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:	Prosper Fingal Residential Service 1
Name of provider:	Prosper Fingal Company Limited by Guarantee
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	14 October 2025
Centre ID:	OSV-0003398
Fieldwork ID:	MON-0039656

About the designated centre

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

Prosper Fingal Residential Service 1 is a designated centre consisting of three properties in North County Dublin. The centre can accommodate up to 15 residents both male and female with a mild to moderate intellectual disability. Some residents may also have a secondary disability such as a physical disability, sensory disability or a mental health need. The service operates 7 days a week for 52 weeks of the year. The staff team consists of a person in charge, social care workers, nursing staff and care assistants. The service operates on the principles of person-centredness, respect and inclusion. Staff aim is to provide a safe and comfortable home within a community environment which supports and promotes independence and well being.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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 14 October 2025	10:00hrs to 18:30hrs	Brendan Kelly	Lead
Wednesday 15 October 2025	10:00hrs to 16:00hrs	Brendan Kelly	Lead

What residents told us and what inspectors observed

This was a two day announced inspection of the designated centre Prosper Fingal Residential Service 1. This centre comprises three houses and the inspector spent time in each over the course of the two days. The inspection was completed to inform a decision to renew registration of the designated centre and to monitor the providers ongoing compliance with the Health Act 2007 (Care and Support of Resident in Designated Centres (Children and Adults) With Disabilities Regulations 2013.

Overall the inspector was not assured the provider had systems in place to maintain safe care and support for residents and to meet their assessed needs in particular with the management of behaviors that challenge and safeguarding residents. The majority of findings from this inspection related to one house within this centre due to resident incompatibility. Across both days of inspection the inspector had the opportunity to meet with and speak to nine of the 15 residents, the person in charge and seven staff. The inspector observed interactions in all three premises, and reviewed key documents in all three locations including HIQA questionnaires completed by residents ahead of the inspection. The inspector also used communication with residents and staff to inform judgments. .

Prosper Fingal Residential Service 1 is a designated centre that consists of three large detached properties in north County Dublin and is registered for a maximum of 15 residents. Recently there had been two new admissions to the centre so there were no vacancies on the day of inspection. Two of the premises are located in close proximity to one another in a small town with the third premises located 10 kilometres away. The inspector spent the first day of the inspection in the houses that were close to one another, revisited one of these for a short period on the morning of day two and spent the remainder of the inspection in the third house.

The first premises was a large detached bungalow. On arrival on the first day of the inspection, the inspector was met by the person in charge, house lead staff, a social care worker, care assistant and one resident was in the house waiting to attend a medical appointment. Prior to attending the medical appointment, the inspector had an opportunity to speak with the resident and complete a walk around the property with the resident. In conversation with the inspector the resident indicated that they were very happy in their home, and spoke positively about the staff working in the centre. When asked if the resident would like to change anything about their home, they indicated that they would not and are "happy with how things are". The resident showed the inspector their bedroom and said that that it was decorated to their liking, and they had many photos of family on display. The inspector observed that it was laid out to meet their needs. The resident spoke about maintaining family contact which they could do as they wish with their mobile phone. The resident informed staff that they were leaving for their hospital appointment and did so independently via the use of a taxi.

Later in the day, a second resident came home from day service to meet with the inspector on their lunch break. The resident sat with the inspector and staff for lunch and chatted about living in the centre. The resident told the inspector that they were very happy in the centre.

The also said they were very happy with the staff and in particular their key worker. The resident spoke about some challenges with their housemates, but spoke positively regarding staff supports in helping the resident manage these challenges and also spoke to the inspector about looking forward to going out the following day with all housemates. The resident spoke about their own diagnosed conditions including their mental health. The resident spoke confidentially about their mental health and spoke about strategies they have in place to manage times when they are experiencing challenges. The resident, with the support of staff talked the inspector through their own HIQA questionnaire and gave the inspector examples of how and why they reached their responses to the questions. The resident also showed the inspector their bedroom which was warm, decorated to their choosing and had photos of family and friends.

The inspector completed a walk around with staff through the remainder of the house. There was a large kitchen where staff were preparing a home cooked meal. A spacious sitting room just off the kitchen provided extra space for residents to use, while another sitting room was located off the hallway. Each resident had their own bedroom that was decorated to their individual likes and interests. Bathrooms were suited to residents' needs.

