



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

Issued by the Chief Inspector

Name of designated centre:	Clondavan
Name of provider:	Three Steps Limited
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	05 November 2025
Centre ID:	OSV-0008592
Fieldwork ID:	MON-0048060

About the designated centre

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

The centre provides medium to long term residential care for up to four children and young people. The centre caters for male or female residents between the ages of six to 18 years of age who have a primary diagnosis of an intellectual disability. The centre is managed by a person in charge supported by a deputy manager, three team leaders and in turn a team of social care workers and healthcare assistants. The centre is in a countryside location within a short drive to a nearby town. The centre has its own transport to facilitate school, activities and appointments for the children.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4
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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	Maureen Burns Rees	Lead
Wednesday 5 November 2025	10:00hrs to 19:00hrs	Erin Clarke	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 young people who were living in the centre. Over the course of the same day, inspectors of social services completed unannounced risk inspections in each of the provider's three designated centres for people with disabilities. The inspections were undertaken following receipt of solicited and unsolicited information which raised concerns regarding the provider's governance and management arrangements and its impact on the quality and safety of care provided.

In this centre, from observations, conversations with staff and young people, and information reviewed, the inspectors found that some child-centred care and support was being provided. However, highly significant regulatory non compliance and areas for improvement were identified in relation to governance and management arrangements, individual assessment and personal plans, fire safety, risk management, complaints management and protection.

The centre is registered to accommodate up to four male or female young people between the ages of six to 18 years of age, who have a primary diagnosis of an intellectual disability. There were four young people living in the centre at the time of inspection and consequently there were no vacancies. The centre was first registered at the end of November 2023 and the four young people were admitted and transitioned to live in the centre soon after.

The centre comprises a large two-storey, six-bedroom house. It is located on its own grounds in a rural setting in county Meath. The centre was spacious with good sized communal areas, including a kitchen-dining area, two sitting rooms and a large sensory/play room. Each of the young people had their own bedroom, with three of the four bedrooms having an en-suite bathroom attached. There was an accessible wrap around front and back garden with room for parking at the side and front of the house. The back garden had a trampoline, two different types of swings, a sand table, a tricycle and some other play items for the young people to use. There was also a table and bench for outdoor dining.

Overall, the centre was found to be comfortable and in a good state of repair. However, it was noted that the flooring in one of the sitting rooms had separated in a number of areas. Some worn paint was observed on walls and woodwork in areas. In the main bathroom there were a number of worn and discoloured surfaces, including tiles, tile grouting and the seal around bath and shower. The shower fitting was noted to be broken. The ceiling of the bedroom and attached en-suite for one of the young people had a small number of brown coloured stains. The windows of one young person's bedroom had blinds in place but they were noted to be broken in areas. Consequently, it was noted that they would not be effective in blocking light from entering the room at times when the young person would be sleeping. In one of the other bedrooms, it was reported that the young person did not like

curtains or blinds on their bedroom window and there were no means to block out light in their room while that young person was sleeping. Although each of the young people's bedrooms had adequate storage facilities for personal belongings, three of the bedrooms had a minimalistic and un-child friendly feel. This was in contrast to the sitting room and play room which had a number of toys, books, floor tents, pictures of residents and cuddly toys in place.

Each of the young people were engaged in a full time school placement. However, their school placements were a considerable distance away and required on average a two hour trip to and from school. No evidence was presented to inspectors that assessments had been completed in relation to educational needs and the appropriateness of the current placements given the journey away for each of the children.

Communication assessments and plans in place were limited and did not provide suitable guidance for staff on how best to communicate with and support individual young people. For example, a communication plan referred to a requirement for a one-to-one speech and language therapy assessment for a young person, which had not yet occurred, but few other details on how best to communicate with the young person. There were limited visual aids available in the centre on the day of the inspection. A visual aid for intimate care displayed in a female young persons ensuite was noted to only refer to intimate care details applicable for a male.

