Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Lime Tree Lodge
Name of provider:	Lotus Care Limited
Address of centre:	Offaly
Type of inspection:	Unannounced
Date of inspection:	08 April 2025
Centre ID:	OSV-0008912
Fieldwork ID:	MON-0046523

About the designated centre

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

Lime Tree lodge provides residential services for up to three children/young adults (six to 18 years) with a diagnosis of intellectual disability and other comorbid conditions such as autism, attention deficiency hyperactive disorder (ADHD), oppositional defiant disorder (ODD), sensory processing disorder, global development delay, and other neurodevelopmental disorders, who may present with additional needs. Lime Tree Lodge is a three bedroom house located in quiet residential area on the outskirts of a large town. Each young person has their own bedroom with en suite bathroom facilities and access to a variety of shared communal spaces. There is a large garden area to the rear of the property. Each young person has been assigned their own vehicle to support them access school or activities of their choice in the local community. Staff are on duty during the day and night time to support the young persons who live here.

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
Tuesday 8 April 2025	10:30hrs to 16:00hrs	Mary Costelloe	Lead
Tuesday 8 April 2025	10:30hrs to 16:00hrs	Carmel Glynn	Support

What residents told us and what inspectors observed

This was the first inspection since the registration of this designated centre which opened in December 2024. The inspection was carried out to assess the provider's compliance with the regulations. Lime Tree Lodge is a residential service which can accommodate up to three children and young adults from six years up to the age of 18 years. At the time of inspection, there were two young persons living full-time in the centre. The inspection was facilitated by the team leader and regional operations manager. The inspectors also met with two other staff members who worked in the centre as well as the person in charge and two recently appointed managers who attended the feedback meeting. During the inspection, the inspectors briefly met with both young persons who lived in the centre.

The inspectors found that while there were governance systems and processes in place to oversee the quality and safety of the service, improvements and further oversight was required to ensure that the service provided was safe, effectively monitored and in compliance with the regulations. Inspectors had concerns that a large number of staff had not been provided with mandatory fire safety training, this posed a risk to the young persons living in the centre. On the day of inspection, inspectors requested immediate action in relation to this issue. The person participating in the management of the centre arranged for fire safety training to take place on 10 April 2025 and in the interim provided verbal assurances that staff who had completed training would be rostered on each shift. Further improvements were also required in relation to other aspects of risk management, assessments and personal plans, access to allied health services and to some health care records required to be kept.

Both residents were teenagers who had moved into the centre in December 2024. Both had full-time residential placements and normally attended special schools during the weekdays. On the morning of inspection, one young person had already left to attend their school and the other young person remained in the house. Staff reported how this young person had chosen to remain at home as they did not wish to attend school on the day but that this was not a regular occurrence. The team leader and staff spoken with advised that both young persons were settling in well and got on well with one another.

Both young persons were generally in good physical health but required supports with communication, in managing some behaviours that challenged, with personal care needs and with other activities of daily living. Staffing arrangements were in place to support both young persons in line with their assessed support needs. Both were provided with two to one staff support throughout the day and evening, with two active staff on duty at night-time. The staff team were familiar with the young persons and were knowledgeable regarding their individual support needs, likes, dislikes and interests.

The inspectors observed that the young person who remained at home appeared

relaxed and content throughout the day. Due to their communication needs they did not speak with the inspectors but were observed to communicate with staff in their own way. The young person appeared to have a good rapport with staff and inspectors could hear playful interactions, laughing and banter during the day. Staff were observed to be very attentive to their needs, regularly checking in with them to ensure that their needs were supported and met. Throughout the day, the young person was observed relaxing in their bedroom, watching television, having snacks and drinks and moving about the house as they wished. They also spent some time relaxing on the day bed in the office with staff. Staff were observed to offer choices and tried to encourage the young person to go outside to spend time in the garden or go for a drive in the car, however, the young person declined, indicating that they preferred to relax in the house. Staff interactions were observed to be respectful, kind and caring.

