Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Gleneden
Name of provider:	Daffodil Care Services Unlimited
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	15 July 2026
Centre ID:	OSV-0007981
Fieldwork ID:	MON-0050177

About the designated centre

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

Gleneden comprises a large two-storey dwelling in a scenic rural area in Co. Tipperary, with access to the local community and amenities. The centre has a capacity for two residents at any one time and services are provided through a bespoke residential service. Services will accommodate for persons aged 18 or younger with the exception of a young person currently completing their final year of second level education. Residents have their own bedrooms. Gleneden provides social care disability services to those requiring support for complex physical or cognitive needs as a result of ADHD, intellectual disability, autism spectrum disorder or other related disability. Staffing levels will be reflective of individual support needs of service users; staff team will be a combination of support and senior support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 15 July 2026	16:40hrs to 19:10hrs	Angela McCormack	Lead
Thursday 16 July 2026	09:40hrs to 15:50hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

This inspection was completed to follow up on actions from the last inspection by Health Information and Quality Authority (HIQA) that was completed in February 2026. At that time, six regulations were not compliant. This inspection found that many areas of non-compliance were addressed; however, one regulation remained not compliant. This related to Regulation 7: Positive behaviour support and the assessments of restrictive practices. This will be elaborated on throughout the report.

Gleneden was home to two young people. The inspection was unannounced and completed over two days, one evening and the following day. The inspector provided a document called 'Nice to Meet You' that inspectors use to help to explain who they are and the purpose of their visit. Both young people agreed to meet, and spend time, with the inspector.

On arrival to the centre on the first evening, the inspector was greeted by one staff member. One young person was reported to be relaxing in the house while the other young person was out doing an activity. The young person agreed to meet with the inspector. They spoke about their life and experience living in Gleneden and showed the inspector around their home. The other young person was met with briefly on their return home. As they were busy throughout the evening, they agreed to talk with the inspector the following day.

Both young people spoke with the inspector about their experiences of living in Gleneden. Overall, feedback was mixed. The young people described being supported to participate in activities they enjoyed and to lead active lives. They acknowledged that things had improved in the centre. However, they both said that a number of staff have left in recent times, some without them knowing, which they found difficult. Both also showed an understanding of the reason why specific supports were in place for them. For example, one young person explained that they understand why supervision was required at times. However, both young people said they found some aspects of the centre to be 'institutional'. This was primarily related to restrictions placed on them. They told the inspector that the reasons for some restrictions had not been fully explained to them and they were unaware of the plans to reduce these measures. However, they also described where restrictive practices had eased for them with regard to monitoring their money and the location of their games console.

Through a review of documentation and discussions with the management team, the inspector found that not all restrictive practices were supported by clear and specific risk assessments. In addition, the rationale for some restrictions including whether they remained proportionate to the young people's current assessed risks was not clearly documented. Furthermore, some risk assessments identified

hypothetical or worst-case scenarios without evidence that these risks had previously occurred or were relevant to the young person.

The inspector also found that some restrictive practices did not have defined plans to reduce them as risks changed. One example was the use of motion sensors outside the young people's bedroom doors. The management team could not demonstrate an individualised rationale for this practice. One young person described the impact of this measure stating 'if I go to get a glass of water during the night it is logged my daily logs'. They also felt that recording 'just natural things that people do during the day' was unnecessary.

Despite this both young people said that they can raise issues and were aware that they can make complaints. One young person said they are happy with their key-worker, and said about the service, that 'they see me as I am now'. One young person also said that don't like living in Gleneden, but more so they just don't want to there, rather than it not being nice. One young person said they were looking forward to turning 18 years, so that they 'can leave care'.

The young people spoke about their interests and their plans for the future, which included further education. They were supported to join community groups, spend time with friends and engage in leisure activities that were meaningful to them such as gaming and having pets. In addition, the young people were supported to maintain links with their families, where relevant. They were supported to meet, and maintain contact, with their representatives and friends.

The inspector spoke with three representatives during the inspection. These included a family representative, a guardian ad litem and an advocate from Empowering People in Care (EPIC). Overall, feedback was good with regard to the current management of the centre and about how the service meets the young people's needs. However, one representative spoke of feedback they had given to the service that continued to be an issue.

The house was nicely designed and reflected the young people's interests, such as dedicated areas for leisure, gaming and playing music. One young person had raised issues about the number of flies in the house. In addition, an outdoor swing set that was purchased for the young people in recent times was not suitable for their age and developmental stage. These areas required completion.

