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:	Glencorry
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	23 July 2025
Centre ID:	OSV-0002383
Fieldwork ID:	MON-0038030

About the designated centre

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

Glencorry is a designated centre operated by St. Michael's House. It is located in a campus based service for persons with intellectual disabilities located in North Dublin. The centre comprises of one large building and provides full-time residential services to six persons with intellectual disabilities. The building consists of six resident bedrooms, a large living room, a large dining room, a kitchen and separate pantry space, a staff office, a staff room, a bathroom, a separate shower room, a utility room, and a large entrance hallway. There is an outdoor patio space to the front of the centre with an area for outdoor dining, a seating area, raised planting beds and a water feature. Residents are supported by a person in charge, a clinical nurse manager, staff nurses, social care workers, care workers, a cook, and a household worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 23 July 2025	09:45hrs to 17:30hrs	Karen McLaughlin	Lead

What residents told us and what inspectors observed

This report outlines the findings of an announced inspection of the designated centre, Glencorry. The inspection was carried out to assess compliance with the regulations following the provider's application to renew the centre's registration and to follow up on regulatory findings from the previous inspection of this centre to ascertain if improvements in compliance had occurred.

The centre consisted of one residential bungalow situated on a congregated campus setting in North Dublin. The designated centre has a registered capacity for six residents, at the time of the inspection there was no vacancies.

The inspection was facilitated by the person in charge for the duration of the inspection. The inspector used observations and discussions with residents, in addition to a review of documentation and conversations with key staff, to form judgments on the residents' quality of life.

Previous inspections of the centre had found that improvements were required to the safeguarding arrangements due to ongoing incompatibility concerns and consequently the conflicting needs of residents, resulting in peer-to-peer safeguarding incidents which were having a negative impact on residents. The changing needs of one resident meant that the centre was no longer able to cater for and support their care needs, particularly in relation to the required living arrangements and their incompatibility with other residents, which was resulting in ongoing safeguarding concerns.

After the March 2025 inspection of this centre the provider outlined their plan to support a resident to transition to a more suitable living arrangement to meet their assessed needs and address incompatibility issues in this centre. This inspection assessed the actions being taken by the provider to address the ongoing incompatibility concerns and to assess the progress being made by the provider to support a resident's transition from the centre.

Prior to this inspection, the inspector requested a written progress update. The provider informed the Office of the Chief Inspector of Social Services, by way of a letter of assurance, that they were engaging with their funder and external providers to source a more appropriate residential placement for the resident to address their assessed needs. Furthermore, the letter stated that an external agency had put forward a funding proposal, to their funder, to provide the resident with an individualised service and an interim transition plan had been developed and was in place for the resident in question.

Assurances by way of a compliance plan update and observations on the day of the inspection showed some progress in terms of the plan to transition the resident to another service and that interim risk mitigation arrangements in place were working, with a notable reduction in safeguarding incidents at the centre. The provider and

the person in charge were responding to the compatibility issues by increasing staffing levels and supporting residents through their personal and behaviour support plans.

The inspector spoke with the person in charge and three staff on duty on the day of inspection, a nurse, a direct support worker and one agency worker. They all spoke about the residents warmly and respectfully, and demonstrated a rich understanding of the residents' assessed needs and personalities and demonstrated a commitment to ensuring residents needs were met to a high standard at all times. Staff highlighted concerns on the compatibility of residents which they felt created a busy and pressurised work environment that could impinge on the quality of service provided to residents and how the peer-to-peer safeguarding concerns occurring in the centre were having a negative impact on residents.

The person in charge accompanied the inspector on a walk around of the centre. Overall, it was found to be clean, bright, homely, nicely furnished, and the lay out was appropriate to the needs of residents living there.

The wall in the hall had the house floor plans clearly displayed alongside the centre's fire evacuation plan. The centre's mission statement, visitors policy and complaints policy were also available in the hall. The bungalow consisted of a large living area and a separate dining area which was connected to a modest sized kitchen. Each resident had their own bedroom which was decorated in line with their preferences and wishes, and the inspector observed that the rooms included family photographs and memorabilia that was important to each resident.

