Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Dunsany
Name of provider:	Three Steps Limited
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	05 November 2025
Centre ID:	OSV-0005280
Fieldwork ID:	MON-0047815

About the designated centre

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

Dunsany is a community based residential centre for up to two adult residents with an intellectual disability. The centre was situated in a rural setting, within a short car journey from a nearby town in Co. Meath. It comprised of a dormer bungalow which has been divided into two separate living areas with two bedrooms in each area and sitting room and activity areas. There is a shared kitchen and utility room which is used by both areas. The house was set on its own grounds with a secure garden dedicated to each of the two living areas. The centre could accommodate two residents, with one living in each of the living areas. The residents were supported 24 hours a day, seven days a week by a staff team comprising of a person in charge, team leader and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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	Karen Leen	Lead
Wednesday 5 November 2025	10:00hrs to 19:00hrs	Lisa Walsh	Support

What residents told us and what inspectors observed

This inspection outlines the findings of an unannounced risk inspection, completed to assess the provider's regulatory compliance in relation to the care and welfare of residents 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 residents, and information reviewed, the inspectors found highly significant regulatory non compliance with the regulations reviewed on the day of inspection. The inspectors found that the regulatory non compliance resulted in areas for improvement that were required in order to ensure that residents were in receipt of a safe and quality service.

Inspectors had the opportunity to speak to one resident, three support staff, the deputy manager, the person in charge, service manager and the director of care over the course of the inspection. Inspectors found that staff spoken to had knowledge of residents needs, however, inspectors found that support staff could not fully engage all residents in meaningful activities both in their home and their local community due to the lack of guidance and lack of consistent review of behaviour supports for residents. Furthermore, inspectors found that in order for one resident to participate in activities they required the support of two staff with inspectors identifying that from September 2025 this level of support was not available throughout the day due to the provider reducing the number of staff available from three to two during periods of the day.

Dunsany comprises a large dormer bungalow located near a town in County Meath. The centre is registered for two residents, at the time of the inspection there were no vacancies. The centre is divided into two separate living areas, with a shared kitchen area. Access to the kitchen area was restricted for one resident which resulted in the resident not being able to access the kitchen in their home. Each separate living area contained a dining area, sitting room or sensory room, resident bedroom, bathroom, staff sleep over room and a staff office. Residents had access to a large enclosed garden, which was equipped with a number of outdoor activities including a trampoline, swings, mud kitchen, sun area, bikes and scooters.

On arrival to the designated centre, inspectors were greeted by the team lead and two support staff. Inspectors were advised that one resident remained in bed and that they were taking a later start to their day and that another resident was leaving the centre to go for a drive with support staff.

On commencing the inspection, support staff discussed with the inspectors that for

one resident meeting the inspectors could have a possible negative affect on their well-being and could result in incidents of self injurious behaviour. In line with the guidance provided by support staff, inspectors did not directly engage with one resident due to the potential stated risks that had been outlined for the resident. The inspectors were informed by support staff that the resident can become distressed and anxious when presented with unfamiliar visitors to their home and this could result in the resident entering a cycle of upset resulting in adverse incidents. Inspectors were informed that the other resident may meet with them if they choose to.

Inspectors completed a walk through of one resident's area within the home while they were attending a drive with staff. Inspectors observed that the resident did not have access to the shared kitchen area. Staff informed inspectors that the kitchen can cause significant upset for the resident, previously resulting in adverse incidents; and that a locked keypad door was required. Inspectors asked support staff how the resident accessed food and drink when they where hungry or thirsty. The inspectors were informed that the resident had access to a small fridge in the dining area of their home which contained snacks for the resident. However, when inspectors checked the fridge they found it was empty of food and shelving. Later, inspectors asked the person in charge how the resident accessed food and drink during the course of the day, and they were informed that snacks were offered as incentive to the resident in between meals and prior to going out on the centre transport.

Through a review of documentation and adverse incidents in the centre, inspectors identified that a number of incidents occurring in the centre were attributed to lack of access to food and the shared kitchen. Inspectors reviewed the behaviour support plan and other supporting documentation for one resident which identified that some of the triggers for the resident's adverse incidents were in relation to requests for food and waiting for meals. Inspectors found that while the resident did not have access to the kitchen in the house, they had a clear visual from their dining room exit door into the kitchen of the centre.

