



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

## Issued by the Chief Inspector

Name of designated centre:	Glenrowan House
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	08 December 2025
Centre ID:	OSV-0008764
Fieldwork ID:	MON-0044311

## About the designated centre

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

Glenrowan House is located in a rural location, not far from a large town. The centre is a two storey detached house that can accommodate up to five residents, both male and female. As part of the centre, there is an annex that is joined to the main house that comprises one resident bedroom, living area and bathroom. This can be accessed from the main house through an internal door and it also has it's own back door for private entry. This can facilitate one resident with their own separate living space, with the main house accommodating four resident bedrooms, two upstairs and two downstairs. Glenrowan House provides 24 hour high support residential for young adults with an intellectual disability and/or autism who may also display behaviours of concern. Care and support is provided to residents with a dual diagnosis of mental ill health and a variety of conditions such as epilepsy, visual impairment, medical conditions and physical disabilities. Residents are supported by a team of registered intellectual disability nurses and healthcare assistants. The service has a vehicle to support residents to access their local community.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	4
--	---

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
Monday 8 December 2025	13:45hrs to 19:25hrs	Angela McCormack	Lead

## What residents told us and what inspectors observed

Glenrowan House designated centre was found to provide person-centred and safe care and support to residents. Residents were supported to make everyday choices in their lives and to do activities that were meaningful to them.

This inspection was an unannounced inspection and was completed to monitor the provider's compliance with the regulations. The inspection was completed over one evening. The inspector provided the centre with a document called 'Nice to Meet You' that inspectors use to help to introduce themselves and explain the purpose of their visit. This was given to a staff member on the inspector's arrival so that residents could be informed of the inspector's visit, on their return home from their day activities.

Glenrowan House could accommodate five residents. At the time of the inspection, there were four residents living in the centre. One resident had sadly died in October 2025. There were no plans for any other resident to move in at this time. The centre comprised a two storey detached house. It also included a self contained annex attached to the main house that included a kitchen/living area, bathroom and bedroom. All four residents were accommodated in the main house. Residents had moved to the centre between June and September 2025. Staff spoken with said that in general residents had settled well into their new home. .

All residents attended an external day service for set days throughout the week. The inspector met with all four residents during the evening after their return from their day service. Residents were observed relaxing in the various communal areas and doing activities of interest. For example, one resident who had an interest in technology was observed watching items of interest on their laptop in the sitting room on return from their day service. Another resident was observed relaxing with a staff member watching a music show on television. The living space was designed to support residents' interests and provided comfortable areas for residents to relax and have downtime pursuing their individual interests.

Residents communicated with the inspector in their own way, by smiling, shaking hands and through verbal means with support from staff members. When asked, residents acknowledged that they liked their home and were happy there. One resident showed the inspector a photograph taken of them on a recent trip away and were observed requesting of a staff member that this framed picture be placed in the hallway. All residents went for a four night break together to a camping village in Ireland, in November 2025. Staff spoken with talked about how residents were supported prior to the holiday through various means including the use of social stories, objects of reference and doing a visual countdown of the days. It was reported that the holiday was a great success and that residents appeared to really

enjoy this. The inspector was informed that for some residents this was their first time going on an overnight holiday since they started living in residential care.

Three residents lived together in another designated centre prior to their move to Glenrowan House. Transition plans reviewed showed how residents were supported to transition safely to their new home in Glenrowan House. One other resident moved into the centre in September 2025. The compatibility of residents had been reviewed prior to the moves, and the inspector was informed that overall all residents had settled in well to their new home. The inspector was informed that residents were planning a Christmas party in their home to mark their first Christmas together, where families would be invited.

The premises itself was beautifully decorated, clean, warm and spacious for the numbers and needs of residents. Residents had spacious bedrooms which were designed and decorated with items of personal interest. Three residents had en-suite facilities with communal bathrooms also available. One resident had a small living area adjacent to their bedroom for their sole use. The communal areas were spacious and well designed to allow residents spend time together or relaxing alone if they wished.

The centre appeared well resourced, with the number of staff and vehicles to support residents with their needs. A number of staff members had moved with residents to the centre as they transitioned to their new homes. This helped to ensure continuity of care at this time. There were also staff members recruited since the move, some of whom had started over the previous two months. Staff spoken with were familiar with residents' needs and spoke about the induction that they received prior to working with residents directly. One staff member who was completing their first shift on the day of inspection, appeared very knowledgeable about residents needs, which they had learned through the days of their induction. This demonstrated that a comprehensive induction programme was in place for new staff members.

Overall, the inspector found that residents were supported with their needs and were provided with a person-centred service.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service provided.

