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:	Glenbow Services
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	11 June 2025
Centre ID:	OSV-0003364
Fieldwork ID:	MON-0046707

About the designated centre

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

Glenbow Services is run by the Health Service Executive and is located a short distance from a town in Co. Sligo. The centre provides residential care for up to seven male and female residents, who are over the age of 18 years and have mild to profound intellectual disabilities. The centre is based on a campus setting and comprises of two bungalow dwellings located within close proximity to each other. Residents have access to their own bedroom, some en-suite facilities, shared communal areas, bathrooms and each bungalow provides residents with level access to a green area. Staff are on duty both day and night to support the residents who avail of this service.

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 11 June 2025	15:00hrs to 19:00hrs	Angela McCormack	Lead
Thursday 12 June 2025	09:45hrs to 15:00hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection which focused on safeguarding. The Chief Inspector of Social Services issued a regulatory notice to providers in June 2024 outlining a plan to launch a regulatory adult safeguarding programme for inspections of designated centres. This inspection was completed as part of this programme.

Overall, the inspector found that residents living in Glenbow were receiving good quality care and support. However, improvements were needed to ensure that this care and support was provided by a stable and consistent team and that institutional practices that were in place for many years were reviewed with residents to ensure that their choices about this were sought. This would enhance the care provided to ensure that it was more person-centred.

The inspection was carried out over two half days, one afternoon and the following morning. This inspector provided the centre with a document called 'Nice to Meet You' that inspectors use to try to help to explain to residents about their visit. The inspector got the opportunity to meet with all six residents. In addition, one family member and four staff members were spoken with.

The centre comprised two bungalows (Glenellen and Rainbow View) located beside each other on a campus setting in a rural location. There was a large building that contained offices and a centralised kitchen on the campus. There was one vacancy in the centre at the time of inspection following the recent sad death of a resident in Glenellen. There were no plans to fill this vacancy as the provider had a plan in progress for residents to move off the campus to group homes in the community. This was part of the provider's decongregation plan. Three residents in Glenellen were consulted about this move and had input into choosing furniture for their new home.

From a walk around by the inspector it was observed that each house was clean, well maintained and suitable to meet the needs and numbers of residents. Residents had individually decorated and spacious bedrooms that had suitable arrangements for the storage of personal property. Main meals were delivered daily from a centralised kitchen located on the campus. In addition, the inspector was informed that laundry in one house was completed at set days of the week by domestic staff. These arrangements were reported to meet the needs of residents. Staff members said that residents could choose from two meal options each day, or they could get alternative food in the house. However, these practices required review with residents to ensure that they were satisfied with the arrangements. This would ensure that residents' opinions were sought about the running of their home, therefore ensuring a more person-centred approach to care and support provided.

Some residents were non-verbal, therefore staff members supported them in communicating with the inspector. Staff were observed to be respectful and

knowledgeable in supporting residents with their non-verbal communications. Residents met with acknowledged the inspector and communicated in their own way. One resident and their family member, who was visiting the centre, spoke with the inspector about what it was like to live in Glenbow.

Through observations and discussions the inspector found that residents were supported with their needs. Some residents were of an aging population and had complex healthcare needs. Residents' needs were assessed, regularly monitored and the support provided met their needs and stage of life. For example, residents were supported to get regular massage therapy in their home, where they could then relax and rest and enjoy the benefits of the massage. This was occurring at the time of inspection. Other residents enjoyed a more active lifestyle, which included attending a centre that was located on the campus during the week. Other activities enjoyed by residents included going to seaweed baths, social farming, shopping and going to concerts.

The inspector spoke about safeguarding arrangements with four staff members and the management team throughout the inspection. Managers were aware of their roles in the safeguarding procedures, reporting requirements and Trust in Care procedures for allegations of abuse by staff members. Staff members spoken were aware of the reporting procedures for allegations of abuse and said that they would report to their line manager and completed records. There were notices observed throughout the homes outlining this procedure and details of the designated officers for safeguarding. Staff members had access to the provider's policies and procedures which were available in each house. Staff members were knowledgeable about individual residents' needs including behaviour supports. The inspector observed warm and caring interactions between staff and residents. Staff members spoke about residents with respect. Residents were observed to be relaxed in their homes where they were observed sitting in preferred seats looking out the window and watching television.

Residents were consulted about the centre through residents' meetings. However improvements were required to ensure that more meaningful participation by residents occurred. The provider identified this as an action through their provider audit in October 2024, and this action was reported to be in progress. This showed that the provider was committed to ongoing quality improvement to improve the lives of residents. The inspector also observed and reviewed easy-to-read documents that were available to residents, as relevant.

