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:	10 March 2026
Centre ID:	OSV-0001804
Fieldwork ID:	MON-0049883

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
Tuesday 10 March 2026	15:00hrs to 19:45hrs	Raymond Lynch	Lead
Wednesday 11 March 2026	10:15hrs to 17:30hrs	Raymond Lynch	Lead
Tuesday 10 March 2026	15:00hrs to 19:45hrs	Jennifer Deasy	Support
Wednesday 11 March 2026	10:15hrs to 17:30hrs	Jennifer Deasy	Support

What residents told us and what inspectors observed

In November 2025, the Chief Inspector of Social Services issued a notice of proposed decision to cancel the registration of this registered designated centre. This was due to the level of non-compliance with the Regulations as found on an inspection of the centre on 05 November 2025, which was having a direct impact on the quality and safety of care provided for the young people living in this service.

The provider responded to the notice with a written representation, outlining the actions that they would take to address the areas of concern.

Overall, the findings from this inspection indicated that the provider had made progress in several areas and had achieved improved levels of regulatory compliance. For example, improvements were found in staffing, staff training and development, infection prevention and control, positive behavioural support and premises. However, a number of key actions were still in progress and had not yet been completed. These actions related mainly to fire safety, personal plans, communication and governance and management and all of these regulations were found to be non-compliant.

Subsequently, taking into account the continued level of non-compliance as found on this inspection and the complex needs of the young people living in this service, the Chief Inspector made the decision to reduce the number of registered beds from five to three until such time as the the issues as detailed in this report, has been adequately addressed. The Chief Inspector also made the decision to reserve judgement on the notice of proposed decision to cancel the registration of this registered designated centre and afford the provider more time to bring the centre into compliance given the progress levels observed on this inspection.

The purpose of this inspection was to ensure that the young people were safe and well cared for and that appropriate action was being taken by the provider to address the issues found on the last inspection. The inspectors spent most of day one of this inspection in the company and/or presence of the young people, so as to meaningfully involve them in the inspection process and to ensure that their lived experiences of the service were represented in this report.

The inspectors also had the opportunity to meet and speak with management and staff about the quality and safety of care. This included the deputy manager, the person in charge and nine staff members. Additionally, one inspector spoke with a manager from the quality team and a family representative so as to get their feedback on the service. Another inspector spoke with a principal social worker involved in the care of two of the young people living in the centre.

This designated centre was located in Co. Meath and was home to three young people aged between 12 and 16 years. The centre was a large detached building on

its' own grounds and it was observed to be clean and well-maintained. Each young person had their own bedroom and bathroom, and shared living spaces included a kitchen, sitting room and an activities room. One young person was seen to enjoy using the play equipment in the garden over the course of the inspection.

The young people interacted with inspectors in line with their preferences and abilities. While none communicated their opinions verbally on the centre; inspectors saw that they each appeared comfortable in their home and in the presence of staff supporting them. Staff were also observed to support the young people in a child-centred, caring and dignified manner. For example, staff members spoke positively to, and about, the young people that they supported. They were seen to interact with them in a fun and engaging manner and offered praise and encouragement regularly. Staff members also took care to ensure the young people were well-dressed and that their hair was neatly done when attending school or other appointments. Staff were also observed to be attentive to the needs of the residents at all times.

For example, a young person was seen to be distressed at times. Inspectors saw that the staff team were responsive to this young person's needs. They were seen to implement their positive behaviour support plan and were knowledgeable about different strategies that could be used to assist the young person to regulate. Staff members also ensured that the young person had pain relief medications as there was a known potential contributor to their distress. They took steps to protect the young person from harm when they engaged in self-injurious behaviour while ensuring that they were not restricting their bodily autonomy.

The designated centre had a large garden with a basket swing and a trampoline. The inspectors were told that one young person loved using this equipment and accessed it in all kinds of weather. Later in the evening, inspectors saw the young person sitting on the swing. It was dark and cold at this point and the young person’s hands were seen to be red when they came indoors. The inspectors asked if the provider had considered installing an indoor swing for the young person. They were told that an egg chair was available and a garden swinging bench; however, the young person was not observed using either of these over the course of the inspection, instead preferring the basket swing in the garden.