Lime Tree Lodge is a dormer style two storey detached dwelling set on its own grounds. The house was found to be well maintained and visibly clean throughout. It was found to be spacious and bright with a variety of communal living spaces available, including a kitchen, living room and large sitting room. The communal areas were found to be furnished and decorated in a comfortable and homely manner including cushions, rugs, and bean bags. There were framed photographs of both young persons displayed. There was a variety of sensory toys, floor games, mini trampoline, yoga ball and arts and crafts materials available. There were two bedrooms located on the first floor and one bedroom on the ground floor. Each young person had their own bedroom with en suite shower facilities. There was a separate bathroom located on the ground floor. Bedrooms were decorated in line with each young persons preferences. One young person's bedroom was sparsely decorated in line with their choosing while the other bedroom was decorated by the young person with bunting and stickers. There was adequate storage for clothes and personal belongings. Young persons had access to a secure garden area to the rear of the house. While there were a set of swings and a slide available, improvements were required to ensure that additional age-appropriate play and recreational facilities were provided. The team leader outlined that they were in the process of ordering outdoor garden furniture, and some raised garden beds for planting.

From conversations with staff, observations made while in the centre, photographs and information reviewed during the inspection, it appeared that young persons had good quality lives in accordance with their capacities, and were regularly involved in activities that they enjoyed in the community and also in the centre. Each young person had a documented easy read version of their weekly activity schedule. Young persons were supported to take part in activities of their choice, including regular walks and drives, going out to get treats and take away meals, attending the cinema, going shopping and visiting local pet farms. Young persons also enjoyed spending time relaxing in the house, watching television, listening to music, completing art and craft activities, baking and playing floor games such as bowling. Both young persons had recently enjoyed attending the local St. Patrick's day parade. There were two vehicles, with one assigned for each young person to facilitate outings and various activities.

Both young persons were facilitated to maintain relations with their respective family members. There were no visiting restrictions in place. There was plenty of space for the young persons to meet with visitors in private if they wished. Staff spoken with confirmed that young persons routinely received visits from family members in the centre and both young persons also routinely visited their family members at home. One young person normally spent every second weekend at home with family and the other young person normally visited family on three evenings a week after school. The team leader spoke of how they were in regular communication with parents including daily updates via text messages as well as sending photographs of young persons partaking in activities that they enjoyed. All communications with family were documented on the computerised documentation system.

Staff continued to ensure that each young persons' preferences were met through daily consultation, weekly house meetings, the personal planning process, regular key working sessions and ongoing communication with young persons and their representatives.

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 persons lives.

Capacity and capability

The findings from this first inspection indicated that there was a clear management structure in place to govern the centre. While there was evidence of good practice in some areas reviewed, further oversight and improvements were required to ensure that the service provided was safe, to ensuring that all staff had been provided with mandatory training, to risk management, to the further development of personal plans, to ensuring timely access to allied health services and to some health care records required to be kept.

The provider had appointed a full-time person in charge, who also had other managerial responsibilities in the organisation. The person in charge had a regular presence in the centre. They were supported in their role by a team leader who worked supernumerary and was responsible for the day-to-day operation of the centre and by the regional operations manager. The regional manager outlined how two new managers had been recently appointed to further strengthen the governance arrangements and to ensure more effective oversight of the service.

The provider had ensured that the staff numbers and skill mix were in line with the assessed needs of the young persons, statement of purpose and the size of the designated centre. The inspector noted that there were adequate staff on duty to support both young persons on the day of inspection. The staffing rosters reviewed indicated that a team of consistent staff was in place.

Improvements and further oversight was required to ensure that all staff were

provided with mandatory training. Training records reviewed indicated that a large number of staff had not been provided with fire safety training and some staff had yet to complete training on manual handling, administration of medication and responding to behaviours that are challenging.

The provider had some systems in place for reviewing the quality and safety of the service including a schedule of weekly, monthly and six-monthly audits. These included regular reviews of medication management, health and safety, infection, prevention and control, fire safety and staff training. The provider also had plans in place to carry out a six monthly and annual review of the service. However, the reviews completed to date had failed to identify the issues found on this inspection.

Regulation 15: Staffing

The provider had ensured that there were adequate staff to meet the needs of young people living in the centre. The staffing consisted of a mix of social care workers and social care assistants. During the day, the two young people living in the centre had 2:1 staffing, and there were two waking night staff during night-time hours. The staff team were supported by a full-time team leader, who was supernumerary to the roster. There were no staff vacancies at the time of inspection.

Inspectors reviewed the previous two month's rosters, with no gaps in staffing cover apparent. There were planned and actual rosters in place. Staffing cover was maintained by a core staff team, with very limited use of agency staff. There was an on call protocol in place for out of hours.

Judgment: Compliant

Regulation 16: Training and staff development

Improvements were required to ensuring that all staff were provided with appropriate training. While all staff had completed mandatory training such as children's first, safeguarding, and infection prevention and control, there were several staff who had yet to be provided with mandatory training, including fire safety, manual handling, administration of medication and safety intervention (CPI) training.

