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 1
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	24 April 2025
Centre ID:	OSV-0007919
Fieldwork ID:	MON-0045775

About the designated centre

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

Sandpiper 1 is a detached two-storey house located in a housing estate on the outskirts of a city. The centre can provide respite and long-term residential care to those with an intellectual disability. It is registered to accommodate up to five residents, over the age of 18 and of both genders. The centre has a kitchen-dining-living room area, a living room, a relaxation room and five bedrooms for residents' use. Residents are supported by the person in charge, social care works and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Thursday 24 April 2025	10:00hrs to 18:25hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Four residents were present on the day of inspection with all of these met by the inspector. One of these residents indicated that they liked coming to the centre and liked the staff. Staff members on duty were seen to interact warmly with residents.

This centre operated a respite service but, according to the centre's statement of purpose, could also provide long-term support if required. When the inspector arrived to commence the inspection, no residents were present. During an introduction meeting with a member of management, it was subsequently confirmed that no resident was receiving long-term support from the centre and, at the time of this inspection, the centre was being used solely for respite. Those that had been availing of respite the previous night had left the centre shortly before this inspection commenced to attend day services. It was indicated to the inspector though that such residents would be returning to the centre for respite later in the afternoon of the inspection.

As a result, the centre was largely unoccupied for much of the inspection with the inspector using this time to read relevant documentation and review the premises provided. The premises where this centre was operated from at the time of inspection was a large detached house. There were five bedrooms available which could be used by residents. Such bedrooms were seen by the inspector and noted to be well-furnished. For example, each bedroom had a bed, a wardrobe, a television and a lockable storage unit on the wall for medicines or money to be kept in. It was also observed that each resident bedroom had a sign on the door that gave the name of a different centre such as Paris and New York.

Two of the resident bedrooms were located on the ground floor while the premises was also equipped with a lift to support residents with mobility needs. One of the ground floor bedrooms was provided with an en suite bathroom while four other bathrooms were present in the centre. These were all seen and noted to be clean and provided with modern ware. Communal rooms provided within the premises included a living room, a large kitchen-dining-living area and a relaxation room. The general décor and furnishing of such rooms, and the overall premises, was of a good and modern standard. For example, the upstairs hall area had two alcove areas with seating provided. Such features resulted in the centre appearing very homely although keypads were seen on the centre's front door.

Within the centre there was a staff bedroom-office while to the rear of the house was an external office for the person in charge (the external office was registered as being part of the centre). When initially viewing the rear garden area, the inspector observed a small trench along part of edge of the garden area. Within this trench was pipping with some yellow tape present which stated "caution electric cable below". When queried the inspector was informed that cabling led from the house to a rear garden shed and had been installed to enable additional washing and dryer machines to be used (such machines were already present in a utility room within

the house). After the inspector queried this matter, someone arrived at the centre to fill in most, but not all, of this trench.

In the final hours of the inspection, residents began to arrive at the centre for respite. In total four residents were availing of respite on the night of inspection with three of these having been present in the centre the previous day also. All four residents had been attending day services operated by the registered provider. The inspector met one of these residents as they were having a cup of tea and some chocolate fingers in the kitchen-dining-living area. This resident told the inspector about how they had been at day services that day where they received a foot massage. The resident said that they did not come to this centre often but liked it when they did so and liked the staff. When asked what they would be doing later in the day, the resident said that they would have dinner and go a disco then.

This disco was organised on a monthly basis by the provider and all four residents were to attend this. Residents appeared to be excited and looking forward to attending this disco. For example, a second resident met showed the inspector and a member of staff the clothes that they would be wearing when they went to disco. This same resident had earlier introduced themselves to the inspector by shaking his hand and had mentioned that they had been playing basketball while at day services earlier in the day. A third resident met highlighted that they had gone for lunch earlier in the day as part of their day services.

It was apparent that the atmosphere in the centre in the centre while residents was present was jovial and sociable with the staff members present engaging positively with the residents generally. Such interactions included residents being warmly greeted by staff when they arrived at the centre and residents being asked what they wanted for dinner. Staff were seen to sit with residents in the kitchen-dining-living area with residents appearing very comfortable with these staff. The upcoming disco was a regular topic of conversation between staff and residents. Excitement for this disco contributed to the atmosphere encountered by the inspector. Near the end of the inspection, the inspector briefly met the fourth resident who was attending the centre for respite. This resident was seen to smile when the disco was mentioned.

