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:	The Glens
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	19 August 2025
Centre ID:	OSV-0004880
Fieldwork ID:	MON-0045060

About the designated centre

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

In this centre the provider aims to provide an individualised residential service to a maximum of five residents. The service is delivered in a purpose built apartment block comprised of three apartments. The location of the designated centre facilitates access to the amenities available in the large busy town. Each of the three apartments is designed to accommodate two residents. Currently, two of the three apartments are shared. The model of support is social and a twenty-four hour staff presence is maintained in the centre. Residents present with a diverse range of needs and abilities and the support provided is informed by an individual assessment of needs that includes domains such as healthcare, education, employment and, meaningful social and community inclusion. The arrangements in the centre are altered as the needs of the residents change. For example, who residents share their apartment with and the level of staff support that residents need. The day-to-day management and oversight of the service is delegated to the person in charge who is supported by a social care worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 19 August 2025	10:00hrs to 18:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken by the Health Information and Quality Authority (HIQA) to monitor the provider's compliance with the regulations. Based on the findings of this inspection residents received the support and care that they needed to be well and to enjoy a good quality of life. However, while there were positive findings this is a busy service and this inspection found there were matters for the provider to address in many of the areas reviewed by the inspector. For example, better oversight was needed of staff supervision and training requirements, improvement was needed in some medicines management practices, in the timely assessment and management of all risk and in the oversight of the fire safety systems. Collectively these findings reflected shortfalls in the designated centres governance and management arrangements.

Since the last inspection the provider had made changes to the configuration of this designated centre. The centre now consists of one building whereas previously up to March 2024 there was an additional house attached and an overall capacity to accommodate eight residents. Five residents now live in the designated centre.

The building is purpose built and consists of four separate apartments one of which is used as a staff office and staff sleepover room. Each apartment is accessed from the main circulation corridor and each apartment provides all of the facilities that residents might need such as a well-equipped kitchen, dining and communal area and laundry facilities. Two of the apartments are shared by two residents and each resident has their own bedroom and their own bathroom some of which are en-suite. One apartment is two-storey with an en-suite bedroom provided at first floor level. One resident does not share their apartment with a peer and the vacant bedroom in the apartment has been converted to a sensory space for the resident. Each apartment has direct access to a pleasant private outdoor area.

This inspection was unannounced. On arrival the inspector noted how well maintained the property was externally with pleasant and welcoming summer planting and general evidence of good maintenance. Overall, the inspector found the premises was well-maintained internally and residents were facilitated to personalise their apartments and their own personal spaces to their liking. The apartments were welcoming homely spaces. However, a full review by the provider of the suitability and safety of areas used for general storage was needed.

There was one staff member on duty supporting one resident. Another staff member had left with two residents to collect some items from the local pharmacy and two residents had left to attend day services. However, prior to the conclusion of this inspection the inspector had the opportunity to meet with all five residents.

The resident who was in the designated centre gestured to the inspector to come in and to sit with them at their dining table. The assessed needs of the resident include communication differences. The resident looked well and was in great form, smiling

broadly and gently taking the inspectors hand at intervals. The staff member was preparing the residents breakfast and the inspector noted how the resident was asked and capably expressed their breakfast preferences using gestures, signs and words. The resident was booked to attend sensory horse therapy at an equine centre. There was an easy, familiar rapport between the resident and the staff member. The person in charge who arrived to facilitate this inspection also received a warm welcome from the resident. The inspector left the resident to enjoy their breakfast undisturbed.

