



**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:	27 January 2026
Centre ID:	OSV-0001783
Fieldwork ID:	MON-0049320

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
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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
Tuesday 27 January 2026	14:35hrs to 18:50hrs	Alanna Ní Mhíocháin	Lead
Tuesday 27 January 2026	14:35hrs to 18:50hrs	Stevan Orme	Support

What residents told us and what inspectors observed

The provider had implemented new governance systems in the centre to improve the oversight of the quality of the service. New staffing arrangements had commenced to provide additional supports to residents to access the community. The provider had engaged members of the multidisciplinary team to complete assessments with residents and to provide training to staff. Documentation used by staff to record choices offered to residents had been modified. Though these actions had resulted in some improvement in the quality of the service, they were in the early stages and further improvement was required. The actions had been recently commenced and additional time was required to determine if they would be sustainable, effective and result in a broad improvement in the quality of the service. Significant further improvement was required to ensure that residents were supported to choose activities that were in line with their interests and that these choices were offered in a consistent manner in line with recommendations from the multidisciplinary team. Significant improvement was also needed in relation to the recording of risks to residents and clear information to staff on how to reduce these risks. Improvement was required in the oversight of staff training.

This centre was inspected on 27 May 2025. Findings from that inspection identified significant areas of non-compliance. Due to the level of non-compliance, the provider was required to attend a warning meeting where a warning letter was issued. 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. Following that meeting, 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 was completed on 4 November 2025 to review the implementation and effectiveness of that compliance plan. Significant failings in relation to the governance and management of this service were identified on that inspection. The provider had failed to implement actions to come into compliance 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 they enjoyed and that were in line with their interests.

As a result of the findings from the inspection of 4 November 2025, the Chief Inspector of Social Services issued a Notice of Proposed Decision to cancel the registration of the centre on 19 December 2025. The provider was afforded 14 days to submit written representations to the Chief Inspector in relation to this notice. The provider submitted the representations within the specified time. The representations outlined how the provider proposed to improve the governance and oversight of the service and to ensure that the service was compliant with the regulations. The purpose of this inspection was to review the effectiveness of these actions and to determine if the quality of the service had improved since the last

inspection. The inspection was unannounced. It was facilitated by the person in charge and their line manager.

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 staff offices, laundry facilities, storage rooms, and staff sleepover areas. Within each apartment, there was a kitchen, dining and living area, and an en-suite bedroom. Each apartment had access to its own enclosed garden area. Inspectors noted that the centre was in a good state of repair and pleasantly decorated. It was warm, clean and tidy. Residents' apartments were personalised with photographs, artwork and items that were reflective of their interests.

The centre was home to three residents. All residents required varying levels of support with their activities of daily living and personal care. Residents required support from staff when communicating their needs and wishes. All residents required the support of staff to access the local community and to engage in activities that they enjoyed. The residents attended day services five days per week. Two residents attended this service in a neighbouring town. The third resident's day service was located in a building next to this designated centre.

One inspector had the opportunity to meet one of the residents. The resident spent time in their apartment with the inspector and staff. The resident spent time listening to music, and appeared relaxed and comfortable in the company of staff.

In addition to the person in charge and area manager, inspectors had the opportunity to meet with two other staff members. These staff members noted that the changes to staffing arrangements had resulted in more opportunity to plan and complete activities with residents in the evenings and at weekends. Staff confirmed that, at times, four staff were available. This meant that residents could be supported to access local activities as two staff were needed to be at the centre at all times to support the other residents. Staff spoke about the community-based activities that residents enjoyed since the last inspection. These included walks in the local area, trips to a local deli for take away lunches or snacks, shopping, and trips to recycle plastic bottles. Staff spoke about offering choices to residents and said that it was important not to present too many options to residents at one time so that they were not overwhelmed. Staff spoke about some of the phrases used by residents to indicate that they did not want to engage in an activity.

