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:	Glencree
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	01 April 2025
Centre ID:	OSV-0002384
Fieldwork ID:	MON-0038140

About the designated centre

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

Glencree is a designated centre operated by St. Michael's House. The centre provides residential care for two adult residents with disabilities. The centre comprises of a two bedroom bungalow. It is located on a campus based setting operated by the provider in north Dublin. Each of the residents have their own bedroom which have been personalised to their own taste. There is adequate communal space within the cottage. There are a number of communal garden areas within the campus which residents have access to. The centre is managed by a person in charge and person participating in management as part of the provider's overall governance arrangement for the centre. The person in charge works in a full-time position and is also responsible for one other service owned by the provider. The staff team is made up of social care workers and direct 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
Tuesday 1 April 2025	10:00hrs to 18:15hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This announced inspection took place over the course of one day and was to monitor the designated centre's level of compliance with 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). It was also to inform a decision on the renewal of the registration of the centre.

The inspector used observations alongside a review of documentation and conversations with residents, key staff and management to inform judgments on the quality and safety of the care and support provided to residents in the centre.

Overall, the inspector found that the centre was operating at a good level of compliance with the regulations inspected. Residents were happy in the centre and received person-centred care and support in line with their individual needs and wishes.

There were two residents living in the designated centre and the inspector was provided with the opportunity to meet both residents. Residents were supported and empowered to live as independently as they were capable of. The residents had active lives, and on the day of inspection were engaged in different activities, in their home and in the community. For example, one resident was supported to go into the city centre using public transport and another resident attended a gym class in their community.

On arrival to the centre one of the residents showed the inspector a video on their electronic device that was about their life. The video included images of the resident enjoying a range of community activities that were meaningful to them and which they appeared to enjoy. On review of the video, and from speaking with staff as well as a review of documents, the inspector was made aware of the resident's advocacy and employment roles. The resident was supported to lecture in third level colleges on subjects such as person centred planning, autism awareness and community participation. The resident was also supported to give talks to local schools providing an introduction to sign language (Lámh) and talking about autism awareness. In line with the resident's communication preferences they were provided communication aids to support them deliver the lectures.

Another residents showed the inspector their outdoor raised vegetable garden. They appeared proud and happy to show it to the inspector and talked about the different produce growing in it. Staff who spoke with the inspector said that the resident had completed a horticulture course which had led to their interest in gardening and growing vegetables. The resident was provided with an individualised day service that was delivered from their home. The centre's annual report noted the positive outcomes the individual service had for the resident and in particular, how it had brought about new friendships for the resident and increased their self-confidence.

The person in charge accompanied the inspector on an observational walk around of the premises, which comprised a single-storey house. Each resident showed the inspector their individual bedrooms. The rooms were observed to be decorated in line with residents individual tastes and included family photographs, framed certificates and memorabilia that was important to them. The inspector observed that one resident's bedroom included a personalised duvet cover and a pillow with a photograph of their family members on it.

The communal living areas included a large bright sitting room, an open plan kitchen and dining area with an adjoining utility room. The inspector was informed that, since the last inspection, new counter tops and cupboards had been installed in both the kitchen and utility (laundry) room. There were three toilet facilities in the house, two of which included shower facilities and one a parker style bath. However, the bath was no longer in use and the inspector was informed that the water connecting to the bath had been switched off.

Overall, the inspector observed that while the residents' home appeared comfortable, welcoming and tidy there were a number of upkeep and repair works needed to areas of the house as well as fixtures and fittings.

In advance of the inspection, residents completed surveys on what it was like to live in the centre (the two residents received assistance from staff in completing the surveys). Their feedback was very positive, and indicated that they felt safe, had choice and control in their lives, got on with each other, could receive visitors, and were happy with the services available to them.

The inspector met with two family members on the day of the inspection. Their feedback was very positive; For example, they were very complimentary of the staff and of the good quality care and support staff provided. They told the inspector that they were always made feel welcome when they visited the centre and that they could visit at any time. They said they were kept informed and updated about important matters in the resident's life. Family members informed that inspector about a time that their family member was unwell and expressed their gratitude of the good quality care and support provided to their family member during that time.

