Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Boyne Manor
Name of provider:	Three Steps Limited
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	05 November 2025
Centre ID:	OSV-0001804
Fieldwork ID:	MON-0047814

About the designated centre

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

Boyne Manor is a residential service which caters for up to five residents, under the age of 18 years, both male and female, with an intellectual disability. The centre is located in a town in County Meath close to a variety of local services and amenities. Each of the residents have their own en-suite bedroom. There is a spacious garden and play areas, as well as large kitchen/dining room and large common areas. Staffing support is provided 24 hours a day, seven days a week by a person in charge, two team leaders and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 5 November 2025	10:00hrs to 19:00hrs	Gearoid Harrahill	Lead
Wednesday 5 November 2025	10:00hrs to 19:00hrs	Brendan Kelly	Support

What residents told us and what inspectors observed

This report outlines the findings of an unannounced risk inspection completed to assess the provider's regulatory compliance in relation to the care and welfare of young people who were living in the centre. Over the course of the same day, inspectors of social services completed unannounced risk inspections in each of the provider's three designated centres for people with disabilities. The inspections were undertaken following receipt of solicited and unsolicited information which raised concerns regarding the provider's governance and management arrangements and its impact on the quality and safety of care provided.

In this centre, from observations, conversations with staff and young people, and information reviewed, the inspectors found highly significant regulatory non-compliance with the regulations reviewed on the day of inspection. Many areas for improvement were required to provide assurance that young people were in receipt of a safe and quality service. This included the quality, ongoing review and evaluation of needs assessments, personal plans, risk assessments and controls, and systems in place to ensure the children were provided a safe, clean and well-maintained home.

Inspectors had the opportunity to meet the children, support staff, the person in charge and their deputy, the service manager and director of care over the course of this inspection. On the arrival of inspectors, two of the children had already left for school and the staff were supporting the third child to start their day. Later in the afternoon the children came home from school and were supported by staff in their home for the remainder of the inspection.

The inspectors had the opportunity to meet with one child on their return from school in the sitting room. Two staff were present with the child, both the child and staff appeared comfortable in each others company. An inspector spoke to the child who briefly engaged with the inspector before heading to the kitchen for a snack.

The inspectors observed staff supporting a second young person towards the end of the inspection. The young person was at the staff office door banging on the door, staff entered the office in a somewhat rushed manner commenting that the child wanted a phone. The staff member was observed to quickly move through the office to find a mobile phone to give to the child. The inspector also observed the staff member to be wearing personal protective equipment (PPE) gloves, there was no indication of when the staff member put on the gloves or for what purpose. The staff member was observed to touch many high contact areas in the office such as handles, computer equipment and various mobile phones before leaving the office and handing the child a mobile phone. Staff were heard to be speaking to the child in a heightened manner in the corridor before leaving the area.

An inspector had the opportunity to briefly meet the third young person in their bedroom shortly before the inspection ended. Two staff were present while the

inspector briefly spoke to the child to ask how their day had gone. The resident indicated via a hand gesture that to the inspector that they were fine.

The centre comprises a large three-storey house in which each young person had a private bedroom and en-suite bathroom. Inspectors walked the premises and observed areas to be dirty and poorly maintained. Ceilings were dirty with patches of dried food, mould, and feacal matter identified as being a result of incontinence wear being thrown. Corners, ceilings and window spaces were heavy with cobwebs and spiders, including over a child's bed. Bedrooms were limited in furnishing and decoration due to identified risks related to property damage, and there was limited use of pictorial signage for children who required support with their communication needs. Furniture items in living rooms were observed to be damaged with torn upholstery, broken legs and cracked table tops. The fabric of some of the furniture used by children was observed to be dirty, with the furniture made of a material which could not be effectively cleaned. Inspectors also observed hardware solutions to prevent damage such as building a timber frame in a child's bedroom to prevent the door hitting the wall, and a bed frame which was screwed into the floor. Inspectors requested from management information on whether they had explored the use of toughened furniture which would resist damage and be easier to sanitise while still being home-like and suitable for children, and they had not.

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 to each child living in the centre.

Capacity and capability

This section of the report describes the oversight arrangements of the centre and how effective they were in ensuring that children were in receipt of good quality care. Based on the findings of this inspection, the management systems and processes in place to oversee the care and support being delivered to the young people in the centre were not effective. In May 2025, there had been a significant change to the provider's governance and management structures with the resignation of the director of care, service manager and the persons in charge for each of the provider's three designated centres within a short time frame of each other. New personnel had been appointed to each of these positions. Inspectors observed various deficits in the the provider's oversight of the centre which resulted in the provider failing to identify important aspects of the quality and safety of resident support and implementing control measures and quality improvement actions in a timely fashion.