The two residents and their supporting staff member had returned from the pharmacy at this point. Again both residents looked well and remembered that the inspector was from HIQA. One resident was hanging their personal laundry on the outdoor line while the other resident was relaxing as the staff member was preparing a substantive lunch for residents to have later. The inspector met these residents at intervals during the day as they came and went with the staff member to attend to different activities. One resident confirmed that they remained active in the internal advocacy forum and they attended an advocacy meeting in the morning. The residents had lunch which they reported they enjoyed and then left again to go to one of the local seaside destinations. There was general discussion of a broad range of matters such as the birthday celebrations they had both enjoyed with family, peers and friends, their interest in sport, the Rose of Tralee festival that was in progress at the time of this inspection and which they had both watched. There was even a mention of world politics and the upcoming national presidential election. One resident did tell the inspector that he missed the house that he had lived in previously but did not expand on this.

In the evening the inspector met with the remaining two residents when they returned from their different day services. One resident just smiled and shook hands with the inspector and then carried on to complete their evening routine. The other resident remembered that the inspector was from Cork, was in great form and proceeded to tell the inspector about the different places they had been and events they had enjoyed during the summer including a trip to Cork. The resident showed the inspector the photos they had on their phone including their trip on a ferris-wheel, the recent meet and greet enjoyed with a favourite television soap personality and visiting a wild-life park. The resident had a great sense of humour and said that some persons thought she had been in Australia when she showed them her photograph of the kangaroos. The resident said they loved attending their community based day service where they had good fun.

Three of the residents met with were sharing an apartment and told the inspector that they were getting on okay together.

It was evident from these interactions, observations and from records seen that residents were engaged and supported to have active and meaningful lives. One resident spoke of their love of being out and about and the importance of community visibility and engagement.

It was evident from what residents spoke of that they had ongoing access to home and family as appropriate to each resident's needs and circumstances and this was

important to them. This included spending regular planned time at home with family for some residents.

The provider had completed the annual quality and safety service review for 2024 and had sought feedback from residents and their representatives. While all representatives had not returned formal feedback the feedback that was received was positive and the centre was rated as excellent.

The staffing levels observed by the inspector were as described by the person in charge and as set out in the staff duty rota. For example, an additional staff member came on in the late afternoon. The provider in consultation with the staff team had implemented a new staff rota to provide the consistency and the support residents needed as their needs and abilities changed and fluctuated.

In summary, this was a good person-centred service. There was evidence that the governance and management structure and arrangements in place operated to a good standard. However, as stated in the opening paragraph of this report the provider was, based on the findings of this inspection, issued with a number of actions as the provider did not demonstrate full compliance with many of the regulations reviewed. Collectively, these findings were indicative of gaps in the consistency and effectiveness of the governance and management arrangements in place. These gaps had the potential to impact on the safety of the service.

The next two sections of this report will discuss those governance and management arrangements and how they did or did not ensure and assure the appropriateness, quality and safety of the service provided to residents.

Capacity and capability

The provider had a clear governance structure in place. There was an established management structure that set out clear lines of responsibility and accountability. The centre presented as adequately resourced. The provider had quality assurance systems and was consistently using these to monitor the quality and safety of the service. However, based on the findings of this inspection these arrangements were not sufficient to ensure all areas of service provision were consistently and effectively overseen.

The person in charge was responsible for the day-to-day management and oversight of the centre. The person in charge had other areas of responsibility, had an office in the providers nearby administration office and was supported in the management and oversight of the designated centre by a social care worker and by their line manager the community manager.

It was evident to the inspector that the person in charge was consistently engaged in the management and oversight of the service and escalated matters to their line manager. For example, the inspector saw the detailed reviews of incidents and

accidents completed by the person in charge and the oversight of these reviews by the community manager. The person in charge ensured that residents had access to the support and services that they needed such as the multi-disciplinary team (MDT), and residents were as needed, supported to use the providers complaint policy and procedure.

The person in charge convened regular staff team meetings. The inspector read the minutes of the 2025 meetings. There was good staff attendance at these meetings and good engagement by staff.

The inspector saw that a planned and actual staff duty rota was in place. The rota reflected good staffing continuity and the staffing levels described and observed.

Formal quality assurance systems included the annual quality and safety review referred to in the opening section of this report, the quality and safety reviews to be completed at least on a six-monthly basis and audits of areas such as infection prevention and control and medicines management practice.