One or both of the inspectors met briefly with each of the four young people in the centre on the day of this inspection. One of the young people had not attended school on the day of this inspection as they were feeling unwell and were present in the centre for a good portion of the day. This young person was reluctant to engage with the inspectors but was observed watching television, having a meal and being taken out by staff to visit their general practitioner. They appeared comfortable in the presence of the staff on duty. The other three young people were met with on their return from school on the evening of the inspection.

Overall, the young people were observed to be in good spirits and comfortable in the company of staff. Three of the four young people had limited or no verbal communication and used alternative communication methods. These young people did not share with the inspectors their views regarding the care they were receiving in the centre. While the inspectors observed residents being supported by staff in a kind and caring manner, it did not take from the concern that suitable support plans were not in place to guide staff practice. Examples of interactions observed, included a young person being supported to have their hair dried following their evening shower and having their evening meal. A young person was observed to guide staff to retrieve their favourite toy from the sitting room and a book from the sensory room.

The fourth young person spoke privately with one of the inspectors. This young person told the inspector that they felt safe living in the centre and that if they had any concerns they would tell a staff member or their professional representative. They spoke about a hotel break they had taken with staff in the preceding period and another two night hotel stay which was planned for before Christmas. This

young person told the inspector that staff were kind to them and to the other three young people. They discussed with the inspector ways in which they felt they were listened to and provided with choices regarding meals and activities. The young person was particularly proud of their bedroom which was en-suite and had been personalised by them to include cartoon characters, teddies and other personal items. The young person had their own key for their bedroom which they liked to lock when they weren't in the centre. The young person spoke about enjoying their school placement despite the significant journey to and from school each day. This young person proudly told the inspector that they had recently been appointed to their school's student council and was also engaged in a youth group. The young person attended swimming and horse riding on a weekly basis. The young person spoke about how they advocated for the other three young people who had limited communication skills. The delay for each of the young people in accessing a required speech and language therapy assessment was of particular concern for the young person.

The inspectors had the opportunity to speak with four staff on duty, the deputy centre manager, the person in charge, the service manager and the director of care. Staff came across as caring and attentive towards the young people and were observed interacting warmly with the young people and to be supportive and respectful of individual wishes and preferred activities. However, a significant number of the staff team were relatively new to working in the centre and as discussed later in the report, assessments of need were not comprehensive and support guidance provided for staff were not sufficiently detailed and did not have input from suitable expertise in specific areas.

There was some evidence that young peoples' representatives were consulted and communicated with, about decisions regarding their care and the running of the centre. It was noted that there had been a complaint by a relative in the preceding period. However, the satisfaction or otherwise of the complainant with the outcome of the management of the complaint had not been recorded. The inspectors did not meet with the relatives or representatives of any of the young people.

The young peoples' likes, dislikes, preferences and support needs were gathered through the personal planning process. However, as outlined later in this report, the needs of some young people had not been comprehensively assessed and consequently suitable support plans were not in place. The inspectors observed the weekly activity plans for two of the young people in the preceding period. The young people participated in different activities depending on their interests. However, the significant travel times for each of the young people to and from school each day impacted on the ability of the young people to engage in activities during the week. Examples of activities that young people participated in included, horse therapy, a youth club, soft play centres, walks in different areas including the woods and beach, and swimming.

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 young people in the centre were not effective. In May 2025, there had been a significant change to the provider's governance and management structures with the resignation of the director of care, service manager and the persons in charge for each of the provider's three designated centres within a short time frame of each other. New personnel had been appointed to each of these positions.

A new person in charge had taken up the position in this centre in July 2025. They had previously held the position of deputy manager in one of the provider's other services. The person in charge held a degree in applied social studies in social care and a certificate in management. They had more than four years management experience and were supported by a newly appointed deputy manager and three team leaders. The person in charge presented with some knowledge of the regulatory requirements and the assessed needs and support requirements for each of the young people. However, they had limited experience in the role, having only taken up the position in July 2025. In October 2025, the person in charge had been given responsibility for another service operated by the provider. The person in charge reported to the inspectors that they had based themselves in that other service over the preceding three week period and that the person in charge from one of the provider's other designated centres was providing cover in this centre.