The inspector found that effective arrangements were in place to support residents to communicate their wishes, and make decisions about the care they received. For example, residents attended weekly house meetings, where meaningful conversations and discussions took place; residents were asked about their week, what they enjoyed about their week, did anything make them sad, if they happy living in their home. These meetings also provided residents with an opportunity to talk about activities they would like to do in the coming week, about meal planning, family conversations and visits as well as updates on their individual goal progression. Meeting also included topics such as the complaints procedures, keeping safe and easy-read guides.

The provider's recent annual review had also ensured that residents (and their representatives) were consulted with and given the opportunity to express their views on the service provided in the centre. Residents' feedback was positive in

regard to choices, daily living, and support to complete goals that were meaningful to them. In particular, residents relayed their happiness of achieving their 2024 goals of holidaying in London and Derry and had already set goal to go on holidays again in 2025. Family and representatives feedback was also positive and there were a number of comments expressing their happiness at the care and support their family member received.

The inspector observed that the residents seemed relaxed and happy in the company of staff and that staff were respectful towards the residents through positive, mindful and jovial interactions. Residents appeared to be content and familiar with their environment. On observing residents interacting and engaging with staff using non-verbal communication, it was obvious that staff interpreted what was being communicated and were able to engage using the same non-verbal communication (such as using the sign language Lámh alphabet).

In summary, the inspector found that each resident's well-being and welfare was maintained to a good standard and that there was a strong and visible person-centred culture within the designated centre. Residents were supported to engage in their community in a meaningful way and their choices, preferences and likes were respected. Residents were supported to be as independent as they were capable of through positive risk taking activities.

Some improvements were needed to the areas of infection prevention and control, record keeping and submitting notifications to bring them back into full compliance. 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 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.

Overall, the findings of this announced inspection were that residents were in receipt of a good quality and for the most part, a safe service, with good local governance and management supports in place. However, improvements were needed to the upkeep and maintenance of the centre. This was to ensure that infection prevention and control measures and systems in place were effective at all times. In addition, some small improvements were needed to both notification of incidents and records and this was to ensure that the provider was in compliance with regulatory requirements.

The management structure in the centre was clearly defined with associated responsibilities and lines of authority. The person in charge was full-time and suitably qualified, experienced, and skilled for their role. The person in charge had a clear understanding of the service to be provided to residents, and was promoting the delivery of a human rights-based approach to their care and support. The person in charge reported to a service manager, and there were effective arrangements for them to communicate with each other.

There were clear lines of accountability at individual, team and organisational level so that all staff working in the centre were aware of their responsibilities and who they were accountable to. There was a staff roster in place and it was maintained appropriately. There were one point five staff vacancies in the centre. These vacancies were being covered by members of the current staff team as well as relief staff who were familiar to residents.

On the day of the inspection, the inspector observed kind, caring and respectful interactions between staff and residents throughout the day. Staff were observed to be available to residents should they require any support and to facilitate their choices. For example, the inspector saw residents being supported to participate in a variety of home and community-based activities of their own choosing.

The inspector reviewed a sample of staff files and found that they included all Schedule 2 requirements. The inspector spoke with a number of staff during the inspection and found that they demonstrated appropriate understanding and knowledge of policies and procedures that ensure the safe and effective care of residents.

The education and training provided to staff enabled them to provide care that reflected up to date, evidence-based practice. A supervision schedule and supervision records for all staff were maintained in the designated centre.

The registered provider had implemented good governance management systems to monitor the quality and safety of service provided to residents. The provider had completed an annual report in March 2025 of the quality and safety of care and support provided to residents during 2024. The report demonstrated that residents, their families and representatives and staff had been part of the consultation process.

The registered provider had prepared a written statement of purpose that contained the information set out in Schedule 1. The statement of purpose clearly described the service and how it is delivered. Subsequent to the inspection, the senior service manager submitted an up-to-date statement of purpose so that it accurately described the responsibilities and whole time equivalent hours of the person in charge.

The provider had suitable arrangements in place for the management of complaints and an accessible complaints procedure, as well as an accessible policy, was available for residents in a prominent place in the centre.