However, the findings of this HIQA inspection reflected shortfalls in the systems of governance and oversight and possible capacity constraints in what was a busy designated centre. This meant that some issues identified by this HIQA inspection were not identified and-or addressed by the providers own systems of management, oversight and quality assurance. While these matters will be discussed in each regulation, collectively, they were indicative of shortfalls in the systems of governance and management.

Regulation 14: Persons in charge

The person in charge worked full-time. The person in charge had the qualifications, skills and experience needed for the role. The person in charge could clearly describe and demonstrate to the inspector how they managed and maintained oversight of the designated centre. The person in charge had sound knowledge of the needs and circumstances of each resident and was very familiar with the general operation of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

Based on the available evidence staffing levels, staffing arrangements and staff skill-mix were suited to the number and the assessed needs of the residents.

Originally, this service was established as a semi-independent service where residents would have required minimal support from staff. However, with age,

residents needs and abilities have changed as evidenced on this and previous HIQA inspections. This had resulted in staffing challenges.

The inspector saw that the provider had in mid 2024 worked with the staff team to adjust and modify staff work patterns so as to improve the continuity of the staffing arrangements and the level of support available to residents. The occupancy of the centre did fluctuate as two residents regularly attended external day services and two residents had a regular pattern of weekend home visits.

The person in charge described how staffing levels were managed in response to the needs of residents and the occupancy of the centre. Additional staffing was in place for example, when all residents were in the designated centre at the weekend. One resident had high support needs and a staffing presence was maintained in their apartment from 08:00hrs to 22:00hrs. Regular staff worked additional shifts as needed and while there was no concerning turnover of staff the provider had an ongoing process of staff recruitment and was currently recruiting relief staff.

The inspector reviewed the staff duty rota for the month of July-August 2025. The rota was well-maintained. It identified each staff member, their role and the hours that they worked. From the staff duty rota the inspector noted the days additional staffing was in place and the good continuity of staffing including the vacant shifts that were worked by regular staff.

There were systems in place for monitoring the adequacy of the staffing levels and arrangements. For example, there was one staff member on sleepover duty at night. Sleepover staff were required to log all sleep disturbances, these were reviewed by the person in change and no regular pattern of disturbance was reported.

Based on what the inspector observed residents had the support that they needed. While residents needs were increasing and they required support in areas where they would previously have had good independence such as looking after their apartments and their own personal care, they remained socially active and busy. A staff member spoken with confirmed the additional support from staff that residents needed but overall was satisfied with the current staffing arrangements.

Nursing advice and care if needed was accessed from within the providers own resources and from community based nursing resources.

Judgment: Compliant

Regulation 16: Training and staff development

The arrangements in place were not sufficient to ensure that all staff were appropriately supervised in line with the providers own supervision requirements. The arrangements in place did not ensure adequate oversight of staff training requirements.

The inspector reviewed the staff training matrix and while baseline mandatory, required and desired training was recorded as completed by most staff there was refresher training that was overdue for a number of staff. The person in charge confirmed that the training matrix was correct. The overdue training included on-line adult safeguarding training for two staff but the in-person safeguarding training was in date.

Additional refresher training that was overdue including safety intervention training with regard to behaviour that was challenging for two staff members and one fire safety refresher training.

There were training gaps in training modules that reflected the assessed needs of residents such as in falls prevention and management and supporting residents to eat and drink safely.

There were systems in place for the support and supervision of staff. This included on-site informal support and supervision with the person in charge and regular staff team meetings. The person in charge described the systems in place for the induction of new staff and confirmed the completion of probationary reviews. The person in charge said that they had advice and support as needed from the community manager and the human resources department. The person in charge was aware of the new support and supervision system implemented by the provider and the training provided to underpin the introduction of this system.

The person in charge described how they mentored and supported the social care worker who was new to this role.