## Capacity and capability

This inspection found that there were good arrangements for the management, and oversight, of the care provided in the centre. However, some areas for improvement were required. These related to fire safety and gaps in training and documentation.

The person in charge was supported in the operational management of the centre by a clinical nurse manager 1 (CNM1) and clinical nurse manager 2 (CNM2). The inspection was facilitated by the CNM2. The systems for the monitoring and oversight of the centre included regular audits completed by the management team and unannounced visits completed by a provider representative.

The centre was found to be resourced to meet the current needs of residents. The numbers and skill mix of staff consisted of nurses and healthcare assistants, and included two staff doing waking night shifts each night.

Overall, the centre was found to be well managed and monitored to ensure that the service was safe and met residents' needs.

### Regulation 15: Staffing

The staffing arrangements in the centre, including the skill mix and numbers of staff, were found to meet residents' needs.

The inspector reviewed the planned and actual rosters for the weeks between 03 November and 07 December. The rosters were well maintained and reflected the staffing arrangements on the day of inspection. There were four staff on duty throughout the day and two waking staff on duty each night. This was found to meet the needs of residents at this time. While there were some temporary staff members used to cover shifts, these staff members were regular staff which helped to ensure consistency of care provided to residents. There was one vacancy for a staff nurse that was reported to be in progress for completion.

Staff files were not reviewed on this inspection.

Judgment: Compliant

### Regulation 23: Governance and management

Overall there were good arrangements for the management, and the oversight, of the care and support provided in the centre. There was a clear governance structure, with roles and responsibilities defined for the various members of the management team. However, the following was found;

- There were gaps in the monitoring and maintenance of staff training records found. For example, it was not known if one staff member had completed safeguarding training until the inspector asked about this. It was later confirmed that the staff member had completed the training, however the record was not in place prior to the inspection.

- There were gaps in the documentation with regard to safeguarding plans. For example, the formal safeguarding plan agreed following an incident that occurred in October 2025 was not printed and available for review on the day of inspection.
- An action was identified at the provider's visit in September 2025 relating to the completion of a built in wardrobe for one resident, with the date for completion identified for 31 October 2025. However, this time frame was not met. The inspector was informed that this was at the stage of seeking quotations and it was hoped that this would be completed over the coming weeks. Actions and time frames identified in audits required improved oversight, so that actions were completed in a timely manner.

Notwithstanding that, this inspection found that residents were protected and consulted about the centre and their lives. The management team carried out audits throughout the year to monitor the safety and quality of care provided. The inspector reviewed the audit folder for 2025, where it could be seen that the schedule for audits in safeguarding, complaints, restrictive practices, fire safety and health and safety were completed as required. In addition, incidents that occurred in the centre were trended and reviewed at team meetings. For example, the inspector reviewed two team meeting records of meetings that occurred in September and October 2025, where it could be seen that incidents, staff training and safeguarding were discussed. In addition, these minutes showed that staff members could raise any issues of concern that they had.

Judgment: Substantially compliant

### Regulation 24: Admissions and contract for the provision of services

The admission of residents to Glenrowan House was found to be safe, transparent and planned in collaboration with residents, their representatives, and the multidisciplinary team (MDT).

A sample of two residents' transition plans and contracts for the provision of care were reviewed by the inspector. From this review, the inspector could see that residents were supported prior to, and during their transition to Glenrowan House. This included visiting the house and choosing bedrooms and furniture. In addition, the two contracts of care that were reviewed by the inspector showed that residents were provided with clear information about the fees to be charged and what the charges covered. These were signed as agreed by residents.

Judgment: Compliant

### Regulation 34: Complaints procedure

The inspector reviewed the provider's policies where it could be seen that there were clear arrangements in place for the receipt and management of complaints in the centre. Complaints were found to be recorded and followed up in line with the procedures.

The procedures were up-to-date and outlined the arrangements for dealing with complaints, including who the nominated complaints officer was and how to appeal the outcome of a complaint. This was also available to residents in an easy-to-read version.

There were no open complaints at the time of inspection. There were two complaints made by a resident during August and September 2025. The inspector reviewed these complaints and could see that they were followed up and resolved to the satisfaction of the resident affected. This showed that the system in place for the management of complaints was followed and was effective in addressing areas of dissatisfaction expressed by residents. In addition, the annual audit schedule for monitoring the centre by the management team included a quarterly review of complaints. This demonstrated good oversight in ensuring that complaints are responded to within the time frames outlined in the provider's procedures.