Inspectors reviewed minutes of senior management meetings which stated that staff were not to spend too much time at the doors of the kitchen as this was increasing behaviours of concern and leading to adverse incidents. Staff were also advised to enter areas of the home through an alternative door from the kitchen. However, there was a clear visual from the dining room to the locked kitchen of the house where residents could see staff in the kitchen participating in meal preparation and their peer members having unrestricted access to food and drinks.

One resident had moved into the centre within the last year and was working towards their goals, with staff learning more about them and their needs. Inspectors were informed that this resident's preferred area of their home was the outdoor area, which they used in all seasons. They enjoyed the swing and had a shed which contained large bean bags where they would relax. On the day of inspection the resident was observed relaxing in their sitting room having snacks while watching television and later went for a drive with staff in the community. Inspectors greeted the resident in the afternoon and attempted to chat with them, however, the

resident did not want to engage and continued to watch their television programme. Inspectors found that this resident had free access to all communal areas within their home including the garden area.

During the course of a walk around of the designated centre, inspectors observed a large bean bag placed against the external wall of the designated centre. Inspectors enquired why the bean bag had been placed outside of the house, the deputy manager informed the inspectors that the bean bag was used by support staff when transitioning one resident from their home into their transport. This was used for the resident as part of each transition to and from transport. Support staff informed the inspectors that the bean bag was placed to the front of the car so that the resident could not access this area while being positioned into their transport. Inspectors were informed that this was done as a safety measure to prevent the resident from participating in property damage. When asked by inspectors how the resident would exit the transport in the community without the bean bag present, support staff informed the inspectors that the resident's behaviours of concern were too severe to allow for staff to offer the resident the option of exiting the vehicle in the community. Inspectors later reviewed the residents behaviour support plan and transport risk assessment and found that the use of the bean bag had not been documented or reviewed as a support measure.

Inspectors found that activities in the centre such as jigsaws, sensory items and soft toys were not stored in residents' main living areas. These items were kept in storage containers in a locked staff meeting room when not in use. Support staff informed the inspectors that this was due to residents requiring a low arousal environment and to reduce property damage.

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 resident living in the centre

Capacity and capability

This section of the report describes the oversight arrangements for the centre and how effective they were in ensuring that residents were in receipt of good quality care. This inspection found that the management systems and processes in place to oversee the care and support being delivered to the residents 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 found that there were significant deficits in the provider's oversight of the centre which resulted in a negative impact on the quality of life and lived experience of residents.

The inspectors were not assured on the day of inspection that there were appropriate management systems in place to ensure that the service provided was safe, consistent and appropriate to residents' needs. The provider's audits failed to self-identify areas for improvement in the centre. The provider had implemented a number of management systems in the centre such as daily management checks and monthly management audits, however, the inspectors found that these audits had failed to identify areas for improvement in the centre.

There was a full time person in charge in the centre, and also a deputy manager and team lead who reported into the person in charge and supported them in the management of the designated centre. However, on the day of the inspection the person in charge informed the inspectors that the provider had a plan in place to give them additional responsibilities for a second centre within the service. The person in charge had been in the process of completing a handover for the second centre but no notification had been made by the provider to the Chief Inspector of Social Services.

Regulation 15: Staffing

Inspectors were not assured that the provider had the required numbers of staff available with the required skill mix having regard to the size and layout of the centre and the assessed needs of the residents. Inspectors were informed that a new position for a 'New directions' staff member was being recruited to work from Monday to Friday 09:00 to 17:00. Documentation reviewed noted the provider had been trying to recruit for this position since at least March 2025. A person was found to have begun in the post, however, they left after initial shadow shifts. Inspectors were informed that the 'New directions' staff would support residents access to the community, however, it would only be available to one resident and not the other resident living in the centre.

Through a review of documentation, inspectors identified however, that this was not an additional post, which local management later confirmed. In addition, from a review of the staff rotas for August and September 2025 there had been a reduction of staffing between 17:00 to 21:00 from September, without any evidence available on the day that there had been a review of residents' assessed needs to inform this reduction. In August 2025, there were two sleep over shifts from 10:00 to 11:00 and a day shift from 09:00 to 21:00. In September, this had reduced to two sleep over shifts from 10:00 to 11:00 and a day shift from 09:00 to 17:00, meaning that staffing from three staff to two staff between 17:00 and 21:00. Staff meeting records also confirmed this reduction of staff.