However, the person in charge said that while regular staff were met with informally, formal staff supervisions were behind schedule and had not been completed this year in line with the providers own supervision policy for at least five regular staff members.

Judgment: Substantially compliant

Regulation 21: Records

Appropriate arrangements were not in place for retaining records not actively in use. These records included residents' records as required by the regulations that had to be retained for a specific period of time. The manner in which they were stored and retained did not ensure the safety, security or the confidentiality of the records.

Judgment: Substantially compliant

Regulation 23: Governance and management

Collectively, the gaps identified by this HIQA inspection indicated the governance and management arrangements in place while good, were not sufficient to ensure this busy service was consistently and effectively monitored so as to ensure the appropriateness, quality and safety of the service.

The inspector found clarity on roles, responsibilities and reporting relationships. The inspector found accountability for the quality and safety of the support and care provided to residents. For example, the person in charge understood their role and responsibilities and ensured for example that residents had access to the healthcare services that they needed.

The ongoing suitability of shared living arrangements was monitored and the provider had worked with the staff team to improve the consistency of the centres staffing arrangements.

The person in charge reported ready access to and support from their line manager who in turn maintained oversight of areas such as of how incidents and accidents were managed in the designated centre.

These reviews of the accidents and incidents were part of the provider's quality assurance systems. These systems included other reviews such as the annual and six-monthly quality and safety reviews required by the regulations. The inspector read the reports of these reviews. They were completed on schedule and provided for consultation with residents, families and staff. The reviews were comprehensive, focused on the quality and safety of the service and made recommendations to drive ongoing improvement.

However, the findings of this inspection reflected shortfalls in the monitoring and oversight of the service. For example, better oversight was needed to ensure that adequate staff training levels were maintained and that staff were supervised in line with the providers own staff supervision requirements. General storage practices were poor including the storage of archived resident records. Improvement was needed in the management of medicines that required additional controls. The response to some identified risks was not timely. Oversight, of fire safety had not ensured that the fire-fighting equipment was inspected and tested on schedule.

Collectively, these findings did not demonstrate consistent and effective oversight of the designated centre by the provider. Individually and collectively each failing had the potential to impact on the quality and safety of the service and the safety of residents.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector read records that included a record of adverse events and their

analysis that had occurred in the designated centre to date in 2025. Based on these records the inspector was assured there were suitable arrangements in place for notifying the Chief Inspector of Social Services of certain events such as injuries sustained by residents and the use of any restrictive practice. The person in charge and the community manager described how they discussed each incident and any notification requirements.

Judgment: Compliant

Quality and safety

This was a person-centred service where the care and support provided was individualised to the needs and abilities of each resident. Residents presented as active and engaged and led busy lives closely connected to home, family and the wider community.

Each resident could in their own way communicate what it was they wanted to do or did not want to do. Verbal communication was not the primary means of communication for two residents. The person in charge was open to and was exploring new ways for supporting residents particularly for persons such as new staff who would not be familiar with the residents.

The inspector saw that residents were spoken with and consulted with and regular group meetings were also held. The inspector read the notes of these meetings and saw that all residents regardless of their differing needs and abilities attended these meetings.

The inspector saw from records such as the detailed staff team meetings and the corrective actions taken after accidents that resident health and well-being was consistently monitored and the person in charge ensured residents had access as needed to healthcare services and professionals.

Medicines were supplied by a community based pharmacist. There were systems for monitoring the safety of medicines management systems. For example, the person in charge had arranged for an assessor to complete a medication management audit in May 2025. The inspector reviewed the medicines management systems and saw corrective actions such as noting the date medications were opened were actioned. However, this inspector found improvement was needed in the storage and record-keeping of medicines that required stricter controls.

The inspector saw that safeguarding information was prominently displayed in the designated centre. Safeguarding systems included the recording and reporting of any unexplained injuries sustained by residents. These were regularly discussed at the staff meetings. The inspector saw that the associated records (body maps) were included in the review of all incidents and accidents.