There was an enclosed garden which had recently been upgraded with a sun shed, barbecue and furniture to make it a more welcoming space for the residents to use during the summer months.

All residents were aware of the inspection visit. In advance of the inspection, residents had been sent 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.

All six of the surveys were returned to the inspector. The feedback in general was very positive, and indicated satisfaction with the service provided to them in the centre, including the premises and meals provided. However, the majority of the surveys noted that not all residents got along and this was impacting on their quality of life. For example, one resident survey mentioned they 'don't like the noise' and choose to stay in their bedroom or the garden by themselves at times.

The inspector met with and spoke to four residents on the day of the inspection. One of the residents was being supported by staff to get ready to go out for the morning. One resident was having their breakfast and told the inspector they liked living here and showed her some toy cars they collected, another resident chose to sing a song for the inspector.

The inspector met with the resident due to move out of the centre, the resident did not communicate their opinion over their current living arrangement. Later they

indicated to the inspector that they would like to show her their bedroom and items of importance belonging to them.

Residents were observed receiving a good quality, person-centred service that was meeting most of their needs. Observations carried out by the inspector, feedback from residents and documentation reviewed provided suitable evidence to support this. The inspector observed residents coming and going from their home during the day, attending day services and making plans for the evening.

Residents were being supported to partake in a variety of different leisure, occupational, and recreation activities in accordance with their interests, wishes and personal preferences. Activities included going on holidays, the cinema, salt caves, attending sporting events, bowling, reflexology and massage, swimming and going out for dinner. Throughout the inspection, residents were seen to be at ease and comfortable in the company of staff. Staff were observed to be responsive to residents' requests and assisted residents in a respectful manner.

Nonetheless, this inspection found there were still improvements required in relation to Regulation 5: Individualised assessment and personal plan, Regulation 8: Protection and Regulation 9: Residents' rights. This is further discussed in the main body of the report under the relevant regulations.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations and, to contribute to the decision-making process for the renewal of the centre's registration. This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

The management structure in the centre was clearly defined with associated responsibilities and lines of authority. The person in charge was full-time and supported in the management of the centre by a service manager. The person in charge reported to a service manager and Director, and there were effective systems for the management team to communicate and escalate any issues.

The registered provider had implemented management systems to monitor the quality and safety of service provided to residents including annual reviews and six-monthly reports, plus a suite of audits had been carried out in the centre.

There was a planned and actual roster maintained for the designated centre. Rotas were clear and showed the full name of each staff member, their role and their shift allocation. On the day of the inspection, there were three vacancies which were managed by block booking regular agency staff to reduce any impact on residents and to support continuity of care for residents.

There were supervision arrangements in place for staff. In addition, staff completed relevant training as part of their professional development and to support them in their delivery of appropriate care and support to residents.

Records set out in the schedules of the regulations were made available to the inspector on the day of inspection, these were found to be accurate and up to date including an accurate and current directory of residents, residents guide and complaints log.

Furthermore, an up-to-date statement of purpose was in place which met the requirements of the regulations and accurately described the services provided in the designated centre at this time.

The provider had effected a contract of insurance against injury to residents and had submitted a copy of their insurance policy to support the application for renewal of the centre's certificate of registration.

This inspection found that systems and arrangements were in place to ensure that residents received care and support that was person-centred and of good quality.

However, improvements were required in relation to residents assessed needs, safeguarding and residents rights. While the provider had responded to safety concerns by increasing staff ratios, enhancing the skill-mix, and introducing additional supports to residents, such as a more structured routine and activity planning, further improvements were required in relation to Regulations 5: Individualised assessment and personal plan, 8: Protection and 9: Residents rights.

This demonstrated the requirement of the provider to continue to progress the transition plan in order to bring about an improved quality of service for all residents in the centre.