Overall, the inspector found that Glenbow service supported residents with their assessed needs and kept them safe.

The next sections of the report review the capacity and capability of the provider, and about how this impacts on the quality and safety of care and support.

Capacity and capability

The inspector found that Glenbow had good arrangements for the management and monitoring of the support provided to residents overall. However, improvements were required in ensuring that staff vacancies were completed in a timely manner and that gaps in training were addressed.

There were range of policies and procedures in place to promote residents' safety and protection. These policies were found to be kept under review by the provider. Meetings held at both local and middle management level reviewed safeguarding. This ensured good oversight of residents' safety. These also allowed for the monitoring of trends of concern so that action could be taken to address any identified safeguarding risks. In addition, there was a comprehensive audit scheduled in place to monitor practices and the safety of residents.

Residents were supported by a skill mix of nursing staff and care staff. There were vacant posts in one house that required completion. A training plan was in place to ensure that all staff had the required training to support residents with their needs and to ensure that residents were protected. However, there were gaps in the records maintained and some refresher training was due.

Regulation 15: Staffing

While the staffing numbers and skill mix were suitable to meet the needs of residents at this time, there was a heavy reliance on agency staff in Rainbow View. This created a risk that residents would be supported with unfamiliar staff. The following was found;

- The inspector reviewed the rosters from in Rainbow View between 20 April 2025 and 08 June 2025, and found that there were five agency filling the healthcare assistant's roles on the roster each week. While recruitment to make these posts permanent were in progress and this action was known by the provider, it was not completed in a timely manner. For example; a provider report from October 2024 set an action for this to be completed by the end of 2024; however at the time of inspection this was not yet completed.

A further review by the middle management team and the Human resources department was due to be held by the end of July 2025 to progress this. Completion of the recruitment of these posts would ensure that residents who required intensive supports (2:1 for some care tasks) and required familiar staff to support their communications had a staff team that were consistent. This would also ensure the retention of staff members. This would further promote residents' safety and protection.

A sample of eight staff member's garda vetting records were reviewed by the inspector where it was found that staff were appropriately vetted.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector reviewed the centre's current training matrix and found that there were improvements required in the records kept at the centre and in ensuring refresher training was completed in a timely manner. The following was found;

- There were gaps in staff training records for staff in one location. For example; three staff members were not included on the matrix, therefore it could not be verified that they had received the training required to support residents. This included agency staff members in one location. The inspector was verbally assured that these staff members had the relevant safeguarding training prior to being able to work in the centre and that the relevant agency ensured that. However, the maintenance of records required improvements to ensure that it was clear that all staff supporting residents had the required training to identify and respond to abuse and protection concerns.
- Three staff members required refresher training in behaviour support.

The inspector reviewed the template for induction for new staff and found that it included information about safeguarding and supports with behaviour, including the policies and procedures related to this. However, one staff member working on the day of inspection did not have the time to complete the induction programme prior to starting their shift. Therefore, the contingency arrangements for staff cover at short notice required review to ensure that relief cover had the necessary knowledge to promote residents' protection and support them with behaviours of distress. This is included under Regulation 23; Governance and management.

The inspector reviewed a sample of four supervision meetings and found that staff were supported through annual meetings with their line manager as required in the provider's policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

This inspection found that some improvements were required in the monitoring of practices and the progression of actions to further promote a rights' based and person-centred service. The following was found:

- There was a heavy reliance on agency staff in Rainbow View. While for the most part the agency staff members used were regular and consistent the completion of the recruitment required addressing. This would ensure that residents were supported with familiar staff and that the centre was fully

resourced in line with the statement of purpose.

- It was not clear through the documentation of residents' meetings how residents were supported a way that was meaningful to them in understanding safeguarding how to self-protect
- Staff safeguarding awareness monthly audits required review to ensure that they were effective in what they aimed to do, which was to assess a sample of staff each month to review their awareness about safeguarding residents. For example; there were two records available for the inspector to review for 2025, both of which audited the same staff member's awareness.
- Induction arrangements and contingency planning for unplanned leave required review to ensure that staff members that provided emergency cover were given a sufficient induction to the service. This would ensure the protection of residents. For example, on the first evening of the inspection there was one staff nurse working in Glenellen who had never worked there before. While a handover was given to them from the night nurse, the behaviour support plans of residents had not been read as agreed. This posed a risk to both residents and staff members as there was a known risk relating to unfamiliar staff and one resident. While the other staff members covering this shift were familiar staff which reduced the risk, the role of the staff nurse in the homes had specific duties that could not be undertaken by care staff, therefore this posed a risk.
- The risk assessment document for the use of agency staff required review as it did not clearly identify what the risks were.