The majority of the auditing and operational oversight was found to be led by the person in charge and the deputy person in charge, who had taken up their respective roles since the aforementioned changes. While these local managers had

a good personal knowledge of the children's health, social and personal care needs, they were not being supported by the registered provider with the relevant expertise and multi-disciplinary input to undertake comprehensive risk assessments and development and evaluation of personal plans.

The staff team were supported through team meetings and individual supervision by their line managers. While these discussed meaningful topics and supported staff to be aware of changing needs and adverse events related to the young people, there was limited information on the progress or success of personal goals, whether trends in incidents had resulted in any review of risk assessments, and what learning and quality enhancement was taken from upheld or partially upheld complaints about the service.

At the time of this inspection, the provider was heavily reliant on the use of agency personnel to meet basic minimum staffing requirements for the three children currently living in the centre, with over 200 shifts in a space of two months covered by contingency arrangements. This was not optimal to ensuring an effective continuity of staff support for the children and assurance that care delivery was consistent.

Regulation 15: Staffing

As each of the current children were assessed to require support on a 2:1 basis during the day, the centre was staffed by six front-line support staff during the day. At night two staff stayed for sleepover shifts, and one waking night shift started at 21:00. At the time of this inspection the centre had staff vacancies equivalent to five whole-time equivalent posts, based on the centre having three of its five beds occupied. The service manager advised that four new staff had been recruited, two of whom had start dates in the coming weeks.

The inspectors reviewed worked rosters for September and October 2025. Parts of these rosters were difficult to review as different names were used for the same staff members and times switched between 12 and 24 hour clock. However, from counting all staff working in this centre, inspectors found that the provider was heavily reliant on agency and relief staff to meet the minimum staffing requirement for the three current childrens' assessed needs. In the two month sample reviewed, 203 worked shifts were covered by contingency staffing resources, 179 of which were covered by agency personnel. Rosters were also not complete, with no record of the days and times the person in charge and their deputy were in the centre, and a number of shifts which were blank on the roster, which the person in charge verbally commented were additional agency shifts. This did not provide assurance that continuity of support was being mitigated for the support of the children in this centre by people who were familiar with the children's care and support interventions, which had been identified as a key aspect of maintaining a low arousal and reducing risk of children becoming distress or anxious.

The inspectors met with and spoke to four of the front line staff working on the day

of inspection. Some members of the staff team were observed to be knowledgeable in terms of the young people's needs and support plans. Some staff were observed to be engaging positively with the children using the service and were observed to be building plans for the day. A staff member was observed by the inspector to on their mobile phone while sitting outside the bedroom of one of the young person. This staff member is required to be outside the bedroom of the young person to mitigate the risk of self-injurious behaviour. This observation was brought to the attention of centre management immediately by the inspector.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had a training matrix in place to outline staff training needs and record their completion. The matrix was maintained by the person in charge as part of their oversight systems. The person in charge and deputy person in charge also conducted supervision sessions with the front line staff team

On the day of inspection, the inspectors reviewed this training matrix and supervision records for members of the front-line staff team. The inspectors observed that the provider had failed in its duty to provide training to the staff team that would ensure the team could adequately support the assessed needs of the children. The training matrix showed significant gaps in staff training and in particular essential trainings given the complex nature of the children using the service. The inspector observed significant gaps in the following trainings:

- Lámh (a manual sign system used by children and adults with intellectual disability and communication needs in Ireland.)
- autism awareness
- developmental trauma
- self-harm
- child sexual exploitation
- human rights
- infection prevention and control
- manual handling

On review of the staff supervision records the inspectors were not assured that the registered provider was supporting the local team to safely and effectively carry out their duties or to ensure a work environment that was conducive to a positive team morale. One staff member commented during supervision that they did not feel supported from senior management and clinicians in the area of medication reviews. A staff member discussed issues with staff not following care plans and not feeling safe in the car with the children. A staff member commented that they are key worker for one child but they do not get to work with the child. Staff highlighted to management ongoing issues with agency personnel. One supervision record indicated that the staff member had already handed in their resignation from the

service.

Judgment: Not compliant

Regulation 23: Governance and management

The inspectors found that the provider had failed to implement effective monitoring and oversight structures by which they could be assured of a safe and quality service for the children living in this centre.

The inspectors were provided minutes of monthly centre management meetings which primarily reviewed corporate and human resource matters. For centre and child support matters, the provider held weekly planning and coordination meetings. Inspectors reviewed the minutes from recent months and observed that these covered changes in childrens' needs, incidents and accidents, and areas on which staff were required to be more vigilant. However there was limited information that matters discussed in these meetings resulted in an action plans for staff. For example, minutes of recent meetings identified issues with childrens' prescriptions, but no action to address this going forward, and for one child who was presenting with a increasing trend in adverse events, there had been no corresponding change to their risk assessment or behaviour support guidance to guide staff on what to do to support them. The inspectors reviewed the centre's log of complaints which were upheld or partially upheld, however there was no evidence available on what actions or learning was taken from these as they were not discussed with staff afterwards.