Registration Regulation 5: Application for registration or renewal of registration

The application for the renewal of registration of this centre was received and contained all of the information as required by the regulations.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual staff rota which was clearly documented and contained all the required information.

The inspector observed staff engaging with residents in a respectful and warm manner, and it was clear that they had a good rapport and understanding of the residents' needs.

The provider had provided additional staffing resources as a measure to reduce the safeguarding concerns in the centre. The person in charge told the inspector that the complement and skill-mix was sufficient and that the additional support measures have had a positive impact on safeguarding residents

There were 3 staff vacancies in the centre. The provider was actively recruiting and one vacancy was being filled via an internal transfer.

Due to vacancies within the existing staff team and the additional staffing resources required to manage the compatibility issues present in the centre, the provider was endeavouring to ensure continuity of care and support through the use of regular relief and agency staff, who are familiar to the residents and aware of all support plans.

Agency and relief staff were provided induction training including provision of personal care, positive behaviour support, Feeding, Eating, Drinking Swallowing (FEDS) support plans and fire safety. The inspector spoke with agency staff on the day of the inspection who said they had been working in the centre the past year and usually works two to three shifts a week. They told the inspector they were happy with the level of support and guidance they had been provided and were familiar with all residents support plans and the procedures for reporting concerns.

Judgment: Compliant

Regulation 16: Training and staff development

There were mechanisms in place to monitor staff training needs and to ensure that adequate training levels were maintained.

All staff had completed or were scheduled to complete mandatory training. Refresher training was available as required.

In addition, training was provided in areas such as feeding, eating, drinking and swallowing (FEDS), first aid and safe administration of medication.

Staff had also completed human rights training to further promote the delivery of a human rights-based service in the centre.

Staff were in receipt of regular support and supervision through monthly staff meetings and quarterly supervisions with the person in charge. Records of these meetings were maintained by the person in charge.

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 three of the regulations.

Judgment: Compliant

Regulation 21: Records

On the day of the inspection, records required and requested were made available to the inspector.

The inspector reviewed a selection of records across Schedules 2, 3 and 4.

The registered provider had ensured that they had obtained, in respect of all staff, the information and documents specified on Schedule 2 of the Health Act 2007. Three of which had been requested by the inspector who reviewed two staff records, including Garda Síochána vetting disclosures and copies of qualifications, and found them to be accurate and in order.

Similarly the sample of records viewed pertaining to Schedule 3 and 4 were correct and in order and were made available to the inspector upon request including the designated centre's statement of purpose, residents' guide and a record of all complaints made by residents or their representatives or staff concerning the operation of the centre.

The inspector found that records were appropriately maintained. The sample of records reviewed on inspection, reflected practices in place.

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.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found the governance and management systems in place had ensured that care and support was delivered to residents in a safe manner and that the service was consistently and effectively monitored. There were effective leadership arrangements in place in this designated centre with clear lines of authority and accountability.

It was evident that there was regular oversight and monitoring of the care and support provided in the designated centre and there was regular management presence within the centre. The staff team was led by an appropriately qualified and experienced person in charge. The person in charge demonstrated a comprehensive understanding of the service needs and of the residents' needs and preferences.The inspector saw that there were systems in place to support the person in charge in fulfilling their regulatory responsibilities. The person in charge reported to a service manager, who in turn reported to a director of nursing.

Local governance was found to operate to a good standard in this centre. Good quality monitoring and auditing systems were in place. The person in charge demonstrated good awareness of key areas and had checks in place to ensure the provision of service delivered to residents was of a good standard. The provider also had in place a suite of audits, which included; fire safety, infection prevention and control, safeguarding and health and safety checklists.

