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:	19 March 2026
Centre ID:	OSV-0005280
Fieldwork ID:	MON-0049257

About the designated centre

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

Dunsany is a designated centre operated by Three Steps Limited. 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. The centre is 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 can accommodate up to 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
Thursday 19 March 2026	10:00hrs to 16:00hrs	Maureen Burns Rees	Lead
Thursday 19 March 2026	10:00hrs to 16:00hrs	Karen Leen	Support

What residents told us and what inspectors observed

This inspection outlines the findings of an unannounced risk based inspection completed to assess the provider's regulatory compliance in relation to the care and welfare of residents who were living in the centre. In particular this inspection, assessed actions taken by the provider as outlined by them in response to the last inspection of this centre on the 5th of November 2025.

From observations, conversations with staff and information reviewed, the inspectors found that some improvements had been made since the last inspection in the centre which promoted safe care and support. However, significant areas for improvement remained in relation to governance and management arrangements, individual assessments and personal plans, behaviour support and general welfare and development.

The centre is registered to accommodate up to two residents over the age of 18 years who have an intellectual disability. There were two young adults with significant complex needs living in the centre at the time of inspection and consequently there were no vacancies.

The inspectors had the opportunity to speak with three staff on duty, the person in charge, the team leader, the service manager and the director of care. Management and staff were noted as caring and attentive towards the residents and were observed interacting warmly with them and to be supportive and respectful of individual wishes and preferred activities. The two residents had limited or no verbal communication and consequently were unable to verbally express their views regarding the care they were receiving in the centre to the inspectors. They used alternative communication methods and were observed to be relaxed in the company of staff. Examples of interactions observed, included a resident going out with staff for a drive in the community, followed by a walk in the garden. The other resident was observed enjoying a snack and spending long periods in the garden as it was a sunny day.

The centre comprises a large two-storey dormer style bungalow, located near a town in county Meath. The centre is divided into two separate living areas with a shared kitchen. The kitchen had restricted access for one of the residents and limited access for the other resident. Each of the residents had access to a small fridge in their living area which was noted to contain some snacks on the day of inspection. Each living area comprised of a dining area, sitting room or sensory room, resident bedroom, staff sleepover room and staff office. Residents had access to a large enclosed garden, which included a trampoline, swings, climbing frame, basketball net, mud kitchen, sensory water flow area, bikes and scooters. One of the residents had an outdoor shed which contained large bean bags. It was reported they enjoyed spending time relaxing in the shed.

Further to the last inspection, maintenance and redecoration had occurred in a number of areas. The provider's maintenance team were on-site on the day of this unannounced inspection and were completing painting on the hall, stairs and landing. The centre was found to be comfortable and in an overall good state of repair. Each of the residents' bedrooms had adequate storage facilities for personal belongings. A number of the rooms had a minimalistic aesthetic, which had been identified as a preference for both of the residents. Each of the residents' sitting rooms had a good supply of sensory items available for the resident using the area. One of the resident's living areas had pillows and blankets on display with pictures of their family members printed on them.

One of the residents was observed at various stages of the day from a distance. From discussions with staff and review of documentation it was evident that this resident could be reluctant to engage with the inspectors or to be in their presence. This resident was observed being supported by staff to go out for drives and go for walks around the centre's large garden.

Inspectors had the opportunity to meet with the second resident who was relaxing in the living room of their area of the house. The resident was lying on their couch with a bowl of cereal beside them. The resident reached out their hand to give each inspector a 'high five'. Once the resident had greeted the inspectors they returned to watching the movie that was playing in the background. The inspectors were brought through the resident's individual side of the house by the person in charge and support staff. The support staff was in place to support the resident with ''New Direction'' day support hours. These hours had been identified in the staff roster Monday to Friday from 09:00 to 17:00. The role of the support staff was to encourage one resident to enjoy and avail of greater activities within the community in line with the 'New Directions Policy'.

Inspectors were informed by staff that the residents individually enjoyed activities in their respective parts of the home which included watching movies, sensory activities and availing of the large garden surrounding the centre. The staff informed the inspectors that one of the residents liked to play with small musical toys. These toys were then exchanged throughout the day with different items. Both residents were supported and encouraged by staff to go out for drives in the community at various times of the day. One of the residents engaged in walks in areas such as local parks, astro-turf pitch areas, sports fields and beaches.