The inspectors reviewed the reports from the two most recent six-monthly quality and safety visits completed by the provider. These reports did not identify and set out any actions for many of the aspects of the designated centre and the quality of children's care, including areas of concern identified on this inspection such as fire safety, supports for behavioural risk or communication needs. These six-monthly visit reports covered one theme each from the National Standards for Residential Services for Children and Adults with Disabilities 2013. For example, the July 2025 audit focused on responsive workforce. In addition to this audit not addressing concerns related to this centre outside this theme, it had also not identified any issue related to significant training deficits, staff knowledge of care plans, and substantial reliance on agency and relief resources to fulfil minimum staffing requirements for the centre.

Centre level checks and oversights were also found to be ineffective based on the findings of this inspection. The cleaning schedule for this centre premises was checked off as complete, including on the day of this inspection, however inspectors observed many areas of this centre to be dirty with cobwebs, dust, mould, dried food and brown staining.

Inspectors observed that much of the operational management of the centre was led by the local management, including risk analysis, restrictive practice reduction,

and creation and updating of personal care plans. Inspectors were not assured that the local management were being supported by the provider to ensure these processes were informed by the relevant expertise and external review.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors reviewed the records provided on complaints submitted to and about the designated centre in 2025. The evidence provided gave generic headline comments about the complaints from children and their families, such as noting that they were unsatisfied with the quality of care and support, and noted that complaints were addressed and closed. However, the centre management could not provide any details on what a complaint was about.

Complaints in the log reviewed were noted as upheld or partially upheld, however no information was available on what this meant for the centre quality improvement or risk review. The inspectors were advised that the outcome, actions and learning from complaints would be discussed at team meetings afterwards, however the minutes of meetings which followed complaint closure did not reference these.

While the complaints log noted that a respective child's placement supervisor was satisfied with the outcome, there was no record kept of how the provider was assured that the person who originally submitted the complaint was satisfied with the outcome and the actions taken on foot of the conclusion. There was no evidence to indicate that the complainant was being referred to the provider's appeals process.

Judgment: Not compliant

Quality and safety

The inspectors were not assured based on their findings that the children using this service were in receipt of either a safe or quality service. Risk management systems were ineffective in identifying or scoring risk appropriately. Risk assessments were completed locally with no multi-disciplinary team input. Behaviour support systems were also ineffective in guiding staff practice with no behaviour support specialist input observed. Communication supports were significantly lacking for all children using the service and in particular children who were non-verbal. Personal planning related to education, life skills, health monitoring, goal planning and preparing for adulthood were not specific or measurable, were lacking in updates and evaluation, or had not been implemented in practice.

The condition of the premises throughout was a serious concern, with out-of-date or rotten food in fridges, no running water in some bathrooms and broken furniture some of the areas being brought to the attention of the provider on the day of inspection by the inspectors. Many areas of the centre were dirty with brown staining, mould, mildew, and heavy dust and cobwebs. Cleaning lists identified that these areas were subject to daily or weekly cleaning up to and including the day of inspection. Infection control practices were also poor regarding management of cleaning tools, handling of clean and soiled items, and hand hygiene practices by staff. The inspectors also observed completely ineffective fire safety systems in place from fire risk assessments to appropriate fire containment. Urgent actions were issued to the provider based on findings related to the premises, fire safety arrangements and infection control standards.

Regulation 10: Communication

Communication plans and supports for the children using the service were lacking and did not provide the front line staff team the appropriate recommended training. One young person in particular required significant communication supports that were not implemented by the provider.

The inspectors reviewed an assessment completed by a speech and language therapist in conjunction with the young person's school. The assessment was not dated so the inspectors were not in a position to verify when the recommendations had been suggested. However, the report stated that additional supports are needed and should take the form of talking mats, Lámh training for the staff team and implementation of Lámh as a form of communication, the use of visual schedules and a total communication approach to be implemented. The report also expressed a need for a consistent approach used between the centre, the young person's school and the young person's family home. The inspectors sought assurances on each of the recommendations and was not provided with any assurances on any of the recommendations. No additional training had put in place by the provider in relation to total communication or Lámh, there was no evidence of any communication meetings between the identified stakeholders. On a walk around of the premises there was limited evidence of the appropriate use of visuals for the young person. The inspectors were shown a folder with visual pictures and staff spoken to by one inspector confirmed that the young person does not engage with the folder in any meaningful way.

The inspectors enquired as to the pathway for referring the young person for an additional speech and language assessment to be carried out in their home. Centre management confirmed to the inspectors that no such referral was in place and that there was no understanding within the team of how to access such supports within the provider.

Judgment: Not compliant

Regulation 17: Premises

The inspectors conducted a walkthrough of the premises, and observed much of the premises to be in an extremely poor state of cleanliness and maintenance. In many areas around the house, including children's bedrooms and bathrooms, inspectors observed high corners, ceilings, windows and air vents which were heavy with dust and cobwebs, as well as a large number of living and dead spiders.