In summary, the four residents present were due to attend to a disco later the day with such residents looking forward to this. This contributed to a positive atmosphere being encountered in the centre with residents also appearing to be comfortable in the presence of the staff on duty. The premises provided for residents in this centre was seen to be well-furnished and homely.

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

An overall good level of compliance as found during this inspection. This indicated that the centre was being appropriately resourced. Some regulatory actions were identified though including relating to an annual review for 2023.

This designated centre was last inspected in August 2023 and previously had its registration renewed for three years in February 2024 when it consisted of one particular house. During the centre's previous registration period, the centre had been subject to regulatory escalation and areas of non-compliance owing to the impact that one resident, who was in receipt of long-term care, was having on the running of the centre. This resident had since transitioned elsewhere although they did return to the centre for a brief period in December 2024 and January 2025 owing to a particular set of circumstances. Also in December 2024, the provider submitted an application to vary a condition of the centre's registration to reflect that the house that the centre was renewed against in February 2024 was being replaced with a new house. This application was granted by the Chief Inspector of Social Services with the provider submitting a signed document dated 7 January 2025 confirming that they wanted this variation to take effect on 10 January 2025.

As a result, the house which the centre was renewed against in February 2024 ceased to be part of a registered designated centre while the new house became the sole preemies for Sandpiper 1. Despite this, the registered provider continued to use the older house for the purposes of providing a designated centre until 24 February 2025 when the new house began to be used. This matter only came to light after it was queried with the provider during March 2025. Although it was indicated on behalf of the provider that they fully understood that they could not use a house as a designated centre unless registered, the use of the old house between 10 January 2025 and 25 February 2025 was not consistent with the requirements of the Health Act 2007 as amended. The reason for the older house's use during this period was put down to an inadvertent delay with communication from the provider indicting that they had "failed to take account of the registration implications of this delay".

Beyond this matter, given the length of time since the previous inspection, it was decided to conduct the current inspection to assess compliance with relevant regulations and the supports provided in more recent times. Overall, the current inspection found a good level of compliance with the regulations. This indicated that residents availing of this centre were being well-supported and that the provider was delivering services in an appropriate manner. In addition, based on findings in areas such as staffing, the centre was being appropriately resourced while there was evidence of the centre being monitored. Some regulatory actions though were identified including an action relating to a 2023 annual review for the centre

Regulation 15: Staffing

Staffing in a centre must be in keeping with the needs of the residents and the centre's statement of purpose. The centre's statement of purpose outlined the staffing in whole-time equivalents with such staffing arrangements intended to meet the needs of residents availing of this centre. The inspector reviewed staff rotas from February 2025 on and found that staffing was being provided in a manner consistent with the statement of purpose. Such rotas and discussions with two members of staff indicated that there was a good consistency of staff working in the centre. Having such a consistency is important to support familiarity for residents while also promoting consistent care and support for residents.

Judgment: Compliant

Regulation 23: Governance and management

Discussions with staff indicated that transport was available for this centre. This, along with the findings under Regulation 15 Staffing, provided assurances that the centre was appropriately resourced. Staff members spoken with during this inspection talked positively of the support they received from management of the centre. In keeping with the organisational structure for the centre, such staff reported to the person in charge. The person in charge oversaw the staff team meetings that took place in the centre. The inspector reviewed notes of such meetings and read that matters such as complaints, restrictive practices, incidents, fire drills and training were recorded as being discussed. The notes reviewed indicated that such meetings took place regularly although only two had taken place in 2025 compared to monthly staff meetings that had taken place from September 2024 to December 2024.

Records provided indicated that there was monitoring systems in operation for the centre. As part of these reports of provider unannounced visits from May 2024 and November 2024 were provided. Such visits are expressly required under this regulation to be done every six months and must be unannounced. During engagement with the provider concerning another of its centre's in the Limerick area during September 2024, it was indicated that there was a practice of linking with designated centres within 24 hours of the start of unannounced visits. Such a process would compromise the unannounced nature of any such provider visit but on the current inspection, the person in charge stated that they had never received any such prior notice. They did highlight however indicated that they may be requested to provide some information in the weeks leading up to a six monthly provider visit.