The manager providing cover was met with on the morning of inspection but presented with limited knowledge of the care and support needs for the young people or of the running of the centre. Staff on duty in the centre were unclear as to the management structure in the centre, in terms of who they were accountable to. Records in relation to a number of management checks were not available in the centre at the time of inspection. On the day of this inspection, the person in charge advised the inspectors that they had recently tendered their resignation.

A serious allegation of abuse had been managed through the provider's complaint process with safeguarding procedures found not to have been followed. The allegation had not been reported to the relevant agencies and evidence was not available to show if a safeguarding review had been completed in line with the providers own policies. Improvements in behavioural support guidance for staff was required for a number of the young people who presented with complex needs. This had not been appropriately identified by the provider through their own monitoring systems.

Regulation 15: Staffing

Although there had been a high turn over of staff in the preceding period, the full complement of staff were in place at the time of inspection. Sufficient staff were considered to be rostered on each shift at the time of inspection. There were actual and planned staff rosters in place. The format of the rosters had recently been reviewed so as to clearly show each staff members full name and grade. There were regular staff meetings and separately management meetings with evidence of communication of some shared learning at these meetings.

Judgment: Compliant

Regulation 23: Governance and management

The management systems and processes in place to oversee the care and support being delivered to the young people in the centre were not effective. Inspectors observed various deficits in the the provider's oversight of the centre which resulted in important aspects of the quality and safety of resident care and support, not being effectively evaluated.

The registered person in charge was found not to be effectively engaged in the governance and management of the centre at the time of this inspection. In the preceding three week period, the person in charge had been basing themselves in another service for which they had been assigned responsibility. The manager who it was reported was providing cover in this centre was met with on the morning of inspection but presented with limited knowledge of the care and support needs for the young people or the running of the centre. Staff on duty in the centre were unclear as to the management structure in the centre, in terms of who they were accountable to.

The oversight arrangements had failed to identify a number of issues found on this inspection. Auditing and monitoring processes had not adequately reviewed the centres approach to the management of behaviours and safeguarding incidents. The inspectors considered that the implementation of behavioural measures had not been effectively evaluated.

The provider had completed an annual review of the quality and safety of the service for 2024. An unannounced visit within the last 6 months had also been completed. However, the review of the quality and safety of care in the unannounced visit was limited as it only covered a single area, that of workforce matters. There were reported daily, weekly and monthly environmental safety checks which were overseen by the person in charge and separate management checks. However, it was evident that a number of these had not been consistently completed in the preceding period. Records of same were not available on the day of inspection but some records were submitted following the inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

It was identified by the inspectors, that a serious allegation of abuse had been made in May 2025, which had been dealt with through the provider's complaint process. However, this allegation or suspicion of abuse had not been notified to the Chief Inspector of Social Services, in line with the requirements of the Regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had a complaints procedure in place, dated April 2023 and a complaints log was maintained. However, the inspectors found that the management of a complaint within the centre was not in accordance with the organisation's policy, national guidance or the requirements of the regulations. A complaint raised in May 2025 which referred to an allegation or suspicion of abuse had only been dealt with through the complaint process. There was limited evidence available to show if the matter had been appropriately investigated, if the complainant had been informed of the outcome of their complaint and or provided with details of the appeals process. In line with the regulations, the centre's complaints procedure required that the satisfaction of the complainant be sought and recorded as part of the complaints management process. This had not occurred. Instead, records showed that the satisfaction of a social worker was documented in place of the complainant's own feedback. This did not meet the requirements of the regulations or the provider's own policy. The complaint procedure was noted not to be displayed in a prominent position on the day of inspection.

Judgment: Not compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the young people. Overall, the inspection found that while the young people living in the centre were supported in line with some assessed needs significant improvements were required regarding the assessments of need and personal support plans in place. In addition improvements were required regarding risk management, fire safety, behaviour support guidance and processes to track reviews and incidents.