Inspectors also observed that one young person chose not to have their personal belongings in their bedroom. In turn, their personal items and clothing were stored in baskets on a large windowsill on the corridor. Storing personal belongings in communal areas (particularly for vulnerable young people) can create dignity issues by infringing on the young person's privacy. There was a small room opposite their bedroom that wasn't in use however, this room had not been considered as a more appropriate alternative for storing the young person's personal property. Notwithstanding, staff were observed to treat and handle the young person's personal belongings with care.

Additionally, inspectors saw that one young person had a very limited diet, choosing to mainly eat cereal, crackers and yogurts. Over the course of the first evening of the inspection the young person had three bowls of cereal and did not eat the

dinner that was on offer. Inspectors were told that this had been the young person's diet for several years and that a review by a relevant multidisciplinary professional had not taken place to ensure that this diet was meeting the young person's needs.

Later in the day, one inspector spoke with a family member over the phone so as to get their feedback on the quality and safety of care provided to their relative in the centre. They said that they were happy with the service and any issues they have had, were dealt with. They said that their relative seemed settled in the centre and had access to things that they liked to do for example a trampoline and swing chair. They were also satisfied that their relative was supported to look well and their clothes were kept clean. They kept in very regular contact with the centre so as to ensure their relative had everything that they needed and to see how they got on in school each day. They told inspectors that they were happy that staff had a good rapport with their relative and said that when their relative visits the family home, they were happy and content going back to the centre. They also said that they felt their relative was safe, that they could visit the centre at any time they wished and were always made to feel welcome.

The family member also said that their relative got to go out and about to places such as play zones and parks, the rugby club, trips to Dublin, go on boat trips and go for drives. On these outings staff would send the family member pictures of their relative enjoying their day out. They said that they loved getting these photographs and their relative seemed very happy in them. The family member also reported that their were days their relative might refuse to go out, but also said that this was typical of any young person. They said that their relative got on well with staff and enjoyed being in their company. When asked had they any complaints about the service they said they had none at this time and that overall, they relative was very well looked after.

Overall, improvements had been made since the last inspection of this service on 05 November 2025 and, staff were observed to interact and support the young people in a caring, person-centred and dignified manner all times. However, issues of non-compliance continued to remain with a number of key regulations.

The next two sections of this report outline 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 care provided to the young people.

Capacity and capability

Inspectors found that while a number of improvements had been made since the last inspection, a number of issues relating to the governance and management of the centre remained.

This inspection identified improvements in a number of regulations to include staffing, staff training and development, infection prevention and control, and premises. For example, a number of gaps in staff training had been addressed (notwithstanding, staff did not have training in communication). Additionally, a review of rosters for February and March 2026 showed that the required number to support the young people were present in the centre.

However, a number of actions from the provider's representation action plan and compliance plan still remained outstanding at the time of the inspection. While evidence of progress was observed, inspectors highlighted the need to see further work completed in this regard.

Regulation 15: Staffing

At the last inspection of this service on 05 November 2025, issues were identified with the staffing arrangements (over-reliance on agency staff) and with the upkeep/accuracy of the staff rosters.

This inspection found that while agency staff were still working in the centre, they had better knowledgeable on the assessed needs of the young people. Additionally, their interactions with the young people were observed to be kind, patient, caring and person-centred. Some agency staff spoken with, had worked in the centre for over two years and so had built up effective relationships with the young people they were working with.