When reading the reports of the two provider visits to the centre from 2024 on the day of inspection, it was noted that they considered relevant matters related to the quality and safety of care and support provided to residents. Some areas for improvement in both 2024 provider visits were identified by those conducting the visits but the actions plans with each visit report read did not assign time frames or responsibilities for addressing these. Given that a recurrent action was noted

regarding communication between the centre and the provider's day services, the inspector requested updated action plans for both 2024 provider visits to the centre.

These were subsequently submitted the day following the inspection. However, when reviewing the report of the May 2024 provider visit report, the inspector noted reference to another such provider visit from December 2023. A copy of this provider visit was not with the copies of the 2024 provider visits so the inspector explicitly requested that a copy of the December 2023 visit be provided the day following the inspection. Despite this request, a report of this visit was not provided. Under this regulation, reports of such visit must be made available on request to the Chief Inspector.

It also a requirement under this regulation that an annual review of the designated centre is conducted to assess the centre against relevant national standards. On the day of inspection, documentation reviewed indicated that an annual review for 2023 had not been done. This was subsequently confirmed during the feedback meeting for this inspection with this put down to the person in charge being absent for a period. An annual review had been completed for 2024 with a copy of this provided the day following inspection. It was noted that this annual review assessed the centre against relevant national standards and provided for consultation with residents and their representatives. While the content of this 2024 annual review was noted, an annual review that covered 2023 had not been completed with this being the responsibility of the registered provider.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A statement of purpose was reviewed during the course of the inspection day. While this was found to contain most of the required information, it was noted that it contained an outdated version of the centre's certificate of registration and was not updated to reflect a change in management. A revised copy of the statement of purpose was subsequently provided the day following this inspection. However, the revised version continued to include an outdated version of the centre's certificate of registration. In addition, it was noted that some of the stated room sizes in the centre were inconsistently stated compared to the centre's floor plans that was provided as part of the December 2024 application to vary. For the example, the floor plans indicated that the size of the kitchen-dining-living area was 48m2 but the statement of purpose suggested that this room had a size of 92.72m2. As such the statement of purpose required further updating while the provider also needed to ensure that the room sizes as stated in the statement of purpose and floor plans were consistent and accurate. This was particularly important given that both formed the basis for a condition of registration.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

During this inspection, the complaints log for the centre was reviewed with two complaints recorded as being made on this log since the beginning of September 2024. Both of these complaints had been escalated internally within the provider. One of these had since been closed but the other remained open at the time of this inspection. While the former complaint had been closed, it was noted by the inspector that the complaints log did not record if the complainant was satisfied or not with the outcome. Recording such information is expressly required under this regulation.

This regulation also requires that measures required for improvement in response to a complaint be put in place. The escalated complaint that remained open had been made on 18 September 2024 and related to residents requesting access to a specific online service. The last entry on the complaints log for this complaint was from February 2025 which indicated that authority had been given to get the service requested. Despite this, it was confirmed that the centre did not have access to the requested service and that its introduction was being delayed by internal matters. The inspector was also informed that residents had not requested the relevant service since the move to the new house for the centre. However, given that the complaint had been made over seven months before this inspection, it could not be said that timely action had been taken in response to the complaint to resolve it.

It was noted though that when reviewing notes of resident meetings that complaints was an area that was regularly recorded as being discussed with residents. On the day of the inspection though, the inspector did not observe a copy of the complaints procedure on display anywhere in the centre. Under this regulation, such information should be displayed in a prominent position. When queried, it was confirmed that such information had not been put on display since the new house began to be used. The day following the inspection, communication was received indicating that information about the complaints process had since been put on display in the staff bedroom-office. While this information was noted, such information had not been on display in the current house for two months until it was raised by this inspection.

Judgment: Substantially compliant

Quality and safety

While the centre was equipped with fire safety systems, some regulatory actions were identified during this inspection related to fire safety. Residents had personal plans provided but some issues regarding the content of some of these personal

plans were noted.

This designated centre was provided with fire safety systems including fire extinguishers and fire doors. Such fire doors are intended to prevent the spread of fire and smoke but issues with some of these doors were observed during the inspection. It was also seen that the layout of the centre might not provide for a safe evacuation route which was highlighted to management of the centre during the inspection. Records provided indicated that staff working in the centre had completed fire safety training as well as safeguarding training. Information about how to ensure the residents' safety while they stayed in this centre, including from a safeguarding perspective, was to be outlined in residents' personal plans. While such plans were found to be in place and contained relevant information, for one resident it was seen that the section on ensuring their safety had not been completed. Another resident's personal plan incorrectly indicated that they had epilepsy.