Training records reviewed by the inspectors showed that only five of the 18 staff had been provided with fire safety training to date. The regional manager reported that fire safety training was scheduled to take place in the coming weeks. A review of the rosters indicated that there were several shifts completed and others planned when there was no staff member on duty who had completed fire safety training. Due to the inspectors concerns and risk to the young person's accommodated, an

immediate action was issued. Prior to the end of the inspection, the local management team arranged for fire safety training for all staff to take place on the 10 April 2025 and provided verbal assurances that in the interim, staff who had completed fire training would be rostered on each shift.

Several staff had not been provided with mandatory training in other areas such as manual handling, administration of medication, and safety intervention (CPI) training. The regional operations manager reported that manual handling and medication training were scheduled in the coming weeks. Improvement was also required to staff training records to ensure accuracy, for example, not all staff names were listed under each training record.

Judgment: Not compliant

Regulation 21: Records

Improvements were required to some records that were required to be maintained in the centre. For example, there were no systems in place to clearly record any on-going medical assessments, treatments or review of young persons by their general practitioner (GP), or of any referrals or treatments by allied health professionals. While the team leader advised that both young persons were seen by their GP in recent months and a follow-up appointment was scheduled with the cardiologist for one of the young persons, they were unable to show inspectors the records of these reviews and appointments.

Judgment: Substantially compliant

Regulation 23: Governance and management

Improvements were required to the governance arrangements in place. Further oversight and improvements were required to ensure that the service provided was safe and effectively monitored, to ensuring that all staff were provided with mandatory training, to risk management, to the further development of personal plans, to ensuring timely access to allied health services and to some health care records required to be maintained. These are discussed further under Regulations: 16, 21, 26, 5 and 6.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider had an admissions policy in place. Both young persons had been admitted to live in the centre in December 2024. A needs assessment had been completed for each young person prior to admission. Each young person had a contract of care which set out their diagnosis, the legal status of each young person, the commissioner of services and each were signed by the young person's family representative.

Judgment: Compliant

Quality and safety

The young persons appeared to be comfortable in their environment and with staff supporting them. The provider had adequate resources in place to ensure that they were supported to attend school, visit family members, get out and engage in activities that they enjoyed on a regular basis. However, as discussed under the capacity and capability section of this report, further oversight was required to the service to ensure it was safe and effectively monitored. Improvements required to staff training, risk management, personal planning documentation, access to allied health professionals and health care records negatively impacted upon the quality and safety of the service.

The inspectors reviewed the files of both young persons. There were comprehensive assessments of the personal, health and social care needs of each young person completed. However, improvements were required to the personal plans reviewed as some inconsistencies and gaps in information were noted. While there were detailed care and support plans in place for many identified issues including intimate care, there were no support plans in place for some other identified issues. Both young persons had health action plans in place, however, inspectors noted many gaps in the information provided.

Personal plans had been developed in consultation with the young persons, family members and key working staff. The plans set out the services and supports provided for each young person to achieve a good quality of life and realise their goals. Progress reviews were taking place regularly and monthly action plans were documented in order to track progress. It was clear from the documentation and photographs reviewed that both young persons were being supported to progress and achieve their chosen goals. For example, a goal for one young person was trying out sensory rooms, and an action plan outlined how the young person had visited two sensory rooms in recent weeks.

Both young persons had retained their own general practitioners (GPs) and pharmacy of choice. The team leader advised that both young persons had been reviewed by their GP since being admitted to reside in the centre, however, as discussed earlier in the report, there were no systems in place to clearly record

these reviews. The team leader advised that appointments and reviews were normally recorded on the computerised daily notes. This system did not allow for the information to be easily retrieved and monitored, posing difficulty in maintaining oversight of appointments and follow-up reviews and ensuring that young persons health care needs were met.

Improvements were required to ensuring that both young persons had access to allied health professionals as required in a timely manner. While both young persons had positive behaviour support plans in place which had been reviewed in October 2024, inspectors were informed that the service did not have access to a behavioural support specialist since January 2025. The team leader advised that a referral for a dietitian review had been made a number of months ago but to date this review had not taken place. The regional operations manager reported that interviews for the posts of behaviour specialist and occupational therapist were taking place later in the week of the inspection.