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

Capacity and capability

The provider had introduced new governance and oversight systems in the centre. These were newly commenced and additional time was needed to ensure that the systems were effective. The provider had introduced systems to report on the implementation of service improvement actions. There was an increased presence of senior managers in the centre with two unannounced visits to the service since the last inspection. Senior managers also met regularly with the person in charge and their line manager. New staffing arrangements had commenced and were in the process of being finalised. A new staff member was undergoing induction during the inspection. Improvement was required in the oversight of staff training.

Regulation 23: Governance and management

The provider had improved the governance systems in this centre since its previous inspection in November 2025. The provider introduced new management meetings and completed unannounced visits from senior managers. The provider changed the frequency of staff meetings and staffing arrangements. Though there was evidence that these systems had been commenced, additional time was required to ensure that the systems were sustainable, effective and resulted in a positive change to the residents' quality of life. Improvement was required in relation to the provider's oversight of staff training in the centre.

The provider had introduced two new regular governance meetings to monitor the implementation of the actions needed to improve the quality of the service. The first was a weekly meeting between the person in charge and their line manager. The second was a meeting between the person in charge and senior managers within the organisation. These occurred every two weeks. Inspectors reviewed the minutes of the three most recent meetings that had occurred in December 2025 and January 2026. Both sets of minutes showed that senior managers received regular updates on the actions that were underway in the centre. There was evidence that documentation from the centre was reviewed and areas for improvement were identified with a named person responsible for completing the action within a specified timeframe.

The provider had completed two unannounced visits to the centre since the last inspection. These visits were completed by senior managers in the organisation. One occurred on 13 November 2025 and another on 22 January 2026. Records of these visits were reviewed by inspectors and they showed that a comprehensive review of the service had taken place. This included a review of restrictive practices, incident records, safeguarding, audit findings and progress towards the implementation of actions outlined in the provider's compliance plan. This presence of senior managers in the centre meant that the provider could be assured that steps were being taken to address areas for service improvement.

The frequency of staff meetings within the centre had changed. Staff now met on a weekly basis with the person in charge. Minutes of staff meetings held in November and December 2025, and January 2026 were reviewed by inspectors. These showed

that discussion took place around safeguarding, communications from senior management, good news stories, and activities tried with residents. Action plans were developed from these meetings with an assigned person and a deadline for completion. This meant that staff were kept informed of changes and initiatives within the service and that management could directly communicate any areas that required additional improvement.

The staffing arrangements in the centre had been altered in order to provide more opportunities for residents to access the community and engage in activities that they enjoyed. There had been an increase in the number of hours staff were rostered midweek and at weekends. Additional staff were also rostered to work Monday and Friday evenings. This was a new development since the last inspection. A member of staff was undergoing induction on the day of inspection to take up this role. The person in charge reported that it was hoped that this increase in staffing would allow residents more flexibility to access the community more frequently.

The provider had identified that all staff in the centre required training in neurodiversity. Since the last inspection, staff had either completed this training or were allocated a space on an upcoming course. It was also identified that all staff required training in supporting residents with behaviour that is challenging. However, though the provider noted that this training was needed by all staff in the centre, it was not included in the centre's mandatory training schedule.

Judgment: Substantially compliant

Quality and safety

Significant improvement was required to ensure that systems were in place that provided residents with opportunities to choose meaningful and enjoyable activities that were in line with their interests. The provider had engaged members of the multidisciplinary team to devise ways of offering choice to residents. Some steps had been taken to implement these recommendations but, on the day of inspection, further improvement was required to ensure that these choices were offered routinely. Documentation relating to residents' daily activities showed that choices were offered to residents but these were not always meaningful.

Significant improvement was also needed in relation to residents' risk assessments. Risk assessments did not always provide adequate guidance to staff on actions that should be taken to reduce risks to residents. This absence of guidance meant that it was not clear how staff should respond to certain incidents. In addition, without this guidance, the provider was unable to monitor that residents were getting the supports they needed as there was no procedure against which to measure staff members' actions.

Improvement was noted in relation to the systems in place to support residents to manage their behaviour. Restrictive practices in the centre were accurately documented and measures to reduce a restrictive practice had commenced. Further improvement was required to ensure that all recommendations in residents' behaviour support plans and occupational therapy reports were implemented.

