Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Forest View Apartments
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	11 May 2026
Centre ID:	OSV-0001783
Fieldwork ID:	MON-0049632

About the designated centre

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

Forest View apartments is a designated centre which has been designed to provide full-time accommodation for three residents. The service can accommodate both male and female adults who may have autism, additional complex needs and behaviours of concern. The centre consists of three individualized apartments and separate staff accommodation which is adjacent to the apartments. The centre is located in a rural setting and is within walking distance of a day centre, which some residents attend. Forest View apartments have access to their own transport to enable residents to access the community. A social care model is provided in this centre, and a combination of social care workers and social care assistants support residents with their daily needs. Residents are supported by up to three staff during daytime hours and two staff provide sleepover cover each night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 11 May 2026	14:30hrs to 18:05hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

The provider's governance and oversight arrangements had resulted in an improvement to the quality of the service in this centre. Residents were routinely offered choices in relation to meaningful activities that were in line with their interests. They were offered choices in line with recommendations made by members of the multidisciplinary team. The residents received positive behaviour support. Risks to residents were reviewed and kept updated. Improvement was required to ensure that the range of choices offered to residents was expanded in line with their interests. Improvement was also required to ensure that the provider completed all actions in line with their target timelines and that all risks to residents were clearly identified and assessed.

The Chief Inspector of Social Services issued a Notice of Proposed Decision to cancel the registration of this centre on 18 December 2025. This was based on inspection findings from 27 May 2025 and 4 November 2025. Following the inspection of the centre in May 2025, the provider was issued with a warning letter due to the level of non-compliance. The letter outlined that the provider was required to come into compliance and that failure to do so would result in the cancellation of the registration of the centre. The provider submitted a plan outlining how they would come into compliance and the timelines by which that would be achieved. A follow-up inspection in November 2025 found that the provider had failed to implement these actions and improve the quality of the service. This impacted negatively on the residents' quality of life and resulted in residents having limited opportunities to engage in activities that were in line with their interests. As a result, the notice of proposed decision to cancel the registration of the centre was issued. The provider submitted representations that outlined how the governance and oversight of the service and compliance with the regulations would be improved. A follow-up inspection of the centre was completed on 27 January 2026 to review the effectiveness of these actions. This inspection found that actions had been commenced but that additional time was required to determine if these actions would result in an improvement to the overall quality of the service. The purpose of this inspection was to determine if the provider's actions had been effective. The inspection was unannounced. It was facilitated by the person in charge.

The centre was home to three residents. All residents required varying levels of support with their activities of daily living and personal care. The needs of one resident had changed since the last inspection due to health reasons.

This centre comprised of one building in a rural location. The building consisted of three separate apartments, all of which had an adjoining door into an area that contained a staff office, laundry facilities, storage rooms, and two staff sleepover rooms. Within each apartment, there was a kitchen, dining and living area, and an en-suite bedroom. Each apartment had access to its own enclosed outdoor space. The centre was in a good state of repair and pleasantly decorated. It was warm,

clean and tidy. Since the last inspection, one apartment had been modified based on an assessment by a healthcare professional. These modifications included a change to the lighting in the resident's bedroom and the addition of tactile cues in the kitchen-living room to promote the resident's independence with daily tasks. There was also a plan to install a folding table in the resident's apartment in line with recommendations from the behaviour therapist. There were plans to install handrails at the back door into two residents' apartments. The person in charge reported that another resident's apartment would likely require refurbishment works based on their changing needs.

The inspector met with two of the three residents who live in the centre. The inspector met with the residents in their own apartments and spent a few minutes in their company. A staff member accompanied the inspector when meeting the residents. Residents greeted the inspector. One resident spoke about their interests and described what they were going to do that evening. Another resident indicated that they planned to leave the centre to visit the local church.

In addition to the person in charge, the inspector had the opportunity to meet with two members of staff. One of the staff members outlined how choices were offered to the residents. They gave information about objects of reference and picture cues that were used so that residents understood the choices being offered and so they could indicate their preference. This was in line with the information within the residents' speech and language therapy report and positive behaviour support plans. Another staff member spoke about how they knew that a resident was becoming anxious or unsettled. They spoke about the ways to respond to the resident and how they supported the resident at these times. Again, this was in line with the information within the resident's behaviour support plan.