For the most part, the person in charge had ensured that incidents and adverse

events were notified to the Chief Inspector of Social Services in line with the requirements of Regulation 31: Notification of incidents. However some improvements were needed to ensure that all quarterly notifications were submitted as required.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Registration Regulation 5: Application for registration or renewal of registration

The application for registration renewal and all required information was submitted to the Office of the Chief Inspector within the required time-frame.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was an experienced, qualified professional and demonstrated their knowledge of the residents' assessed needs. Through speaking with the person in charge, the inspector found that they demonstrated sufficient knowledge of the legislation and their statutory responsibilities of their role and of their legal remit to 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 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' needs and endeavoured to ensure that they were met in practice.

The person in charge had commenced their role in the centre in November 2024. The person in charge was employed on a fully time basis and oversee the designated centre and an individualised day service. Management hours for the person in charge have been increased by eight hours per month to facilitate any additional work relating to the day service. The statement of purpose note that these hours are in addition to the designated centres' whole time equivalent hours. Overall, the inspector found that local monitoring systems and structures in place supported this arrangement in ensuring effective governance, operational management and administration of the designated centres concerned.

Judgment: Compliant

Regulation 15: Staffing

There was a roster in place and it was maintained appropriately. The roster demonstrated that the person in charge was based on site and clearly recorded their management hours as well as shift hours.

A review of a sample of rosters for the months January to April 2025 indicated that there were sufficient staff on duty to meet the needs of residents on a daily basis.

The current staffing arrangements were made up of a person in charge, social care workers, direct support workers and regular relief staff. There was one and a half whole time equivalent vacancies in the centre. The vacancies were covered by permanent staff working additional hours and regular relief staff. The inspector was informed that one relief staff was previously a permanent staff member. Overall, the inspector found that these arrangements in place were ensuring continuity of care for residents, which was resulting in positive outcomes for residents.

From speaking with staff, the inspector observed that there was a staff culture in place which promoted and protected the rights and dignity of residents through person-centred care and support.

A sample of four staff files were viewed and were found to meet the requirements of Schedule 2 of the regulations.

Judgment: Compliant

Regulation 16: Training and staff development

There was a system in place to evaluate staff training needs and to ensure that adequate training levels were maintained.

All staff had completed or were scheduled to complete mandatory training some of which included, fire safety, safeguarding, safe medicine management, food safety, positive behaviour supports and infection prevention and control training (IPC).

Furthermore, specific training and support was offered to the team in order to support residents assessed needs. For example training in feeding eating and swallowing (FEDS). Staff who spoke with the inspector advised that they had completed training in sign language (Lámh) which was in line with one of the resident's ways of communicating. Through-out the day the inspector observed on several occasions, staff using Lámh alphabet signs when communicating with one of

the residents.

Staff were in receipt of one to one supervision meetings with the person in charge. The person in charge had put a schedule in place for supervision meetings to take place throughout 2025. On review of a sample of meeting minutes, that had taken place in quarter one of 2025, the inspector saw that topics such as residents' support needs, guidelines, health and safety, risk management, work with families, wellbeing and new opportunities, but to mention a few, were discussed and goals set and reviewed. On speaking with staff, they advised the inspector that they found the meetings beneficial to the their practice and supportive in nature.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was made available and was up-to-date with all the required information.

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

The provider had not ensured that all records that are required to be kept in the designated centre were in place or that they were appropriately recorded. In particular, with regard to schedule 4, where it relates to Fire Safety.

For example: The inspector observed that labels on fire extinguishers in the house noted a service date of January 2025. However, on the day of the inspection, on review of the centre's fire safety folder, there was no record of the service, or of the number, type and maintenance of the extinguishers.

In addition, where a service of fire safety equipment had taken place in January 2024, the inspector found that the recording on the maintenance certificate to be inadequate. For example, on review of the certificate, there was no signature or written comment regarding the service included by the technician.

Overall, improvements were needed to ensure that oversight systems in place identified when records were not completed as required and where they were completed, that they were completed adequately and in a way that provided

assurances of the service completed and by who.

Subsequent to the inspection, a completed certificate of inspection, of fire extinguishers and blanket, for January 2025 was submitted to the inspector.

In relation to information and documents to be obtained in respect of staff, currently and previously employed at the designated centre, the inspector reviewed a sample of four staff records and found that they contained all the required information in line with Schedule 2.

