with our Enabling a Restriction Free Environment Policy. This will be completed by the end of December 2025.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: Protocols have been put in place to ensure there is a thorough follow-up happening where all allegations are made. Screening is completed in accordance with national policy and reported accordingly. Incidents not meeting the threshold of a notification were reported to the designated officer who reported to the HSE SPT who were in agreement with the screening process, including protocol and tracking system that is in place. This was completed by the 25th of July 2025.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/11/2025
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/11/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	30/11/2025

	state of repair externally and internally.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/11/2025
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	30/11/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with	Substantially Compliant	Yellow	31/12/2025

	national policy and evidence based practice.			
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	25/07/2025