Regulation 10: Communication

Based on observations and discussions during this inspection, residents had access to various media within the centre such as televisions, radios and Internet access. Some residents had previously requested access to a specific online service in September 2024 but it was indicated that this was not yet in place at the time of this inspection. This is addressed under Regulation 34 Complaints procedure.

Judgment: Compliant

Regulation 11: Visits

Given the size of the premises provided with various communal rooms available including a living room and a relaxation room, there was sufficient space available for residents to receive visitors in private if they wished to do so.

Judgment: Compliant

Regulation 17: Premises

The premises provided for residents was seen to be presented in a clean, well-furnished and well-presented manner on the day of this inspection. There were five bedrooms available for residents' use with suitable storage facilities provided in these. Suitable communal facilities and multiple bathrooms of a good standard were also provided based on observations during this inspection.

Judgment: Compliant

Regulation 18: Food and nutrition

Suitable facilities were present within the centre's kitchen-dining-living area for food and drink to be stored hygienically in. These facilities included multiple presses and two fridges. The inspector looked inside such facilities and noted them to be clean with various types of food and drink stored in the centre on the day of inspection. These included fruit, vegetables, meat, tea, milk, yogurt, soup and cereals. During the inspection, residents were overheard being asked what they wanted to have for dinner.

Judgment: Compliant

Regulation 20: Information for residents

This centre had a residents guide that was seen during this inspection. This was noted to be presented in an easy-to-read format and when reading this guide the inspector found that it contained all of the required information. This included information on how to access inspection reports and the arrangements for resident involvement in the running of the centre.

Judgment: Compliant

Regulation 28: Fire precautions

Staff working in this centre had completed fire safety training based on records provided during the course of this inspection. One of the staff members spoken with also confirmed that they had taken part in fire drills with further records provided indicating that such fire drills had been conducted regularly since the new house of the centre began to be used. Such drills were conducted at varying times and with different levels of staff supports. Low evacuation times were seen to be recorded in each of the fire drills conducted.

However, no fire evacuation plan for the centre overall was provided during this inspection. Discussions with staff and management indicated that the only evacuation routes for the centre were the front door or via an rear exit from the kitchen-dining-living area. Based on this, it was observed that, given the layout of the centre, if a resident was present in one bedroom on the ground floor they would have to pass through the kitchen-dining-living area to access one of these

evacuation routes.

As the kitchen-dining-living area represented a higher risk room for a fire, this meant that this bedroom was potentially an inner room (a room which did not have direct access to a circulation corridor for evacuation purposes). It was acknowledged that there was a large window present in this bedroom which could potentially be used for evacuation to the outside of the centre. However, there was no indication that this had been identified as being an evacuation route, fire drills conducted made no reference to this being used as such and it was unknown if this window would be suitable for residents to use. Following the inspection, the provider undertook to review this matter.

The provider also indicated that other matters relating to fire safety observed by the inspector during the inspection were to be reviewed. These included a gap under a fire door and part of the doorframe of another fire door missing part of its seal. Such matters had the potential to impact the intended function of fire doors which is to prevent the spread of fire and smoke. The inspector also observed a small hole in the ceiling of a lift room which could also impact fire containment but the day following the inspection, it was communicated that this had been addressed. In the same room, it was observed that the space created for the lift also left some small gaps between the ground floor and the first floor.

Aside from such matters, it was seen that the centre was provided with other fire safety systems including emergency lighting, a fire alarm, fire extinguishers and a fire blanket. Records provided indicated that these had been serviced by external contractors to ensure that they were in proper working order. Internal staff checks were also being carried out for the fire safety systems including the fire alarm and fire exits. Such checks were to be documented daily, and while these were generally recorded as being done, there were some dates in March 2025 where such checks had not been recorded as being completed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Although this centre supported a high number of different residents with respite care, it was found that arrangements were in place to ensure that such residents were provided with personal plans. Having such plans is required under this regulation. During this inspection, the personal plans of four residents were reviewed by the inspector. In general, these were found to contain information to guide staff on supporting residents' needs while in this centre. However, it was noted that a section in one resident's personal plan around supports to ensure the resident's safety had not been completed even though the overall personal plan was marked as being reviewed in July 2024.