There were three young people living in the centre at the time of this inspection and, each child was staffed on a 2:1 basis throughout the day. On review of the rosters for the first two weeks of January 2026, a number of gaps in staffing were identified which required the person in charge and or the deputy manager to provide direct care and support to the young people. However, on review of the rosters for the month of February and first week of March 2026, the inspectors noted the following:

- six staff were on duty each day (providing 2:1 staffing support to each of the three young people)
- one staff worked waking night duty
- two staff were on a sleep-over arrangement

The person in charge and deputy manager worked Monday through to Friday each week in the centre and, a staff member was identified as a shift lead/team lead each day (inclusive of Saturdays and Sundays)

The staff team consisted of a mixture of social care workers and health care assistants. Over the course of this two-day inspection the inspectors spoke with nine staff working in the centre (including agency staff). Generally all staff spoken with were able to demonstrate that they were aware of the needs of the young people and, at all times were observed to be person-centred, kind and caring in their

interactions with them. They were also observed to support the daily individual choices of the young people and encouraged their independence. For example, one inspector observed staff offering a young person a number of food options for breakfast and, the young person decided for themselves what eat. Additionally, the staff member and young person both helped clean up the table after breakfast.

Since the last inspection there were noted improvements regarding the layout and presentation of the rosters. For example, the inspectors were able to determine the staffing levels to include what staff were on duty each day and night and, who was responsible for team lead/shift lead duties each day. It was observed that the full-name for some staff was not on the roster however, this was actioned under Regulation 23: governance and management.

One inspector viewed the staff personnel files for the six staff on duty on day two of this inspection and noted that all six had the following on file:

- A vetting disclosure
- references
- Children's First training
- photographic identification

The person in charge also had systems and a schedule in place for the supervision of their staff team. Staff spoken with over the course of this two-day inspection raised no concerns about the care provided to the young people.

Judgment: Compliant

Regulation 16: Training and staff development

At the last inspection of this service on 05 November 2025, the training matrix was reviewed and a number of gaps in staff training were identified to include communication, autism awareness, manual handling and infection prevention and control.

On this inspection one inspector requested to view the actual certificates of completion of training for the six staff on duty on day two of this inspection and noted that all six had the following on file:

- fire safety
- training in the management of behaviours of concern
- safeguarding of vulnerable adults
- Children's First
- first aid
- manual handling
- infection prevention and control
- hand hygiene

- autism awareness
- safe administration of medication
- vetting and references

Staff spoken with also demonstrated that they were familiar with some of the assessed needs of the young people. For example, one staff was able to talk one inspector through the procedures and protocol in place on what actions to take when or if one particular young person had a seizure. A family member of this young person was spoken with by one inspector over the phone on the day of this inspection. They expressed gratitude and were complimentary of staff with regard to the actions they took and the support they provided to their relative the last time they had a seizure in the centre.

A number of agency staff were working in the centre over the two days of this inspection. One inspector spoke with one of those staff and they were familiar with the behavioural support required for two of the young people. They also said that they loved their work and expressed no concerns about the service. Additionally, they had an application on their phone from the agency they worked through, confirming that they had completed training in Children's First, infection prevention and control, fire training, open disclosure and cardio-pulmonary resuscitation. They also had evidence of vetting on this application. This staff member confirmed that they did not have training in the safe administration of medication however, said that they did not administer medication to any of the young people and, there were always staff on duty who had this training. Additionally, the person in charge confirmed this saying only staff with adequate training were permitted to administer medication.

The person in charge also confirmed with the inspectors that all staff, including agency staff had vetting on file and had completed Children's First and behavioural support training. Additionally, they all had vetting on their files.

Some training remained outstanding at the time of this inspection. For example, training in communication and self-harm/ligature training was required for some staff. The person in charge confirmed that some of these staff were relatively new to the centre and a plan would be put in place to provide this training.

Judgment: Compliant

Regulation 23: Governance and management

This inspection found a number of improvements had been made relating to staffing, training, premises, infection prevention and control and positive behavioural support. However, a number of issues continued to remain with regards to governance and management of this centre. For example,

- the annual review for the quality and safety of care for 2025 had not been fully completed at the time of this inspection. The person in charge explained that they were waiting on additional information and feedback to finalise this review. However, as per the provider's written assurances to the Office of Chief Inspector on 23 December 2025, this review should have been completed and finalised by 28 February 2026.
- an in-depth audit of the centre under Regulation 23: governance and management had been undertaken since the last inspection however, this audit was not finalised at the time of this inspection. The inspector spoke (over the phone) with the manager responsible for this audit and was assured that a number of key areas had been reviewed to include staffing, training, notifications, the young peoples details and restrictive practices. However, this audit had not been fully completed at the time of this inspection.