Improvements were required to ensure that health passports that were recorded for both young people were current and had pertinent information unique to them in case they needed to be admitted to the hospital. For instance, one young person had a medication allergy that was not noted in their health passport, which put them at risk if the medication was given to them in a hospital.

The management team had taken measures to safeguard young persons from abuse. All staff had received specific training in the protection of vulnerable people and children. There were comprehensive and detailed personal and intimate care plans to guide staff. The inspectors were satisfied that a safeguarding incident reported to the Chief Inspector of Social Services in January 2025 had been managed appropriately in line with safeguarding policies. The local management team advised that there were no active safeguarding concerns at the time of inspection and that there had been no negative interactions between the two young persons accommodated. All staff spoken with advised that both young people got on well together.

While there were systems in place for the identification, assessment, management and review of risk, improvements were required to risk management. Inspectors viewed the risk register and a sample of risk assessments which showed a review date of December 2024. Some risk assessments required review as they were found to be generic and not specific to the centre. For example, the fire safety risk assessment outlined issues as a cause for concern such as residents with complex medical needs, specialised equipment, outdated infrastructure and smoking areas which were not relevant to this centre. While there were regular reviews of health and safety and fire safety taking place, the reviews had failed to identify the risks found on this inspection such as the risks associated with staff being rostered on duty without having been provided with fire safety training.

The local management team continued to regularly review all restrictive practices and restrictions in use. There were a small number of environmental restrictions and one physical restriction in use while availing of transport. All restrictions in use were risk assessed and there was a clear rationale for their use outlined. Staff spoke of

how they were currently trialling a less restrictive safety transport aid.

Regulation 17: Premises

Lime Tree Lodge was found to be well maintained and visibly clean throughout. The internal spaces were designed and laid out to meet the needs of the young persons living there. It was found to be spacious and bright with a variety of communal living spaces which were suitably decorated and furnished. Each young person had their own bedroom with en suite shower facilities. However, the external spaces could be further enhanced by the provision of additional age-appropriate play and recreational facilities.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Improvements were required to risk management. Due to the inspectors concerns and risk to the young person's accommodated, an immediate action was issued during the inspection. Only five of the 18 staff had been provided with fire safety training. A review of the rosters indicated that there were several shifts completed and others planned when all staff on duty had not completed mandatory fire safety training.

While there were regular reviews of health and safety and fire safety taking place, the reviews had failed to identify the risks found on this inspection such as the risks associated with staff being rostered on duty without having been provided with mandatory fire safety training.

Risk assessments required review as they were found to be generic and not specific to the centre. For example, the fire safety risk assessment outlined issues as a cause for concern such as residents with complex medical needs, specialised equipment, outdated infrastructure and smoking areas which were not relevant to this centre. however, it did not identify the main risk which was that staff on duty had not been provided with fire safety training.

Important information specific to one young person who was allergic to a specific medicine was not included on their health passport. This posed a risk to the young person should they be administered this medicine in hospital.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Improvements were required to personal planning documentation. While there were detailed care and support plans in place for many identified issues including intimate care, communication and behavioural support, there were no support plans in place for other identified issues. For example, there was a detailed support plan documented to support one young person to manage issues with constipation, however, there was no support plan in place for the same issue identified for the other young person. There were no support plans in place for one young person identified as requiring support with asthma and eczema. There was gaps in the information provided in the health action plans for both young persons, for example, there was no information regarding vaccination status, and the most recent review dates under ophthalmology, dental, and audiology were noted as 'unknown' or 'awaiting update from parents'.

Judgment: Substantially compliant

Regulation 6: Health care

Improvements were required to ensuring that both young persons had access to allied health professionals as required in a timely manner. While both young persons had positive behaviour support plans in place which had been reviewed in October 2024, inspectors were informed that the behavioural support specialist post had been vacant since January 2025 and therefore, they had no access to behaviour support at present. The team leader advised that a referral for a dietetic review had been made a number of months ago as both young adults had issues relating to constipation but to date this review had not taken place.