Judgment: Compliant

## Quality and safety

Glenrowan House provided good quality care and support to residents. Residents' wellbeing, safety and protection were promoted. However, improvements were required in fire training for temporary staff and fire drills. This will be elaborated on under Regulation 28: Fire precautions.

The person in charge ensured that all residents had assessments completed of their health, personal and social care needs. Care plans were developed following residents' move to Glenrowan House. These reflected individual residents' care and support needs in their new home. Residents had access to MDT supports where required.

Residents' wellbeing and general development was promoted. Residents were supported to do activities that were meaningful to them. In addition, residents had opportunities to try out new experiences. Furthermore, residents were supported in line with their communication needs to prepare and be informed about proposed plans so that they could make informed choices.

In summary, Glenrowan House provided high quality, person-centred care to residents.

## Regulation 10: Communication

The centre promoted a total communication approach in supporting residents with their communication preferences.

Residents communicated through a variety of means, such as verbal communication, gestures, Lamh signs, pictures and the use of objects of reference. In addition, residents were supported to try other augmented communication methods, such as a device called a 'quick talker' and talking mats.

The inspector reviewed two residents' support plans. These plans outlined residents' preferred communications and described what individual communications meant. This helped to ensure that residents' communication preferences were known to staff members supporting them.

Staff were observed communicating with residents in line with their care plans throughout the inspection. In addition, residents had access to laptops, SMART televisions, mobile phones, and the Internet, in line with their individual choices. One resident was observed spending time on their laptop and using headphones to listen to music, throughout the evening.

Judgment: Compliant

## Regulation 13: General welfare and development

Glenrowan House supported residents with the development of skills and personal wellbeing, where residents were supported to do activities that were meaningful to them and that met their general welfare and developmental needs.

All four residents attended an external day service throughout the week. In addition, residents had access to leisure and recreational activities in their home, such as jigsaws, arts and crafts and using the Internet to watch music videos for example.

Residents were also supported to maintain contact with their families and friends. Some residents enjoyed visits to family members and some residents met up with family members regularly. For example, the inspector was informed that one resident met up with a family member regularly to go swimming.

Residents also enjoyed a range of activities and interests outside their home. These included going to the local library, bowling, going to the cinema and going on day trips to amenities of interest to them. Residents went on a four night holiday together in November 2025, where the inspector was informed that residents enjoyed this new experience. This all supported residents' overall wellbeing and

development, through the provision of stimulating, interesting, individual activities and new experiences.

Judgment: Compliant

### Regulation 17: Premises

Glenrowan House was found to be suitable to meet the needs and numbers of residents. Four residents lived in the main house, which was spacious and well maintained. There was an annex attached to the main house that could accommodate one resident and allow them to have their own living space. This was vacant at the time of inspection.

Bedrooms were observed to be spacious and included storage space for residents to keep their personal items. One resident was in the process of getting a wardrobe for their bedroom. Residents who required aids and appliances had these in place. There were suitable facilities for cooking and for doing laundry. In addition, there were communal rooms and areas for residents to receive visitors and to relax together or alone, if they wished.

Judgment: Compliant

### Regulation 28: Fire precautions

The centre had good arrangements for fire precautions, including fire containment measures, an alert system and fire fighting equipment. Residents had up to date personal emergency evacuation plans (PEEPS) and a number of fire drills had been completed. However, the following was found;

- A fire drill to reflect the scenario of minimum staff working with the maximum number of residents had yet to be completed. This was required to ensure that residents could be evacuated to safe location in the event of a fire, when there were two staff members working.
- A review of the training matrix by the inspector found that five temporary staff did not have the provider's mandatory fire training completed. However, these staff did not work alone and their induction to the service covered the centre's fire arrangements. This reduced the risk to residents; however the timely completion of the provider's mandatory training was required.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

Residents' personal plans had been reviewed and updated based on a comprehensive assessment of their needs, since their move to Glenrowan House. These plans included MDT input, as required.

The inspector reviewed a sample of two residents' personal plans and assessments of needs, from where it was seen that up to date care plans were in place to guide staff in the supports required. These included; personal and intimate care plans, behaviour support plans, health related plans, and communication plans.

In addition, residents were supported to achieve meaningful, personal goals for the future. A sample of two residents' person-centred plans were reviewed by the inspector, where it could be seen that goals were kept under review so that they were achieved in a reasonable time frame. In addition, the plans reviewed were accessible to residents and included easy-to-read language and photographs. Residents' annual review meetings were completed, two of which were reviewed by the inspector, which showed participation by residents and their representatives as relevant.