Overall, the inspector found good systems for the identification and management of risk linked to these accident and incident reviews. The inspector followed particular lines of enquiry based on notifications submitted to the Chief Inspector of Social Services. There was a risk assessment and risk management plan in place for risks such as for the risk for falls. There was evidence of controls such as referral to the MDT and review of the environment by the occupational therapist. However, one control was outstanding, the replacement of the stairs carpet. In addition, while the person in charge described how the risk associated with a resident spending time alone in the designated centre had been considered the explicit assessment of the risk as referred to in records seen had not been completed.

Overall, the inspector found that the location, design and layout of the centre was suited to the stated purpose and function of the centre. However, the suitably and safety of the general storage arrangements in the centre required review by the provider.

Oversight, was maintained of the fire safety arrangements in the designated centre. For example, each resident had a personal emergency evacuation plan and regular drills tested the plans and the centres evacuation procedure. However, fire safety oversight had not identified the potential risk of the storage arrangements in the designated centre or that the inspection of the fire-fighting equipment was slightly overdue.

Regulation 10: Communication

Each resident was supported to communicate in their own way. Some residents were good and effective verbal communicators while others used a variety of methods to communicate such as words, gestures and manual signing. A total communication approach was used in the designated centre. The person in charge described the importance of having in place a regular team of staff who were familiar with the communication styles of each resident so as to support effective communication.

The inspector observed no barriers to communication as staff and residents discussed plans, routines and residents choices.

The person in charge recognised that challenges could arise if this familiarity was not present and was supporting new ways to support communication. For example, one resident always wanted to know what staff member was on sleepover duty. The inspector saw that a visual staff duty rota had been introduced and was prominently displayed in the notice board in the main hallway.

The inspector saw that residents had good access to televisions, mobile phones and personal devices. Residents were out and about and obviously informed about local events and events further afield that were of interest to them.

Judgment: Compliant

Regulation 11: Visits

Arrangements were in place that ensured residents had ongoing access to home and family as appropriate to their individual circumstances. Some residents had a very regular pattern of going home to family at weekends and for holidays. The person in charge worked with families and supported residents if any changes were needed to these plans.

Judgment: Compliant

Regulation 17: Premises

This inspection identified unsuitable general storage arrangements.

Residents were provided with a comfortable home and the concept of having their own apartment. Residents were facilitated to personalise their apartments and had good privacy within the apartments. For example, each resident had their own bathroom.

Each apartment had its own well-equipped kitchen and laundry facilities. Residents were provided with adequate personal and communal space. Residents had good personal storage space. There was direct access from each apartment to a compact but pleasant outdoor area that residents used. For example, some residents had facilities for hanging out their personal laundry and maintained pleasant tubs of summer planting.

The provider monitored the ongoing suitability of shared living arrangements and made changes as needed in consultation with residents if shared living arrangements were not going so well. Residents did live in close proximity to each other so it was important that they could live amicably together.

In the context of their assessed needs one resident did not share their apartment with a peer and largely received an individualised service. The vacant bedroom in the apartment had been converted to a sensory room for the resident.

While walking around the centre the inspector noted, within two residents bedrooms, doors that had a locking mechanism on them but that were unlocked. There was a third similar door at the top of the stairs in the two-storey apartment. When the inspector opened the doors they led to general storage areas. There were matters that made this arrangement unsuitable.

Firstly, two storage areas were within the bedrooms of two residents. This raised

privacy considerations. Secondly, the rooms were freely accessible to the residents and this created risk. Thirdly, two of these storage areas were within the attic space and had the potential to create a fire safety risk. This will be discussed in Regulation 28: Fire Precautions.

One of these storage areas backed on to an ensuite bathroom and there was an unpleasant smell in the storage room that was potentially due to waste management systems.