Regulation 13: General welfare and development

The provider had taken steps to address shortcomings in this area and had commenced new systems to offer choices to residents to engage in activities that they enjoyed. However, these measures had not yet proven effective at ensuring that residents were regularly offered choices or supported to engage in activities that were in line with their interests. A disconnect remained between the systems recommended by the multidisciplinary team and the practices used by staff as recorded in the residents' daily logs.

Since the last inspection, members of the multidisciplinary team made further recommendations about systems that could be implemented to offer choice to residents in relation to their preferred activities. Multidisciplinary team members attended the centre to give guidance and provide training to staff. This included a speech and language therapist, an occupational therapist and psychologist. It was advised that object-based or picture-based systems be implemented to offer choices to residents. Inspectors observed that residents had boxes in their apartments that contained some of these objects and pictures. However, these were not always maintained in line with multidisciplinary team recommendations. For example, for one resident, one of the listed objects was not in the box and an additional item was included without corresponding information about its meaning. Further, no clear process on how staff should offer these choices had been developed. The person in charge reported that choices were offered to residents on an ad hoc basis. Inspectors' review of daily logs noted that this had not been effective at ensuring that all residents were regularly offered choices in relation to their daily activities and interests.

The inspectors reviewed the daily logs for two residents from 1 January 2026 to 18 January 2026. The provider had engaged the support of a psychologist to review these logs and feedback to management on the quality of information recorded. This review was underway on the day of inspection. The daily logs showed records of the residents leaving the centre to buy take away meals and snacks. One resident went to a local pub and another went shopping. The logs recorded choices that the residents were offered throughout the day. However, the choices were not always meaningful. For example, for one resident it was recorded whether the resident had chosen between red or brown sauce, and tea or coffee. In some cases, the fact that the resident had decided to eat dinner was recorded as a choice. The logs did not reflect the recommendations made by the multidisciplinary team. For example, one resident's behaviour support plan stated that, through the use of objects or an object reference board, the resident should be offered a real choice of activities by

presenting at least two options rather than offering one choice that can be declined. This system of offering two choices was not recorded or evidenced in the logs. This meant that it was not clear that residents were routinely offered choices and opportunities to engage in activities of their choosing in line with their interests.

Judgment: Not compliant

Regulation 26: Risk management procedures

Improvement was required to ensure that there was clear guidance to staff on the control measures that should be implemented to reduce risks to residents.

Inspectors reviewed the risk assessments that had been developed for two residents. The risk assessments had recently been reviewed by the person in charge. They identified known risks to the residents and control measures were recorded to guide staff. However, not all risk assessments gave adequate information to staff or reflected all control measures in place in the centre. For example, for one resident there was a known risk of injury in relation to their behaviour. The resident's risk assessment did not adequately guide staff on how to ensure that the resident had not injured themselves when they engaged in this behaviour. Further, for the same resident, the risk assessment relating to falls did not record the use of a watch to monitor for falls which had recently been introduced in the centre. In addition, the use of a sensor at night time to alert staff when the resident got out of bed was not recorded as a control measure. Therefore, it was not clear how and when these monitoring systems should be implemented and how staff should respond when alerted. The lack of clear guidance increased risks to the residents' safety as staff may not implement all measures as required. Also, monitoring staff's implementation of these control measures was not possible as the process had not been defined.

Judgment: Not compliant

Regulation 7: Positive behavioural support

There was an improvement in the systems to support residents to manage their behaviour. However, further action was required to ensure that all recommendations made by members of the multidisciplinary team were fully implemented.

Since the last inspection, an occupational therapist had completed assessments with residents regarding their sensory needs. This occurred in November 2025 and formed part of the residents' supports in relation to their behaviour. The occupational therapist provided a report and recommendations after this assessment. This was reviewed by inspectors who found that most aspects had

been introduced but not all elements had been trialled with residents. For example, one resident had been recommended a trial of a particular cushion relating to their movement and this had not yet been trialled. There was no clear plan as to when this would be trialled with the resident.