One resident required a two to one staffing ratio at all times, as per their risk assessments, which meant that the other resident would not have sufficient staff support available to them based on their assessed needs between 17:00 and 21:00. Records also indicated that the resident left without staff support had had an adverse incident during this time frame. Management noted that incidents like this

would happen and directed staff to check on the resident to ensure they are happy.

The reduction in staff between 17:00 and 21:00 also impacted residents ability to engage in meaningful activities after 5pm as there was insufficient staff available for them to leave the centre based on their assessed needs.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, the inspectors found that the provider had failed to effectively implement monitoring tools and management systems to ensure that the service was effectively managed and that residents were being provided with a safe and quality service.

While the provider had a suite of internal audits available such as daily management checklists, monthly management audits and weekly planning and coordination meetings with senior management, the inspectors found that these systems were not identifying or addressing concerns or risks highlighted within the centre. For example, the planning and coordination meetings held for residents on the 15 April , 29 April and 13 May 2025 highlighted a number of concerns for residents including the need for medical review, medication review and the on-going use of restrictive practices in the centre. Inspectors found that under the minutes a template held sections for decisions, actions, person(s) responsible, action due date and current status the entry for these essential components were entered as not applicable, despite residents requiring support in the aforementioned areas of care.

While the inspectors found that the provider was completing six monthly unannounced provider led audits of the centre, these audits were ineffective in capturing and actioning key areas of concern in the centre as highlighted in the course of inspection such as fire procedures. The six monthly unannounced audit conducted by the provider reviewed one singular theme from the National Standards for Residential Care for Adults with Disabilities. For example, the six monthly provider unannounced audit completed in August 2025 focused on theme seven: responsive workforce. The inspectors found that the auditing system utilised by the provider was not tailored to identify concerns outside of the chosen theme.

The provider had recently made changes to the staffing levels in the centre, since September 2025. The inspectors found that the provider had not completed a formal review of the residents assessed needs in line with the reduction of staffing in the centre and that the change in the staffing whole time equivalence had not been reflected in the statement of purpose. As a result of the decrease in staff, the designated centre as not resourced to ensure the safe and effective delivery of care and support in line with the statement of purpose or the residents assessed needs.

While there was a defined management structure in place, the person in charge had recently been requested to provide governance and management support to second centre within the providers remit. Due to the high level of non compliance found on

this inspection, the inspectors were not assured that the person in charge would have the sufficient supports or administration time available in order to ensure that the governance and management oversight required for Dunsany would be met.

An annual review for 2024 was not available for inspectors to review. Inspectors requested this review, however, the person in charge could not provide it during the course of the inspection. The inspectors acknowledge that the person in charge had commenced their post in June 2025, however, on the day of the inspection they could only present the inspectors with the annual review completed for 2023.

Judgment: Not compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the residents. Overall, the inspection findings identified significant concerns regarding the centre's risk management processes and residents access to supports which would reduce the use of restrictive practices in the centre and uphold residents' human rights. Inspectors found that due to the lack of appropriate behaviour supports and multidisciplinary review residents were being subjected to institutional practices such as living in restricted and isolated environments with no plans for reduction and community development. Furthermore, inspectors identified a number of concerns in relation to Regulation 28: fire precautions in the centre. Leading to an urgent action plan being issued to the provider immediately following the inspection, to be returned within five working days.

Inspectors found that the provider had failed to operate the designated centre in a manner that is appropriate to resident age and assessed needs, with a failure respond to residents changing needs in a timely manner. Inspectors found that the provider had failed to provide relevant multidisciplinary supports in line with identified changing needs for residents over a 12 month period which had led to access to the community being restricted to specific periods of the day or only from within a vehicle and limited access to areas of the designated centre. Furthermore inspectors found that the provider was implementing a number of restrictive practices such as the locking of rooms in the designated centre as staff were unable to provide supports to resident during adverse incidents due to an ongoing lack of positive behaviour support guidance and training.

Inspectors found that while the provider had implemented a number of arrangements to protect residents and staff from the risk of fire, such as fire doors and emergency lighting, inspectors found that there was a number of concerns in relation to the evacuation procedures for residents, completion of fire drills and the containment measures in place in the event of a fire. Furthermore, inspectors found that residents' Personal Emergency Evacuation Plans (PEEPs) contained the wrong information which could lead to support staff implementing a non-prescribed two

person hold to a resident during a fire evacuation.

