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:	Sandpiper 2
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	22 August 2025
Centre ID:	OSV-0004830
Fieldwork ID:	MON-0047938

About the designated centre

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

Sandpiper 2 is a residential service providing full time care for up to ten adult men and women, with intellectual disabilities. The centre comprises of three residences located in the environs of a large town. The three houses are located in residential areas with access to local shops and amenities. The houses are two-storey with gardens at the rear of each house. The houses have been adapted to suit the needs of the current residents. Two residents live in one house with staff support. Three residents live in another house with the support and space required for their assessed needs. The third house supports three residents in the main house and has an adjoining self-contained single level area that can support the needs of one resident. Residents have access to transport and the service is provided through a social care model of support. Residents regularly attend day services outside of the designated centre. Residents are not usually present in the centre between 9am – 4pm Monday to Friday. Residents are supported by social care staff during the day, with a sleep over staff at night time in each of the houses. The multi - disciplinary team are available to support the needs of the residents. Individuals are supported to access other services such as GP, consultant services and chiropody as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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
Friday 22 August 2025	10:30hrs to 19:10hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

From what the inspector observed and from speaking with residents and staff, residents living in this centre for the most part being offered a good quality service tailored to their individual needs and preferences. Significant improvements had taken place for some residents in relation to the premises where they received their service. Efforts were being made to provide a service that was safe and effective for residents. However, this inspection found that staff and management inconsistency were impacting on the overall quality of service being delivered and some improvements were required in relation to governance and management, notification of incidents, fire precautions and personal planning.

The centre is comprised of three premises. Since the previous inspection a new premises had been added to the footprint of the centre, and an older premises removed also by applications to vary submitted by the provider. Some refurbishments had been completed in another of the premises also. All three of the premises are located in urban housing developments in a city. Residents have access to local amenities such as shopping centres, supermarkets, cinemas, and recreational facilities. All premises visited during this centre were seen to be clean and reasonably well maintained, although one was due to have some general upkeep and maintenance works completed once a resident had transitioned out. All residents had their own bedrooms, personalised according to their individual tastes. Communal areas were homely and there were numerous pictures of residents on display and televisions were located in all communal areas.

This centre is registered to provide supports to ten adults. At the time of this inspection, nine residents were living in the centre and there was one vacancy. One resident was due to move out of the centre in the weeks following the inspection also. This was an unannounced risk based inspection completed over one day. As part of this inspection the inspector met with residents and staff and observed some residents in their homes. Some residents were attending day services when the inspector visited their home and one resident was in hospital and the inspector did not have an opportunity to meet with all of these residents on this occasion. A review of a selection of relevant documentation was also completed.

The inspector met with or observed five residents during the inspection. Some residents chose not to interact at length with the inspector and did not respond to all of the inspectors questions and their wishes were respected. Some residents showed the inspector their bedrooms or around their home. Residents told the inspector that they felt safe in their home and told the inspector that they liked the staff that worked with them. Three of these residents had moved into a new home since the previous inspection and told the inspector about this. These residents presented as content with their new living arrangements are were very proud of their new home, and seen to be comfortable to move around freely and enjoy the facilities available to them. Positive and respectful interactions were observed

between residents and the staff supporting them during the inspection and residents appeared comfortable in the presence of the staff present in the centre.

In total, the inspector met four staff members, including some additional staff recruited from an agency to provide supports during day service hours that facilitated one resident to remain in their home during these periods in line with their changing needs. Some of these interactions were brief but the inspector had an opportunity to interview two of these individuals. The named person in charge was unavailable at the time of this inspection. However, a person in charge who had been absent from their role since February 2024 was in the process of returning to the role and made themselves available to facilitate the inspection. Some family members were also met with briefly when they were visiting a resident, although they opted not to meet with the inspector privately.

The provider had submitted applications to vary the footprint of the centre since the previous inspection to reflect a number of premises changes that had occurred. The first premises visited by the inspector had been refurbished and works that had been ongoing at the times of the previous inspection of this centre had been completed. There were no residents present at the time of the inspectors visit. Residents had moved back into their home, following a period spent living in another designated centre to facilitate these works. The inspector completed a walk-around of this premises and the adjoining self-contained apartment and saw that these premises offered a very good standard of accommodation to residents and had taken into account the needs of the residents intended to be accommodated there. The apartment was vacant at the time of this inspection and consideration had been given to potential impact of a new resident moving in on the current residents in this house. Steps had been taken to reduce this impact, such as a dedicated walkway and entrance separate to the main house.