These reviews and audits should be completed in a timely manner and available for review at the time of this inspection as they are an important factor in ensuring the young peoples safety, help improve and maintain the quality and safety of care, and are used as evidence with regard to compliance with the regulations.

Some auditing of the service however, was being completed. For example, a member of the senior management team undertook regular reviews of the premises since the last inspection. This inspection identified that there had been significant improvements to the maintenance and upkeep of the premises since the last inspection. Additionally, on review of the minutes of a recent Centre Managers' meeting, the inspectors observed that a review of training had been completed which identified gaps that needed to be addressed. Additionally, rosters had been improved upon since the last inspection and, no gaps were identified on the roster for the month of February 2026 and first week of March 2006.

Notwithstanding, the auditing of the centre continued to require review taking into account the cumulative findings on this inspection and other issues the inspectors observed over the two days. For example:

- the child safety statement required review and updating so as to ensure it accurately reflected the name of the centre, provided an accurate description of staff qualifications and, an accurate description of the safeguarding training undertaken by staff. It is important that this mandatory document was accurate as it provides details on the policies, procedures and risk assessments in place to protect the young people living in this centre from harm
- while the person in charge said that the complaints policy had been reviewed, the complaints document provided for review on the day of this inspection did not provide information as to how the provider was assured the complaint was addressed to the satisfaction of the complainant. This issue was also highlighted on the last inspection.
- as found in the last inspection, there were a number of vacancies on the staff team and there continued to be an over reliance on the use of agency staff in this centre. High used of agency staff can impact on safety and continuity of care so this issue also continued to require review. Additionally, it was

observed that the surname for some staff working in the centre was not documented on the roster

- while this inspection found that all shifts were covered for the month of February and first week of March 2026, there were a number of staffing shortfalls in January 2026. The person in charge informed the inspectors that when there were shortfalls of staff, they and or the deputy manager would cover so as to ensure continuity of care was provided to the young people. The provider needed to keep this under review so as to ensure the person in charge and deputy manager had at all times, adequate protected time to manage the day-to-day operations of the centre.

Judgment: Not compliant

Quality and safety

Overall, the inspectors found that the young people were supported to take part in activities they enjoyed and where appropriate, supported to keep in contact with and spend time with their family members. Staff were also observed to support and respect the young people with their choices regarding their daily routines.

Additionally, improvements were found with infection prevention and control and premises and the house was observed to be clean and well-maintained on the day of this inspection. While some improvements were found with positive behavioural support and risk management, aspects of these regulations continued to require review.

However, this inspection found that a number of issues remained with fire safety precautions, communication and individual personal plans

Regulation 10: Communication

All three young people living in the designated centre presented with communication needs. The provider had failed to ensure that each child had a comprehensive assessment of their communication needs completed by a relevant multidisciplinary professional. While there was some guidance on young people's files, for example through positive behaviour support plans, individual education plans (IEPS) or summary reports received from school, these guidelines were inconsistently implemented. Staff members had not received any training in supporting the communication of the young people. Staff member told inspectors that they relied on their own experience and familiarity with the young people's preferences and routines in order to support their communication.

The provider had identified that some of the young people would benefit from an assessment by a speech and language therapist; however, they had not yet identified a referral pathway in order to access this support.

There was an inconsistent approach to using visual supports to assist young people to understand information and to communicate their preferences. Some care plans recommended the use of social stories and picture boards; however, staff members were unfamiliar with these and they were seen to be stored in inaccessible areas such as the staff office. One communication care plan detailed that the care team had developed a PECS (Picture exchange communication system) book to support a young person to communicate. Staff spoken with were not familiar with this PECS book or the care plan. An IEP for one young person detailed that they benefited from using objects of reference and first/then boards; however these were not implemented in the centre.