Judgment: Substantially 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 HIQA 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

The provider had arrangements in place to ensure that a quality service was being provided to residents in the centre. The inspector found that for the most part, governance and management systems in place in the centre were effective in ensuring good quality of care and support was provided to residents.

There was a clear management structure in place with clear lines of accountability. Overall, there was satisfactory oversight and monitoring of the care and support provided in the designated centre as well as regular management presence within the centre.

An annual review of the quality and safety of care during 2024 had been completed in March 2025. The annual report demonstrated that residents, their family, and staff had all being consulted in the process. Overall, on review of the annual report, the inspector found the feedback to be highly complementary and positive about the

quality of the care and support provided to residents in the centre .

In addition to the annual report, a suite of audits were carried out in the centre including six-monthly unannounced visits in June and December 2024, monthly data reports, incident and accident trackers, health and safety checklists, medication management, fire safety, and infection, prevention and control (IPC) checks. For the most part, the monitoring systems in the centre were effective in ensuring quality improvements in the centre and overall, positive outcomes for residents. However, on review of the infection, prevention and control audit for 2024 and the local infection, prevention and control checks for January to March 2025, the inspector saw that they had not identified all issues found on the day of the inspection. This is addressed in full under regulation 27 in the quality and safety section of the report.

The person in charge had put in place an additional oversight tool to log and monitor maintenance works required to the centre. This provided easy access and oversight of work completed, and yet to completed, as well as monitoring the effectiveness of the system.

Staff team meetings were taking place regularly and provided staff with an opportunity for reflection and shared learning. On review of the minutes of the March 2025 meeting the inspector saw that topics such as the monthly report, progress of residents' goals, staff roster, petty cash, cleaning, daily handovers, but to mention a few, were discussed and shared at the meetings.

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. A further copy of the statement was submitted after the inspection which accurately included the whole time equivalent and responsibilities of the person in charge.

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

On review of a sample of the centre's incident forms (eforms), body charts and daily and monthly progress records, between September and December 2024, the inspector saw that a resident had incurred a number of non-serious injuries which had not been notified to the Chief Inspector as required by the regulations. In addition, there were some gaps in the recording of the incidents.

Listed below are some of the non-serious injuries and the gaps found in the recording.

A body chart completed in November 2024, recorded an eight centimetre scratch on a resident's arm, where the cause was unknown. There was no incident form completed to record the injury. The person in charge and service manager reviewed the documents with the inspector however, no incident form was found.

In October 2024, an incident form noted a cut to a resident's finger resulting in a small bleed. There was no associated body chart completed for this injury.

There was another incident form completed on 16th of October 2024 regarding a resident's fall however, there was no associated body chart for the same day. On further review the inspector found a body chart (completed on 21st of October). The person in charge informed the inspector that it was likely related to the incident on the 16th of October which noted 'a bruise that was yellow in colour and possible a few days old'.

Another, incident form noted an injury relating to steam hurting a resident's finger however, there was no associated body chart attached.

Overall, the inspector found that information governance arrangements in place to ensure that the designated centre complied with quarterly notification requirements (non-serious injuries) were not effective and required improvement.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had established an effective complaints procedure underpinned by a comprehensive policy. The complaints procedure and policy was available in an easy-to-read format and accessible to residents. A copy of the procedure alongside information on advocacy was located in a communal space in

the centre.

From speaking with staff and a review of records, the inspector saw that the complaints procedures were regularly discussed with residents at their weekly house meetings to promote awareness and understanding of the procedures and to allow them a space to make a complaint if they so wished.

The inspector was informed on the day, that there were no open complaints. On review of the complaints and compliments log, the inspector saw that it included seven compliments which were mainly from families relaying their happiness of the care and support provided to their family members.

Judgment: Compliant

Quality and safety

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

The inspector found that the person in charge and staff were aware of residents' needs and knowledgeable in the person-centred care practices required to meet those needs. Improvements were required in relation to the upkeep and repair to the centre's premises and well as fixtures and fittings so that the infection prevention and control measures in place were effective in keeping residents safe in their home.

The provider had put infection, prevention and control (IPC), measures and arrangements in place to protect residents from the risk of infection. There were daily and weekly cleaning checklist for staff to complete. There were local infection prevention and control monthly checks and provider led infection prevention and control audits. However, the inspector found on review of these monitoring tools that they were not effective in identifying presenting infection prevention and control risks or putting appropriate and timely actions in place.