Assessments of some of the young people's health and social care needs had been completed and informed personal support plans. However, the needs of some young people had not been appropriately assessed and consequently suitable support plans were not in place. For example, the toileting needs and supports for one young person. Evidence was not presented to the inspectors to show where known health risks such as urinary tract infections, constipation, and skin breakdown had prompted a review of infection-control practices or environmental hazards. There was limited evidence to show that the provider had assessed the impact for the young people of travelling a total of four hours a day to and from school. It was noted that there were reviews of each of the young people's care in the centre by the commissioner of their service and their placement supervisor.

A number of the young people presented with complex needs and behaviours which could be difficult for staff to manage in a group living environment. Behaviour support plans had been devised by staff and the management team. However, the inspectors found that the behaviour support guidance provided for staff was not sufficiently detailed and did not have input from a behavioural expert. Following incidents involving physical intervention, limited evidence was available to show that a post-incident review or a behaviour plan update had occurred, despite the clear potential for recurrence.

Senior management and a consultant clinical neuropsychologist attended weekly planning and coordination meetings where it was reported that each young person's presentation was discussed. However, the records of the discussions at these meetings contained minimal information and evidence was not presented to show where outcomes from the meetings had resulted in changes being made to individual young persons personal plan.

Regulation 17: Premises

Overall, the centre was found to be comfortable and in a good state of repair. However, it was noted that the flooring in one of the sitting rooms had separated in a number of areas. Some worn paint was observed on walls and woodwork in areas. In the main bathroom there were a number of worn and discoloured surfaces, including tiles, tile grouting and the seal around bath and shower. The shower fitting was noted to be broken. The ceiling of the bedroom and attached en-suite for one of the young people had a small number of brown coloured stains. The windows of one young person's bedroom had blinds in place but they were noted to be broken in areas. Consequently, it was noted that they would not be effective in blocking light from entering the room at times when the young person would be sleeping. In one of the other bedrooms, it was reported that the young person did not like curtains or blinds on their bedroom window and there were no means to block out light in their room while that young person was sleeping. Although each of the young people's bedrooms had adequate storage facilities for personal belongings,

three of the bedrooms had a minimalistic and un-child friendly feel which was at odds with the rest of the home.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had not ensured that an effective risk management system was in place to identify, assess, and mitigate risks to the young people. The inspectors found that key clinical and behavioural risks were not reflected in the risk register or were recorded without current control measures. The inspection found no structured system for analysing trends across incidents, notifications, or health monitoring data. Physical incidents, self-injury, and infection-related health risks had occurred but were not analysed or escalated appropriately. The risk register, dated 10 October 2025, contained limited and outdated information, with no linkage between individual incidents and organisational learning.

Inspectors requested to review post-incident reviews, which should occur promptly following any restrictive practice or physical intervention. There were delays in providing these documents during the inspection despite multiple requests. When received, only four partially completed post-incident review forms were provided, all dated from February 2025, despite evidence that incidents involving restrictive practices or physical interventions had occurred.

Judgment: Not 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. However, improvements were required regarding the arrangements for fire containment and safe evacuation.

There were fire containment doors in place which were fitted with self-closing devices. However, a fire containment door leading from the kitchen which contained a self closing device, was noted to become stuck on opening. Consequently, the door did not fully close by itself, requiring to be pushed shut with force. This meant that the self closing hinge was ineffective on this door and in the event of fire could lead to the spread of smoke and fire and a reliance on staff to close the door. This meant that young people may not be protected in an emergency. In addition, it was noted that the smoke seal strip was missing from the door of the staff sleep over

room and that one of two, fire extinguishers were missing from their allocated position in the front hall.

There was evidence of fire evacuation drills taking place and that the four young people evacuated from the centre in a timely manner. However, night time simulated drills had not been undertaken in the preceding 12 month period and it was not clear from the records if alternative evacuation routes were considered or if all staff working in the centre had attended a fire drill in the preceding period. Consequently, the provider could not be assured that the young people could be evacuated safely from the centre in a night time scenario with minimum numbers of staff on duty in line with national fire safety requirements.