Inspectors reviewed a number of documents in place to support residents in their home and when accessing their community. The inspectors found that a number of supports were documented for staff to refer to when supporting residents. However, a number of recommendations from health and social care professionals had not yet been put in place.

The inspectors found that for one resident it was evident that they enjoyed participating in sensory activities. The resident had access to a sensory item in the evening which they would use before bed. However, inspectors found that a formal sensory review for the resident had not taken place to determine their sensory

support needs. Inspectors reviewed evidence from reviews completed in 2022 and 2024, which indicated that the resident would benefit from greater sensory input.

For another resident inspectors reviewed music therapy reports from 2020 and the resident's needs review from January 2026, six years later which identified that the resident should be supported with music therapy. The resident had an identified goal in place for music therapy to be in place by March 2026. However, on the day of the inspection a referral for music therapy had not yet been made for the identified resident.

There was evidence that the residents' representatives were consulted and communicated with, about decisions regarding their care and the running of the centre. The inspectors did not meet with the relatives or representatives of either of the residents. However, staff reported that they were happy with the care and support that was being provided.

The next two sections of the 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 the young peoples lives.

Capacity and capability

The management systems and processes in place to oversee the care and support being delivered to the residents had improved since the last inspection. In 2025, there had been significant changes to the senior management structure in the centre and across the provider's services. These changes still required time to fully embed so as to ensure consistent and long term improvements. In addition, a number of timelines for actions identified in the provider's compliance plan response to the last inspection had not been reached and required actions had not yet been completed.

Further to the last inspection, the person in charge role had been restated so that it was clear they were only responsible for this centre. They had taken up the position in July 2025 and were in a full time position and had protected time for the role. The person in charge held appropriate qualifications for the role of person in charge, these included qualifications in social care, healthcare and management. They had almost 10 years of management experience. They had previously held the position of deputy manager in this centre. The person in charge presented with a reasonable knowledge of the regulatory requirements and the assessed needs and support requirements for each of the residents. The person in charge was supported by a team leader who had some protected time for their role.

There were clear management structures in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge reported to

the service manager who in turn reported to the director of care. The person in charge and service manager held formal meetings on a regular basis. Since the last inspection, some management audits and checks had been completed in the centre which identified areas for improvement.

Regulation 15: Staffing

Inspectors found that the provider had completed a review of the staffing arrangements in the centre. This review identified the supports required by residents in the designated centre during the day and at night time. A new directions support worker had commenced in the designated centre and was working with one resident Monday to Friday between the hours of 09:00 and 17:00.

At the time of the inspection there was one whole time equivalent vacancy in the centre. Inspectors carried out a review of the planned and actual rosters in place for the centre in January, February and March 2026 and found that this vacancy was filled with regular staff completing additional hours and a small contingency of relief staff.

The inspectors had the opportunity to speak to five support staff, the team leader, the person in charge, service manager and the director of care. The inspectors observed warm interactions between staff and residents throughout the course of the inspection.

While inspectors found that the provider had made improvements to the staffing arrangements in the centre, improvements were required in relation to the supports in place for staff in order to further enhance the lived experience of each resident in the designated centre. This will be discussed further under Regulation 23: governance and management.

Judgment: Compliant

Regulation 23: Governance and management

The management systems and processes in place to oversee the care and support being delivered to the residents in the centre had improved since the last inspection. The person in charge was now only responsible for this centre and was suitably qualified and experienced and considered to be effectively engaged in the governance and management of the centre. Clear management structures had been put in place, that identified lines of accountability and responsibility.

However, a number of actions identified in the provider's compliance plan response to the last inspection had not yet been completed. These included identified actions in relation to individual assessment and personal support plans, behaviour support

and risk management arrangements. As identified at the time of the last inspection, unannounced visits to review the quality and safety of care as required by the regulations were limited and only covered a single area, that being workforce for the last visit. The person in charge reported that a further unannounced visit had recently been completed. However, the findings from the visit had not yet been provided to the centre and were not accessible on the day of this inspection. It was noted that a schedule of other regular management checks and audits were being completed by the person in charge since the last inspection and had identified some areas for improvement. There was evidence to show that actions were being taken to address issues identified in these centre based audits.

Judgment: Substantially compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the residents. Further to the last inspection, limited improvements had been made to the assessments of residents' individual needs to inform personal support plans put in place. In addition areas for improvements remained in relation to the evaluation of personal support plans, behaviour support guidance and processes to track incidents and reviews. Significant improvements had been made in relation to risk management arrangements and fire containment measures.