However, the provider had identified that the service was not meeting the assessed needs of all residents living in the centre. The ongoing incompatibility issues and safeguarding concerns that date back for a long period of time evidenced there was a persistent challenge in meeting residents' needs safely and appropriately. Safeguarding concerns were well documented and due to the complex nature of the compatibility issues, the introduction of ongoing multi-disciplinary meetings and increased staffing demonstrates a concerted effort to mitigate against safeguarding risks and improve residents quality of life.

At the time of the inspection a new plan was in motion with an external provider now identified to support the resident to move to a more suitable placement to meet their needs. The provider's interim mitigation arrangements to manage safeguarding, by increasing staff ratios and routine management and activity planning, until the transition was approved and funding confirmed, were mitigating the impact of the incompatibility issues on all residents. This was an observable improvement from the previous inspections.

Nonetheless the efforts made by the provider and person in charge to address these matters, including plans to transition one resident, had not yet been fully implemented and required the provider to ensure a consistent drive to progress to conclusion.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed by the inspector. It was found to contain the information as required by Schedule 1 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.

A copy was readily available to the inspector on the day of inspection.

It was also available to residents and their representatives.

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 overall, 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 reviewed three incidents documented in the designated centre's incident log during the course of the inspection, and found that they corresponded to the notifications received by the Chief Inspector.

Judgment: Compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived there.

The findings from this inspection demonstrated residents' well-being and welfare were supported by a good standard of evidence-based care and support, for the most part. However, not all residents' assessed needs could be met in the centre and and this was having a negative impact on the quality and safety of service provided to them and their peers.

This inspection found that the provider and person in charge were operating the centre in a manner that supported residents to receive a service that was person-centred. There was a comprehensive assessment of need in place for each resident, which identified their health care, personal and social care needs. These assessments were used to inform detailed plans of care, and there were arrangements in place to carry out reviews of effectiveness. Nonetheless, not all residents' assessed needs were being met in the centre and and this was having an adverse impact on the quality and safety of service provided to them and their peers.

While significant efforts had been made both internally and externally, by the provider and the person in charge, to source a suitable alternative living arrangement for the resident in question, the placement had not yet come to fruition and available for the resident to transition to. As a result the incompatibility issues were still impacting all residents living in the centre albeit improved safeguarding mitigation arrangements were now in place to lessen the impact to residents.

The design and layout of the premises ensured that each resident could enjoy living in an accessible, comfortable and homely environment. The provider ensured that the premises, both internally and externally, was of sound construction and kept in good repair. There were some minor maintenance issues were identified by the person in charge and they had already been reported to the provider's maintenance department.

While the residents' day-to-day experiences in their home was not optimal, it was found that the person in charge and staff members endeavoured as much as possible to support residents to exercise their rights. However, the measures in place to mitigate against further peer to peer incidents meant that the environment

was not entirely conducive to support all residents to exercise choice and control over their daily life and the right to feel safe in their own home.

There were appropriate fire safety measures in place, including fire and smoke detection systems and fire fighting equipment. The fire panel was addressable and there was guidance displayed beside it on the different fire zones in the centre. The inspector observed the fire doors to close properly when released.

There were arrangements in place that ensured residents were provided with adequate nutritious and wholesome food that was consistent with their dietary requirements and preferences. Residents feeding, eating and drinking support needs had been well assessed. There were plans in place to guide staff in supporting residents in this area.

A residents' guide was available in the designated centre. The residents' guide was reviewed on the day of inspection and was found to contain all of the information as required by Regulation 20.

The inspector found that the quality and safety of the service provided in the centre to residents was significantly compromised due to deficits and risks in relation to the assessment and meeting of residents' full needs, safeguarding and resident's rights.

Regulation 17: Premises

The registered provider had made provision for the matters as set out in Schedule 6 of the regulations.

The registered provider had ensured that the premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents. The centre was maintained in a good state of repair and was clean and suitably decorated.

The centre had also been adapted to meet the individual needs of residents ensuring that they had appropriate space that upheld their dignity and improved their quality of life within the designated centre.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents with assessed needs in the area of feeding, eating, drinking and swallowing (FEDS) had up-to-date FEDS care plans on file and there was guidance

regarding their meal-time requirements including food consistency and residents' likes and dislikes.