Improvements were also required to ensuring that health passports documented for both young persons were up-to-date and included important information specific to each in the event of they requiring hospital admission. For example, one young person was allergic to a specific medicine, however, this was not identified in their health passport and posed a risk to the young person should they be administered this medicine in hospital.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had systems in place to support staff in the identification, response, review and monitoring of any safeguarding concerns. All staff had completed training in Children's First and safeguarding. There were no active safeguarding

concerns at the time of inspection. The inspectors were satisfied that a safeguarding incident reported to the Chief Inspector of Social Services in January 2025 had been managed appropriately in line with safeguarding policies. Safeguarding was regularly discussed with staff including at the monthly team meetings.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Lime Tree Lodge OSV-0008912

Inspection ID: MON-0046523

Date of inspection: 08/04/2025

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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Fire Safety Training:
• In response to the immediate action issued by inspectors, fire safety training was completed for all staff within 48 hours of the inspection Completed 10/04/2025
• A review of rosters was conducted, and only staff with completed fire training were rostered on duty until full compliance was achieved. Completed 08/04/2025
• A fire training register was updated and cross-referenced against rosters to ensure continued compliance and oversight. Completed 08/04/2025
Other Mandatory Training
• The following actions have been taken:
o Manual handling and medication administration training are scheduled To be completed 30/05/2025
o CPI (Safety Intervention) training has also been prioritised and placed on the training calendar, with upcoming dates communicated to staff. To be completed 30/05/2025
Oversight and Compliance Monitoring:
• The Training Department has commenced structured compliance meetings to:
o Further review of training records across all centres to be completed 14/06/2025
o Staff names are clearly listed under each training record to be completed 14/06/2025
Ongoing Quality Assurance:
• A monthly training audit is conducted by the Person in Charge and submitted to the senior management team. Completed 02/05/2025
• Results of training compliance will be reviewed as part of the organisation's senior management team agenda item at SMT meetings, with continuous improvement monitored by the Quality, Safety and Practice Development Manager. Completed 06/05/2025

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

The record keeping system for medical appointments will be updated and will be reviewed by the senior management team. To be completed 30/05/2025

A retrospective review of all medical / health appointments attended will be completed by the PIC. Relevant details and any follow-up actions will be clearly documented. To be completed 30/05/2025

Regulation 23: Governance and management	Not Compliant

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

• Additional systems have been implemented to ensure effective governance and oversight in the following areas – To be completed 14/06/2025
• Staff Training & Development
• Risk Management
• Individualised assessment & personal planning
• Record maintenance
• Healthcare

• The Senior Management Team and Regional Services Manager meet monthly for governance review meetings. These meetings ensure senior management governance and oversight of centres. Completed 06/05/2025

Records:
The record keeping system for medical appointments will be updated and will be reviewed by the senior management team. To be completed 30/05/2025

A retrospective review of all medical / health appointments attended will be completed by the PIC. Relevant details and any follow-up actions will be clearly documented. To be completed 30/05/2025

Fire Safety Training:
• In response to the immediate action issued by inspectors, fire safety training was completed for all staff within 48 hours of the inspection Completed 10/04/2025
• A review of rosters was conducted, and only staff with completed fire training were rostered on duty until full compliance was achieved. Completed 08/04/2025
• A fire training register was updated and cross-referenced against rosters to ensure continued compliance and oversight. Completed 08/04/2025
Other Mandatory Training
• The following actions have been taken:
o Manual handling and medication administration training are scheduled To be completed 30/05/2025

o CPI (Safety Intervention) training has also been prioritised and placed on the training calendar, with upcoming dates communicated to staff. To be completed 30/05/2025
Oversight and Compliance Monitoring:
• The Training Department has commenced structured compliance meetings to:
o Further review of training records across all centres to be completed 14/06/2025
o Staff names are clearly listed under each training record to be completed 14/06/2025
Ongoing Quality Assurance:
• A monthly training audit is conducted by the Person in Charge and submitted to the senior management team. Completed 02/05/2025
• Results of training compliance will be reviewed as part of the organisation's senior management team agenda item at SMT meetings, with continuous improvement monitored by the Quality, Safety and Practice Development Manager. Completed 06/05/2025
Review and Revision of Risk Assessments:
• All risk assessments have been further reviewed and updated to ensure they are centre specific. Staff training on updated risk assessments To be completed 14/06/2025

Individual Healthcare Risk:

• The young persons health passport has been reviewed and updated to include specific medicine allergies completed 08/04/2025.
• All relevant staff have been informed of the updated health passport and same is filed in the medical and personal planning folders. Completed 29/04/2025
• The young persons health passport has been reviewed and updated to include specific medicine allergies completed 08/04/2025.
• All relevant staff have been informed of the updated health passport and same is filed in the medical and personal planning folders. Completed 29/04/2025

Individualised Assessment and Personal Planning:

Any newly identified healthcare risks are immediately incorporated into both the personal plan and health action plan, with corresponding risk assessments created or updated. To be completed 30/05/2025