Finally, the items stored in these rooms were diverse and included a fold-up bed, a mattress, bedding, shopping bags, full bags that the inspector did not open and boxes of unidentified items. However, the inspector also noted numerous boxes of archived resident's records. This will discussed again in relation to Regulation 21: Records.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Overall, there were good systems in place for identifying and managing risks but there was some inconsistency in these systems.

The inspector reviewed the overarching risk register, a purposeful sample of resident's individual risk management plans and discussed with the person in charge how risk in the designated centre was identified, assessed and managed.

The person in charge has a good understanding of the different risks that presented in the centre and the individual needs and risks of the residents. Risk assessment and management was closely aligned to the assessment and support of residents needs.

The inspector saw that risk assessments were reviewed and updated at regular intervals by the person in charge. For example, following incidents and accidents that occurred. The risk register and plans identified the high-risk areas in the centre such as behaviours of concern, the risk for unexplained injuries, falls management and the administration of medicines that required additional controls.

The inspector reviewed the overview report of incidents and accidents that had occurred in the centre for quarters one and two of 2025. The person in charge had comprehensively reviewed each incident and accident. The person in charge had taken actions to protect the safety of residents as a result of incidents that had occurred. Corrective actions included referral to the MDT, environmental reviews and speaking with residents about for example, the importance of wearing good footwear and correctly using equipment such as their mobility aids.

The inspector saw that incidents, how they were recorded and managed and any

learning from the incidents was discussed at each staff meeting.

Any controls in place were proportional to the risk identified and there was no evidence that they impacted on resident quality of life.

The provider did support positive risk taking. For example, a resident had requested to be facilitated to spend some time alone in the designated centre. The person in charge described how this time was limited and the resident had been provided with and educated on the use of a personal alarm. However, clear documentation, including appropriate risk assessment was not in place to underpin how the resident was supported to safely stay on their own in the centre. For example, records seen confirmed that the resident had had two falls in their apartment.

All recommended risk management controls were not in place. The replacement of the carpet on the stairs was outstanding as was staff training such as in falls prevention and management.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had fire safety management systems and there was oversight of fire safety. However, this oversight did not ensure all precautions against the risk for fire were in place.

The inspector saw that the designated centre was fitted with fire safety measures that included a fire detection and alarm system, emergency lighting, fire-fighting equipment, manual call-points and doors with self-closing devices designed to contain fire and its products. Actions to be taken in the event of fire were prominently displayed as were diagrammatic evacuation plans. Escape routes were clearly signposted and were unobstructed on the day of inspection. There were different means of escape from each apartment one into the main circulation corridor and another directly to an outside space.

Each resident had a PEEP and regular simulated drills tested the evacuation procedures. The person in charge maintained oversight of these drills, monitored resident and staff participation and the time taken to evacuate residents. This included ensuring one staff member could evacuate all five residents in a timely manner. There were no reported obstacles, good evacuation times were reported and the provider had identified the evacuation time to be achieved.

The inspector saw documentary evidence that the fire detection and alarm system was inspected and tested on a quarterly basis as was the emergency lighting. However, the inspection and testing of the fire-fighting equipment was, based on the last servicing date seen, overdue since the 07 July 2025.

The inspector was not assured by the use of two spaces under the attic for general

storage including items that were flammable. There was evidence of fire detection devices but not of adequate containment measures. The third storage area was beneath the stairwell but on visual inspection that presented as of solid construction. However, this should be established by the provider.

The inspector noted that one fire-door in one apartment was not closing freely and was making contact with the floor.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Improvement was needed in the procedures in place for the management of medicines that had stricter controls.

The inspector reviewed the medication management systems in the designated centre with the person in charge and generally safe practices were in place for ordering, receiving, storing, disposing, and administering medicines.

Medications were prescribed by a registered prescriber and supplied by a community based pharmacy that was responsive to the needs of the service.

A medication record for one resident was reviewed and the inspector found that staff administered the medications in line with the instructions of the prescription.