The next two sections of this report present the inspection findings regarding the governance and management in the centre, and how this impacts the quality and safety of the service provided.

Capacity and capability

The provider introduced enhanced oversight and governance arrangements in this centre at the beginning of 2026. On this inspection, it was found that these arrangements were effective at monitoring the quality of the service, identifying further areas for improvement and ensuring that actions were completed in line with the provider's compliance plan. Improvement was required to ensure that routine audits in the centre were improved in line with the provider's timelines.

Regulation 23: Governance and management

The provider introduced enhanced governance and oversight arrangements. On the last inspection of this centre in January 2026, these arrangements had just commenced. On this inspection, it was noted that the arrangements remained in place and were effective at monitoring the quality of the service. Improvement was required in relation to the routine audits used in the centre and the planned roll-out of a new financial audit had not yet taken place in line with the provider's timeline.

The person in charge met with their line manager on a weekly basis. The inspector reviewed the minutes of the meetings that were held on 17 and 23 April 2026. These meetings had a standing agenda that included a review of the daily notes recorded for each resident. This review identified if residents were offered choices in relation to their daily lives. Updates to service improvement actions and compliance plans submitted to the Chief Inspector were reviewed. A plan was generated at the end of each meeting with specific actions with a target timeline for completion. This meant that the quality of the service was continuously reviewed, actions progressed and new areas for service improvement identified.

In addition, the person in charge met with members of senior management on a monthly basis to provide an update on the care and support of residents, staffing and operational issues, and updates on service improvement actions. The most recent meeting had taken place on the day of inspection. A member of senior management had also completed an unannounced visit to the centre on 22 April 2026. The report from this visit was not yet completed and not available for review on the day of inspection.

The person in charge had completed an annual report of the service in February 2026. This report again identified actions for service improvement. The report was reviewed by the inspector and it was found that the actions were reflective of the issues that were discussed at the weekly and monthly meetings with senior management.

Incidents in the centre were recorded and reviewed. The inspector reviewed the incidents that were recorded for one resident in January 2026. The person in charge completed an analysis of the incidents and matched them to the resident's risk assessment to determine if any actions were needed to avoid a recurrence.

The person in charge completed an updated training needs analysis in February 2026. This identified the specific training modules required by staff for this service and the target completion rate. The inspector reviewed the training records maintained by the provider and noted that all staff had up-to-date training in these modules. This included training in neurodiversity, safeguarding, and managing behaviour that is challenging. Where refresher training was required, staff had places booked on upcoming courses.

There had been changes to the staffing in the centre since the last inspection. Given the changing needs of one resident, a staff member had been allocated to support that resident during their admission to hospital on a 24 hour basis. The person in charge reported that this occasionally impacted on the availability of staff in the

evenings to support residents. The person in charge reported that evening shifts were covered by relief staff, the person in charge, and a member of staff who also provided cover to other centres at night. The person in charge reported that business cases had been submitted to change the staffing arrangements in the centre in light of one resident's changing needs. The person in charge said that a new staff member was due to commence work in the coming weeks to provide additional support for social activities in the evenings.

Improvement was required in relation to the routine audits in the centre. It had been identified on previous inspections that the routine audits used in the service did not always identify all areas for service improvement. In response, the provider had committed to introducing a pilot financial audit in January 2026. On the day of inspection, this had not yet been commenced.

Judgment: Substantially compliant

Quality and safety

The provider had improved the systems to offer choices to residents in relation to activities that were meaningful and in line with their interests. The provider ensured that appropriate supports were used so that residents were offered choices in line with their needs as outlined in speech and language therapy reports, and behaviour support plans. Further improvement and additional time was required to ensure that residents were offered choices to engage in activities in the locality and wider community.

Risk assessments were regularly reviewed and updated. Improvement was required to ensure that all risks to residents were identified, defined and assessed.