From a review of two children's 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

While there was an assessment of need in place for each young person, there was not observed to be a comprehensive assessment of the young person's health, personal and social care needs underpinning the assessments. The inspection identified significant concerns relating to the assessment, planning, and review of young peoples' healthcare, behavioural and social needs. Health assessments were incomplete and not updated in response to ongoing issues, including bowel, toileting, and continence difficulties among several young people. For example, some young people were experiencing recurrent urinary tract infections, constipation, and skin irritation, yet there was no clear record of multidisciplinary review or care plans to guide staff practice. It was noted that a psychology, speech and language therapy and occupational assessment was outstanding for each of the young people. The person in charge reported that the psychology assessment had been completed for one of the young person but that the report had not yet been submitted to the centre.

Three of the young people had limited verbal communication. However, communication assessment and plans to guide staff on how best to communicate with the young people were not sufficiently detailed. For example, a communication plan for one young person provided minimal guidance and referred to a requirement for a one-to-one speech and language therapist assessment for the young person. It was noted that a professional recommendation for a one-to-one speech and language assessment and the adaptation of augmentative communication devices for each of the young people was outstanding for more than 12 months. There were limited visual aids available in the centre on the day of the inspection. For example, a visual aid for intimate care displayed in a female young persons en-suite was noted to only refer to intimate care details which would only be applicable for a male

young person. Some 'now' and 'then' visual timetables were in place but from speaking with staff and observations on the day it was evident that these were not regularly used.

The young people were supported and encouraged to take part in a number of social and developmental activities. Each of the young people were engaged in a full time school placement. However, all four residents spent in total up to four hours a day driving to and from school. There was limited evidence that the provider had assessed the impact of such significant travel times going to and from school on the welfare and development of the young people. No evidence was presented to show that the provider had considered engaging with educational professionals regarding possible suitable school placement located closer to the centre. It was noted that the long commute for the young people during the week and early mornings impacted on activities that they could engage in, in the evenings after school.

Judgment: Not compliant

Regulation 7: Positive behavioural support

A number of the young people presented with known behavioural needs that required structured, proactive interventions. However, behaviour support plans reviewed by the inspectors were inconsistent and not informed by current multidisciplinary assessments.

A number of young people exhibited on occasions behaviours of concern, including physical incidents, self-injury, and resistance to personal care routines. Despite these known risks, the provider had not ensured that each young person's behaviour support plan was reviewed following incidents or updated to reflect changes in triggers, antecedents, or effective interventions. Assessments and plans had been devised by members of the staff team with limited evidence of input from a behavioural specialist or evidence that they were based on a recent suitable assessment by an appropriate expert. The inspectors found that the plans did not always provide step-by-step guidance to ensure that staff identified when they needed to intervene to prevent or reduce an incidence of a behaviour of concern. Consequently the provider could not be assured that staff consistently used the same techniques. While there was evidence that the behaviour support plans were regularly reviewed by staff members, these included a limited review of behavioural incidents and strategies to manage behaviours and how effective these strategies had been.

Staff reported awareness of residents' triggers but were not guided by written, current strategies to prevent or de-escalate behaviours. Primary and secondary interventions recorded in some plans, such as redirection, engagement in activity, or prompting to use the toilet, could not be applied effectively in the environment where one young person's behaviours for example, most frequently occurred, namely while travelling in a vehicle. The behaviour support plan had not been

assessed for its effectiveness in this context, and there was no evidence of environmental or situational adaptations to mitigate risk.

Judgment: Not compliant

Regulation 8: Protection

There were some measures in place to protect young people from being harmed or suffering from abuse. However, on the day of inspection, the inspectors identified that in May 2025, there had been a serious allegation or suspicion of abuse which had been dealt with through the providers' compliant process and had not been appropriately reported or responded to in line with the provider's safeguarding policy and or national guidance for the protection and welfare of children.