Other communication supports were purchased and were put into use over the course of the inspection; however, there was a lack of a suitable assessment to determine if these visual supports were appropriate to meet the young people's communication needs.

Judgment: Not compliant

Regulation 17: Premises

The premises had been significantly improved upon since the last inspection and were found to be clean, warm and generally well maintained on the day of this inspection.

Each young person had their own en suite bedroom and, they were decorated to their individual assessed needs and preferences.

However, the inspectors observed that the premises could have been utilised to better effect to further promote the privacy and comfort of the young people. For example,

- The storage areas for the young peoples' personal belongings and toys could be improved upon
- As detailed in section 1 of this report: consideration had not been given to utilising spare rooms in the centre to better meet the needs and preferences of the young people
- A mattress cover for one young person required replacing
- A hand wash sink was required in the kitchen.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

At the last inspection of this service on 05 November 2026 a number of issues had been identified pertaining to the management of risk. While this inspection found improvements with regard to the risk management process, a number of issues remained ongoing.

The person in charge informed the inspectors that managers had received training in risk management and, guidance had been provided to staff on risk at a recent staff meeting.

One staff member spoken with was able to inform staff about risks related to behaviours of concern and how such risks should be managed. For example, the young person was on 2:1 staffing support throughout the day, staff had training in the management of behaviour, behavioural support plans were in place and a structured daily routines was in place for the young person. The inspector observed a staff member supporting a different young person with a specific behaviour and the support they provided was person-centred, reassuring and professional.

Another staff member spoken with informed staff about a recent incident that had occurred in the centre where a young went missing when on an outing in a park. The young person left the park on a scooter through a small gate and as they were going at speed, staff could not catch up with them. The staff member explained how this incident occurred and what measures would be in place going forward to prevent this situation from reoccurring. For example, they said that they would now be aware of where the exits and gates were in the park going forward and which gates were locked or open. This was so the young person could not exit the park unnoticed. They also said that one staff would be ahead of the young person and one staff behind them at all times so as they were always in the line of view of staff. They explained to the inspector that the young person loved playing on their scooter in the park and, such an issue had never occurred in the past. Staff also carried a house phone with them with up-to-date pictures of the young people when on social outings.

Additionally, a risk assessment for absconsion reviewed on 05 March 2025 informed that the following control measures were in place to mitigate this risk:

- all three young people were on 2:1 staff support while accessing the community
- an absence disability plan was in place
- the police were to be contacted for support
- management on call were to be contacted
- the front gate to the house was locked
- a waking night staff member was on duty

The staff member above also spoke about what actions to take to support a young person and ensure their safety when or if they had a seizure. The young person in question had a seizure in 2025 and as a result was hospitalised. The staff member

said that if the young person had a seizure they would administer rescue medication after five minutes and, once the young person came around, they were brought to the hospital for review. If they didn't come out of the seizure, an ambulance would be called.

However, aspects of the risk management process continued to require review. For example:

- some of the control measures above as explained by staff regarding a child going missing or a child having a seizure were not adequately documented in the paper work provided to the inspector for review
- the last inspection found that some young people were at risk from ingesting inedible objects and, a number of control measures were in place to address this risk. For example, personal hygiene products and toiletries were kept under lock and key and, no unsafe liquids were left out. Additionally, any arts and crafts materials used in the centre were safe and non-toxic. Inspectors also observed that all young people were on 2:1 staff support throughout the day and the laundry/utility room was kept locked. Young people were also supervised during personal care and showering. However, (and as found on the last inspection), the scoring regarding a break in control measures in this risk assessment remained low and this issue was discussed with the centre manager at the last inspection. The scoring of these risk assessments continued to require review so as the service could be assured the risk was adequately assessed and mitigated.