Notwithstanding that, there were good systems in place to oversee the centre. There was a clear governance structure with defined roles and responsibilities for the management team. The local management team compromised a full-time person in charge, supported by a clinical nurse manager 1 (CNM1) who worked 15 hours per week in the centre and had delegated management tasks.

The inspector reviewed the auditing systems which included an annual schedule of audits for 2025. These audits covered areas such as residents' personal plans, complaints, safeguarding and finances. Audits were completed in line with the provider's schedule for the most part, and generally were effective in identifying actions for improvement. The provider also completed six monthly unannounced visits to the centre as required in the regulations, where they reviewed areas such as incidents, safeguarding and restrictive practices.

The inspector reviewed meeting records from January 2025 to May 2025. These meeting notes showed that reviews of safeguarding incidents and safeguarding plans took place at each meeting. A team meeting was held the morning of the first day of inspection. Staff members spoken with said that they could raise concerns at meetings and that they had done so at the most recent meeting.

Judgment: Substantially compliant

Quality and safety

The inspector found that residents received safe and good quality care. However, a review of some long established practices such as the delivery of meals from a centralised kitchen on the campus and the arrangements for the completion of laundry, was required. This would ensure that residents are consulted about their home and therefore promoting a a more person-centred approach to care.

Residents' needs, wellbeing and protection were monitored through the procedures in place for auditing and reviewing care plans. This meant that any change in a residents' needs could be identified in a timely manner. Residents had access to multidisciplinary team (MDT) supports where this was required.

Residents' protection was promoted through audits, incident reviews and discussions about safeguarding at various meetings. The management team undertook a look back review of residents' daily notes in 2024, where they found possible protection concerns. These were then followed up in line with the safeguarding procedures. Learning from incidents was evident through meeting notes and discussion with staff members.

In summary, the inspector found that the service provided was safe, regularly monitored and residents' wellbeing were promoted. However, improvements as noted under the Regulation 9: residents' rights, would ensure a more person-centred, individualised and rights' based approach to care.

Regulation 10: Communication

The inspector reviewed three residents' care plans and found that residents who required supports with communication had support plans in place. Residents communicated in a variety of ways, including verbal means, through Lámh signs, picture board, objects of reference and gestures. The inspector observed residents communicating in their preferred communication methods. Staff were observed to be knowledgeable in communicating with residents and did so in a caring and respectful manner. The inspector was informed that familiar staff was very important to residents to enable them to communicate their choices effectively. Staff members explained the content of one resident's support plan to the inspector where it was clear that staff members knew residents well.

Residents had access to MDT supports also, to further support them in communicating their will and preferences.

Judgment: Compliant

Regulation 17: Premises

The premises were laid out to meet the needs and numbers of residents. Both locations provided residential care for three residents each at the time of inspection. Residents had individual bedrooms that were designed and decorated to meet their needs and individual preferences. In addition, residents had access to spacious communal rooms and rooms to have visitors in private if they wished. Residents had access to aids and appliances as required.

Both locations had kitchen facilities and access to laundry facilities; however it was not clear that residents in one location could launder their clothes when they chose to. This is covered under Regulation 9: residents' rights.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector reviewed the risk management folder in the centre and found that there were assessments completed for any identified risks. In general, these were well documented, assessed and kept under review. Some risk ratings on residents' individual risk assessments did not reflect the actual impact of the identified risk. This was addressed on the day by the person in charge. In addition, the risk assessment documentation regarding the use of agency staff was unclear as to what exactly the risk was that was assessed. This documentation gap is covered under Regulation 23: governance and management.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of three residents' personal plans and assessments of needs across the two locations. The inspector found that support plans were developed where the need was identified. These included; positive behaviour support plans, communication plans, intimate and personal care plans and health related plans. The plans were comprehensive and regularly monitored. The plans gave guidance to staff on how to provide safe and effective care. Staff spoken with were knowledgeable about residents' care needs.

A collaborative approach was evident through the personal plans. Residents and their representatives were found to be involved in annual review meetings where care practices and safety were reviewed. In addition, where residents required support from members of the MDT, this was available. For example; behaviour support specialists and speech and language therapists were involved in residents' care. This ensured that residents were supported with their needs by a skilled and

knowledgeable team, which in turn promoted the safety and protection of residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector reviewed the policies and procedures that the provider had for behaviour management and for restrictive practices. These were found to be up to date and provided clear guidance on how to support residents. They also included the roles and responsibilities of staff members, management and the MDT.