Judgment: Compliant

## Regulation 7: Positive behavioural support

There were good arrangements in place for supporting residents with behaviours and feelings of distress. These were underpinned by the provider's policies and procedures for behaviour support and for restrictive practices, both of which were available and reviewed by the inspector.

Two supports plans for behaviour and stress reduction were reviewed by the inspector. These were found to provide clear guidelines to staff members on how to best support residents. Staff spoken with were found to be knowledgeable about the specific supports that residents required. Support plans were developed with input from MDT. It was evident through the documentation reviewed by the inspector and through discussions with staff members, that every effort was made to support residents at times of distress and that effective communication and offers of choice were key components of positively supporting residents.

There was ongoing monitoring of restrictive practices in use in the centre. The inspector reviewed two residents' support plans and assessments, and found the restrictions used were assessed and were based on risks to the health and safety of residents. In addition, there were protocols in place that provided clear rationales on their use. This ensured that restrictions were used appropriately and as a last resort to reduce risks of harm.

Judgment: Compliant

## Regulation 8: Protection

The protection of residents was promoted in Glenrowan House. Incidents that were possible protection issues were screened in line with the safeguarding procedures and every effort was made to ensure residents felt safe in their home.

The provider had policies and procedures for safeguarding and intimate care, both of which were available in the centre and reviewed by the inspector. The inspector reviewed two care plans and found that supports required by residents in the area of intimate and personal care were clearly documented to guide staff.

There were seven possible protection concerns since July 2025, all of which had been notified to the Chief Inspector as required. The inspector reviewed the safeguarding folder and could see that all incidents were screened in line with the safeguarding procedures. However, there were gaps in the documentation held, as the formal safeguarding arising from one incident was not available for review. Despite that residents were found to be protected and it was clear from documentation reviewed that the plan had been formulated, however was not available on the day of inspection. This is covered under Regulation 23: Governance and management and relates to gaps in documentation.

The inspector reviewed two staff meetings that occurred since July 2025, and saw that safeguarding was discussed at these meetings. A staff spoken with was aware of the safeguarding procedures and what to do if a concern arose. In addition, safeguarding was an agenda topic for discussion at residents' meetings.

Incidents were kept under review and trends identified. With regard to the protection concerns since July 2025, the inspector was informed that these primarily related to residents adjusting to their new home, and that incidents had reduced overall as residents settled into their new environment.

Judgment: Compliant

## Regulation 9: Residents' rights

The service provided in Glenrowan House was found to promote residents' rights, and respected their individuality and unique personalities.

This could be seen through the care plans reviewed by the inspector and the language used in various reports. It was also evident through discussions with staff

members and observations throughout the inspection that residents were treated with respect and had the autonomy to make choices in their lives.

Residents were consulted about their lives and were supported to identify goals that they would like to achieve in the future. The inspector reviewed two residents' personal-centred plans where it could be seen that residents were supported make choices and pursue activities that they were interested in. For example, going to music festivals, concerts, and going on holidays.

The inspector also reviewed four residents' meetings that occurred between November and December 2025, where it could be seen that residents were given information about the service and where they had opportunities to choose activities and meals. Residents had access to easy-to-read documents that included information about rights and advocacy services.

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
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
<b>Quality and safety</b>	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

# Compliance Plan for Glenrowan House OSV-0008764

Inspection ID: MON-0044311

Date of inspection: 08/12/2025

## Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

## Section 1

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

### Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>Person in Charge and Clinical Nurse Manager 2 to review the training folders to ensure all certificates are in place . Date for completed 12.01.2026</p> <p>Person in Charge and Clinical Nurse Manager 2 will provide a copy of indivudal training analysis to each staff member with deadline to complete same. Date completed 08.01.2026</p> <p>Person in Charge and Clinical Nurse Manager 2 has ensured all formal safeguarding plans are available onsite. Date completed: 09/12/25.</p> <p>Clinical Nurse Manager 2 has scheduled for a company to install wardrobe in resident's bedroom. Date completed: 09/01/2026</p> <p>Resident will be supported in choosing design of wardrobe for their bedroom. They will be supported using visual aids as per their communication passport. Date completed: 09/01/2026</p> <p>Wardrobe will be installed in resident's bedroom. Date for completion: 08/02/26  </p>	
Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <p>A fire drill evacuation has been completed which reflects a scenario of minimum staff working with maximum number of residents. Date completed: 30/12/25</p> <p>Person in Charge and Clinical Nurse Manager 2 will review training matrix and ensure all temporary staff have completed fire training. Date completed 13.01.2026.</p>	

## Section 2:

### Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	08/02/2026
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements	Substantially Compliant	Yellow	13/01/2026

	for the evacuation of residents.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/12/2025