Regulation 13: General welfare and development

From inspectors observations, a review of documentation and speaking with staff in the centre, inspectors were not assured that both residents were supported and encouraged to integrate and participate in the community in which they lived. While one resident was beginning to engage in activities in the community, one resident had not been supported or encouraged to do this. For example, staff reported that one resident liked to go for a drive in the community, which they did regularly. However, while out driving in the community there had been no support provided to the resident to get out of the vehicle, in a year with support staff informing inspectors that this was due to the resident's behaviours.

Throughout the previous year, there had been short periods of time where the resident had no recorded significant adverse events. However, during these periods there was no evidence of any attempts to engage the resident in meaningful activities in the community. There was no evidence that an assessment had been completed or any referrals sent to seek support and guidance from an expert in this area to ensure that the resident had opportunities to participate in activities and live a full and meaningful life.

One resident was observed to live in isolation in the centre with no opportunities to make friends, have meaningful relationships with others or be involved in the community. In the past year this resident only had the opportunity to engage with staff in the centre, outside of their family.

The provider had been proactive with a plan to implement a 'new directions' worker for one resident, which would help facilitate their engagement to activities and the community. However, this would only be available to them and not the other resident living in the centre. In addition, with the introduction of this new position, the provider had reduced staff hours since September 2025 with one of the three staff on duty finishing at 17:00 instead of 21:00, meaning that residents choice to in activities was further limited to specific times of the day due to staff availability.

Judgment: Not compliant

Regulation 26: Risk management procedures

Inspectors reviewed the risk register for the centre and found that it was not subject to regular review. The last review of the risk register was completed in April 2025. Inspectors found that the risk register did not reflect risks identified by the inspectors during the inspection. Inspectors found that a number of actions required

in relation to risk management were outstanding or required review. For example:

- one staff member was awaiting medication training which was to be completed by 30 April 2025 and was recorded as being overdue.
- a request had been made for one resident to have a capacity assessment to support them with the decision to purchase a new car and to manage their finances. This was also noted as overdue since April 2025.
- due to stated behaviours of concern, one resident required an observation by a clinical psychologist which was to be completed by the 2 April 2025 and was recorded as overdue.
- a consultation with a clinical psychologist was to followed up by 3 April 2025 and was noted as overdue.

The inspectors were not assured that residents had safe staffing levels in place in order to ensure that the assessed needs of each resident was being met and to ensure that residents could be supported to evacuate in the event of a fire, as detailed in Regulation 15: Staffing.

Post incident reviews were taking place in the centre, which included reviews of incidents occurring affecting both residents and staff. Inspectors found that the information detailed in the reviews were repetitive in nature and that the actions identified had not been completed in order to support residents post incidents or to reduce the possible re-occurrence of such incidents. For example, the inspectors reviewed four post incident reviews completed on the 20 September 2025, two completed following incidents on the 26 September 2025 and 28 September 2025. Each of the post incident reviews stated that a medication review was required for one resident as per medical advice. However, inspectors found that this resident had not received a medication review in a 12 month period despite the commencement of newly prescribed medication in October 2024.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors completed a walk through of the designated centre with the deputy manager. The designated centre was equipped with internal fire doors, however inspectors found that for a number of rooms including, sitting room, kitchen, dining room and sensory room, the doors were left open during periods of the day. The inspectors observed that no fire doors in the designated centre were fitted with self-closing mechanisms which would ensure that the fire doors would automatically close in the event of a fire in the centre. Support staff stated that these doors were closed when residents were home, however, inspectors observed a number of these doors including the kitchen door leading to one side of the house to remain open throughout the course of the inspection.

The inspectors spoke to the person in charge and the deputy manager with regards

to plans in place by the provider to upgrade the fire doors to enhance the safety of residents in the centre in the event of a fire. When clarity could not be given in relation to planned works, the inspectors sought assurances by speaking to the Service Manager and the Director of Care for the provider in relation to possible time frames or plans for the upgrading of fire systems. Inspectors were informed that the provider had arranged for an architect to visit to centre to review the works required. Inspectors requested that the provider update inspectors in relation to the time frame or plan in place by during the course of the inspection, however, this was not provided to inspectors. As a result, the inspectors issued the provider with an urgent action in relation to Regulation 28: fire precautions.