Staff spoken with were knowledgeable regarding FEDS care plans and were observed to adhere to the directions from specialist services such as speech and language therapy, including advice on therapeutic and modified consistency dietary requirements. The inspector had the opportunity to observe some mealtime experiences for residents, including breakfast and lunchtime meals. Residents were provided with wholesome and nutritious food, which was in line with their assessed needs.

The inspector observed suitable facilities to store food hygienically and adequate quantities of food and drinks available in the centre. The fridge and presses were stocked with lots of different food items, including fruit and vegetables.

Judgment: 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 28: Fire precautions

The registered provider had implemented good fire safety systems including fire detection, containment and fighting equipment.

There was adequate arrangements made for the maintenance of all fire equipment and an adequate means of escape and emergency lighting arrangements. The exit doors were easily opened to aid a prompt evacuation, and the fire doors closed properly when the fire alarm activated.

Following a review of servicing records maintained in the centre, the inspector found that these were all subject to regular checks and servicing with a fire specialist company.

The inspector reviewed fire safety records, including fire drill details and the provider had demonstrated that they could safely evacuate residents under day and night time circumstances.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured assessments of residents' needs were completed and informed the development of personal plans. The inspector reviewed three residents' assessments and plans. They were found to contain an up-to-date and comprehensive individual assessment of the residents' needs. This assessment was informed by the resident, their representatives and relevant multidisciplinary professionals.

The plans, included those on personal, health, and social care needs, were up to date, sufficiently detailed, and readily available to staff in order to guide their practice. Staff spoken with were knowledgeable regarding residents' assessed needs and were observed providing support that was in line with residents' care plans. A staff member showed and talked the inspector through one residents personal plan and goal planning.

The individual assessment informed care plans which guided staff in the delivery of care in line with residents' needs. Care plans were written in a person-centred manner and clearly detailed steps to maintain residents' autonomy and dignity. Staff spoken with were informed regarding these care plans and residents' assessed needs.

The inspector saw that care plans were available in areas including communication, positive behaviour support, social supports, residents rights, health care and safeguarding, as per residents' assessed needs.

However, while written support planning arrangements and oversight was of a good standard the service could not meet the needs of all residents.

The provider had not ensured that the appropriate arrangements were in place to meet the needs of one resident. The changing needs of the resident meant that the centre was no longer able to cater for and support their care needs, particularly in relation to the required living arrangements and their incompatibility with other residents, which was resulting in ongoing safeguarding concerns and impacting on safety and quality of the overall care and support provided to the collective resident group.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had implemented systems, underpinned by written policies and procedures, to safeguard residents from abuse.

There were effective arrangements for staff to raise concerns. In addition to the staff supervision and support arrangements, staff also attended regular team meetings which provided an opportunity for them to raise any concerns about the quality and safety of care and support provided to residents.

Staff working in the centre completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. Staff spoken with were knowledgeable about abuse detection and prevention and promoted a culture of openness and accountability around safeguarding. In addition, staff knew the reporting processes for when they suspected, or were told of, suspected abuse.

The provider and person in charge had made extensive efforts to ensure that residents were safe from potential abuse in the centre, however their efforts were not effective. The incompatibility of residents and associated safeguarding concerns which presented in 2022, 2023, 2024 and 2025 had not been resolved, and this meant that residents were living in a centre that did not protect them from potential and actual abuse.

Safeguarding incidents were notified to the safeguarding team and to the Chief Inspector of Social Services in line with regulations. Since the beginning of 2025 there has been a reduction of safeguarding incidents, with trending showing nine in total notified between March and July. Both staff and residents expressed that this was due to increased one to one staffing for the resident causing concern and all residents changing their routine and increased activity planning outside the centre to avoid conflict.