On walking around the centre, the inspector observed areas of the house, including fixtures and fittings, that were in poor upkeep and repair, many of which were in place for a lengthy time. For example, rust on radiators, lime scale on residents' shower hose and unclean extractor fans. Overall, this meant that areas and fixtures could not be cleaned effectively and posed the risk of spread of infection to residents and staff, and was impacting on their safety. Details of the deficits are listed under regulation 27.

Despite the above issues, the inspector observed a homely and friendly environment that was laid out and decorated in line with residents' likes and preferences. Staff engaged with residents and attended to their needs in a kind and professional manner. For example, staff communicated with residents in accordance with their

individual communication preferences. The inspector also found that the provider, person in charge and staff team were promoting and supporting a human rights-based approach to the care and support provided to residents.

Residents were supported to maintain important relationships. For example, family and friends could freely visit residents in the centre, and residents were supported to visit families outside of the centre. On speaking with family members on the day, the inspector was informed that they always felt welcomed by the person in charge and staff during their visit to the centre.

The inspector observed good fire safety precautions. For example, there was fire-fighting and detection equipment throughout the house, and staff had received fire safety training. Individual evacuation plans had also been prepared, and were tested during scheduled fire drills. Some improvement was required in relation to fire safety related record-keeping, this has been addressed under Regulation 21: Records

The provider had ensured that the risk management policy met the requirements as set out in the regulations. There were systems in place to manage and mitigate risks and were endeavouring to keep residents and staff members safe in the centre. Individual and location risk assessments were in place to ensure the safe care and support provided to residents.

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.

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

Residents had communication support plans in place in addition to personal communication and hospital passports. 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-read format, pictures, photographs and sign-language.

On speaking with staff they were aware of communication supports residents required and were knowledgeable on how to communicated with residents. For example, staff used alphabet format when using the sign language Lámh as this was on of the preferred methods for one resident.

On observing staff communication and engage with residents it was clear that they understood what residents were communicating and their preferred method. When speaking with staff they told the inspector about one resident who could verbalise their wants and wishes however, during times that the resident was upset, the resident preferred to use sign language, which was always accommodated. This

helped with lessening the resident's anxieties and reducing the risk of further upset for them.

Judgment: Compliant

Regulation 17: Premises

The physical environment of the house appeared clean and tidy however, due to the required upkeep and repair not all areas of the house could be effectively cleaned.

On a walk around of the centre, the inspector observed that the design and layout of the premises ensured that each resident could enjoy living in an accessible, comfortable and homely environment. This enabled the promotion of independence, recreation and leisure and enabled a good quality of life for the residents living in the designated centre.

Residents expressed themselves through their personalised living spaces. The residents were consulted in the décor of their rooms which included family photographs, paintings, education certificates and memorabilia that were of interest to them. The inspector observed the two residents' bedrooms to be personal to each resident and relayed their likes an interests. On review of feedback from residents and families, both residents were happy with the layout and decor of their bedrooms.

The residents living environment provided appropriate stimulation and opportunity for the residents to rest and relax and enjoy activities that are meaningful and personal to them. There was a small outdoor space to the back of the house. In line with one resident's likes and interests there was a raised vegetable bed with an array of vegetables and herbs growing in it. The resident appeared proud to show off the produce.

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 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 cover noted that it was last reviewed in 2023.

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.

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.

Two examples include:

A risk assessment had been completed for the potential risk of slips, trips and falls and included measures to mitigate the risk such as staff completing observational checks and ensuring no obvious trip hazards or walkways blocked.

Where a risk assessment had been completed to mitigate the risk of fire in the centre, measures included daily fire safety checks, fire drills and staff fire safety training.

Judgment: Compliant

Regulation 27: Protection against infection

There were a number of upkeep and repair works required that were impacting on the effectiveness of cleaning which in turn impacted on the arrangements for ensuring the best possible infection, prevention and control arrangements and required improvements.

During a walk around of the premises the inspector observed the following areas that required action to mitigate health and safety risks;

Staff office:

Door and frame chipped paint.