The provider had effective systems to support residents with their behaviour. Restrictive practices were reviewed to ensure that they were the least restrictive option in place for the shortest duration of time.

Regulation 13: General welfare and development

The provider had implemented new systems to ensure that residents were offered choices in relation to their existing daily activities. Further improvement was required to ensure that residents were offered more opportunities to engage in meaningful activities in the wider community and locality.

The inspector reviewed the daily notes that were recorded for two residents from 1 April 2026 to 3 May 2026. These showed that residents were offered choices in

relation to their daily activities. The notes recorded how these choices were offered. This included using objects, pictures and verbal cues that were in line with the information contained within the residents' speech and language therapy reports and behaviour support plans. How residents accepted or declined choices was also recorded. The inspector noted that residents were regularly offered a variety of activities within the centre that were of interest to the residents. This included walks, facials, music, baking and trips to the local shop or hotel for coffee. The options offered to residents was dependent on the number of staff on duty, as discussed under regulation 23: governance and management. The person in charge reported that these records were useful to identify activities that the residents liked and disliked. For example, the records indicated that one resident consistently declined to engage with sensory objects and the person in charge reported that this would be reviewed by the occupational therapist.

Though there had been an improvement in the meaningful choices offered to residents since the last inspection, further improvement was required as the range of options for the residents remained limited. Since the last inspection, a behaviour support practitioner had completed five sessions with staff to identify goals for more social interactions for the residents and engagement in the community. The person in charge reported that the focus of the next staff meeting in the centre was to plan for these activities. Further time was required to determine if these actions would result in a wider range of options being offered to residents.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had an effective system for reviewing risk assessments in the centre. Improvement was required to ensure that all risks were clearly identified and had corresponding risk assessments to guide staff practice.

The inspector reviewed the risk assessments that had been developed for one resident. These had been updated since the last inspection. The risk assessments clearly defined the risk. The steps that should be taken to promote the resident's safety were outlined and gave clear guidance to staff.

The inspector reviewed the incidents that had been recorded for this resident in January 2026. This showed that incidents were mapped against the resident's risk assessments to ensure that control measures were still effective. This meant that risk assessments were continually reviewed to ensure that they were effective and up-to-date.

The inspector noted that not all known risks were clearly identified and assessed. For example, the person in charge reported that cooking and baking did not occur in two residents' apartments due to the risks to those residents. However, this risk was unclear as it had not been assessed. Without an appropriate risk assessment, the

specific risk to the residents had not been identified and it was unclear what control measures should be implemented to support the residents with cooking and baking activities.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider had systems to ensure that residents received the necessary supports in relation to their behaviour.

Positive behaviour support plans had been developed for residents in this centre. They were reviewed by the inspector. These plans gave information on how to maintain a supportive environment for the residents and how to respond when the residents needed additional support. They had been developed by an appropriately qualified professional. In speaking with the inspector, staff demonstrated a good knowledge of the content of these plans. Staff told the inspector how to maintain a supportive environment for the residents. They spoke about how residents were supported to make choices. They told the inspector how they knew that residents were upset or uncomfortable and what supports to offer at these times. This was in line with the information in the residents' plans.

The inspector's review of residents' daily notes showed that staff recorded when residents were indicating that they were upset or uncomfortable. The staff members' response to these situations was also recorded and was in line with the residents' behaviour support plans.

The restrictive practices in this centre had been reviewed by the provider's rights review committee on 15 April 2026. The person in charge reported that, following this meeting, there had been no changes made to the restrictive practices in the centre and that they would be reviewed again in six months by the committee.