A second premises was visited in the afternoon and the inspector had an opportunity to meet with both residents in this centre in the time spent there. One resident was supported to remain at home during the day and two staff members, one provided by a home-care agency, were present with this resident. This resident was observed enjoying a home-cooked lunch. This resident was very welcoming, offered the inspector a cup of tea, and interacted with the inspector at periods throughout the day. The second premises visited had existing fire containment and fire alarm systems in place but was not as modern as the other two premises and at the time of this inspection the provider had identified that this premises was not fully suitable to meet the changing needs of one resident living there. This resident now required the use of mobility and manual handling equipment and the premises did not offer the space required for this type of equipment. There were plans for this resident to transition to another of the providers' designated centres that would be better suited to meet this residents current and future needs. The inspector was informed in the weeks following this inspection that this transition had taken place. The inspector was told by the returning person in charge that the provider intended to carry out some refurbishment of the premises following this transition.

Residents that had been living in another part of the centre during the previous inspection had also moved into a new home and this was visited on the evening of

the inspection. This was a three storey new build property and offered a very high standard of accommodation to the three residents living there. All areas of the house were spacious with ample natural lighting. Both this premises and the newly refurbished premises were seen to have fire doors and modern fire alarm systems installed in line with the providers plans to bring the centre fully into compliance with fire regulations. All three residents were present in this house when the inspector visited in the evening after residents had returned from day services, although they choose not to interact at length with the inspector. They did communicate however that they loved their new home and it was clear that they were very proud of it. Some residents enjoyed staying in their home independently for periods of time and while the inspector was present, the staff member working here and one resident left the house to collect a Friday evening takeaway at the request of residents.

Residents met with told the inspector they liked their homes. A resident showed the inspector her bedroom in one house and other residents consented to the inspector viewing their homes. One resident told the inspector that there had been no transport available to bring them to mass on the previous Sunday but they had been out for tea and a bun at the weekend. The inspector spoke with staff about this and was told that arrangements had been made for this resident to attend mass with a friend, who the resident also spoke about during this visit.

Overall, this inspection found that the provider had made progress with their efforts to bring the premises that made up this centre into compliance with the regulations relating to fire precautions in this centre. However, some inconsistency among the staff team, numerous management changes and the remit of the management team in the centre had contributed to some instances where full oversight had not been maintained and this had the potential to impact on the providers' ability to provide residents with safe and person centred services that met their assessed needs. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

While overall, this inspection found that the day-to-day services being provided to residents were good quality and appropriate to meet residents' needs, local management systems in place in this centre at the time of this inspection had not fully ensured that oversight could be maintained of all aspects of the service. Efforts had been made by the provider to address ongoing non compliance related to fire safety precautions and at the time of this inspection, all parts of the centre were fitted with fire doors and appropriate alarm systems, although some issues were identified in relation to the information available around the evacuation of residents.

Other issues were identified also in relation to the notification of incidents and the consistency of staff in one area.

The last inspection of this centre took place in July 2023 and since then a number of changes had occurred. One premises had been added to the footprint through an application to vary to allow for three residents to transition into a new home. Another premises was subsequently removed on the renewal of registration of the centre in December 2023 and some refurbishment works had also been completed on another premises. This unannounced risk based inspection was carried to assess ongoing compliance with the regulations and to review these changes.

There was a clear reporting structure present in the centre. The person in charge, an area manager, was supported by front line staff and a team leader. The person in charge reported to the Acting Head of Community Services, who reported to the Director of Services. They in turn reported to a Chief Executive who reported to a board of directors. An individual appointed as person in charge of the centre had been absent since May 2024 and this individual was about to recommence duties in the centre at the time of this inspection and was present at the time of the inspection in their capacity as area manager for the service.

In the interim period there had been two changes of person in charge notified to the Chief Inspector, the most recent of these in January 2025. While the provider had appointed an appropriately qualified and experienced person in charge to cover this absence for this period, these individuals had a very large remit including person in charge and person participating in the management of other designated centres under the remit of the provider. The findings of this inspection indicated that this had impacted on these individuals' ability to provide full oversight across all aspects of the service. For example, quarterly notifications had not been submitted by the provider to the Chief Inspector as required and some documentation oversights had the potential to impact on resident safety and personal planning as outlined under Regulations 28 and 5. Also, some information was not readily available to the inspector during the inspection despite the best efforts of the individual who facilitated the inspection. Staff also reported issues with the wifi in some areas of the centre and reported that this could make it difficult to update documentation stored on a central drive in a timely manner. While it is acknowledged that there were some members of the management team unexpectedly unavailable on the day of this unannounced inspection and this likely impacted on this, this did indicate that the provider had not maintained full oversight of the centre during absences of key management personnel.