Toilet and shower room (mainly used by staff but available to residents):

Sealant surround on shower tray crumbling off. Green stained residue on base of shower tray. Skirting board chipped paint. No toilet roll holder in place. Lime scale on one of the sink taps. Rust on radiator. Extractor fan in ceiling above the shower was not clean - rust coloured and black grime observed inside the fan. The Velux window was replaced however, the surround area required plastering and painting as large chips observed.

Cleaning equipment:

No adequate storage for mop buckets – green and red buckets left outside the back of the house. The inspector was informed that there was no storage facility for them. There was no blue mop bucket in place, which was not in line with standard precautions to ensure minimum risk of contamination.

Hallway:

Skirting in hallway observed to be chipped. (Where new skirting had been put in place in the kitchen and bottom half of hallway, the maintenance department had been contacted to paint a second coat - this was ongoing since 2023).

Laundry room:

The laundry room required upkeep and repair. Paintwork for the room had been logged with maintenance department however, there was no plan or date to completed the work. The inspector observed cracked plaster on upper walls of the room. The extractor fan was unclean and full of debris. There was chipped paint and plaster on the wall beside laundry exit door and there was chipped paint on door frame going into the kitchen from the laundry room.

Kitchen:

The radiator in kitchen was badly rusted underneath (this has been identified on the provider's 2024 infection prevention and control audit but not on the local monthly infection prevention and control audits).

Resident's wet room (shower, sink and toilet):

There was rust observed on the radiator and a patch of rust on the floor. Lime scale was observed around and on shower controls. The shower head was grubby and stained. The shower hose was covered in lime scale. The sealant on the timber cover behind the toilet was observed as unclean and black grime was observed in the cracks of where the timber joined. The sealant between the wet room ground and wall areas was observed as unclean and stained and required a deep clean. Mould was observed on the timber surround of the Velux window. The extractor fan in the room was observed as unclean. There was no toilet roll holder provided in the room.

A number of auditing and monitoring systems in the centre, such as provider led

and local infection prevention and control audits had not been effective in identifying many of the deficits identified on the day. The person in charge had recently put a maintenance log in place to track works to competed and to be completed. On review of the log, the inspector saw that in February 2025, three items (paint utility room, cracked tile in bathroom and paint skirting board in kitchen and hallway) were submitted to the maintenance team for repair. On review of the unannounced six monthly visit of the centre, the inspector saw that paintwork of the skirting in the kitchen had been identified as work required since May 2023 and had been raised as an action in the October 2023 and August 2024 unannounced visits. The annual report completed in March 2025, which was collated using information from two six monthly reviews, had included an action that referred to outstanding paint tasks however, overall had not identified the poor upkeep and repair as listed above, or the impact or risks it posed to residents health and safety. In addition, the local monthly infection prevention and control checklist for January to March 2025, had ticked that all surfaces in the centre were clean and in good upkeep and repair.

There was no plan or timeline to complete the upkeep and repair works required and the timeliness to address some paintworks was not satisfactory. Where there were areas in disrepair that impacted on the effectiveness of the infection prevention and control measures in place in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

For the most part, the registered provider had ensured that there were effective fire safety management systems in the centre that ensured the safety of residents in the event of a fire.

On review of the centre's fire safety folder, the inspector saw that emergency lights and fire alarms were serviced by an external company within the required timeframe. Fire safety blankets and extinguishers were service in January 2025 however, some improvements were needed to the record-keeping of external documents to ensure they were in line with regulatory requirements. This is addressed under regulation 21.

Staff completed daily, monthly and quarterly fire checks of the precautions in place to ensure their effectiveness in keeping residents safe in the event of a fire.

All staff had completed fire safety training and were knowledgeable in how to support residents evacuate the premises, in the event of a fire.

A day and night-time fire drill had taken place during 2024, that included the most amount of residents and the least amount of staff on duty. This was to provide assurances that residents could be safely and promptly evacuated and to ensure the effectiveness of the fire evacuation plans. The next fire drill was scheduled for June

2025.

In addition, the person in charge had prepared fire evacuation plans and resident personal evacuation plans for staff to follow in the event of an evacuation. On review of one resident's personal evacuation plan the inspector saw that it included Lámh signs and pictorial supports to support the resident in line with their communication assessed needs and preferences. Residents' personal evacuation plans were reviewed on a yearly basis (or sooner if required) for their effectiveness during fire drills and reviews.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed residents' assessments of needs, and found that they were comprehensive and up to date. The assessments were informed by the residents, their representatives and multidisciplinary professionals as appropriate.