Assessments of the residents' health and social care needs had been reviewed by the person in charge and team leader since the last inspection and informed personal support plans put in place. However, there had been a significant delay in completing a functional assessment for both of the residents which it was proposed would be used to inform personal support plans put in place.

As identified at the time of the last inspection, the residents presented with complex needs and behaviours which could be difficult for staff to manage. The individual living arrangements supported the management of behaviours and limited the impact for the other resident in the centre. Behaviour support plans had been devised by staff and the management team. However, the behaviour support plans did not have input from a behavioural expert. On review of records since the last inspection, there was evidence to show that a post incident review occurred following incidents involving physical intervention and that any learning informed a review by staff of the behaviour support plan in place to manage any re-occurrence.

Senior management and a consultant clinical neuro-psychologist attended weekly planning and coordination meetings. The format and recording of these meetings had been revised since the last inspection. Records were noted to now include details on each resident's presentation and actions agreed for individual resident's care.

Regulation 13: General welfare and development

The inspectors found that due to a lack of appropriate guidance and support as stated in Regulation 7: positive behaviour support and Regulation 5: assessment and personal plans, this had a further impact on the general welfare and development of residents living in the designated centre.

The inspectors completed a review of one-to-one support notes for the two residents in the designated centre. Both residents were being supported to complete daily bus drives within their local community. For one resident, it was deemed unsafe for them to access their community due to an identified high risk of the resident potentially running away or absconding from staff support. For the second resident, support staff were offering them choice while in the community to leave their bus and go for a walk. Inspectors found from January to March 2026, the second resident had only agreed to leave the transport on three occasions.

From discussion with staff and the person in charge they had identified that the resident had a new staff who had commenced as a new directions community support staff. Staff identified that the resident was still building trust with the new staff member and that this may be the possible cause. However, inspectors found no evidence of a formal review in the preceding six month period where the resident was refusing community access.

As discussed the provider had recently appointed a staff in the position of "New directions" support for one resident in the centre. The support staff supported one resident between the hours of 09:00 to 17:00 Monday to Friday. The inspectors discussed with staff and the person in charge the supports in place for activities should the resident request to leave their home after the hours of 17:00, staff noted that an additional staff moved from administration hours to frontline support at this time.

For the second resident, the support plans in place highlight the importance of their daily walk in the centre garden and for staff to follow the daily routine guideline in place. However, inspectors found that the daily routine did not include the resident's goal of going for a walk every day and building skills towards accessing the community. Through review of documentation and discussion with staff it was evident that one resident had not left the centre vehicle when on a social outing for greater than a 12 month period due to safety concerns. This review highlighted that both residents in the centre had seen a decrease in community access in the preceding six month period.

Furthermore, in the compliance plan submitted to the Chief Inspector the provider had given assurances that one resident would have a comprehensive medical review by a psychiatrist to inform ongoing care planning and ensure all health-related needs are fully understood and addressed by December 2025. On the day of the inspection, the inspectors found that a comprehensive medical review had not been

completed. The inspectors found that an increase in medication had occurred, this will be discussed further in Regulation 7: positive behaviour support.

The inspectors found that there had been an improvement in time spent with family in the designated centre for one of the residents. This had been an identified goal for the resident. Inspectors reviewed goal planning for the resident which identified that family wanted to visit their loved one in their home. Support staff had commenced by engaging in video calls to the family, which had then developed to a visit to the centre and spending time with their loved one in March 2026.

Judgment: Not compliant

Regulation 26: Risk management procedures

Further to the last inspection, there had been marked improvements in relation to risk management procedures and arrangements to identify, assess and mitigate risks. However, a number of actions specified in the compliance plan submitted by the provider to the Chief Inspector, in order to bring the centre into compliance had not been completed in line with the time lines proposed. This included that a full training programme for staff would be completed by January 2026 and that a new risk management system would be introduced in January 2026. As of the day of inspection these had not yet been achieved.

Environmental and individual risk assessment and treatment forms had been revised since the last inspection and these promoted the health and safety of the residents, visitors and staff. The risk register was reviewed and found to contain key clinical and behavioural risks and control measures in place. In contrast to the last inspection the risk register was found to be now subjected to regular review and was reflective of relevant risks in the centre. It was noted that further to the last inspection, post incident reviews had been completed promptly, following significant incidents and physical interventions, in order to support residents and or to reduce the possibility of a re-occurence of such incidents.