Risk management strategies are essential for the identification and assessment of risk. More importantly, effective risk management helps mitigate against potential dangers and supports a safe environment and service for the young people. In turn, the issues as identified above, continued to require review.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The inspectors saw that there were significant improvements in respect of the infection prevention and control (IPC) arrangements of the centre subsequent to the last inspection in November 2025. The designated centre was seen to be very clean and well-maintained. Furniture had been replaced and was clean and comfortable. There were colour-coded mops, chopping boards and a colour-coded laundry system implemented. Cleaning schedules were in place and inspectors saw, on the first day of the inspection, that a company had been contracted to complete a deep clean centre. Three of the contracted company's staff were in the centre completing this deep clean.

Staff members spoken with were knowledgeable regarding the procedures for cleaning laundry. There were defined protocols for dealing with IPC-specific risks

presenting in the centre. Staff spoken with could describe these protocols and how they were implemented.

The inspectors saw staff members engaging in good hand hygiene practices over the course of the inspection. All staff had recently completed IPC and hand hygiene refresher training. Food was also seen to be stored hygienically in the centre's fridges.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had reviewed the fire management systems in the centre subsequent to the last inspection and, in particular, had reviewed the fire evacuation arrangements to ensure that all young people could be safely evacuated in the event of a fire.

The provider had enhanced the fire containment facilities and had installed automatic door closers on doors throughout the centre. Door wedges had been removed; however, inspectors saw that two fire doors were wedged open using shoes on the day of inspection. This potentially rendered the fire containment equipment ineffective and required review by the provider.

Inspectors also saw that a final exit door, in the utility room, was locked by a keypad and a key. Inspectors asked the person in charge to unlock the door however a key could not be found in a timely manner. Inspectors were told that all final exit doors were key locked by night time. This posed a risk to the young people living in this centre in the event of a fire occurring by night.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed all three of the young peoples' files which contained their assessments and care plans. Inspectors found that these were not a comprehensive reflection of each young person's health and social care needs and they were not informed by all of the relevant multidisciplinary professionals. There were significant gaps in respect of assessing and monitoring young people's dietary, general health, and their education rights and requirements. Actions required by care plans were not implemented in a timely manner, and in many instances, it was not established who was responsible for implementing these.

One young person was seen to present with sensory needs and sought tactile input from the inspector and staff over the course of the inspection. The inspector was told by staff that a sensory assessment had not been completed.

One young person's care plans detailed that there were multiple outstanding healthcare assessments including, for example, a review by a dentist, dietitian and a requirement for a blood test. This young person had not attended a dentist in "a number of years". The care plans detailed that these needs should be actioned between April to June 2026; however, there had been no progress in sending referrals or making appointments at the time of inspection. The care plans detailed that it was the responsibility of "management" to action these goals. It was not determined which manager was ultimately responsible.

A young person was also seen to have a very limited diet. Inspectors saw, on looking at files, and were told that this young person had not had an assessment by a dietitian to determine if this diet was meeting their needs.

Inspectors were told that one child was on a reduced timetable in school. Since 2024 this child, who was in primary school, had only attended school each day for approximately 30-40 minutes. The provider had failed to advocate for this child's right to a full education and had not reviewed the suitability of this school placement to determine if it was appropriate to meet their education needs.

Additionally, this child was due to transfer to secondary school in September 2026. A suitable school placement had not yet been secured. Inspectors were told that the provider had applied to schools but that the application was rejected as there was a lack of an up-to-date and comprehensive assessment of the child's needs to support the application. An assessment was ongoing at the time of inspection. It was acknowledged by managers on the day of inspection that this assessment should have been completed in a timely manner to plan for the known upcoming transition.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Each of the young people's files contained an up-to-date positive behaviour support plan. This plan detailed proactive and reactive strategies to assist the young people. The inspectors spoke with two staff in detail regarding these behaviour support plans. Staff members were informed of the plans and could describe how they responded to incidents of concern in a child-centred manner. Staff members told the inspectors that direct interventions were used as a last resort and were mindful of the need to uphold young people's autonomy and choice.