Overall, this inspection found that there had been improvements since the last inspection in a number of areas. However, the assessments of restrictive practices required review to ensure that they were proportionate to the risks of harm to the young people and were reviewed as the least restrictive measure.

The next two sections of the report outline the governance and management arrangements and describes about how this impacts on the quality and safety of care provided.

Capacity and capability

Overall, the inspector found that the provider had made improvements to achieve compliance with the regulations since the previous HIQA inspection. Improvements were found in staffing, staff training and in the oversight and governance of the centre. These improvements contributed to a more consistent and safe service and provided enhanced oversight of the care provided to the young people. The inspector was informed that further changes were planned with regard to governance structures within the organisation, which the management team felt would further enhance the overall governance of the centre.

Further improvements were required however, to ensure that identified actions were completed in a timely manner. The inspector also found gaps in documentation relating to protection referrals and noted that feedback given to the service was not managed through the complaints process. These areas required further development to ensure continuous service improvement and to further enhance the good care and support provided.

Regulation 15: Staffing

This inspection found that there were improvements in staffing since the last inspection by HIQA, with a number of newly recruited staff in place. The numbers and skill mix of staff were found to meet the current assessed needs of the young people.

The inspector reviewed the planned and actual staff rosters between 13 April and 16 July 2026. The skill mix included team leaders, deputy team leaders, residential social care workers, social care workers and support workers. Three staff were rostered during daytime hours, with two staff covering sleepover duties each night and one staff member covering a day shift and finishing in the evening. This supported the young people to do individual activities that were meaningful to them and to ensure their safety at night time.

The young people spoken with said that a number of staff members had left over recent times. For example; one young person said that seven staff members had left in the past year. Following a period of staffing instability, the provider had recruited a number of new staff members to join the team. Staff spoken with said that things had improved and there was now a consistent staff team in place. This was reflected in the recent rosters reviewed by the inspector.

The inspector reviewed a sample of five staff member's personnel files, including two recently recruited staff members. From this review it was found that all of the information that is required under Schedule 2 of the regulations was in place. These

included An Garda Siochana vetting, two references, photograph identification and work history. The inspector noted that some staff members had previous experience supporting young people. For example; one staff member spoke about their voluntary work with an organization that provides telephone support to children and young people experiencing distress and upset.

Judgment: Compliant

Regulation 16: Training and staff development

Staff members working in Gleneden were supported in meeting the needs of the young people through ongoing training and regular support and supervision from their manager.

The person in charge was found to have good oversight of the training needs of the service. They ensured that all staff members working in the centre completed the mandatory training required. These included training in Children's First, Behavior support, Medication training, First Aid and Fire safety. From a review of the training records and matrix, the inspector could see that all staff had either completed, or were booked in to complete, the relevant training within the coming weeks. There was a plan in place to address training gaps which related to the most recent staff members. This was planned to be completed by 31 August 2026. A risk assessment was in place for the use of agency and untrained staff to ensure that there were suitable control measures in place. In addition, where refresher training was due, this had been identified and a plan put in place for the relevant staff members to complete this. Staff members' training certificates were maintained and available for review by the inspector. A sample of five staff member's certificates were reviewed and found to be in place.

Five staff members spoke with the inspector throughout the two days of inspection. Staff spoken with said that they felt well supported and enjoyed their work. Staff members were supported and supervised through regular appraisal meetings with their manager. A schedule was in place for these meetings to occur throughout the year. Some staff members that were in a team leader role had undertaken 'supervisor training' also to support them in providing support to other staff members.

In addition, newly recruited staff members underwent a comprehensive induction process to the centre. A sample of one new staff member's induction checklist was reviewed by the inspector which showed areas covered including health and safety, protection and care and support needs. Staff members were required to work a probationary period also. These measures helped to ensure that all staff members received ongoing support, training and had opportunities for professional development. In addition, the centre was found to provide additional supports to

staff members to foster team building. For example, on the second day of inspection a number of staff team were going on a team building day together.

Judgment: Compliant

Regulation 23: Governance and management

Improvements were found in governance and management of the centre since the last HIQA inspection. These included the active presence of a person in charge in the centre who was supported in the operational management of the centre by team leaders, and enhanced arrangements for monitoring and overseeing the centre by both the senior and local management team.