It was also identified that another resident's personal plan indicated that the

resident had epilepsy but after querying this with the person in charge, it was confirmed that this was not correct. When reviewing the same resident's personal plan it was seen that records of the resident's last annual multidisciplinary review were from June 2023. When this was queried, it was suggested that the resident may have had such a review, which is a regulatory requirement, more recently. As such, the inspector requested confirmation of this. Following the inspection it was indicated that no such review had taken place during 2024 but that one had been scheduled for 1 May 2025.

Judgment: Substantially compliant

Regulation 8: Protection

Documentary evidence was provided which indicated that any safeguarding matters which had occurred or been alleged since the August 2023 inspection had been appropriately screened with safeguarding plans put in place where necessary. It was indicated to the inspector that there was one safeguarding plan active at the time of this inspection with staff members spoken with aware of this. Records provided also indicated that staff working in this centre had completed relevant safeguarding training. Contact information for the provider's designated officer (person who reviews safeguarding concerns) was seen to be on display in the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Sandpiper 1 OSV-0007919

Inspection ID: MON-0045775

Date of inspection: 24/04/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Staff meetings will be convened monthly • We will ensure that Annual reviews are completed going forward as per regulation. We can confirm that 2024 Annual Review has been completed. • The purpose of linking with the designated centre within 24 hours of the start of a 6 month review was to ensure that access to the home and to minimise disruption at times when a reviewer may be collecting files in the early morning for review off site. This practice ceased from 01/01/2025 following engagement with the regulator regarding same. • Information regarding the status of actions from previous 6 month reviews as well as other relevant information (e.g. Annual review report, Accident and Incident Report trend analysis, Information on notifications to HIQA) is requested from each designated centre on a 6 monthly basis. While this information is used to inform the 6 month review process there is no information provided regarding the date / time of the unannounced visit as part of the request for this information. The unannounced visit can take place any time from a day to several weeks after the request for information and remain unannounced to both the Person in Charge, Staff and residents. • On receipt of a 6 month review report there is an expectation that the PIC review the report with their manager and that responsibility for actions as well as timelines are agreed and recording on the report. All persons in charge will be reminded of this requirement at the next provider / person in charge meeting scheduled to take place on 28/05/2025. • The 6 month review report from Dec 2023 was forwarded to the inspector on 14th May 2025. • All persons in charge will be reminded of the requirement to have historical 6 month review reports readily available to the inspector on the day of inspection if requested at the next provider / person in charge meeting scheduled to take place on 28/05/2025.	

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

• Floor plans will be changed following installation of additional fire exit door and associated works due to be completed and floor plans modified by 14.07.25
• Statement of Purpose will be updated and resent to inspector following update and receipt of floor plans

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

• Complaints procedure displayed on notice board in staff office the day following the inspection 25.04.2025.
• PIC amended documentation to reflect that Person Supported was satisfied with outcome of complaint referred to in report 24.04.2025.
• Complaints will be resolved in a more timely manner (ref installation of on line service-resolved on 9/5/2025.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• Additional fire exit door on ground floor to be installed 14.07.2025
• Door frame seal missing and will be replaced by 09.06.2025
• Gap under fire door in the staff office will be completed 09.06.2025
• Hole in ceiling above lift completed on day of inspection-24.04.2025
• Documented in relief information folder reminding relief staff to complete daily fire checks.
• Completion of fire checks will be reviewed PIC as part of their oversight role in the designate centre.

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:

• The residents personal plan identified by the inspector as having epilepsy was corrected immediately by the Person in Charge as being an error and file amended accordingly on the day of inspection (25/04/2025).
• The Person in Charge confirmed that the resident identified as not having a multidisciplinary review since 2023 was scheduled for review on May 1st and this review took place on May 1st and minutes now on file.

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)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	28/05/2025
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on	Substantially Compliant	Yellow	28/05/2025

	request to residents and their representatives and the chief inspector.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	14/07/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	14/07/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	14/07/2025
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	14/07/2025
Regulation 34(1)(d)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a	Substantially Compliant	Yellow	09/05/2025

	copy of the complaints procedure in a prominent position in the designated centre.			
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Substantially Compliant	Yellow	09/05/2025
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	09/05/2025
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	01/05/2025
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a	Substantially Compliant	Yellow	01/05/2025

	review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.			