At the time of this inspection, the 'absent' person in charge was present and told the inspector that they were returning to the role and were due to complete an induction to the service on the week of the inspection, but that this had not fully occurred yet due to unforeseen circumstances. However, this individual also held a very large remit within their role for the provider and told the inspector that they would have responsibility for two designated centres, an area manager role with responsibility for a respite service and a large day service. Team leaders were in place in both designated centres to support the person in charge in their role. The returning person in charge told the inspector that they had escalated concerns in

relation to their remit and had met with the Acting Head of Services about this. They had also attended a meeting to discuss the staffing complement in the service and since that two staff had been allocated to provide for continuity of care for residents in one house and cover two long term leave vacancies.

The inspector interviewed two staff members working in the centre. Staff spoke about a number of management changes that had occurred in the centre within the previous two years. They told the inspector they felt the residents living in the house they worked in had a good quality of life and reported that the provider was responsive to concerns raised. For example, staff had reported difficulties in managing the changing needs of one resident and the provider had put in place additional staffing to support the existing staff team.

Overall, this inspection found that there was evidence of areas of good practice but also evidence of slippage in relation to compliance with the regulations in this centre. This meant for the most part, the providers structures and a committed core staff team were contributing to the efforts to ensure that residents were being afforded safe and person centred services, but that some improvements were required. The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

The registered provider was ensuring that the number of staff was appropriate to the number and assessed needs of residents, the statement of purpose and the size and layout of the designated centre. However, some issues were identified in relation to the consistency of staff in one area of the centre. The provider had taken into account residents' changing needs and provided additional staffing where required, including additional day support and waking night staff in one area of the centre. Some of the staffing in place was unfunded but the provider had committed to ensuring this remained in place for the safety and well-being of residents.

Residents in each house were supported by staff teams consisting of social care workers and support workers. Four residents were supported by one staff by day and a sleepover staff by night in one location. In the second location, three residents are supported by one staff member by day and a sleepover staff member by night. In the third location two residents were supported by two staff by day and two waking staff members by night and additional support hours were in place to allow for one resident to be active in the community as the second resident required two staff to be present for personal care. In this area, one of these staff was additional to the regular centre roster and was allocated from another agency care provider on a 24 hour basis until a planned transition occurred for one resident.

A sample of the staff roster over a six week period was reviewed by the inspector. This showed that staffing levels were appropriate to the number and assessed needs of the residents living in the centre and were maintained at the levels outlined in the

centre's statement of purpose. The centre was staffed by a core team of suitably skilled staff and rosters showed efforts being made to provide a consistent staff team to provide continuity of care for residents, but that this was not fully in place at the time of this inspection for one location in particular.

- In one unit, staffed by 2 Social Care workers (opposite shifts) on a sleepover shift Monday to Thursday and full weekend shift including sleepovers from Friday to Monday, both social care workers were on long term leave and these shifts were being covered by relief staff. This meant that there were no permanent consistent staff allocated to this area. The rosters reviewed indicated some efforts to allocate regular relief staff to this area if possible.

The returning person in charge told the inspector that inconsistency of staff was a concern in this area but that this had been escalated and discussed with management on the week of the inspection and that two specific staff had been allocated to the centre to cover these shifts to address this.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had ensured that the designated centre was resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. The provider had ensured that there was a clearly defined management structure in the designated centre and an annual review of the quality and safety of care and support had been completed. However, the management systems in place had not fully ensured that that the service provided is safe, consistent and effectively monitored.

Staffing levels in the centre were seen to be able to provider for the care needs of residents and additional staffing had been provided to cater for one residents' changing needs. The provider had made changes to the footprint of the centre that provided for a better standard of accommodation for most residents. Prior to the renewal of registration of this centre, there had been ongoing non compliance in relation to Regulation 28 in this centre. However, the provider had completed the plans that were in place to bring the centre into compliance with this regulation and following a premises change for one cohort of residents and upgrades to another premises, all three premises accommodating residents had appropriate fire containment and alarm systems in place. Some issues in relation to the documentation and practice around fire precautions were identified as will be outlined under Regulation 28.

An annual review had been completed in respect of the centre for the previous year and the inspector reviewed this document. This included consultation with residents and their family members. Unannounced six-monthly visits were being conducted by a representative of the provider and a report on one of these carried out in January

2025 was reviewed, with the inspector told that another visit had taken place in July but that the report was not yet available. There was some evidence that the action plans arising from these unannounced visits were not being completed in full. For example, the report dated February 2025 highlighted an issue in relation to the submission of quarterly notifications to the chief inspector and included an action in relation to this. However, this had not been completed and this inspection found that these notifications had not been submitted for almost a year. These were subsequently submitted retrospectively in the weeks following this inspection.