Evidence was not provided to the inspectors on the day of inspection to show that the allegation had been subject to a thorough review. The inspectors found that the allegation or suspicion of abuse had not been screened in line with the provider or national policy. This demonstrated a lack of understanding among management regarding the appropriate categorisation and escalation of concerns that may constitute abuse or safeguarding risks. The concern was instead processed through the complaints system rather than the safeguarding pathway, resulting in external statutory bodies not being notified.

Inspectors requested information regarding the investigation and outcomes of this matter. However, the relevant documentation was not available for review during the inspection. This lack of transparency and record-keeping did not demonstrate the provider's ability to show that the concern had been appropriately investigated or that safeguarding measures had been implemented to ensure the safety and welfare of the resident involved. Before the end of the inspection day, the inspectors received verbal assurances that the provider would complete a full review of this incident and all other incidents and complaints in the preceding period to ensure adherence to the provider's safeguarding policy.

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	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Clondavan OSV-0008592

Inspection ID: MON-0048060

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 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>Action 1: The audits completed going forward will incorporate an analysis of static and dynamic risks identified by the Board, HIQA Inspection Reports, and the Model of Care Evaluation.</p> <p>Action 2: The Planning & Coordination (P&C) minutes template has been updated from 03/12/2025 to improve the recording of discussions, decisions, and assigned actions. The new template will support clearer governance oversight.</p> <p>Action 3: A new MDT Consultation Notes template was introduced from 26/11/2025 to ensure all multidisciplinary inputs are formally documented and integrated into governance and decision-making processes.</p> <p>Action 4: A new standing agenda has been developed for the Centre Managers Meetings from the 19/12/2025 to specifically highlight and record any issues arising within the service.</p> <p>Action 5: All updated governance documents and processes, including the new templates and agenda structures, were reviewed on 11/12/2025 to ensure consistency and compliance with regulatory requirements. These include:</p> <ul style="list-style-type: none"> • Terms of Reference for Planning and Coordination Meeting • Terms of Reference for Complaints, Child Protection and Vulnerable Adults (monthly) meeting • Audit and Risk Management processes. <p>Action 6: The terms of reference for annual review of Quality and Safety of Care and Support was</p>	

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

Action 7:

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

Action 8:

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

Action 9:

Centre Managers reviewed daily operational checks during the Centre Managers Meeting on 05/11/2025 to strengthen oversight and ensure consistent governance practices.

Regulation 31: Notification of incidents	Not Compliant
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

Action 1:

The Centre Manager will contact the Social Services Duty Manager to clarify whether any outstanding incident reports are required to be submitted at this time.

Action 2:

Safeguarding procedures, including requirements for reporting notifiable incidents, were reviewed and discussed on 02/12/2025. Any learning from this discussion will be incorporated into current practice.

Regulation 34: Complaints procedure	Not Compliant
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Action 1:

The existing complaints process and policies was appraised on 11/12/2025 by Director of Care and Service Manager to ensure it provides a clear, transparent, and consistent approach to receiving, recording, and managing complaints. Additionally, any changes were highlighted during the Centre Managers meeting on 19/12/2025.

Action 2:

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

Action 3:

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

Action 4:

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

Action 5:

Complaints procedure has been moved from the office within the centre and is now displayed in an area accessible to the public.

Regulation 17: Premises

Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Action 1:

Both floors within the centre will be repaired/replaced to ensure the environment is safe, well-maintained, and suitable for residents' needs.

Action 2:

The Director of Care will review the maintenance logs to verify that all identified issues have been recorded, prioritised, and appropriately actioned.

Action 3:

All windows will be reviewed to assess and address any privacy concerns. A window tint will be installed.