Bathrooms were visibly dirty and inspectors observed a build-up of mould along tile and bath edges and patches of mould on a bathroom ceiling. Some ceilings and furniture were dirty with dried food and brown faecal matter. Inspectors observed holes in walls and torn and flaked plaster and safety padding. Furniture such as couches, wardrobes and tables were observed with broken legs, torn upholstery, and broken wood and veneer. Fabric of furniture was stained with brown smearing.

The provider had failed to maintain effective oversight of a routine cleaning schedule of rooms and fixtures, as these were checked off as cleaned on a daily or weekly basis, including on the day of the inspection. As a result of these findings, by 12:00 the inspectors issued the provider an urgent action plan for return in the days following this inspection, on what would be done to ensure these issues were addressed and that systems to oversee them going forward were revised.

Judgment: Not compliant

Regulation 26: Risk management procedures

Inspectors were very concerned in relation to the risk management systems implemented by the registered provider. Risk assessments were completed by the local management team who had no formal training in compiling risk assessments. There was no system in place to oversee the risk assessments and control measures implemented. This meant that all aspects of risk were not being appropriately identified, scored or reviewed. Risk assessments were not informed by data collected in the centre and were not formed on using an evidence based approach. For example, risk assessments were in place for one young person regarding seizures, yet the young person did not have a diagnosis of any seizure related condition. This risk assessment was scored a six on the provider risk matrix.

A second risk assessment was reviewed for another young person around the ingesting of chemicals which was in place due a previous serious incident. The scoring regarding a break in control measures in this risk assessment was two which was the lowest possible score. The inspector immediately discussed with centre management that a break in the control measure could lead to a significant and life changing injury to the young person.

In centre fire drills it had been identified that one young person will not evacuate. This was not identified in the centre's main fire risk assessment or a risk assessment specific to the young person despite ongoing evidence that this is a significant risk. The centre had a lack of appropriate fire containment due to fire doors not being fitted with closers and were left open. Again, this had not been identified in centre risk assessments despite a previous inspection in 2025 highlighting the same concerns around fire containment.

Inspectors also reviewed evidence of a young person who will urinate inappropriately, yet this behaviour was not subject to a risk assessment despite the behaviour being common knowledge in the centre.

The inspectors also met with a staff member working on the day of inspection and discussed pertinent risk for the staff member to be aware of in working with the young person to whom they were assigned for the duration of their shift. The staff member was not aware of any of the key identified areas of risk for the young person, confirming to the inspector that they had not read any of the risk assessments in place. The staff member was also unaware of the centre's designated officer and could not explain to the inspector the systems in place to report any such concerns.

Overall, inspectors observed a total lack of risk analysis and review from the registered provider. A previous inspection in 2025 highlighted concerns on the part of the provider regarding the oversight, tracking and reviewing of risk, these concerns continue to be relevant from this inspection.

Judgment: Not compliant

Regulation 27: Protection against infection

During the walk of the premises referenced elsewhere in this report, maintenance issues observed by inspectors included surfaces which were stained, worn, cracked, rusted or flaked which severely impacted on the ability to effectively clean and sanitise surfaces, including on furniture used by residents.

Inspectors observed poor management of dirty or soiled items being stored in close proximity to clean items, cleaning tools and food items. In a utility room, mop poles and a box of mop heads were stored in a cluttered corner with a vacuum cleaner, baskets which had been used for soiled laundry, food items, used towels and a new rug. There was inadequate separation between cleaned and used laundry and towels and their containers. Seven mop buckets were stored outside the house next to a sign stating “do not leave mops and buckets outside” and these buckets were observed to be dirty with garden debris and moss, with a full bin bag laying on top of these and various other items for disposal stored in the same space. This area also had a weighted blanket hanging out to dry on a clotheshorse, which was rusted from being outside.

Inspectors were not assured that staff were facilitated to engage in hand hygiene best practices. The utility room was not equipped with hand sanitiser gel or a hand washing sink. Inspectors asked staff members how they washed their hands after handling soiled items and were told that they would either use the kitchen sink or a bathroom on the opposite side of the house, either of which required contact with door handles and door release switches. Besides the medication space, inspectors did not observe hand sanitiser available around the house, and staff were observed wearing disposable gloves while moving from room to room including handling doors and phones. During the premises walk in the morning, inspectors observed that two children's bathrooms did not have a supply of water to the sinks, and before inspectors left in the evening, they checked these sinks again and observed that the water was still off, with no indication that this had been identified since the children had come home in the afternoon. The provider confirmed by email the following morning that a plumber had been out and resolved this issue.

Inspectors observed failings in basic food safety practices, with multiple items observed in the refrigerator which were rotten with visible mould on them. These food items were discarded once identified by the inspector. Raw chicken was thawing in close proximity to an open container of milk. The refrigerator itself was observed to be rusted in parts.