There were a schedule of checklists in relation to health and safety, fire and risk completed on a regular basis. There were arrangements in place for investigating and learning from incidents and adverse events involving the residents. The inspectors reviewed a record of all incidents and accidents in the centre since the last inspection. These were reviewed by the person in charge and where required, learning was shared with the staff team and risk assessments were updated to mitigate against any re-occurrence.

There was limited evidence of reviewing tracking of Incidents and near misses. The inspectors reviewed a report which showed that trends of certain behavioural incidents were recorded for the residents and submitted for review by the clinical neuro psychologist. However, there was insufficient evidence to show that this informed the proactive identification of underlying issues and areas for improved

support. The inspectors were advised of systems commencing through which the provider could trend incidents to identify patterns of events and their causes and triggers.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management, including fire safety detection and alert system, emergency lighting internally and externally and fire fighting equipment which were subject to regular servicing. Further to the last inspection, self closing hinges linked to the fire alarm system had been fitted on all doors. However, the provider had identified that three of the doors required to be replaced to meet fire safety standards and ensure fire containment. A date for this work to be completed had not yet been confirmed. The provider's compliance plan submitted to the Chief Inspector had stated that the fire safety handbook gap analysis against the regulations would be completed by the end of February 2026 but this had not yet been achieved.

Further to the last inspection, a competent fire person had been commissioned by the provider to undertake fire safety risk assessments. In addition, the fire policy, evacuation plans and personal emergency evacuation plans (PEEP) were reviewed and updated.

There was evidence of fire evacuation drills taking place and that the residents evacuated in a timely manner.

From a review of both resident files, personal emergency evacuation plans (PEEP) were noted to be in place that outlined what supports they required to evacuate in the event of a fire and took into account their cognitive ability.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Inspectors reviewed the individual assessments and personal plans for both residents in the designated centre. Inspectors found that while the person in charge and team lead had completed reviews for both residents' personal plans, the information used to inform the care and support for the individual residents was based on sources of information and professional reviews completed from 2020, 2022 and 2024. There had been a delay in completing a planned functional assessment for both residents which was to be used to inform personal support plans. On the day of inspection, the person in charge reported that the consultant

neuro psychologist had reported that the functional assessment for both residents would be completed within the following two week period.

The inspectors found that for one resident, the support documentation guided staff to follow the recommendations in place from a review completed by a neuropsychologist and a senior occupational therapist from January and February 2026. However, the inspectors found no recommendations were in place to guide staff practice and no evidence was in the resident's file of these reviews taking place.

Sources of information for residents' needs assessments included speech and language therapy assessments from April 2020 which highlighted for one resident that staff should support the resident with Lámh signs. However, on review no staff in the designated centre had completed training in Lámh sign language. Additional sources of information included behaviour therapy review from March 2022 and an occupational therapy review from August 2024.

The inspectors reviewed the person centred plans in place for each resident in the designated centre and found that the goals were centred around aspects of care, were not always specific or measurable and that social goals had not been developed or reviewed in line with supporting both residents to access their local community or to offer choice within the community or home.

The inspectors found that monthly goals included the following:

- Health – a review of medication administration and audit
- Finances – ensure that staff checked finances daily
- Personal care – encourage residents to dress independently
- Personal emergency evacuation plans (PEEPS) for safe evacuation
- Family involvement- increase family involvement in the centre.
- Take away- this goal was in place to encourage one resident to eventually enter the fast food restaurant and sit and have a meal.

The inspectors reviewed the needs review and goals for residents which had a number of outcomes set for completion to support residents, which remained outstanding. For one resident, the goals assessment had highlighted the opportunity to liaise with external organisations such as local sensory groups or Autism groups. However, inspectors could find no evidence of reviews occurring or plans identified for the resident to support this goal. For another resident, their needs review identified that the resident would benefit from a music therapist and one was to be sought by March 2026. At the time of the inspection the resident did not have access to music therapy and support staff and the person in charge identified that one had not been sought.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The inspectors found that the provider had failed to meet the time-lines on their action plan submitted to the Chief Inspector in relation to Regulation 7: positive behaviour support. The provider had submitted an action that positive behaviour support plan reviews would be conducted in January 2026 with the appropriate clinical team. However, on review of both residents' behaviour support plans the inspectors found that sources of information used for the plans included music therapy reports from August 2020, clinical neuro-psychological assessment from March 2022, speech and language assessment from May 2023 and behaviour report from 2024. In addition, identified recommendations from reported reviews completed in January and February 2026 from the clinical neuro-psychologist and occupational therapist were not in place nor available to staff.