Regulation 26: Risk management procedures	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</p> <p>Action 1: Targeted risk-management training commenced on 03/12/2025 to strengthen staff understanding of identifying, assessing, and mitigating risk.</p> <p>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.</p> <p>Action 3: Existing risk-management procedures will be reviewed and refined throughout December 2025, pending the implementation of the new system from mid-January 2026 onwards.</p> <p>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.</p> <p>Action 5: Mandated post incident reviews will be examined and implemented as part of the risk management procedure.</p>	
Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <p>Action 1: Fire drills will be scheduled to include all new starters, ensuring they are fully familiar with evacuation procedures and their responsibilities in the event of an emergency both during the day and night.</p> <p>Action 2: Personal Emergency Evacuation Plans (PEEPs) will be reviewed on a monthly basis to ensure they remain accurate, up to date, and reflective of each resident's current needs.</p> <p>Action 3: A competent fire person is commissioned by Three Steps to undertake full fire safety risk assessment with Clondavan.</p>	

<p>Action 4: All fire extinguishers are in their allocated positions from day of inspection.</p> <p>Action 5: The kitchen and sensory room fire doors have been repaired from 09/12/2025.</p>	
Regulation 5: Individual assessment and personal plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <p>Action 1: The Needs Review, Personal Plan, and Behavioural Support Plan were updated on 01/12/2025 to ensure they clearly reflect each resident's support requirements, proactive strategies, and positive behavioural interventions. A new introductory section was added to all documentation outlining the names, roles and sources of information contributing to the assessment.</p> <p>Action 2: A full review of the Programme of Care was completed with the Centre Manager and Deputy Centre Manager on 08/12/2025 to ensure all assessments and personal plans accurately reflect current needs and supports. Programme of Care documentation now needs to be rewritten in line with the above-named templates. This process will be completed by 31/01/2026.</p> <p>Action 3: All files will be organised and updated, including the removal of outdated photographs of former managers, to maintain accurate and relevant documentation. This has commenced and will be completed by 10/01/2026.</p> <p>Action 4: A comprehensive training and needs analysis session will be held on 16/01/2026, using a new template designed to identify gaps, enhance consistency, and ensure personal plans align with residents' assessed needs.</p>	
Regulation 7: Positive behavioural support	Not Compliant

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

Action 1:

The Terms of Reference for Rights Review and Restrictive Practices Review will be finalised to ensure clear governance, accountability, and oversight. The first Rights Review and Restrictive Practices Review Committee meeting will commence in April 2026 and continue quarterly thereafter.

Action 2:

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

Action 3:

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

Action 4:

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

Action 5:

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

Action 6:

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

Action 7:

Relevant training has been scheduled for staff regarding the use of SmartBox devices and awaiting CDNT forms to be filled out by the school. A follow-up meeting will be arranged once the forms are returned and the training has taken place.

Action 8:

The Centre Manager and Deputy Centre Manager will participate in therapeutic-based training delivered by Dr. McAuliffe commencing week starting 19th of January. This training will strengthen their capacity to implement positive behavioural support strategies and reduce reliance on restrictive practices.

Regulation 8: Protection	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection:</p> <p>Action 1: The CCPVA process has been reviewed to identify and address any gaps in reporting, follow-up, or oversight. The first CCPVA Meeting is due to take place on 06/01/2026 and will run monthly.</p> <p>Action 2: A full review of May 2025 incident was undertaken including incidents and complaints in the proceeding period to the inspection.</p>	

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/01/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/01/2026
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained	Substantially Compliant	Yellow	31/01/2026

	regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	11/12/2025
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	11/12/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more	Not Compliant	Orange	31/01/2026

	frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
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(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	12/11/2025
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/12/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting,	Substantially Compliant	Yellow	09/12/2025

	containing and extinguishing fires.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	10/12/2025
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	02/12/2025
Regulation 34(1)(d)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a	Substantially Compliant	Yellow	11/12/2025

	prominent position in the designated centre.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	19/12/2025
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	19/12/2025
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	19/12/2025
Regulation 05(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	Not Compliant	Orange	01/12/2025

	need and circumstances, but no less frequently than on an annual basis.			
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	08/12/2025
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	31/01/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the	Substantially Compliant	Yellow	31/01/2026

	effectiveness of the plan.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	01/04/2026
Regulation 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	01/04/2026
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	06/01/2026
Regulation 08(5)	The registered provider shall ensure that where there has been an incident, allegation or suspicion of	Not Compliant	Orange	06/01/2026

	abuse or neglect in relation to a child the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements are complied with.			
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