The person in charge and staff told the inspector that they had concerns regarding ongoing behavioural incidents and peer-to-peer safeguarding concerns occurring in the centre and the impact these were having on residents. They also spoke about some of the interventions that had been put in place. These included additional staffing, higher levels of supervision and activity planning so that residents were kept separate from each other to avoid incidents. While these measures were easing the situation, they were for short term use only as some of the interventions were restrictive in nature and therefore impacted on all of the residents' rights to freedom and choice in their home.

As discussed earlier in this report, the person in charge and the director of nursing told the inspector that the provider was engaging with their funder. An external

provider has put a business case to the Health Service Executive (HSE) to provide the resident with an individualised service.

However, without further intervention, the inspector could not be assured that residents were protected from all forms of abuse at all times. Residents are were still at risk and their quality of life is was being impacted upon in their own home.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had ensured that the centre was operated in a manner that ensured residents had participated and consented to decisions about their care and support.

The inspector saw that staff interactions with residents were in a manner which upheld residents' dignity and provided residents with choice and control. Staff were seen offering residents choices, responding to their needs and providing direct assistance in a manner which respected residents' right to dignity and privacy.

Each resident had access to facilities for occupation and recreation with opportunities to participate in their local community in accordance with their wishes. Residents were further supported to make their own choices in terms of meal planning and activity activation.

It was identified through the providers last six monthly unannounced audit that residents weekly group meetings were no longer effective due to the presenting compatibility issues in the centre. The person in charge developed a local policy whereby one to one meetings would be carried out with each resident to support participation and decision making on a daily basis.

Staff told the inspector that they had supported residents to use the provider's complaints policy and procedures to make complaints about the service in an effort to support residents' rights and to try to bring about a resolution to the situation that was ongoing in the centre. There were two open complaints on the day of inspection pertaining to compatibility and safeguarding issues in the centre that have remained unresolved. The annual review for the year 2024 reflects this with one resident commenting that they 'made a complaint about another resident' and another saying 'sometimes the noise level from another resident' upsets them.

Residents no longer wanted to live with each other and due to the nature of the incidents and their frequency demonstrating the implementation of a rights-based approach to care was proving challenging in the centre and improvements were required.

Judgment: Not 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 15: Staffing	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 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Glencorry OSV-0002383

Inspection ID: MON-0038030

Date of inspection: 23/07/2025

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Action Person Responsible Date Status Meeting held between HSE Head of Disability, HSE REO, SMH DON and PIC for consideration of funding proposal from external provider. Outcome: Application to be progressed to General Manager level DON and PIC 13/08/25 Complete Further communication between SMH and external provider to ensure continued family visits due to proposed location of new service. Outcome: Significant distance from family being discussed with service user. DON and PIC 14/08/25 ongoing Mitigating safeguarding risks. Additional support for service user (1.87WTE) Outcome: Reduced safeguarding incidents. PIC 28/02/26 ongoing Recruitment campaign with external agency to fill current vacancies. Regular agency staff utilized to ensure continuity. Outcome: Regular and familiar staff to support service user's needs. HR and PIC 31/12/25 ongoing Compatibility Assessment Meeting to review effectiveness of ongoing supports. PIC 30/09/25 pending Expected date for completion of transition of service user to external service. 28/02/25 28/02/25 pending	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:	

Action Person responsible Date Status
Meeting held between HSE Head of Disability, HSE REO, SMH DON and PIC for consideration of funding proposal from external provider.
Outcome: Application to be progressed to General Manager level
DON and PIC 13/08/25 Complete
Further communication between SMH and external provider to ensure continued family visits due to proposed location of new service.
Outcome: Significant distance from family being discussed with service user.
DON and PIC 14/08/25 Ongoing
Mitigating safeguarding risks. All staff trained in Safeguarding policy. Additional support for service user (1.87WTE)
Outcome: Reduced safeguarding incidents.
PIC 28/02/25 Complete
Recruitment campaign with external agency to fill current vacancies. Regular agency staff utilized to ensure continuity.
Outcome: Regular and familiar staff to support service user's needs.
HR and PIC 31/12/25 Ongoing
Staff received training re complaints and compliments management.
Outcome: Open complaints will be reviewed regularly and in adherence to SMH complaints policy.
PIC and complaints officer 29/08/25 Complete
Compatibility Assessment Meeting to review effectiveness of ongoing supports. PIC 30/09/25 Pending
Expected date for completion of transition of service user to external service. DON and PIC 28/02/26 Pending