The inspector reviewed the restrictive practice policy and procedure which had recently been updated. Amendments noted showed the provider's commitment to promote a rights based approach to care. For example, the guidance was updated to include clear rationale and assessments for comfort checks to be completed on residents at night when they were sleeping. It outlined the need for an assessment on what the risks were to warrant this. The person in charge agreed that they would be undertaking an updated assessment for residents in Glenbow to review the need for regular checks at night time. This approach promoted residents' rights to privacy and personal autonomy.

In addition, the inspector reviewed three positive behaviour support plans. All plans were found to be up-to-date, regularly reviewed and included input from the relevant MDT. It was clear to the inspector through a review of the plans and discussions with staff that every effort was made to establish the causes of behaviours. This promoted a person-centred and safe approach to care.

Restrictive practices in use in the centre included lap belts and bed rails. These were found to be clearly assessed and included relevant MDT input such as occupational therapists. They were kept under ongoing review to ensure that they were the least restrictive measure and that there was clear rationale for their use. This showed how the provider strived to achieve a balance between residents' rights and protecting them from the risk of harm.

Judgment: Compliant

Regulation 8: Protection

The inspector reviewed the policies and procedures that the provider had in place for safeguarding vulnerable adults and for the provision of intimate and personal care. These policies and procedures were available to staff in the centre. In addition, the inspector observed posters and notices on display throughout the centre outlining the process for reporting incidents of a safeguarding nature. The inspector

spoke with four staff members about safeguarding arrangements. Staff spoken with were aware of the safeguarding procedures and what to do in the event of protection concerns. Staff members said that they could raise concerns at team meetings, and that they regularly do so on residents' behalf.

The inspector reviewed the safeguarding folder maintained in the centre. Records showed that safeguarding concerns that occurred since the last inspection by HIQA, had been reported and investigated in line with the safeguarding procedures. The associated safeguarding plans that were in place were kept under ongoing review.

In March 2024, the Chief Inspector received information relating to concerns about residents' protection. A provider assurance report was sought from the provider at the time. This led to a look back review of residents' notes by the management team where a number of possible concerns were then identified. The inspector discussed this with the management team and also saw documentation that showed that all these concerns were taken seriously and appropriately screened. In addition, it was clear that learning was taken from these possible protection concerns, many of which related to unexplained bruising, to ensure that staff were more vigilant to possible protection concerns.

The inspector saw easy-to-read material that was available for residents about how to self-protect. Two residents spoken with said that they were happy in the centre. A family member spoken with said they had no concerns about the care their family member received. However, the documentation regarding residents' meetings required review, as it was not clear that residents' were supported to understand safeguarding in a way that was meaningful to them. For example, the inspector reviewed seven residents' meeting notes for Glenellen that took place between January 2025 to June 2025 where it was found that on the topic of safeguarding, the relevant section on the meeting record was blank or it recorded 'no issues' about this topic. Therefore, it was not clear how and when, residents were supported with information on how to self-protect. This is covered under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector noted, and was told, about some practices that were institutional in nature such as the delivery of meals from a centralised kitchen and laundry being completed outside the house. Staff members spoken with said that residents were offered a choice at meal times, and that if they didn't like any meal, that this could be supplemented in the centre. They said that non-verbal residents could show their dissatisfaction with meals by pushing the meal away and that this was respected. However, the following was found;

- This required review with residents to ensure that their wishes with regard to

these practices were established and to check if they would like changes to this, such as being involved in cooking and preparing meals in their own home. This review would further support residents' autonomy and their right to make decisions about their day-to-day lives.

Notwithstanding that, the inspector observed that residents were treated in a respectful manner by staff members. All six residents were met with by the inspector. One resident and their family member spent time talking with the inspector. Other residents communicated in ways other than verbal means and were supported by staff members in communicating with the inspector. Residents who used verbal means to communicate expressed that they were happy in their homes. In addition, observations by the inspector on the non-verbal communication by residents showed that they appeared relaxed in their home and were supported by kind and caring staff members who included them in conversations.

Three person-centred plans (PCP) were reviewed and showed that residents' individual preferences were respected about how they spend their days. Inspectors reviewed residents' meetings since January 2025, and found that consultation occurred with residents about food choices and activities.