Health action plans for both service owners will be reviewed and updated to include:
• Current vaccination status
• Latest dates for ophthalmology, audiology, and dental reviews (obtained directly from parents and relevant services) To be completed 30/05/2025
Access to Behavioural Support Services:
• While both service owners had Positive Behaviour Support Plans (PBSPs) in place (reviewed in October 2024), the vacancy of the Behaviour Support Specialist since January 2025 led to a gap in ongoing specialist input. The PBS role has been filled and will commence on 15/05/2025

Access to Dietetic Services:
• The dietetic referral, originally submitted due to issues related to constipation for both service owners, had not resulted in a scheduled appointment at the time of inspection. This referral has been re-sent with follow-up communication to the relevant HSE

department, and the Person in Charge is actively pursuing an appointment date. Completed 15/04/2025
Health Passport Updates:

• The young persons health passport has been reviewed and updated to include specific medicine allergies completed 08/04/2025.
• All relevant staff have been informed of the updated health passport and same is filed in the medical and personal planning folders. Completed 29/04/2025

Regulation 17: Premises	Substantially Compliant

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

• To compliment the existing array on indoor age appropriate play equipment and in consultation with the service owners and staff team the person in charge has sourced additional age-appropriate meaningful therapeutic outdoor play and recreational equipment. Shop ordered equipment has been delivered and we await bespoke purpose built equipment to be manufactured. To be completed 30/05/2025

Regulation 26: Risk management procedures	Not Compliant

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

Fire Safety Training Compliance:
• In response to the immediate action issued by inspectors, fire safety training was completed for all staff within 48 hours of the inspection Completed 10/04/2025
• A review of rosters was conducted, and only staff with completed fire training were rostered on duty until full compliance was achieved. Completed 08/04/2025
• A fire training register was updated and cross-referenced against rosters to ensure continued compliance and oversight. Completed 08/04/2025
• Internal audits are being reviewed and tracked to ensure all identified risks are effectively managed Completed 30/05/2025

Review and Revision of Risk Assessments:
• All risk assessments have been further reviewed and updated to ensure they are centre specific. Staff training on updated risk assessments To be completed 14/06/2025

Individual Healthcare Risk:

• The young persons health passport has been reviewed and updated to include specific medicine allergies completed 08/04/2025.
• All relevant staff have been informed of the updated health passport and same is filed in the medical and personal planning folders. Completed 29/04/2025

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• The young persons health passport has been reviewed and updated to include specific medicine allergies completed 08/04/2025.
• All relevant staff have been informed of the updated health passport and same is filed in the medical and personal planning folders. Completed 29/04/2025

Any newly identified healthcare risks are immediately incorporated into both the personal plan and health action plan, with corresponding risk assessments created or updated. To be completed 30/05/2025

Health action plans for both service owners will be reviewed and updated to include:
• Current vaccination status
• Latest dates for ophthalmology, audiology, and dental reviews (obtained directly from parents and relevant services) To be completed 30/05/2025

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

Access to Behavioural Support Services:
• While both service owners had Positive Behaviour Support Plans (PBSPs) in place (reviewed in October 2024), the vacancy of the Behaviour Support Specialist since January 2025 led to a gap in ongoing specialist input. The PBS role has been filled and will commence on 15/05/2025

Access to Dietetic Services:
• The dietetic referral, originally submitted due to issues related to constipation for both service owners, had not resulted in a scheduled appointment at the time of inspection. This referral has been re-sent with follow-up communication to the relevant HSE department, and the Person in Charge is actively pursuing an appointment date. Completed 15/04/2025
Health Passport Updates:

• The young persons health passport has been reviewed and updated to include specific medicine allergies completed 08/04/2025.
• All relevant staff have been informed of the updated health passport and same is filed in the medical and personal planning folders. Completed 29/04/2025

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	14/06/2025
Regulation 17(3)	The registered provider shall ensure that where children are accommodated in the designated centre appropriate outdoor recreational areas are provided which have age-appropriate play and recreational facilities.	Substantially Compliant	Yellow	30/05/2025
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in	Substantially Compliant	Yellow	30/05/2025

	Schedule 3 are maintained and are available for inspection by the chief inspector.			
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	14/06/2025
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	30/05/2025
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	30/05/2025
Regulation 05(4)(a)	The person in charge shall, no	Substantially Compliant	Yellow	30/05/2025

	later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).			
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	15/05/2025