As noted on the previous inspection of the centre, residents had behaviour support plans that were devised by psychologists with input from the person in charge. These plans gave clear guidance to staff on the supports that should be offered to residents in relation to their behaviour. The person in charge reported that the plans were reviewed by psychology in recent weeks but new reports were not available on the day of inspection. Again, some recommendations within these reports had been commenced with residents; for example, the use of a body map with one resident to indicate pain. However, again, not all recommendations had been fully implemented. For example, a visual schedule had not yet been introduced for one resident and the use of objects to make choices had not yet been fully implemented as outlined under regulation 13: general welfare and development.

The provider had updated their documentation on restrictive practices since the last inspection. All of the residents' restrictive practice logs were reviewed by inspectors. These logs recorded all restrictions in use in the centre and the reason for their use. The provider had commenced a trial of reducing a restrictive practice for one resident in line with recommendations from the provider's human rights committee.

Judgment: Substantially 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	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Forest View Apartments OSV-0001783

Inspection ID: MON-0049320

Date of inspection: 27/01/2026

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
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>Outstanding staff training has been booked for 19th March 2026.</p> <p>The PIC has a plan in place for all other due training to be attended</p> <p>The PIC has updated the Training needs analyses to represent the current training needs with the centre, and will continue to nominate staff members for any training required</p> <p>The Provider will continue to progress the actions identified and committed to in the action plan submitted following the Inspection of 04/011/2025 and the actions committed to in the representation submitted to the authority on 02/01/2026.</p> <p>In addition, the PPIM will continue weekly business meetings with the PIC.</p> <p>The PIC will continue to facilitate staff meetings on a regular basis to ensure all information and guidance is shared with the team members.</p> <p>The provider will continue to hold monthly Governance and Oversight meetings to monitor and progress the action plan. This will include providing any additional support that may be identified at this forum.</p> <p>The PIC will complete progress updates on Individuals Plans to represent the progress on choices and schedule of activities for residents. Next update due 20/04/2025</p>	

Regulation 13: General welfare and development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 13: General welfare and development:</p> <p>The PIC has reminded Staff at the meeting on 26.02.2026 of the protocol and materials to be included in the box of objects of reference. Staff are asked to check the contents of the box at the beginning of their shift to ensure the right cues are there for people. The PIC will review this through spot checks and give update at business meeting with PPIM 06/03/2026</p> <p>The PIC has developed the schedule for each resident and will monitor its implementation on a weekly basis. This will be reviewed at business meeting between PIC and PPIM. 06/03/2026</p> <p>A programme of enhancement focusing on broadening the choice and opportunities for participation for each resident has commenced 18/02/2026 and will be completed by 05.03.2026</p> <p>This programme is facilitated by a member of the psychology team.</p> <p>The PIC will introduce a food diary. This will be used to track the choices made by residents in terms of menu planning and monitoring what is offered and chosen by residents. This will commence on 02/03/2026.</p> <p> </p>	
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>The Personal Risk Management Plans have been reviewed and updated to incorporate all control measures in place for the person. This will provide the appropriate guidance for staff members. The PIC will share with the staff team on 05/03/2026</p> <p>The proposed use of any devices for monitoring falls has been included by the PIC in Personal Risk Management Plans and the designated centre's risk register as appropriate. 24/02/2026</p>	

<p>]</p>	
<p>Regulation 7: Positive behavioural support</p>	<p>Substantially Compliant</p>
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The PIC is engaging with OT to develop and provide guidance on the use of the "sit and swivel" cushion which will be reviewed in three months 27/02/2026</p> <p>All Positive Behaviour Support Plans are up to date and include all current guidance for staff in supporting each resident. The Clinical Lead will review the behaviour strategies. 9/3/2026.</p> <p>The PIC will follow up with SLT to ensure the visual communication for individual schedules are representative of the residents' choices.</p> <p>When this work is completed, the outcome will be shared at a staff team meeting. 20/04/2026</p> <p>]</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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	03/04/2026
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.	Not Compliant	Orange	03/04/2026
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	Not Compliant	Orange	03/04/2026

	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	03/04/2026
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.	Not Compliant	Orange	05/03/2026
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	24/02/2026