Staff team meeting records were viewed in one house in the centre. The folder reviewed documented that the last team meeting took place in March 2025 and that January and February 2025 team meetings had been cancelled due to leave arrangements. The team meeting minutes reviewed indicated that staff had been informed of safeguarding procedure changes and that discussion had taken place in relation to personal planning, finances and medication management.

There was a governance structure in place that set out the lines of accountability within the service. Overall, residents were seen to be offered a good quality service that was responsive to their needs and issues identified concerning the day-to-day care and support of residents were responded to promptly. However, the systems in place did not always mean that the service provided could be effectively monitored and this had the potential to impact on the quality and safety of the services being provided. As discussed in the capacity and capability section of the report the remit of the person in charge appeared to be contributing to challenges in maintaining full oversight of all aspects of the service, indicating that the arrangements in place were not fully effective and were not robust in ensuring continuity of oversight at all times:

- Quarterly notifications had not been submitted for the centre since July 2024 and there was late reporting of an NF06 notification.
- Not all actions arising from the providers audit and review systems had been completed in a timely manner.
- Staff team meetings had not occurred on a regular basis.
- Staffing levels were adequate but inconsistency of staff was prevalent in one area in particular.
- Some documentation was not up-to-date including some personal plans, resident information and risk assessments.
- Full oversight of fire precautions in the centre was not demonstrated-some personal evacuation plans were not in place and fire drill records for 2025 were absent in one area of the centre.

Some of these issues are discussed and addressed in further detail in other sections of this report and it is acknowledged that a change of management was occurring at the time of this inspection following the return of key personnel.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had not notified the chief inspector in writing of any incidents that had occurred in the designated centre. The inspector reviewed the notifications submitted by the provider since the previous inspection and saw that no quarterly notifications or nil return notifications had been submitted as required since July 2024. This included notifications related to minor injuries and the use of restrictive practices in the centre.

An NF06 (any allegation of suspected or confirmed abuse) notification had also not been reported to the Chief Inspector within a three day period as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider had in place a complaints procedure that included easy-to-read guidance in relation to how to make a complaint. This was available to the residents and was viewed by the inspector on display in the centre. When speaking with some of the staff working in the centre, they presented as familiar with the complaints procedures in place. There was evidence that residents and their representatives would be supported to raise issues or concerns and that these concerns would be taken seriously and used to inform ongoing practice in the centre. An example of this is discussed under Regulation 8: Protection. Opportunities to raise complaints were available to residents through regular resident meetings and the inspector saw some of these records also. A sample of five weeks meeting minutes from one area were reviewed and these showed that residents were offered the opportunity to raise complaints and the procedure was discussed with residents. No complaints had been documented as received during these meetings. From speaking with some of the residents, the inspector was satisfied that residents would be comfortable to raise issues or concerns.

Complaints logs were reviewed in two areas of the centre. One area had no complaints logged and another area had one complaint logged. This had been appropriately documented, including details of the complaint and the outcome of the complaint, and was resolved at the time of this inspection.

The two staff interviewed were familiar with the complaints procedures in the centre and one staff member told the inspector about a recent complaint raised on behalf of a resident and how this had been resolved.

Judgment: Compliant

Quality and safety

From what the inspector observed and heard while in the centre, residents in this centre were being well cared for and were living good lives in this centre. The inspector met with some of the residents and staff team during the inspection and there were good indications that a good quality service was being provided to residents and that the provider had put in place arrangements to support residents' changing needs. However, some slippage in relation to compliance with the regulations had occurred since the previous inspection, as mentioned in previous sections of this report. Some issues were found in relation to fire precautions, personal planning, risk management and residents' access to their finances. While, on the whole, there was little evidence to demonstrate that some of these issues had impacted significantly on residents at the time of this inspection, they did have the potential to impact on the ongoing quality and safety of the service being offered to residents.

The provider had completed their plans to replace one premises and refurbish another premises and residents were now living in homes that provided a very good standard of accommodation to them. One residents' needs had changed since the previous inspection and the premises they occupied was no longer fully suitable to meet their needs. The provider had taken steps to assess if the required changes could be made to the existing premises and this was not found to be feasible. There were plans for this resident to transition out of the centre in the weeks following this inspection so that their assessed needs could be fully met in a more suitable premises.

A number of longstanding issues in relation to compliance with the regulation concerning fire precautions had been addressed by the provider through the premises changes that had occurred since the previous inspection. Precautions against the risk of fire had been considered and put in place including fire-fighting equipment, fire doors and fire alarm systems. Arrangements had been made for maintaining fire equipment, reviewing fire precautions, testing fire equipment, detecting, containing and extinguishing fires and giving warning of fires. However, the procedures for evacuating residents in one house were not in place and fire drills in another centre were not able to be located during this inspection. This is outlined under Regulation 28: Fire precautions.