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Action Person responsible Date Status
Meeting held between HSE Head of Disability, HSE REO, SMH DON and PIC for consideration of funding proposal from external provider.
Outcome: Application to be progressed to General Manager grade.
DON and PIC 13/08/25 Complete
Further communication between SMH and external provider to ensure continued family visits due to proposed location of new service.
Outcome: Significant distance from family being discussed with service user.
PIC 14/08/25 Ongoing
Mitigating safeguarding risks. All staff trained in Safeguarding policy. Additional support for service user (1.87WTE)
Outcome: Reduced safeguarding incidents.
PIC 28/02/25 Complete
Regular support from the Designated Officer to ensure that all safeguarding plans are reviewed regularly and are up to date. DO Ongoing Ongoing

The PIC will endeavour to review the going activities and the environment with the designated centre, with the aim of maximising the quality of life for all residents within the house PIC Ongoing Ongoing
Recruitment campaign with external agency to fill current vacancies. Regular agency staff utilized to ensure continuity.
Outcome: Regular and familiar staff to support service user's needs.
HR and PIC Ongoing Ongoing
Service users informed of their Rights and advocacy service aware of ongoing compatibility concerns.
Outcome: Service users supported to make complaints to protect their Rights.
PIC Ongoing Ongoing
Staff received training re complaints and compliments management.
Outcome: Open complaints will be reviewed regularly and in adherence to SMH complaints policy.
PIC and complaints officer 29/08/25 Complete
Compatibility Assessment Meeting to review effectiveness of ongoing supports.
PIC 30/09/25 Ongoing
Expected date for completion of transition of service user to external service. PIC and DON 28/02/25 Ongoing

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Meeting held between HSE Head of Disability, HSE REO, SMH DON and PIC for consideration of funding proposal from external provider.
Outcome: Application to be progressed to General Manager grade.
DON and PIC 13/08/25 Complete
Further communication between SMH and external provider to ensure continued family visits due to proposed location of new service.
Outcome: Significant distance from family being discussed with service user.
PIC 14/08/25 Ongoing
Mitigating safeguarding risks. All staff trained in Safeguarding policy. Additional support for service user (1.87WTE)
Outcome: Reduced safeguarding incidents.
PIC 28/02/25 Complete
Regular support from the Designated Officer to ensure that all safeguarding plans are reviewed regularly and are up to date. DO Ongoing Ongoing
The PIC will endeavour to review the going activities and the environment with the designated centre, with the aim of maximising the quality of life for all residents within the house PIC Ongoing Ongoing
Recruitment campaign with external agency to fill current vacancies. Regular agency staff utilized to ensure continuity.
Outcome: Regular and familiar staff to support service user's needs.
HR and PIC Ongoing Ongoing

Service users informed of their Rights and advocacy service aware of ongoing compatibility concerns.
Outcome: Service users supported to make complaints to protect their Rights.
PIC Ongoing Ongoing
Staff received training re complaints and compliments management.
Outcome: Open complaints will be reviewed regularly and in adherence to SMH complaints policy.
PIC and complaints officer 29/08/25 Complete
Compatibility Assessment Meeting to review effectiveness of ongoing supports.
30/09/25
Expected date for completion of transition of service user to external service. 28/02/25

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	28/02/2026
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	28/02/2026
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of	Substantially Compliant	Yellow	28/02/2026

	meeting the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/02/2026
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	28/02/2026
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	28/02/2026