Residents had access to advocacy services, however the inspector was informed that none of the residents had been referred for this service, but would be if needed.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Glenbow Services OSV-0003364

Inspection ID: MON-0046707

Date of inspection: 12/06/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance with Regulation 15 the following actions have commenced; • A further review of staffing has been undertaken and all vacancies verified and identified. The recruitment of seven additional posts has commenced. The campaign to recruit required Health Care Assistants will close on the 11.07.2025. The interviews for these posts will be scheduled before 15-9-25 .Expected date for Health care assistants to be in post by 30-11-25 • Staff Nurse Interviews are scheduled to take place week commencing 21-07-25. Expected date for nursing staff to be in position is 31-10-25 • Training records and Garda vetting information will be sought prior to any staff commencing work in the center. Training records for Agency staff will be maintained within an individual folder, which is maintained by the Person in Charge prior to adding these new agency staff to the centers matrix after three rostered days	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance with Regulation 16 the following actions have been undertaken and commenced; • The CS-CDLMS Disability Service Training Matrix has been implemented within this center and is updated monthly.	

• All current staff working within the center have been added to the training matrix. This is inclusive of all agency staff. Completed 13-6-25

• In the event of unplanned leave and the introduction of a new staff to the centre new staff will be added to the training matrix within three rostered days.

• Training records and Garda vetting information will be sought prior to any staff commencing work in the centre. Training records for Agency staff will be maintained within an individual folder prior to adding these new agency staff to the centers matrix after three rostered days.

• One staff has received their 2 day training in Behavioral support. (Completed 17th/18th June 2025). Two additional staff are scheduled for the one day refresher training in Behavioral support on 30th September 2025.

• All staff within the centre have completed the HSEland Safeguarding online training. In addition to this all staff have now completed the 'Hiqa National Standards for Adult Safeguarding –Putting the standards into Practice'

• A site-specific induction template is currently being developed for the center. This will include information on the needs of each individual resident in relation to Behavioral support, Safeguarding plans and Safe mealtime guidelines, and any other relevant information to ensure the protection and safety of each resident. All new HSE and agency staff will complete the site-specific induction prior to commencement in post or rostered shift. Date to be completed 21-07-25

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• A further review of staffing has been undertaken and all vacancies verified and identified. The recruitment of seven additional posts has commenced. The campaign to recruit required Health Care Assistants will close on the 11.07.2025. The interviews for these posts will be scheduled before 15-9-25 .Expected date for Health care assistants to be in position by 30-11-25

• Staff Nurse Interviews will be held the week commencing 21-07-25. Expected date for nursing staff to be in position is 31-10-25

• The center's Statement of Purpose will be reviewed and updated once the recruitment has been completed.
• An MDT meeting was held on 08-07-25 and included the Speech and Language Therapist to discuss how we can explore the residents understanding of safeguarding and the exploration of aids to assist this process.

• The agenda item of safeguarding will now be discussed as part of the residents' bi

annual satisfactory questionnaire.

• Additional Communication systems, which will be trialed, include pictorial and video resources and a "Show me tool" which measures resident's responses to experiences that they are exposed to. An animated video explaining safeguarding will also be shown and documenting the resident's response using the identified checklist. To be completed 15-08-25

• The current residents meeting template will be reviewed and adapted to demonstrate the preferred communication style for each resident. This review will also include consideration of the supports required to aid the communication of each resident, while considering their cognitive ability and capacity. The agenda will be amended to reflect topics of interest to the resident.

• The CS-CDLMS Safeguarding Awareness tool audit will be completed monthly with the staff team and will be monitored to ensure all staff are included at least annually. All actions arising from this audit will be added to the centers QIP and closed out within a timely manner. To be completed by 15-08-25

• In the event of staff unplanned leave within the Centre, the PIC will in the first instance; endeavor to replace the vacancy with familiar members of the staff team and familiar agency staff if necessary. If this is unsuccessful and an agency staff is required, a site-specific induction template is currently being developed for the centre. This will include information on the needs of each individual resident in relation to Behavioral support, Safeguarding plans and Safe mealtime guidelines, and any other relevant information to ensure the protection and safety of each resident. All new HSE and agency staff will complete the site specific induction prior to commencement in post or rostered shift. Date to be completed 21-07-25.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

To ensure compliance with Regulation 9 the following actions have commenced;

• A review of the current practices of residents receiving their meals from a centralized kitchen and having their laundry completed outside the home, has commenced. The review is consisting of a trail period of presenting experiences of both cooking within the center and residents participating in laundering their clothes if they so wish. Sensory Information will be offered in the form of smells and tactile experiences. A checklist will be completed to ascertain how the resident feels about the activity. Pictorial evidence will also be gained when completing the activity with the residents consent. The MDT team will review the information from the activities and a program designed to ensure each residents will and preferences related to laundering clothing and cookery will be promoted depending on their reaction. This review will be completed by 30-10-25.

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 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/10/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/09/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and	Substantially Compliant	Yellow	31/10/2025

	support in accordance with the statement of purpose.			
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	15/08/2025
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	31/10/2025