Based on these findings, the provider was issued an urgent action plan for return in the days following this inspection.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors completed a walkthrough of the centre with the person in charge. Inspectors found rooms along fire evacuation routes, including bedrooms and living rooms, which were not equipped with self-closing mechanisms (which would result in the fire doors closing automatically in the event of a fire). In the event of a fire, fire doors would need to be manually pulled shut to provide containment of fire and smoke within the centre. Door wedging was also observed which compromised fire containment in a kitchen and utility room area. Other fire doors had been damaged. These had not been identified and risk assessed in the centre’s risk register or six-monthly quality and safety reports, and as such there was no action or time frame to address these safety concerns.

Issues related to fire containment had been identified on the previous regulatory inspection in April 2025 and there was no evidence that the actions set by the provider and committed to had been completed in a timely fashion or that a comprehensive fire risk assessment by a competent person had been undertaken. The provider had committed in writing to the Chief Inspector following that inspection to have these completed by July 2025. Inspectors were verbally advised that this assessment would be undertaken, but by the end of this inspection, no

clarity was given on when this was scheduled to happen.

The provider had failed to provide assurances that there were adequate arrangements to ensure the safe and timely evacuation of residents in the event of a fire. Fire drill records which identified as a simulated night drill scenario did not test procedures followed by resources available at night. For example, said practice evacuations had six staff members participating instead of three staff who would be present on an actual night shift, and had not accounted for the time factor resulting from up to three residents and two staff being asleep, and that the staff would be down to two when one staff was required to remain at the assembly point. A resident was identified as refusing to leave during multiple practice evacuations during the day, with drills being called off after five minutes. There had been no risk assessment undertaken to address and control this risk. While refusal to leave had been identified in their personal evacuation plan there was no guidance to staff on how they would respond to this risk to ensure their safety and ensure there was no delay in evacuating the other children requiring the support of two staff.

Based on these findings, the provider was issued an urgent action plan for return in the days following this inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider had care plans in place for each of the children using the service. Inspectors reviewed two childrens' care plans on inspection and found significant concerns with the content and quality of the care plans. On review of information regarding the children's educational placement, one child had moved school yet the information contained in the care plan was from their previous school. The student support profile in place for the child was dated from 2022 with no evidence found by the inspectors of a more recent profile

The Individual Education Plan (IEP) for a second child was dated February 2025, a more up to date IEP regarding the new school year is planned for November 2025. The information also contained the contact details of previous centre management.

Health care plans were poorly maintained with recommendations from health and social care professionals not being implemented as requested. In 2024 the provider was requested to monitor the bowel and urine output and fluid intake of one child. The inspector asked for evidence of this data collection, centre management confirmed that they tracked fluid intake for one month in 2024 which then stopped with no guidance to stop, and that they had not tracked bowel or urine output at any point. The child's IEP from February 2025 identified toileting as a "priority learning need". The last completed toileting questionnaire as observed by the inspector was completed in 2021.

Goals were observed to be poorly identified and tracked. The inspectors could not

observe any formal assessment to identify meaningful SMART (specific, measurable, achievable, realistic and timely) goals for children. Often goals were set monthly, there was no evidence of the child's involvement in selecting meaningful goals and the review of goal implementation was inconsistent. For example, on review of goals for 2025, inspectors saw that identified goals related to eating of inedible items, road safety, personal hygiene, brushing teeth, arts and crafts and going to a fast food restaurant. Goals were inconsistently reviewed; reviews outlined that the children did not want to engage in the conversation with staff and then a new goal commenced the following month.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Inspectors reviewed the behaviour support systems the provider had in place and found the systems to be poor, not reflective of the needs of the children using the service, and completely lacking in behaviour specialist input.

A previous inspection from 2025 identified that behaviour support practices were devised by the local team with limited evidence of behaviour specialist input. The findings of this inspection mirrored the concerns of that previous inspection. Behaviour support plans continued to be designed and implemented by the local management team.

On review of two of the behaviour support plans there was no evidence of a functional assessment or analysis of the behaviours. There was no system in place to track or trend behaviours to help inform and guide staff practice. The behaviour support plans were found to offer limited guidance to staff, for example in responding to behaviours of concern the guidance discusses the proximity of staff to the young person. However, there are no indicators as to when the proximity is too close or too far. The plan also discusses the importance of continuity of familiar staff, as discussed in another section of the report over 200 shifts in the months of September and October 2025 were covered by personnel outside the core support team.

As outlined in various other sections of the report the concerns identified regarding guidelines for staff in the young people's support plans are mirrored and repeated findings from the report earlier in 2025.

The inspector met with an agency staff member who had been working in the centre for an extended time. The staff member had been assigned to one of the young people for the day. The inspector discussed the resident's behaviour support plan with the staff member. Through the course of the conversation it was apparent that the staff member was not aware of the specific strategies in place, ending in the staff member confirming to the inspector that they had not read the behaviour support plan of the young person. This information was relayed immediately to

centre management by the inspector.