The assessments informed comprehensive care plans which were written in a person-centred manner and detailed residents' preferences and needs with regard to their care and support.

The inspector found that the plans demonstrated that each resident was facilitated to exercise choice across a range of daily activities and to have their choices and decisions respected. Personal plans were regularly reviewed and residents, and their family members, were consulted in the planning and review process of their personal plans.

The person in charge carried out regular audits of the documentation within the personal plans to ensure information within them was relevant and up-to-date. Keyworkers completed monthly reviews and reports of the progress of residents chosen goals to ensure they they were on track or achieved.

Residents were provided with an accessible format of their personal plan in a communication format that they understood and preferred. There were photographs and picture formats of activities residents had taken part in within their plan, on separate notice boards and folders. One resident preferred to have part of the personal plan on an electronic devise. During the inspection, the resident sat with the inspector and showed them a video titled "my life" that they had been supported to put together and upload onto the devise. The video demonstrated how the resident had been supported to choose, progress and achieve goals that were meaningful to them.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were arrangements in place to provide positive behaviour support to residents with an assessed need in this area.

The inspector reviewed one resident's plan related to providing residents with supports to manage their behaviours. The plan was found to be detailed and was developed by an appropriately qualified person and had been reviewed within the past year. The plan contained proactive and reactive strategies to guide staff to support the resident in managing their behaviour.

Staff had up-to-date knowledge and skills to respond to behaviour that is challenging and to support residents to manage their behaviour.

The provider had ensured that staff had received training in the management of behaviour that is challenging and received regular refresher training in line with best practice.

The inspector found that the person in charge was promoting a restraint-free environment within the centre. At the time of the inspection there were no restrictive practices in place, the last restrictive practice in the centre had been removed in quarter two of 2024.

Judgment: Compliant

Regulation 8: Protection

Where safeguarding incidents had occurred in the centre, the person in charge had followed up appropriately and ensured that they were reviewed, screened, and reported in accordance with national policy and regulatory requirements.

The inspector also noted the following:

The training matrix demonstrated that all staff had been provided training in safeguarding of vulnerable adults and all was up-to-date.

From reviewing four staff files with regard to schedule 2 of the regulations, all four staff had appropriate vetting in place.

There was an up-to-date safeguarding policy in the centre and it was made available for staff to review.

Information on how to contact the designated officer, complaints officer and independent advocacy was on display in the centre in a communal area.

Two staff members spoken with in detail on the day of the inspection, were knowledgeable about their safeguarding remit; Staff understood their role in adult protection and were knowledgeable of the appropriate procedures that needed to be put into practice when necessary. They told the inspector that they would report a concern to the person in charge/designated officer if they had one and were aware of the policies and procedures in place relating to safeguarding.

Residents' personal plans included person-centred and up-to-date intimate care plans. The plans detailed the supports required to protect each resident's autonomy and dignity in delivering personal care.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Glencree OSV-0002384

Inspection ID: MON-0038140

Date of inspection: 02/04/2025

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: In response to the finding of this regulation a signed fire certification form was sent from the organizational fire officer to the PIC and PPIM on the 02/04/25 this was immediately sent onto the assigned HIQA inspector for proof that fire certification had been completed for this centre on 17/01/202 A call also took place between the organizational fire officer and the PPIM in relation to the unclear signatures completed by outside contractors on the fire equipment which was raised in this report. A conversation was had between the organization and external contractor which worked to rectify this situation going forward. All works in relation to the finding in this report relating to regulation 21 has been completed by issue of compliance plan on the 15/05/2025.	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: On April 17th 2025, the PIC and PPIM met to discuss the findings of the HIQA report. It was decided here that any future minor injuries that didn't require first aid would be returned in HIQA quarterlies. The PIC addressed the staff team at the April staff meeting and asked the team to notify her of any minor injuries straight away and the PIC has set up a log to record this. The PIC and PPIM also when completing Monthly Data reports will look for any potential unreported incidents and address same with staff members. The PPIM has also	

requested the PIC send him on a draft copy of the quarterlies before they are sent to HIQA to ensure incidents are included.