The inspector reviewed a number of records of meetings that occurred since the HIQA inspection in February 2026, which demonstrated that a comprehensive review of practices was occurring. These included incident review meetings, regional meetings, and management meetings. In addition, a monthly senior management oversight report was completed which reviewed areas of practice including where there were areas of strength and where actions were required. The inspector reviewed five of these records held between February and June 2026 where it could be seen that a comprehensive review took place. In addition, audits were completed in safeguarding and supervision, with actions identified for improvement. The arrangements for oversight also included reviews of significant events and incidents where it was recorded where actions such as notifying HIQA and completing child protection and welfare referral forms (CPWRF) were completed. This all demonstrated that there was a consistent system in place for overseeing the quality and safety of care provided, and which was generally effective in identifying areas for improvement.

However, some additional improvements were required as the following was found;

- An issue was raised by the young people and their representatives regarding the number of flies in the house. This was reported to be related to a nearby farm. The issue was under review with actions identified to address this; however not all of the actions were completed and this required action in a timely manner.
- A piece of equipment in the garden for use by the young people was not age appropriate or suitable for their stage of development and size. It was reported to the inspector that plans were in progress to address this; however this required completion in a timely manner.
- There were gaps in documentation maintained at the centre in relation to CPWRF. While measures were taken to address protection concerns raised, the gap in documentation meant that this was not easily demonstrable.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider ensured that there was a policy and procedure in place for complaints which included an appeals process. The two young people were aware that there was a complaints procedure and knew who to speak with.

However, the following was found;

- Recurring feedback from a young person's representative expressing dissatisfaction about communication systems had not been treated, and therefore not resolved, as a complaint. In addition, this representative said that they were not fully sure about the complaint's procedures for the centre.
- One young person said while they know how to complain, things do not always get sorted.

These points required review to ensure that all young people supported and their representatives, are aware of Gleneden's complaints procedures and to ensure that feedback expressing dissatisfaction with the service was followed through and resolved to the satisfaction of the person raising the issue.

Judgment: Substantially compliant

Quality and safety

The inspector found that the provider had made improvements in protection and risk management. Young people were found to be supported by staff who understood their individual needs. However, improvements were required to ensure that restrictive practices and risk management arrangements consistently reflected a rights-based approach and were proportionate to identified risks.

The inspector found that some restrictive practices were not supported by sufficiently individualised and specific assessments. It was not clearly evident that some practices remained proportionate to the young people's current assessed risks. Furthermore, the young people were not aware of a reduction plan for reducing or removing the restrictions as risks changed. Consequently, the inspector found that the cumulative impact of this had the potential to negatively impact on the young people's privacy, autonomy and independence.

Regulation 26: Risk management procedures

There was a risk management system in place to identify, assess and monitor risks in the centre. However, improvements were required in the assessment of risks to ensure that they were evidence based and accurately reflected risks of harm to the young people.

The following was found;

- The inspector found that one young person had a location tracking application installed on their mobile phone. However, while there was an assessment relating to online safety and Internet monitoring, there was no documented assessment about tracking the young person's movements.
- In addition, the young person's risk assessment noted risks including alcohol use and criminal activity despite no evidence that these behaviors had ever occurred. Therefore, it was not clear how these presented as a current risk. This indicated that some risk assessments were not sufficiently individualised or based on evidence.
- The risk assessment regarding the house alarm was not specific as to what parts of the house were alarmed. For example, this did not include the use of motion sensors outside the young people's bedrooms.

Nonetheless, the inspector found that risk management had improved since the last HIQA inspection. There were systems in place for regular review and monitoring of risks. This included a centre risk register, with noted open risks. In addition, management meetings occurred regularly to review risks, five of which were reviewed (between April and June 2026) by the inspector.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspection found that restrictions in place impacting on the young people were not appropriately assessed as to whether they were the least restrictive measure for the shortest time.

The following was found;

- The provider had implemented some restrictive practices that were not consistently supported by individualised assessments. In addition, it was not clearly evident that they remained proportionate to the young people's current assessed risks. For example, both young people had motion sensors located outside their bedroom doors in addition to overnight security measures including locked external doors, a house alarm and two staff members on duty overnight. The management team was unable to provide a clear rationale or individual risk assessment to support the use of the motion sensors for each of the young people, with one staff saying that it may be

company policy. This indicated that they were likely in place as a standard practice. One young person described the measure as intrusive stating they could not leave their bedroom during the night to get a drink of water without alerting staff. As a result, it was not demonstrable that some restrictive practices were the least restrictive approach necessary to safeguard the young people.