Inspectors reviewed a sample of restrictive practices to ensure these were under regular review and proportionate to the level of risk associated with their use. Regular reports were composed by the local management team, however there was limited evidence of multidisciplinary input or specific and measurable strategies to trial alternatives. One restriction had been in place for over a year without any evidence of incidents or near-misses, yet was only revised to a less restrictive intervention on request of a family member. For another environmental restrictive practice, the inspector asked why it was in place for the affected young person, and they were told by management that the restriction was actually not relevant to that child at all, and had just not been removed when another child no longer lived in that area of the house. This restriction had been retained in multiple review cycles without this being identified.

Judgment: Not 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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Boyne Manor OSV-0001804

Inspection ID: MON-0047814

Date of inspection: 05/11/2025

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Action 1: A recruitment campaign across a national platform was reimplemented last week to ensure we have active advertisements running over the Christmas and New Year period. Action 2: The current roster template was reviewed and updated so that staffing levels, shift patterns, and skill mix are aligned with residents' assessed needs and regulatory requirements. Action 3: The service will continue to actively review the staff skill mix to ensure appropriate qualifications, competencies, and experience are available across all shifts. Action 4: A Three Steps recruitment event is advertised on social media and scheduled for 14/01/2026 at a local hotel to assist with staff recruitment.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Action 1: Management will ensure that the newly appointed Care Team Members are fully inducted into all mandatory and service-specific training requirements, supporting their transition into the role and strengthening overall leadership capacity within the centre.	

Action 2:
A comprehensive training and needs analysis session will be held on 16/01/2026, using a new template designed to identify gaps, enhance consistency, and ensure personal plans align with residents' assessed needs. This will be presented to the Board at the February Board meeting on 13/02/2026.

Action 3:
The Model of Care training will be completed by all staff on completion of the first audits in March 2026.

Action 4:
The Model of Intervention training will be completed by all staff with a view to an appropriate number of staff being identified within the organisation to complete the Train the Trainer course offered by the Model of Intervention. This will have commenced from March 2026.

Action 5:
Once the Model of Intervention has been implemented to a level that demonstrates competence in the Model of Intervention the supervision records will be reviewed to include the Model of Intervention and its reflective practices component are appropriately recorded to ensure congruence with goal planning and behaviour support plans for each young person. Particular attention will be given to the keyworkers for each young person in this process to both empower their role and ensure adherence with the Model of Care and Model of Intervention. The Model of Intervention will also necessitate external supervision with the external consultant implementing the Model of Intervention for the organisation. The implementation of the Model of Intervention will be overseen by the Clinical Director and Director of Care in consultation with the external consultant.

Action 6:
Any recommendations from the internal audits completed in January 2026 referring to training and staff development will be implemented and the implementation of same will be reviewed at monthly Board meetings.

Action 7:
A member of the Human Resources team, whom will be returning from maternity leave on 15/01/2026 will be responsible for completing a review of staff training at an organisational level which will emulate from the Training Needs Analysis to be completed on 16/01/2026.

Regulation 23: Governance and management	Not Compliant

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

Action 1:
The audits completed going forward will incorporate an analysis of static and dynamic risks identified by the Board, HIQA Inspection Reports, and the Model of Care Evaluation.

Action 2:
The Planning & Coordination (P&C) minutes template has been updated from 03/12/2025 to improve the recording of discussions, decisions, and assigned actions. The new template will support clearer governance oversight.

Action 3:
A new MDT Consultation Notes template was introduced from 26/11/2025 to ensure all multidisciplinary inputs are formally documented and integrated into governance and decision-making processes.

Action 4:
A new standing agenda has been developed for the Centre Managers Meetings from the 19/12/2025 to specifically highlight and record any issues arising within the service.

Action 5:
All updated governance documents and processes, including the new templates and agenda structures, were reviewed on 11/12/2025 to ensure consistency and compliance with regulatory requirements. These include:
• Terms of Reference for Planning and Coordination Meeting
• Terms of Reference for Complaints, Child Protection and Vulnerable Adults (monthly) meeting
• Audit and Risk Management processes.

Action 6:
The terms of reference for annual review of Quality and Safety of Care and Support was undertaken on 11/12/2025. The Centre Management Team received training on the updated Terms of Reference at the Centre Managers Meeting on 19/12/2025. Findings from the review will be submitted for Board approval to ensure effective governance oversight at the February Board meeting on 13/02/2026. The Annual Review for 2025 will be completed and report finalised by the 28/02/2026 and subsequently presented to the Board meeting in March.

Action 7:
The implementation of an independent Rights Review and Restrictive Practices Review Committee will be completed in the first quarter of 2026.