All staff had received training in the safe administration of medications. The person in charge had carried out a risk assessment for each resident to establish their capacity or not to self-administer their own medications. Staff were supporting two residents in the self-administration of their medications.

There were medication reconciliation systems in place and procedures for responding to any errors.

There was a medication management policy in place and readily available to staff. The policy included the procedures for the management of controlled medicines.

The person in charge had arranged for a medicines management specific audit to be completed in May 2025. This inspector found that some but not all of the actions that issued from that review were implemented.

For example, this inspector found that the management of controlled drugs was not fully in line with the providers policy or general legislative requirements. The inspector found that access to the keys was not suitably restricted. A controlled medicines register was maintained but there was some inconsistency in the record-keeping. For example, the stock balance was not always altered when a new supply was received. Stock balances were completed at changeover of staff. However, these were not completed for both controlled drugs at the same time and were not

completed for every change of shift. This meant that if a discrepancy did arise there was compromised accountability and traceability.

Judgment: Substantially compliant

Regulation 6: Health care

Residents presented as well. The inspector saw from records seen that the health and wellbeing of each resident was monitored and supported in a variety of ways including through diet and nutrition, exercise and meaningful social interaction and engagement.

Residents had appropriate access to their general practitioner (GP) and out-of-hours medical services as needed. The person in charge ensured that residents had access to other healthcare professionals and attended clinical reviews with the residents. There was documented evidence that residents were supported to access for example dental care, psychiatry, psychology, neurology, positive behaviour support, occupational therapy, physiotherapy and screening services. The staff team supported residents in times of illness and, if for example, they required hospitalisation. The inspector saw how the support and care provided had contributed to a resident (who was recovering from a fall at the time of the last HIQA inspection) making a good and full recovery.

Judgment: Compliant

Regulation 8: Protection

The provider had systems in place that sought to protect residents from harm and abuse.

The provider had safeguarding policy and procedures and all staff had completed safeguarding training. On-line refresher training was out-of-date. These staff members had in-date in person safeguarding training with the designated safeguarding officer. Staff were required to complete both trainings. This is addressed in Regulation 16: Training and staff development.

The residents presented as comfortable in the designated centre and with the staff members on duty. Residents told the inspector that all was well in the designated centre and there was nothing they would like to discuss or change.

Information on safeguarding including the contact details of the designated safeguarding officer was prominently displayed.

Residents had access to and participated in the internal advocacy forum and were

supported to use the provider's complaints policy.

The provider monitored how well residents lived together and supported residents to understand what was required of them for this to happen such as respecting the privacy and rights of others.

There were systems in place that supported the safeguarding of residents such as the monitoring of restrictive practices and their impact and the monitoring of any unexplained injuries. These matters and a safeguarding plan that was active in the day service but not in the residential service were seen to be discussed at each staff meeting.

Judgment: Compliant

Regulation 9: Residents' rights

Based on the findings of this inspection residents rights were respected and promoted.

Residents were spoken with and listened to. For example, the inspector discussed a notification that had been submitted to HIQA. The person in charge described a matter that had arisen that a resident did not wish to discuss with their family; this was respected. There was subsequent consultation, discussion and agreement with the resident in relation to future information sharing. A resident had expressed a wish to spend some time alone in the designated centre. For example, if staff were dropping another resident somewhere or had an errand to do. This was facilitated.

Residents clearly had good choice and control over their daily routines, where they went and how they spent their leisure time.