The issue highlighted in the report was between Sep- Oct 2024 all other quarterlies completed have been notified to have compliant since this time.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
In response to the findings of this report in relation to regulation 27: Protection against Infection the provider has responded as laid out below;

There were a number of upkeep and repair works required that were impacting on the effectiveness of cleaning which in turn impacted on the arrangements for ensuring the best possible infection, prevention and control arrangements and required improvements. During a walk around of the premises the inspector observed the following areas that required action to mitigate health and safety risks;
Staff office:
Door and frame chipped paint -
The PIC met Technical services on the 16th of April to discuss the response to the findings of the above report after she logged the issues again on the 2nd of April after initial feedback from the report. At this meeting he signalled that paintworks where projected to be completed within Glencree by the end of Q1 2026 and made the PIC and PPIM that we are currently 93 on the priortity lists for any works that would require a contractor. This was revisted on the 20/05/2025 after rejection of the initial compliance plan and a meeting occurred between Glencree management and the Technical Service Dept who agreed to bring the date for completion of works forward to the end of Q4 2025.
Toilet and shower room (mainly used by staff but available to residents):
The PIC met Technical services on the 16th of April to discuss the response to the findings of the above report after she logged the issues again on the 2nd of April after initial feedback from the report. At this meeting he signalled that paintworks where projected to be completed within Glencree by the end of Q1 2026 and made the PIC and PPIM that we are currently 93 on the priortity lists for any works that would require a contractor. On the 16th of April the shower tray was measured by technical services. Staff cleaned extractor fans on the 2nd of April to the best of their ability but technical services reported that they are better to be replaced than cleaned and have logged this job. Toilet roller holders fitted and installed on the day of the inspection. Radiator, plastering and additional painting in this area to be painted in line with timelines above given re: contractor works

Cleaning equipment:
. New mophead and bucket bought immediately on the 1st of April 2025. Storage facilities upgraded - Action now complete 21/05/2025
Hallway:
The PIC met Technical services on the 16th of April to discuss the response to the findings of the above report after she logged the issues again on the 2nd of April after initial feedback from the report. At this meeting he signalled that paintworks where projected to be completed within Glencree by the end of Q4 2025 and made the PIC and PPIM that we are cur rently 93 on the priortity lists for any works that would require a contractor.

Laundry room:
The PIC met Technical services on the 16th of April to discuss the response to the findings of the above report after she logged the issues again on the 2nd of April after initial feedback from the report. At this meeting he signalled that paintworks where projected to be completed within Glencree by the end of Q1 2026 and made the PIC and PPIM that we are currently 93 on the priortity lists for any works that would require a contractor. Extractor fan cleaned on the 1st of April 2025 by night staff however Technical services have signalled the need for a replacement and this will be completed in line with timeline above.

Kitchen:
The PIC met Technical services on the 16th of April to discuss the response to the findings of the above report after she logged the issues again on the 2nd of April after initial feedback from the report. At this meeting he signalled that paintworks where projected to be completed within Glencree by the end of Q4 2025 and made the PIC and PPIM that we are currently 93 on the priortity lists for any works that would require a contractor.

Resident's wet room (shower, sink and toilet):
The toilet roll holder was immediately put in place on the day of the inspection 1/04/25. The shower head was replaced on the 08/04/2025. New shower hose to be purchased on the 17/05/2025 and fitted. The PIC met Technical services on the 16th of April to discuss the response to the findings of the above report after she logged the issues again on the 2nd of April after initial feedback from the report. At this meeting he signalled that paintworks where projected to be completed within Glencree by the end of Q4 2025 and made the PIC and PPIM that we are currently 93 on the priortity lists for any works that would require a contractor.

All outstanding works above have been assigned to the QEP and closer attention in internal audits will be given to issues relating to IPC in this centre on future occasions. A timeline and plan is now in place for all works and all tasks have been included in the centre quality improvement plan to be closed off by the end of Quarter 1 2026.

Judgment: Not compliant

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 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	15/05/2025
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.	Not Compliant	Orange	31/12/2025
Regulation 31(1)(d)	The person in charge shall give	Substantially Compliant	Yellow	15/05/2025

	the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.			