Inspectors reviewed the Personal Emergency Evacuation Plans (PEEPS) for both residents living in the centre. Inspectors found that there was not sufficient information available to guide staff practice when assisting residents to safely evacuate their home in the event of a fire. The inspectors found that PEEPs for one resident had been a duplicate of information copied from the evacuation plan in place for their peer member. One resident may require the use of a specialised hold completed by two staff to assist them to safely evacuate their home, however, inspectors found that this information was duplicated onto another resident's form who did not require a hold by staff in order to evacuate. Furthermore, inspectors found that the PEEP did not clearly identify at what point in the evacuation process should the 'hold' be implemented by staff. On review of both residents' information it was evident that during fire drills both residents had at one point refused to leave the centre. Inspectors found that the misinformation assigned to one resident could lead to the resident being placed in a hold by support staff if they refused to leave the centre.

Inspectors requested to review the fire evacuation plan for the designated centre, however, on the day of the inspection no fire evacuation plan was available for review. The inspectors requested the fire evacuation plan on three occasions during the course of the inspection, the person in charge and support team could not provide a fire evacuation plan and furthermore, when asked by inspectors there was no clear guidance by staff on which resident presented with higher needs and who required immediate support to exit the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors found that goals in place for residents were subject to regular review by support staff. However, inspectors identified that while goals were being reviewed through one-to-one keyworker supports the review did not identify clear action plans when a goal was not being met for the resident. Furthermore, the goals identified for residents did not promote meaningful activities but were based around aspects of care such as toilet regimes and on-going dental support plans. Inspectors reviewed a goal for one resident for running or walking freely either within their

local community or an enclosed all weather games area. Inspectors found that this goal had been in place since February 2024, with no progress having been made for the individual and no guidance or supports in place to assist the resident to meet this goal.

Inspectors found that a speech and language therapy review had been completed for one resident in May 2023, this review highlighted a number of strategies to assist one resident with their communication needs. These strategies included visual aids and the implementation of intensive interaction strategies. The inspectors could find no evidence that staff had received training in the area of intensive communication strategies and no evidence of support plans in place to guide staff practice. While the inspectors found that residents had visual aids such as social stories in place, from review of the social stories used to support residents understanding of activities and plans for their day inspectors found that the information in the social stories were out of date, contained the wrong information or did not include essential parts of residents plans. For example, accessible information for one resident in relation to who to make a complaint to contained pictures of the wrong staff and the social story for one resident in relation to their transition to transport from their house did not incorporate the use of the bean bag while transitioning on and off transport.

Inspectors reviewed the personal planning meeting for one resident which held in February 2024 and found that family members of one resident had expressed their concerns in the change in the presentation of their loved one and their inability to avail of community integration. The family members had recognised that the provider had made a number of referrals in order to ascertain if the change in their loved ones presentation was due to medical concern. In June 2025, it was discussed at a staff meeting how frequency of a resident's instances of behaviours of concern had increased, and instances of self injurious behaviours had increased over recent months. However, there were no action in place to ensure the resident was assessed and their needs were met. In July 2025, the parents of one resident enquired about medication changes that may be required for the resident based on an expert opinion they had sought. There was an action in staff meeting records for the psychiatrist to be contacted in relation to the resident's medication, however, on the day of inspection the resident was still awaiting a medication review. In September 2025, family members continued to raise concerns about the changes in presentation and increases in self injurious behaviours for one resident, which were discussed at staff meetings. However, no actions were noted to respond to these concerns. Inspectors found that a number of referrals had been made by the provider for one resident in February 2024, however, on the day of the inspection the provider had failed to ensure that the needs of the resident were assessed by appropriate healthcare professionals. For example, a medication review post commencement of new medications in October 2024.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Inspectors reviewed one behaviour support plan in place in the centre and found that the behaviour support plan was based on a review completed by a paediatric neuropsychologist in March 2022. Inspectors found that the support plan in place did not currently guide staff practice in a manner that would reduce identified triggers for the resident. Furthermore inspectors found that the support plan was contradictory in nature with relevant risk assessments and person centred plans in place for the resident. For example, the behaviour support plan stated that the resident required a low arousal environment when engaging in behaviours of concern. However, associated support plans, reviews and risk assessments stated that staff were to act in a jovial manner when the resident was participating in behaviours of concern.