The person in charge was aware of the Assisted Decision-Making (Capacity) Act 2015 and described the processes in place to support a resident as they transitioned to the service. This included support from social work and legal representation.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Glens OSV-0004880

Inspection ID: MON-0045060

Date of inspection: 19/08/2025

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme; and that staff are appropriately supervised. This will be ensured by: • Training matrix has been updated to reflect recent training attendance/ completion, and mandatory and essential trainings have been booked, including refresher trainings for staff who require it. • Necessary refresher training will be completed by 31 October 2025. • PIC has scheduled a supervision meeting with each staff member in the coming weeks – at these meetings, each respective staff member's performance review will in turn be scheduled – to be completed with all staff before the end of Q4 2025. (Overall completion date: 31/12/2025)	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Records kept in accordance with this section and set out in Schedule 3 shall be retained for a period of not less than 7 years after the resident has ceased to reside in the designated centre. This will be ensured by: Records have now been removed from the DC and have been allocated to the relevant archiving department who will faciliate the correct processing for these records in line with the regulations, and organisational procedure. [Complete]	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
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. This will be ensured by:

• Actions arising in other listed regulations will be completed as outlined.
• A comprehensive Quality Improvement Plan will be created and maintained by the PIC to incorporate all audit actions plans. The PIC will regularly review and update the QIP in line with arising actions identified that would continue to improve the quality of the service provided to residents.

[Completion date: 30 September 2025]

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The registered provider shall make provision for the matters set out in Schedule 6. This will be ensured by:
• As outlined above, residents' archived records have now been removed from the DC.
• The non-personal items stored in storage areas located within resident's rooms have been cleared out; and residents have been consulted in the use of these storage areas.
• The storage areas in one resident's bedroom have been confirmed to be fire proofed.
• Upstairs storage areas have been confirmed to meet the requirements within fire regulations. As per guidance sought and received, upstairs storage areas have been cleared of all non-combustable items.
• In one upstairs storage area – professional advice has been sought on the smell noticed on inspection. This will be resolved by fitting the appropriate valve on an open vent.
• An unused locking mechanism on one residents' storage area door will be removed.
[Overall completion date: 30 September 2025]

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies. This will be ensured by:

• One resident's request to spend time alone in the DC has been formally risk assessed, with this risk assessment documented. The resident has also agreed to an additional mitigation to further reduce the associated risk, by wearing a falls-detection watch.
• The replacement of the carpet on the stairs as per OT recomendations is in progress, and will be completed during residents' current break away at his family home, prior to his return to the DC.
• Outstanding and refresher trainng for staff in falls prevention and management will be completed by 05/09/2025.
[Overall completion date: 15 September 2025]

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services. This will be ensured by:
• The inspection and testing of the fire-fighting equipment has been completed.
• The non-personal items stored in storage areas located within resident's rooms have been cleared out; and residents have been consulted in the use of these storage areas.
• The thrid communal storage space under the attic has also been cleared of combustable items, and items no longer required or in use within the DC.
• The third storage area beneath the stairwell within a residents bedroom has been confirmed to be of solid construction and is fire proofed.
• Fire-doors in all apartments will be reviewed to ensure they are closing freely; and remedial action will be taken where required to rectify any that are not.
[Overall completion date: 15 September 2025]

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines in particular controlled drugs (in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988 (S.I. No. 328 of 1988), as amended). This will be ensured by:

• A separate key-box will be installed to ensure secure storage of the keys for the controlled drugs press. All other actions arising from medicines management specific audit have been completed.
• Medication management risk assessment has been reviewed to identify additional necessary mitigations including – change of medication count time in line with change of shift, confirming a date/ time for additional count on collection of new supply of medication, and ordering of new, more accessible controlled drug register recording book.
• Above additional mitigations will be discussed with the team at their next scheduled team meeting, to ensure all staff are consistent in their record keeping in the controlled drug register.

[Overall completion date: 08 October 2025]

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 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	31/10/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2025
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2025
Regulation 21(3)	Records kept in accordance with this section and set out in Schedule 3 shall be retained for a period of not less than 7 years after the resident has ceased to reside in the	Substantially Compliant	Yellow	05/09/2025

	designated centre.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/09/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	15/09/2025
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	15/09/2025
Regulation 29(4)(d)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal	Substantially Compliant	Yellow	08/10/2025

	and administration of medicines to ensure that storage and disposal of out of date. unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988 (S.I. No. 328 of 1988), as amended.			