Action 8:
The implementation of a Risk Management Platform across the organisation that is accessible to Centre Managers, Senior Managers, Clinicians, and the Board will be completed in the first three months of 2026. The Governance Advisor for the Platform is presenting to the Board meeting on 09/01/2026 with implementation and training to follow thereafter.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Action 1:
The existing complaints process and policies was appraised on 11/12/2025 by Director of Care and Service Manager to ensure it provides a clear, transparent, and consistent approach to receiving, recording, and managing complaints. Additionally, any changes were highlighted during the Centre Managers meeting on 19/12/2025.

Action 2:
The complaints documentation has been updated so that all relevant evidence is stored in one place, including information provided by both the complainant and the service. Commencing following training on the 19/12/2025.

Action 3:
A structured method for confirming whether the complainant is satisfied with the outcome has been incorporated into the process to ensure appropriate follow-up and resolution. Commencing following training on the 19/12/2025.

Action 4:
Each complaint review will include documented recommendations to support service improvement, learning, and ongoing quality enhancement. Commencing following training on the 19/12/2025.

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
Action 1:
On 15/12/2025, the Service Manager met with the Centre Manager and newly appointed Deputy Centre Manager to review all relevant communication-related files and procedures.

Action 2:
Any gaps or outdated processes identified during the review were addressed promptly, and updated procedures have been communicated to all relevant staff to support consistent and effective communication practices.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Action 1:
Walk round of premises undertaken by Service Manager, Centre Manager and Deputy Centre Manager and schedule of urgent works identified from inspection. This completion of these works commenced from the 06/11/2025 and is reviewed at fortnightly maintenance meetings with Service Manager and Director of Care.

Action 2:

New furniture and appliances were purchased in November, and old damaged furniture removed by the maintenance team.

Action 3:
The process for the completion of maintenance works has been reviewed at the Centre Managers meeting on 07/11/25. Centre Managers are to sign off on all works carried out on maintenance logs with a clear audit trail evident.

Action 4:
The Director of Care and/or Service Manager undertake weekly Centre walk rounds commencing from 10/11/25 capturing outstanding works requiring completion, including decoration of rooms. This will be captured on the maintenance logs and be part of an ongoing schedule of works. The Director of Care will provide an update to the Board at the next Board meeting scheduled for 09/01/2026.

Action 5:
Outstanding works will be discussed and noted at the fortnightly maintenance meeting as part of the overall maintenance and premises governance process. These will also be highlighted to the Board as part of the Director of Care's monthly report.

Action 6:
A full centre deep clean was completed on 11/11/25 by an external cleaning service. Quarterly deep cleaning is scheduled going forward.

Action 7:
Existing cleaning schedules and procedures were reviewed by the Service Manager and Centre Manager at an additional staff meeting on 12/11/25.

Action 8:
The storage of mops and buckets in utility area was reviewed on 12/11/25. Designated mops and buckets used for cleaning soiled matter were identified & labelled. The utility room functions were reviewed, and changes were implemented last week in relation to food storage, labelling, and cleaning product storage,

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Action 1:
Targeted risk-management training commenced on 03/12/2025 to strengthen staff understanding of identifying, assessing, and mitigating risk.

Action 2:
A full training rollout on risk-management procedures will take place across the organisation in January 2026, with centre-based sessions scheduled to ensure all staff receive consistent guidance.

Action 3:

Existing risk-management procedures has been reviewed and refined throughout December 2025, pending the implementation of the new risk management platform system from January 2026.

Action 4:
All new and emerging risks will be added to the Risk Register during the monthly Risk Management Meeting. The updated Risk Register will be circulated monthly to ensure transparency and effective oversight. The Risk Register will also be presented to the Board by the Director of Care monthly.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Action 1:
Staff undertake introduction to Infection, Prevention and Control (IPC) as part of their induction. All care team staff took this training as refresher training from 10/11/25. Further IPC training will be completed specifically for the staff in Boyne Manor on 02/01/2026 by an external trainer.

Action 2:
Hand hygiene training for non HSE staff was completed by care team staff from 10/11/25.

Action 3:
The plumbing issues with the supply of water to hand washing sinks identified during the inspection were fixed on 06/11/25.

Action 4:
Daily checks of food in fridge by care staff are captured on schedule checklist.

Action 5:
Hazzard Analysis and Critical Control Points (HACCP) training on food hygiene was previously completed by only 2 staff members per Centre. Additional care team staff will complete the training including the identification of a Centre lead. This will commence in January 2026.

Action 6:
The Director of Care and/or Service Manager complete weekly Centre walk rounds which commenced on 10/11/25 capturing outstanding works needed, including decoration of rooms.

Action 7:
Centre audits of National Standards by external independent practitioner will commences in January 2026. The outcome of the audits will be presented to the Centre Manager, Service Manager, Director of Care, and Board. Consideration of the external trainer for IPC and HACCP completing an audit of the centre will also be given by the Board if warranted.

Action 8:
Hand sanitizers were installed by maintenance staff around the centre on 24/11/25.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Action 1:
Self-closing arms were fitted to outstanding fire doors on 11/11/25.