Inspectors found that while the provider had notified the Chief Inspector that a number of internal rooms in the designated centre were locked during certain periods of the day such as kitchen and staff sleep over bedrooms, the provider had failed to notify that other areas of the centre were locked. For example, a sensory room for one resident was locked at night time. When inspectors questioned the rationale for the sensory room to be locked at night time, inspectors were informed that this was due to the possible development of poor habits for a resident who may try to enter the room during night time periods and fall asleep there.

Inspectors reviewed minutes of meetings held by senior management, referred to as planning and coordination meetings from April and May 2025 which provided an overview of residents' presentation on a weekly basis. Inspectors found that the centre only had access to the minutes of the planning and coordination meetings from January to May 2025 to support staff knowledge and practice. Inspectors reviewed a meeting held on the 22 April 2025 which recommended that staff completed training in theraplay strategies in order to support residents who participate in behaviours of concern. Additional minutes from a planning and coordination meeting held on the 06 May 2025 highlighted that staff were still awaiting training in theraplay strategies. The inspectors requested the training records of staff who had completed theraplay training, however, no record was available for inspectors review and support staff or senior management could not confirm if the training had taken place. In addition, inspectors found that the planning and coordination meetings discussed the rate of occurrence of incidents for residents in the centre for self injurious behaviour or behaviours directed at support staff. However, these meetings did not action supports required by residents to decrease or identify the possible cause of incidents in the centre.

Behaviour support plans in place for one resident for example, identified that food, meal times and waiting for meals were difficult periods and could lead to self injurious behaviour. However, as previously discussed this resident did not have adequate supports in place in order to ensure that they could readily access food and drinks.

Inspectors found that residents had support plans in place titled ''expectations, rules and consequences''. These support plans documented a number of plans for residents including what social behaviours are expected, these support plans did not

identify the creator of the support plan and was not signed off by a support staff or member of the multidisciplinary team.

Inspectors found that for one resident their access to community activities and supports was limited to a number of bus drives throughout the day. The resident did not have an opportunity to leave the bus to participate in activities despite support plans in place identifying the need to find safe areas for the resident to participate in supported walks.

Inspectors found that the language used to identify possible behaviours was not appropriate to describe the residents presentation during times of upset or distress. For example, an emotional support plan in place for one resident under the topic "issue presenting" the description in place identified as "outbursts- tantrums" that appear to be out of the blue with no obvious signs, causes or triggers. Inspectors found no review of support plans to identify possible triggers.

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 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 26: Risk management procedures	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 Dunsany OSV-0005280

Inspection ID: MON-0047815

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: The service completed a structured review of current staffing arrangements, conducted by the Centre Manager, Team Leader, and Service Manager on 03/12/2025. Appropriate cover is in place at all times which can be evidenced by the roster. Action 2: Review assessment of staff qualifications, skills, and overall mix in line with CORU to ensure appropriate alignment with residents' needs on 16/12/2025. Action 3: Full analysis of the care agreements and service level agreements for both residents will be completed on 16/12/2025. Action 4: Statement of Purpose & Function will also be reviewed on 11/12/2025 to ensure it accurately reflects current service delivery and staffing structures.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Action 1: Centre Managers reviewed daily operational checks during the Centre Managers Meeting on 05/11/2025 to strengthen oversight and ensure consistent governance practices.	

Action 2:
The terms of reference for the P&C (Planning & Coordination) meetings will be reviewed on 11/12/2025 to reflect current governance structures and the appointment of the new Business Administrator.

Action 3:
A new minutes template has been developed and introduced to ensure daily meetings capture key discussions, decision-making processes, and assigned actions in a clear and accountable manner.

Action 4:
The Service Manager has reviewed and updated the P&C template on 05/12/2025 to improve clarity, consistency, and alignment with governance requirements.

Action 5:
Audits were discussed at the Centre Managers Meeting on 28/11/2025, including the proposal to introduce a new information-led audit tool. Recurring themes and issues identified across services will inform the audit design. The revised audit system will be implemented by the end of January 2026, in line with the next scheduled audit cycle.