Residents took part in regular house meetings that included information about various topics including rights, health and safety and complaints. Plans were seen to be overall provide good guidance for staff to ensure that residents were appropriately supported, but some issues were identified in relation to the updating and review of person centred planning documentation in the centre. Residents were observed to be active in their community and had transport available to them to attend day services, leisure activities and healthcare appointments. There was evidence of consultation with residents and their representatives on issues relevant to the running of the centre.

Regulation 13: General welfare and development

Overall, the findings of this inspection indicated that the registered provider was providing residents with appropriate care and support, having regard to the nature and extent of residents' disabilities and assessed needs and his or her wishes. The registered provider was providing access to facilities for occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. Residents were seen to be well supported in this centre in line with their assessed needs and wishes. Residents were supported to maintain personal relationships. For example:

- The inspector saw that there was ongoing consideration of changes that occurred for residents. Where the provider had recognised that they were unable to meet the changing needs of one resident and provide fully appropriate support to the resident to meet their ongoing and future needs in the centre, they had put in place alternative arrangements to ensure the resident was well cared for in the interim, and had worked towards sourcing a more suitable placement for the resident.
- The provider was in the process of making arrangements to transition this resident to a new home at the time of this inspection in order to fully meet their assessed needs. In the interim, the provider had made efforts to ensure that this residents needs could be catered for as much as possible in their current home. For example, this resident now required the support of two staff for personal care and transfers. Additional staffing provided by an agency was in place to support the providers' own staff with this during the day and this meant that this resident could remain at home and enjoy a slower pace of life and a personalised service, rather than attending full time day services as they had done previously. Care plans for the management of specific healthcare concerns were noted to be in place and provide good guidance to staff.
- The inspector was also told by the returning person in charge and the staff working in this house about how they were supporting the remaining resident with the changes that would be occurring following this transition and it was evident that this was being carefully considered so that it would have the least impact on the resident.
- A psychology report for one resident dated 11/07/2025 was reviewed and this referred to input from other allied health professionals including speech and language therapy and occupational therapy. This resident had reviewed ten weeks of psychology input recently to support them with their mental health.
- Family visits were facilitated in the centre and the inspector observed that families were comfortable to spend time with their relatives in the centre and that there was good relationships between families and staff and management in the centre.
- Residents were supported to access community based activities and the inspector saw evidence of this in residents' files, photographs on display and from what residents and staff spoke about. Residents had access to full time

day services. Two residents did not attend day services regularly, due to personal preferences or changes to their assessed needs and these residents were facilitated and supported with this.

Judgment: Compliant

Regulation 17: Premises

The registered provider had ensured that the premises was designed and laid out to meet the aims and objectives of the service and the number of residents accommodated. As previously mentioned, the provider had added a new premises to the footprint of the centre, and removed another premises. Substantial renovation works had also been completed in a second premises. The inspector visited all three locations and completed a walk around of the premises that comprised the centre was completed by the inspector. Premises' were observed to be clean, warm and bright throughout on the day of the inspection, and overall communal areas were seen to be homely and welcoming. The new premises and the refurbished premises were seen to offer enhanced, bright, well furnished and modern living spaces for the residents that were accommodated in them.

There was outdoor areas available for the use of residents. Residents had access to laundry and waste facilities also. Resident bedrooms and living areas were seen to be decorated in a manner that reflected the individual preferences of residents and afforded privacy to residents.

This centre was designed to provide a service in community homes for residents who did not have significant mobility needs. While the changing mobility needs of one resident could not be fully accommodated within the current premises that they occupied, there were plans for this resident to transition to another designated centre that was more suitable to meet their needs. Aids and equipment were provided for safe people moving and handling in the interim period. The storage of this equipment did pose some challenges due to the layout and space available in this house but given the impending transition, this was a temporary issue.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had put in place systems for the assessment, management and ongoing review of risk but there was some evidence that this was not fully effective and issue was identified in relation to the review of risk and the updating of documentation. Overall, there were indications that risk was well managed in this centre. Processes and procedures relating to risk were set out in an organisational

risk management policy and this had been reviewed as appropriate. A system was in operation for the recording and review of incidents occurring in the centre.

Some of the practices observed to manage risk included:

- Additional staff including waking night staff were introduced in one area of the centre in response to a residents' changing needs and to facilitate safe manual handling and people moving practices and people moving.
- Missing person plans were viewed in two residents' files and one residents' plan had been updated following an incident that had occurred to reflect learning from this.