- Furthermore, the inspector found that some restrictive practices did not have defined plans for reduction and the young people said they were not aware of plans, if any, for some of these practices to reduce.
- Some restrictive practices were not individually assessed. For example; the inspector found that one young person had a location tracking application installed on their mobile phone. However, while there was an assessment relating to online safety there was no documented assessment supporting the need for location tracking and to assess if this was the least restrictive measure.

Judgment: Not compliant

Regulation 8: Protection

The service was found to promote the protection of young people. Concerns raised were found to be taken seriously and addressed through the implementation of the child protection procedures, where relevant. The centre had developed a child safeguarding statement setting out their commitment to child protection.

The young people were protected through the safe recruitment, training, and supervision of staff and through arrangements for the ongoing monitoring and review of practices, risks and safeguarding procedures. In addition, this inspection found that there were good systems for sharing information and collaborating with the young people, their representatives and other agencies involved in the young people's care. This helped to ensure that each young person was protected and supported appropriately. This also demonstrated a culture of openness and transparency. While there were no open protection concerns, both young people had individual safeguarding plans to promote their ongoing protection.

The young people were found to be supported in a positive way with their feelings. Regular meetings and discussions were held with the young people to support them in voicing their concerns and to agree plans for their future. Where supports were required, there were care plans in place that provided guidance to staff members on how to best support the young people. Both young people said they felt safe in the centre and said they can go to staff members if they have any concerns.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Gleneden OSV-0007981

Inspection ID: MON-0050177

Date of inspection: 16/07/2026

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: - Centre management has completed a number of actions in response to the issue raised, this has included; Company Maintenance Team and external services completing pest control, installation of window screens and continuation of daily hygiene checks. - Garden equipment has been ordered. - A review of the Company's Standard Operating Procedures in relation to the management and process of NF06's and CPWRFs has been completed, within the management team, to ensure moving forward all required documentation is on file. Effective 24/08/26, the Director of Services attends the centre on a weekly basis to provide effective Governance and Oversight. The Director of Services and Person in Charge work in collaboration to ensure that all issues are responded to in a timely fashion.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: - A Service User Friendly Complaints policy has been developed and reviewed with the service users. The policy is available to access and read, via the service user notice board. This includes their rights and the process of how to appeal the outcome of a complaint, should they remain dissatisfied. This policy will be reviewed on a quarterly basis, within service user meetings. - The Complaints Procedure has been shared with service user's representatives, to ensure that all are aware of how to make a complaint, how a complaint is processed and how to appeal to a complaint's outcome. This will be shared with service users' representatives during the admission process. - Centre Management continue to have regular contact with service user's	

representatives and will record any dissatisfaction as formal complaint.

Effective from 24/08/2026, all complaints will be reviewed by the Director of Services and commented upon within the Monthly Governance and Oversight Report. Complaints will be reviewed to identify any current themes, outcomes on a Monthly basis within the Incident Report Group and within a 6 monthly complaints audit.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
- Management have completed a full review of risk management and associated restrictive practices, to ensure that all restrictive practices have their own individual assessment.
- Risk Management training has been scheduled with the staff and management team, with particular focus on identifying individualized risks measured to the service, this is scheduled for 04.09.2026
- Monthly Senior Management meetings include Risk Management and Use of Restrictive Practice as standing items on the agenda, for discussion and review to ensure that all restrictive practices are reviewed on a regular basis and in place for the shortest timeframe necessary.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
- Centre and Senior Management have conducted a review of the centre's use of restrictive practices to ensure that they are informed by the service user's individual assessment and level of risk and are in place for the shortest timeframe necessary.
- Management have completed a full review of risk management and associated restrictive practices, to ensure that all restrictive practices have their own individual assessment.
- The Restrictive Practice Assessment template has been reviewed and updated, to include identification of a plan for reduction of restrictions.

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 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	11/09/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	11/09/2026
Regulation 34(2)(c)	The registered provider shall ensure that complainants are	Substantially Compliant	Yellow	11/09/2026

	assisted to understand the complaints procedure.			
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Substantially Compliant	Yellow	11/09/2026
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 national policy and evidence based practice.	Substantially Compliant	Yellow	11/09/2026
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	11/09/2026