The inspectors observed staff members intervening during four incidents of concern over the course of the inspection. Staff members responded in a kind and gentle manner and took measures to protect young people from injuring themselves

without restricting them. Staff members were seen to use encouraging and positive language and often used fun and humour to re-engage young people in routines.

There were a high number of restrictive practices in place in the centre. Most of these were recorded on the centre's restrictive practices log. The inspectors saw that an additional restrictive practice, relating to the storage and use of the remote control, had not been identified as such.

While restrictive practices were logged, there was a failure to review these to ensure that they were implemented for as short a duration as possible. For example, the inspectors were told that one young person was limited to using their smart phone to one hour per day. This had been implemented six years ago when the young person was still in primary school with the intention of ensuring that the phone did not distract from other daily activities. It had not been reviewed to determine if this was still appropriate or required, or if the young person could have a longer time on their phone as would be more consistent with a young person of their age.

Door alarms were also in place on young people's bedrooms doors. The inspectors were told that these were activated by night with the intention of waking sleepover staff should the young person leave their bedroom. However, inspectors were told by one staff that one of the young people very rarely left their bedroom by night and usually slept through the night. It was therefore not established that these restrictive practices continued to be required, or that they had been reviewed to look at other less restrictive measures. Inspectors were told that the provider was in the process of setting up a rights and restrictive practices review committee at the time of inspection.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Boyne Manor OSV-0001804

Inspection ID: MON-0049883

Date of inspection: 10/03/2026

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	Not Compliant

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

1. A Safety Management Review audit was completed on 09/03/2026 which includes cross-sections of various themes.

2. The centre's audit system has since been revised in line with Regulation 23 requirements, including the adoption of the Regulation 23 Audit Template.

3. An unannounced audit was commenced by an External Consultant/Service Manager on 29/01/2026. A feedback meeting took place on 16/04/2026 and the final report will be presented to the Board on 24/04/2026.

4. The Governance Policy was formally reviewed and updated on 12/02/2026 to reflect the revisions made to the centre's audit systems and governance arrangements, ensuring alignment with regulatory requirements.

5. Annual Review for the Quality & Safety of Care for 2025 was completed for the centre on 30/03/2026.

6. An accessible version of the Annual Review for the Quality & Safety of Care for 2025 is currently being developed and will be completed with all residents by 31/05/2026.

7. The Safeguarding Statement will be updated and provided to the Tusla Child Safeguarding Statement Compliance Unit for review and approval by 04/05/2026.

8. The Complaints Policy will be further reviewed and updated to provide a clear process for identifying and satisfying the complainant by 31/05/2026.

9. Centre Manager has filled in full names of all staff on the roster and will continue with

a coherent roster layout going forward.

10. An organisational weekly recruitment meeting has been implemented involving the Centre Manager and Deputy Centre Manager, taking place every Monday since 09/03/2026, to proactively review staffing levels, address recruitment needs, and monitor progress in filling vacancies.

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
1. For one resident a referral has been made to the CDNT as the CDNT are not currently providing a service to this young person.

2. For the other two residents, they are both under the CDNT already and a referral for SLT has been made. The need for SLT input is highlighted in the Individual Family Support Plans (IFSP). However, no timelines for same has been provided. Centre Management will continue to liaise with the CDNT.

3. If SLT cannot be provided by the CDNT within a suitable timeframe Three Steps will engage an external consultant to complete outstanding assessments.

4. A full clinical review for placement for one resident is scheduled for 30/04/2026 by the Louth Meath Director of Nursing.

5. Centre Management will review the Programme of Care to ensure a consistent response to communication is in place for all young people. This will be completed by 22/05/2026.

6. The above will then be reviewed with the care team during their next team meeting on 27/05/2026.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Ongoing intervention is being completed with one of the residents to encourage personal belongings to be stored in their bedroom. While this intervention is underway, the care team have identified more storage areas for the resident.