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 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Forest View Apartments OSV-0001783

Inspection ID: MON-0049632

Date of inspection: 11/05/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Vi clarity finance audit pilot will be rolled out to the service by 31.07.2026 • The PPIM and PIC will meet for Bi-weekly business meetings to review activity trackers and daily log reviews. These meetings will continue bi-weekly until September at which time the required frequency will be reviewed and amended in line with the needs of the service at that time which will be measured on the information gathered through daily log reviews and progress updates. • Monthly governance and oversight meetings will continue until September at which time the required frequency will be reviewed and amended in line with the needs of the service at that time which will be measured on the information gathered through daily log reviews and progress updates. • The Organisations Quality, Safety and Service improvement team will be asked to complete a focused audit of the service by the end of October.	
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development:	

· A team meeting was held on the 19.05.2026 to review the work completed in the BSS workshops. Part of this work included identifying more community-based activities and how to improve links to the community. The PIC is integrating the newly identified goals with a specific focus on community-based activities into the weekly activity tracker and will continue to review daily logs weekly to ensure both align. It was also agreed that a weekly event in line with the residents' interests would be organized by the service in a nearby Venue by the team. The trial of these events has begun.

· Progress updates will be completed month ending June, July, August and September to measure and ensure that residents are offered more opportunities to engage in meaningful activities in the wider community and locality.

· These progress updates will measure what is working for the people supported and what support is needed to expand going forward. They will also allow for the opportunity to review any learning which may identify new areas of interest to be explored as well as barriers which may need to be overcome.

• A series of dates for team meetings which will be attended by OT to complete progress updates have been agreed with the team as follows:
29.06.2026
28.07.2026
20.08.2026
30.09.2026

• Targets for progress updates will be as follows:
-June;
Review how inclusion in a local Mayo County council community project is working for one resident. The resident has recently begun to engage with this project, and it is planned to support the resident to take up a voluntary role with the project on a trial basis with the review to measure the resident's enjoyment of this role.

Review in house activities for residents with OT to explore the possibility of additional activities that could be offered and the engagement in currently recommended in house activities

Review weekly events in local venues as agreed with BSS at the wellbeing and enhancement workshop and develop a program of scheduled events in line with the residents' interests. This review will be completed through a team meeting on June 29th.

-July;
Review how the expansion of one resident's interest in their health and wellbeing is progressing and look to increase their opportunities in this area. This resident is also being supported to plan for an event which has been identified as being an enjoyable experience, this will be reviewed in July as well as exploration of further opportunities in line with this interest also.

Review the progress of the creation of a social community group and the scheduling of various events in line with the group's interests. This will be reviewed through a team meeting on July 28th and meetings with other management teams involved in the social community group.

July's meeting will also focus on agreeing a schedule of events and outings with residents during the day service closures in August, these will be integrated into the activity tracker for this period.

Review in house activities for residents with OT to explore the possibility of additional activities that could be offered and the engagement in currently recommended in house activities

-August;
Review the progress of one resident's involvement in a local community group that is in line with their interests. This will be reviewed as part of a team meeting on August 20th

Review the schedule of events and outings that was agreed during July's meeting for the day service closures and their progress.

Review in house activities for residents with OT to explore the possibility of additional activities that could be offered and the engagement in currently recommended in house activities

-September;
A full review of all wellbeing and enhancement opportunities will be completed through both team meetings and a governance and oversight meeting. This will include a summary of progress to date outlining identified social and community integration opportunities identified and trialed through the use of community mapping, BSS workshops, and team meetings. This review will be completed at the team meeting in September and presented at the Governance and oversight meeting. This meeting will also involve an initial draft of planned activities for the coming months.

· The PPIM and PIC will meet for Bi-weekly business meetings to review the activity tracker and daily log reviews. These meetings will continue bi-weekly until September and with the required frequency reviewed and amended in line with the needs of the service at that time which will be measured on the information gathered through daily log reviews and progress updates.
· Monthly governance and oversight meetings will continue until September at which time the required frequency reviewed and amended in line with the needs of the service at that time which will be measured on the information gathered through daily log reviews and progress updates.

• The Organisations Quality, Safety and Service improvement team will be asked to

complete a focused audit of the service by the end of October.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • Personal risk management plans and the service risk register have been updated to capture the risk posed to residents when cooking in their apartments	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	16/10/2026
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	06/11/2026
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community	Substantially Compliant	Yellow	16/10/2026

	in accordance with their wishes.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/07/2026
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.	Substantially Compliant	Yellow	24/05/2026