However, improvements were required to ensure that the review of documentation in this area was occurring in line with the provider's policy, and to ensure that documentation in place was fully reflective of the measures in place to mitigate against risk. Individualised risk assessments were viewed in residents' files and were reviewed for two residents. A risk assessment in place for one resident in relation to choking was viewed in their file. This had a very high risk rating and there was no evidence that this had been reviewed since September 2024. It was also unclear if this had been escalated to the risk forum in line with the providers' policy. However, there was some evidence observed during the inspection that action had been taken to reduce this risk, including a referral for support in this area from an appropriate allied health professional and staff were observed to follow guidelines in place.

Judgment: Substantially compliant

Regulation 28: Fire precautions

It is acknowledged that since the previous inspection, the provider had completed a plan to ensure that all residents were accommodated in premises that were equipped with up-to-date fire management systems including fire doors and fire alarm systems. However, the registered provider had not ensured, by means of fire safety management and fire drills at suitable intervals, that staff and, is so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. The person in charge had not ensured that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.

- Personal emergency evacuation plans for four residents living in this house were not able to be located at the time of this inspection. This meant that all staff did not have up-to-date information available to them about supporting these residents to evacuate in the event of an outbreak of fire or other emergency scenario. While records viewed showed that residents in this house had taken part in successful fire drills recently, this house was being staffed solely by relief staff at the time of this inspection and this meant that

all staff would not be familiar with these residents or their specific needs in this area. This issue had not been identified prior to the inspection.
- A review of fire drill records in another location showed that a number of drills had taken place in 2024 following the residents move into this house, however no evacuation drill records were located for 2025.
- Some gaps were noted in the daily fire checks being completed in a part of the designated centre that was staffed by relief staff at the time of the inspection.
- Some gaps were noted by the inspector under fire doors in two premises. These required review by a competent professional to ensure that these fire doors were operating correctly and would offer effective protection in containing fire and smoke in the event of an outbreak of fire.

Personal emergency evacuation plans were put in place by the returning person in charge on the day of the inspection, once they were made aware of this issue, and the inspector was informed that fire drills had also been carried out in all locations following the inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed four residents' files and personal plans during this inspection. The person in charge had ensured that an annual assessment of need had been completed for residents and overall the registered provider had arrangements in place to meet the assessed needs of the residents living in this centre. Personal plans were in place that, for the most part, reflected residents' assessed needs and outlined the supports required by residents.

For example, the inspector saw details of multidisciplinary team reviews completed in the sample of residents' files reviewed and these included input from a number of health and social care professionals. There was evidence of good healthcare supports being provided, including access to screening programmes and mental health supports. Overall, support plans in place for residents were comprehensive and the inspectors' observations during this inspection indicated that staff were familiar with and followed the guidance contained in these.

However, the inspector reviewed information in a plan in place for one resident that had not been fully updated to reflect changes that had taken place for them. This resident did not have an up-to-date personal centred plan and had not taken part in personal planning for some time based on the evidence viewed in their personal file. The last recorded efforts made in this area were in February 2024 and while it was recorded that the review of the residents plan had been put on hold pending a medical procedure, there were no clear efforts to resume this process since then.

Three out of the four personal plans viewed contained details of goal setting and there was some evidence that some residents had made progress with or achieved some of the goals they had set, such as to visit Knock or go on a family holiday.

However, some goals did not have evidence of review or timely progression. For example, one resident had a goal to try volunteering. This had been set in March 2025 but no progress was documented at the time of this inspection in August 2025. Another resident had identified priorities as part of preparation for a planning meeting documented in May 2025 but there was no documentation to show that this meeting had taken place and no progress with these goals was indicated.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had arrangements in place to safeguard residents from abuse. A 'National Policy for the Safeguarding of Vulnerable Adults at Risk of Abuse' dated July 2024 was in place and was viewed by the inspector. A designated safeguarding officer was in place if required.

The inspector had an opportunity to speak with a number of different staff across two different staff teams as they went about their day-to-day business during this inspection and interviewed two of these staff. The staff interviewed had a good awareness of the safeguarding procedures that were in place in the centre and were able to tell the inspector what they would do if they had a concern.

Staff spoken with reported that they received safeguarding training including how to identify and report suspected abuse and staff knew who the designated officer for the provider was and where to find their contact details.

Residents spoken with indicated to the inspector that they felt safe in their homes and that they were well cared for by the staff that supported them. One resident indicated it was "alright" when asked if they felt safe in their home but did not provide any context or further detail to this and told the inspector that staff would help them if they had a problem.