Furthermore, the provider had submitted assurances to the Chief Inspector that staff in the designated centre would have up-to-date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents in managing identified behaviours by January 2026. The inspectors found that while senior management in the centre had attended a meeting in January 2026 in relation to model of intervention, this had yet to be completed with front-line staff in the centre.

The inspectors reviewed the behaviour support plan in place for one resident and found that recommendations required to support and guide staff when supporting the resident were not available to staff. For example, for one resident in line with their behaviour support guidelines, an identified behaviour for the resident was change in body language with the resident pacing, hands on head, covering ears, dropping to the ground and stamping feet. As part of the behaviour management plan in place, staff were to review recommendations in place from principle specialist clinical neuro-psychologist and senior occupational therapist. However, inspectors found no recommendations in place for the resident in their file and staff could not access, show or outline to the inspectors the reported recommendations on the day of the inspection.

Inspectors found that for one resident they had experienced an increase in the use of medication management in November 2025 as prescribed by their doctor. However, review notes were not in place from the prescribing doctor regarding their review requirements and subsequent increase of the medication. In addition, inspectors found no review or monitoring documentation in place for the resident in line with the increase in medication. For example, no baseline monitoring or observations had been recorded since the increase in medication had been implemented.

Staff informed the inspectors that the change in medication had seen a positive impact on the residents' behaviour of concern with a noted decrease in resident and staff incidents. However, staff informed the inspectors that the resident's incidents of self-injurious behaviour remained high.

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	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially 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-0049257

Date of inspection: 19/03/2026

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	Substantially 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 11/02/2026 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 commenced by a Service Manager on 29/01/2026. A feedback meeting is scheduled to take place on 12/05/2026 and the final report will be presented to the Board on 22/05/2026. 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.	
Regulation 13: General welfare and development	Not Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: 1. A full MDT Needs Review will be completed by 30/06/2026, and the PCP and Personal Plans will be updated by September for both residents.	
Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

1. Data on behavioural incidents has been collected for both residents from August 2025 to March 2026 and is with the clinical team for review and trend analysis.

2. The Behavioural Analysis for both residents will be completed by the end of May/start of June which will provide the care team with guidance on identifying patterns of events and their causes and triggers.

3. The provider is currently transitioning to BoardX to strengthen the monitoring and analysis of risk trends within the service. The risk review process will be migrating to this system, and training for the Centre Manager and Team Leader commenced on 04/04/2026.

4. Risk meetings have been taking place since January 2026 at the start of each month where the Risk Register is reviewed at service level.

Regulation 28: Fire precautions	Substantially Compliant

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

1. The three fire doors were replaced and fitted within the centre on 26/03/2026.

2. The Centre Manager has reviewed the fire handbook since the Centre Managers Meeting which took place on 20/03/2026 and will provide feedback during the next Centre Managers Meeting on 21/05/2026.

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:

1. A full MDT Needs Review will be completed by 30/06/2026, and the PCP and Personal Plans will be updated by September for both residents.

2. Following the above action, a full clinical neuropsychological assessment will be completed to identify what support is required i.e. Occupational Therapy, Speech & Language Therapy, Dietician, Music Therapy, etc.

3. The Functional Analysis for both residents will be completed by 31/05/2026.

Regulation 7: Positive behavioural support	Not Compliant

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

1. Relationship Development Intervention (RDI) training for Centre Managers will commence on 27/05/2026 to help both residents with their emotional, social, and relationship skills.

2. 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.

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

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.

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	30/06/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/05/2026
Regulation 26(2)	The registered provider shall	Substantially Compliant	Yellow	30/06/2026

	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.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	21/05/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	21/05/2026
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	30/06/2026
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that	Not Compliant	Orange	30/06/2026

	arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/06/2026
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	30/06/2026
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/06/2026
Regulation 07(3)	The registered provider shall	Not Compliant	Orange	31/07/2026

	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.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	31/05/2026
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	31/05/2026