2. The need for further handwash sink in the centre was discussed during the maintenance meeting which took place 21/04/2026. We are currently awaiting a plumber to come and install same.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. All risks and Risk Assessment Treatment Forms (RATF) were reviewed on 01/04/2026 in line with the Three Steps Risk Assessment Framework Tool.

2. A Serious Incident Review (SIR) took place on 20/04/2026 where the incident mentioned in the report was thoroughly reviewed. The Situational Management Plan has since been updated to reflect the learnings from the SIR.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. The Fire Safety Management Policy was reviewed and updated on 12/02/2026, the centre management team received training on the 20/02/2026 and the care team will be reviewing the policy to ensure full understanding and compliance with the revised procedures on the 13/05/2026.

2. A fire safety provider visited the centre on 07/04/2026 to review electronic automatic door closers. The centre is awaiting the fire safety provider to return and fit the electronic automatic door closers to three doors.

3. Centre Management will liaise with a competent fire person and alarm provider for guidance on centre exit doors at night for fire safety evacuation.

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:
1. For one resident a referral has been made to the CDNT as the CDNT are not currently providing a service to this young person.

2. For the one resident who is already under the CDNT. The need for OT input is highlighted in the Individual Family Support Plans (IFSP). However, no timelines for same has been provided. Centre Management will liaise with the CDNT to ensure the appropriate referral has gone in.

3. If OT cannot be provided by the CDNT within a suitable timeframe Three Steps will engage an external consultant to complete outstanding assessments.

4. A full clinical review for placement for one resident is scheduled for 30/04/2026 by the Louth Meath Director of Nursing.

5. Centre Management will review all Personal Plans to ensure timelines and persons responsible for actions are clearly noted. This will be completed by 31/05/2026.

6. A full clinical neuropsychological assessment is underway for one of the residents and will be completed by 31/06/2026. The outcome for same will help plan the education needs for this resident going forward. Applications to schools in the local area have already been submitted in relation to this young person.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

1. The Behaviour Support Policy will be further updated by the 31/05/2026 to explicitly include detailed processes and individual behaviour support plans, ensuring clarity, consistency, and alignment with regulatory requirements.

2. The Positive Behavioural Support Plans will be completed for all young people by the 31/05/2026, ensuring that each plan is individualised, comprehensive, and informed by assessed needs.

3. The Functional Analysis was completed in January 2026 which helped inform the development and review of behaviour support strategies.

4. The behaviours of each young person are formally reviewed at Planning & Coordination (P&C) meetings, with input from the multidisciplinary team, to ensure ongoing oversight and timely intervention. These discussions are recorded in the P&C minutes for each centre.

5. A review of the P&C Terms of Reference took place on 31/03/2026 and a new bi-weekly meeting format which includes centre management and care teams attending the meeting will commence on 13/05/2026.

6. Significant Events Notifications (SENs) and cumulative SENs are reviewed in line with the Functional Analysis to ensure consistency, learning, and appropriate response to behavioural incidents.

7. Phase 2 of the assessments will be completed by the end of June, with the final phase completed over the summer, with Social Work involvement, and all assessment reports expected by September.

8. Evidence of restrictive practice review will be documented going forward.

9. The Terms of Reference for the Rights and Restrictive Practices Committee will be finalised and implemented, with the committee scheduled to meet in April to ensure appropriate oversight of rights-based practices.

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	31/07/2026
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	27/05/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the	Substantially Compliant	Yellow	31/05/2026

	number and needs of residents.			
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	31/05/2026
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.	Substantially Compliant	Yellow	31/05/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment,	Not Compliant	Orange	27/04/2026

	management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/05/2026
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/05/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/05/2026
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/07/2026

Regulation 05(2)	The registered 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).	Not Compliant	Orange	31/07/2026
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).	Not Compliant	Orange	31/05/2026
Regulation 05(4)(b)	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 outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	31/05/2026
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	Not Compliant	Orange	31/07/2026

	frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.			
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Not Compliant	Orange	31/05/2026
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	30/04/2026