Safeguarding measures in place in the centre included the provision two-to-one staffing for a resident that required this support for transfers and personal care. Staff rotas reviewed, observations on the day of this inspection, and discussions with staff indicated that this was usually in place. The intimate care plan in place around this was detailed and provided good guidance to staff.

A number of notifications had been received by the chief inspector from the provider in relation to allegations of suspected or confirmed abuse. One family had raised a concern in relation to a resident not receiving appropriate foot and nail care in the previous year. The information submitted to the chief inspector and the evidence viewed on inspection indicated that the provider had responded seriously and taken

prompt action in relation to this. The inspector viewed records that showed that this resident was now receiving regular input from a chiropodist.

Some other potential concerns had also been notified to the Chief Inspector and the inspector was told by management about the steps the provider had taken to protect residents and initiate a formal investigation into these concerns.

Judgment: Compliant

Regulation 9: Residents' rights

Overall, residents' rights were respected in this centre. However, residents were restricted in accessing their own money in a timely manner on occasion.

There was evidence that residents were consulted with about their day-to-day lives in this centre. For example:

- In one house, the inspector observed residents asking a staff member to collect takeaway for them and saw that residents had chosen different places to eat from and this was facilitated by the staff member on duty. There was also house meetings documented that showed that residents were informed and consulted with about issues that mattered to them.
- Individual service agreements were viewed in a sample of 3 files and separate letters to residents included specific details of charges paid by residents.
- Tenancy agreements were in place for residents and residents had been registered with the residential tenancy board.
- Information relating to ward of court systems was viewed in one residents' personal file.

Overall, residents were supported to exercise choice and control over their daily lives and participate in meaningful activities. Residents were heard to be offered choices in relation to their food and mealtimes. Activities such as shopping, day trips and visiting friends and places of interest were documented in residents' file and the inspector saw photographs and was told by residents about some of the activities they enjoyed.

Residents' access to funds was discussed with the returning person in charge and a staff member during the inspection. Residents did not always have full access to their own money at all times. This meant that residents could not always decide how to spend their own money or had to wait a period of time for access to funds or approval for larger purchases. Due to staff vacancies, some residents were even further impacted by the financial arrangements the provider had in place. For example, in the house staffed by relief staff, sometimes residents were given "loans" from the provider due to no authorised signatories being available to withdraw their

money and this was documented in resident information viewed. This meant that residents could not spend their own money freely and were dependent on specific staffing arrangements being in place to access their own monies.
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 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Sandpiper 2 OSV-0004830

Inspection ID: MON-0047938

Date of inspection: 22/08/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Full-time staff member has returned from their un-scheduled leave in late September. This return will contribute to improved continuity of care and support for residents. • Review of rosters and ongoing recruitment continues to ensure consistent relief where possible to fill vacancies and leave. The recruitment of social care staff is challenging in the current environment of full employment. • To ensure continuity of care and maintain consistent standards during a period of unscheduled leave, a full-time staff member has been temporarily assigned to the area on an interim basis.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A new Person in Charge (PIC) was appointed on a full-time basis to Sandpiper 2 on 30th September 2025. • Bi Monthly team meetings will be scheduled for all staff, with a structured agenda designed to be informative, educational, and task-focused. Regular topics will include fire precautions, updates to personal plans, and other relevant operational matters. • Quarterly notifications were submitted retrospectively by the Area Manager on 21st September 2025 in line with regulatory requirements, during the period in which the PIC position was vacant. Outstanding notifications have been submitted by PIC. • Staffing levels at 75 Cul Crannagh have been stabilised following the return of one full-time staff member and the interim appointment of a second full-time staff member, ensuring continuity of care and consistent service delivery.	

• All personal emergency evacuation plans, previously not present, have now been completed and placed within the house for immediate access. • A revised Fire Drill Record template was circulated to all houses on the 12.10.2025. These records will be reviewed and verified by the PIC during routine site visits to ensure compliance and oversight. • 6 month review meeting scheduled with Area Manager and PIC on receipt of report and reviewed at local management team meeting to ensure all actions are addressed • The Person in Charge (PIC) will ensure that a comprehensive review of all Personal Emergency Evacuation Plans (PEEPs) is completed and updated. Target date for completion: 07.11.2025 • The upcoming quarterly fire drill schedule will be re-issued and clearly displayed in each residence for staff awareness. Target date for completion: 20.10.2025