Action 2:
All wedges were removed from centre. Staff re-orientated to fire policy through the additional staff meeting on 12/11/2025. All staff were reminded to remove wedges if seen anywhere in the centre.

Action 3:
Full fire safety risk assessment was completed for Boyne Manor on 13/11/25 by an external person with appropriate qualifications and experience. The report was received recently and all actions will be completed by the end of January 2026.

Action 4:
All residents Personal Emergency Evacuation Plans (PEEP's) were reviewed as part of the additional team meeting on 12/11/25.

Action 5:
The Three Steps Fire Safety Management Policy was discussed with all Centre Managers at a meeting on 07/11/25 to feedback on the outcome of the Inspection, the key concerns highlighted regarding fire and safety procedures and the focus needed on fire drills and the procedure to follow in case of a fire were discussed.

Action 6:
Additional fire safety training for the care team from Boyne Manor was completed on 10/12/25 by our regular external fire trainers.

Action 7:
Staff were re-orientated to the organisations fire policy and evacuation procedure during staff meeting on 12/11/25.

Action 8:
Fire drills took place in the centre on the following dates:
• 30/10/2025 this fire drill was before the inspection, but unsuccessful and was reference in the inspection report.
• 12/11/2025 this fire drill was completed following the inspection and was successful on this occasion with all young people leaving the premises.
• 12/12/2025 this fire drill was successfully completed with all young people leaving the premises.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Action 1:
The Needs Review, Personal Plan, and Behavioural Support Plan were updated on 01/12/2025 to ensure they clearly reflect each resident's support requirements, proactive strategies, and positive behavioural interventions. A new introductory section was added to all documentation outlining the names, roles and sources of information contributing to the assessment.

Action 2:
A full review of the Programme of Care was completed with the Centre Manager and Deputy Centre Manager on 15/12/2025 to ensure all assessments and personal plans accurately reflect current needs and supports. Programme of Care documentation now needs to be rewritten in line with the above-named templates. This process will be completed by 31/01/2026.

Action 3:
All files will be organised and updated, including the removal of outdated photographs of former managers, to maintain accurate and relevant documentation. This has commenced and will be completed by 10/01/2026.

Action 4:
A comprehensive training and needs analysis session will be held on 16/01/2026, using a new template designed to identify gaps, enhance consistency, and ensure personal plans align with residents' assessed needs.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Action 1:
The Terms of Reference for Rights Review and Restrictive Practices Review will be finalised to ensure clear governance, accountability, and oversight. The first Rights Review and Restrictive Practices Review Committee meeting will commence in April 2026 and continue quarterly thereafter.

Action 2:
The Needs Review, Personal Plan, and Behavioural Support Plan templates has updated to ensure they clearly reflect each resident's support requirements, proactive strategies, and positive behavioural interventions. A new introductory section has been added to all documentation outlining the names, roles, and sources of information contributing to the assessment.

Action 3:

Reviews of Positive Behaviour Support Plans, to be conducted in January 2026, will include appropriate members of the clinical team.

Action 4:
Collaborative Behaviour Support Plans and Goal Planning with external stakeholders (for example, schools) will be reviewed by clinicians with regularity and appropriate meetings will be attended by clinicians at the request of the Centre Management team, Service Manager and/or Director of Care. These will be discussed at weekly P&C meetings.

Action 5:
The Model of Intervention will further inform Behaviour Support Plans through the structured framework of reviews and reflective practice it provides. The implementation of the Model of Intervention and its incorporation in organisational documentation for our disability services will be congruent with the roll out of training at centre and senior management level and in line with the Model of Interventions protocols.

Action 6:
The Behaviour Support policy will be reviewed and updated throughout the Model of Intervention process.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	15/12/2025
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Not Compliant	Orange	15/12/2025
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	Not Compliant	Orange	16/03/2026

	than full-time basis.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	15/12/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	16/01/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Red	06/11/2025
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Red	11/11/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery	Not Compliant	Orange	28/02/2026

	of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	19/12/2025
Regulation 23(2)(a)	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 prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	28/02/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the	Not Compliant	Orange	03/12/2025

	designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Red	10/11/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	10/12/2025
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.	Not Compliant	Red	12/11/2025
Regulation 28(4)(b)	The registered provider shall	Not Compliant	Red	12/11/2025

	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.			
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Substantially Compliant	Yellow	11/12/2025
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	19/12/2025
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.	Not Compliant	Orange	19/12/2025
Regulation 05(2)	The registered	Not Compliant	Orange	31/01/2026

	provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 05(6)(a)	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 multidisciplinary.	Not Compliant	Orange	01/12/2025
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.	Not Compliant	Orange	01/12/2025
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	Not Compliant	Orange	01/12/2025

	needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Not Compliant	Orange	01/12/2025
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	01/04/2026
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	01/04/2026