Action 6:
An annual review process will be undertaken on 11/12/2025 to evaluate the quality, completion, and submission of audits. This review will be submitted for Board approval to ensure effective governance oversight at the January Board meeting on 09/01/2026.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Action 1:
Service will update and amend the Need Review, Personal Plan, and Behavioural Support Plan documentation to ensure they reflect current best practice and accurately capture each resident's support requirements. These will be further reviewed during service development & integration of Social Care & Clinical Practice.

Action 2:
On 03/12/2025, the Service Manager attended the centre to review all relevant forms and provide direct guidance to the Centre Manager and Team Leader on how to complete the updated documentation correctly and consistently.

Action 3:
A full review of one resident's Programme of Care will be completed on 03/12/2025 to

ensure their developmental, social, and general welfare needs are clearly identified and appropriately planned for.

Action 4:
Consultant Psychiatrist will carry out a comprehensive medical review of the resident on to inform ongoing care planning and ensure all health-related needs are fully understood and addressed.

Action 5:
The MDT Consultation notes for the Consultant Psychiatrist will be examined, and a clear record will be maintained of all actions arising from those consultations to ensure appropriate follow-up and accountability.

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 will be reviewed and refined throughout December 2025, pending the implementation of the new BoardX system from mid-January 2026 onwards.

Action 4:
All new and emerging risks will be added to the Risk Register during the monthly Service Manager Meeting. The updated register will be circulated monthly to ensure transparency and effective oversight.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Action 1:
Door closers fitted to all fire doors on 12/11/25.

Action 2:
A competent fire person was commissioned by Three Steps to undertake full fire safety risk assessment at Dunsany. Fire risk assessment was completed by BM on 13/11/25.

Action 3:
Centre Fire handbook was reviewed at meeting on 13/11/25 and updated.

Action 4:
Fire policy, evacuation plan and PEEPS were reviewed and updated at staff meeting on 13/11/25.

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:
An additional team meeting for Dunsany staff was scheduled for 13/11/25 with Director of Care present to discuss the Fire Safety Management Policy highlighting the procedures, ensuring dates for the implementation of fire drills and ensure clarity with all staff on procedure to follow in case of a fire.

Action 7:
A fire team/company have been commissioned to do additional fire safety training for the care teams which is booked to take place on 10/12/25.

Action 8:
Fire safety handbook gap analysis against the regulations to identify the areas that need further development to be completed by the end of February. To be discussed at the Centre Managers meeting starting in January 2026.

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:
A full review of the Programme of Care was completed with the Centre Manager and Team Leader on 03/12/2025 to ensure all assessments and personal plans accurately

reflect current needs and supports.

Action 2:
All files were organised and updated, including the removal of outdated photographs of former managers, to maintain accurate and relevant documentation.

Action 3:
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.

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 & Restrictive Practices will be developed on 11/12/2025 to ensure clear governance, accountability, and oversight. The updated meetings will commence in April 2026 and will continue on a quarterly basis.

Action 2:
The Centre Manager and Team Leader will participate in therapeutic-based training delivered by Consultant Neuro-Psychologist commencing week starting 19th of January. This training will strengthen their capacity to implement positive behavioural support strategies and reduce reliance on restrictive practices.

Action 3:
The Needs Review, Personal Plan, and Behavioural Support Plan will be updated to ensure they clearly reflect each resident's support requirements, proactive strategies, and positive behavioural interventions. A new introductory section will be added to all documentation outlining the names, roles, and sources of information contributing to the assessment.

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 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	12/12/2025
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	13/12/2025
Regulation 15(1)	The registered provider shall ensure that the	Not Compliant	Orange	16/12/2025

	number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	03/12/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	16/12/2025
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with	Not Compliant	Orange	09/01/2026

	standards.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	03/12/2025
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	03/12/2025
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	14/11/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	14/11/2025
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	03/12/2025
Regulation 05(3)	The person in charge shall	Not Compliant	Orange	03/12/2025

	ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).			
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	03/12/2025
Regulation 05(4)(c)	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 is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	03/12/2025
Regulation 07(1)	The person in	Not Compliant		26/01/2026

	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.		Orange	
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	26/01/2026
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	11/12/2025
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under	Not Compliant	Orange	03/12/2025

	this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	03/12/2025
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.	Not Compliant	Orange	03/12/2025