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • Incident notifications were backdated by the Area Manager following the inspection conducted on 21st September 2025. • Moving forward, the Person in Charge (PIC) for the area will be responsible for monitoring and ensuring that all incident notifications are logged promptly and in a timely manner in line with regulation	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • Risk assessments will be reviewed to ensure that risk ratings accurately reflect the evidence provided. Target date for completion: 07.12.2025 • Missing Person Plans within the area will be reviewed and updated where necessary to ensure accuracy and effectiveness. Target date for completion: 07.11.2025	
Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: • The Person in Charge (PIC) will ensure that a comprehensive review of all Personal Emergency Evacuation Plans (PEEPs) is completed and updated. Target date for completion: 07.11.2025 • The upcoming quarterly fire drill schedule will be re-issued and clearly displayed in each residence for staff awareness. Target date for completion: 20.10.2025 • A team meeting will be organized to review and reinforce fire safety procedures and precautions with all staff. Moreover, this will be an on-going agenda item • The Area Manager has engaged with the Facilities Manager regarding the condition of fire doors in two premises. Target date for completion: 06.11.2025 • As part of regular site visits, the PIC will review the Fire Folder at each premises to ensure there are no gaps in the "Daily Fire Checks" documentation. • The PIC will also ensure that fire evacuation procedures are clearly displayed in a prominent location and are readily accessible to all staff and residents.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • Personal Centred Plans (PCPs) will be reviewed in each residence. Where PCPs are out of date, keyworkers will be supported to recommence the planning process. • A keyworker in Cul Crannagh who has recently returned from extended leave will be supported to initiate the PCP process for their assigned individuals. • PCPs will be included as a standing agenda item at bi-monthly team meetings to ensure continuous review and discussion. • The Person in Charge (PIC) will incorporate regular reviews of Multi-Disciplinary Personal Plans (MPMPs) and will liaise with keyworkers regarding any updates or additional information required. • For PCP goals where no supporting evidence has been identified, the PIC will work collaboratively with keyworkers to update and accurately reflect the current status of each goal. • The risk assessment pertaining to choking has been concluded and closed, as the individual in question has since transitioned out of the centre and is no longer under our care. This information has been shared with the PIC in this individual's new designated centre as part of the transition process.	
Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: • The BOCSILR Policy on the Handling of the Personal Assets of Adults Supported by the Services includes a permission form which supports people to opt in or opt out of support from the BOCSILR in the management of their personal assets. • No resident is restricted from managing their own personal assets if they choose to opt out of support from the BOCSILR. Residents may choose to manage their personal assets independently, with a decision supporter or another person outside of the services should they choose to. • In order to support people to make an informed decision information is provided to them regarding the nature of the support that the BOCSILR can offer to them in terms of the management of their personal assets. • At present the BOCSILR have identified one suitable deposit account and one suitable current account through which support can be offered in a safe manner both for the person supported and for staff. • The BOCSILR Policy on the Handling of the Personal Assets of Adults Supported by the Services clearly sets out the limitations on direct access to personal assets inherent in the use of this type of account in order to ensure full transparency when a person is choosing to opt in or opt out of support. • Every effort is made to mitigate the impact of the restrictions on direct access to personal assets inherent in the use of this type of account and these are set out in the policy. • Limitations on direct access to personal assets inherent in the use of this type of account as well as those in place to minimize the vulnerability to misappropriation of funds are not notified to the regulator as restrictions as each person support has the right to opt in or opt out of support. • As the actions of Banking institutions in response to this demand for type of bank account are outside of the control of the BOCSILR the date for compliance has been reflected as the 31st December 2026 to reflect this reality. • The BOCSILR is committed to exploring all alternative accounts that may facilitate less restrictive direct access to personal assets for people supported who opt in to support from the BOCSILR. In this regard the engagement with the assisted decision making department with the HSE seeking guidance in assisting residents in relation to banking arrangements was commenced on 11/11/2024. Engagement with banking institutions has also been pursued to identify possible suitable banking products that would be a less restrictive alternative for residents within the service. • Inconsistencies in keyworker availability, due to unplanned or extended leave, may have contributed to deviations from the standard financial procedures, including the provision of "loans" rather than following the traditional process. • One individual supported within the area received their new bank card on 02.10.2025.	

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 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	30/11/2025
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	07/11/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Substantially Compliant	Yellow	07/12/2025

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	07/11/2025
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.	Not Compliant	Orange	07/11/2025
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Not Compliant	Orange	07/11/2025
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse	Not Compliant	Orange	21/09/2025

	incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	31/10/2025
Regulation 31(4)	Where no incidents which require to be notified under (1), (2) or (3) have taken place, the registered provider shall notify the chief inspector of this fact on a six monthly basis.	Not Compliant	Orange	31/12/2025
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a	Substantially Compliant	Yellow	31/12/2025

	manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/12/2025
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	31/12/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in	Substantially Compliant	Yellow	31/12/2026

	accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			