The inspector had the opportunity to observe staff interact with both residents and at all times staff were knowledgeable of residents' needs and interacted in a person centred, warm, professional manner.

In the afternoon, the inspector moved to the second house. This location was a large detached house with its own grounds and views of the sea. Here, the inspector met with two staff and four of the five residents, as one resident was staying with family ahead of a medical appointment. The inspector chatted with one resident who talked about their employment in the community and the holidays abroad they had been on with both family and alone with a peer. The resident spoke positively about their independence and how important it is. The resident also proudly showed the inspector their bedroom and trophies they had won for sporting achievements. The resident’s bedroom was warm and decorated with many photos of family and friends.

A second resident sat down with the inspector and spoke of their happiness in the centre. The resident indicated they were happy with the staff team and felt safe in their home. They spoke about what they would do and who to talk to if they did not feel safe. A third resident was in a large sitting room writing a letter, and they informed the inspector they were writing a letter to the CEO of the organisation. The resident appeared happy and comfortable in the presence of staff and was fully engaged in their task. The inspector observed a fourth resident in their bedroom using an electronic tablet. The resident later had a brief conversation with the

inspector, and appeared to be happy and comfortable communicating with staff and briefly indicated to the inspector that they were happy with their home.

The inspector completed a walk around of the house with the person in charge. The house was warm, homely, decorated in line with residents wishes and was spacious enough to accommodate all residents and staff. One staff member completed a walk around with the inspector. The inspector observed the premises again to be decorated in line with residents' wishes. Individualised bedrooms were observed each with televisions and evidence of personal items and hobbies on display.

On the second day the inspector visited the third house, which was a large detached property on its own grounds in a rural location. When the inspector arrived there were no residents present and the inspector met with two staff and the person in charge. One staff member completed a walk around of the home with the inspector. The inspector observed the premises again to be decorated in line with residents' wishes. Individualised bedrooms were observed each with televisions and evidence of personal items and hobbies seen by the inspector.

The residents returned to the centre in the early afternoon. One resident indicated that they would like to speak with the inspector and did so with the person in charge present for support. The resident indicated to the inspector from the outset that they were not happy in the centre. When the inspector asked the resident what it was like living in the centre they replied "it's just tough sometimes". The resident spoke about incidents with a housemate that involved both verbal and physical incidents, this is discussed further in Regulation 8 later in the report. Throughout the remainder of the inspection the resident required reassurance from both staff and the inspector that they would remain in their home. The resident indicated that this was because they were afraid of having to leave because of what they had told the inspector.

The inspector met a second resident in the kitchen, the resident was having lunch upon their return from day service. The inspector observed the resident was seeking ongoing reassurance from staff regarding the presence of an external maintenance worker. The resident presented in good form and readily engaged with the inspector. The resident indicated they were happy in their home and spoke positively about their day and upcoming activities.

The inspector had the opportunity to briefly speak to a third resident who had come home from day service. The resident was in good form and spoke positively about their home before continuing on with the rest of their day.

In summary, the residents were for the most part being supported to engage in a variety of at home or in their community; however, there were areas of improvement identified to ensure all residents experienced positive lives. The inspector was not assured in particular regarding the compatibility of residents in one of the houses that made up this centre. The inspector found that the provider's oversight systems in place to assure that all residents are safe and protected in their home were ineffective. The next two sections of this report will outline the

governance and management systems in place and how they impact on the quality of the lived experiences of the residents.

Capacity and capability

This inspection was completed to inform a decision on renewal of the centres registration and to assess ongoing compliance with the regulations. The inspector was not assured that the registered provider had effective systems in place to ensure residents were safe and happy in all three locations that comprise this centre.

The providers systems for oversight and monitoring included audits and reviews. These were not found to have been completed as required by regulation. In addition they were not found to be effective in identifying areas where improvement was required. Governance documents reviewed such as six monthly audits and team meeting minutes showed a lack of appropriate escalation and response to ongoing compatibility and safeguarding concerns.

While the provider had a consistent staff team in place, the inspector was not assured that the provider had ensured all staff had been in receipt of training to meet the specific diagnosed needs of residents in each of the three premises. The inspector also found that the provider admissions criteria, with specific reference the oversight of new residents financial affairs was not adhered to.

Regulation 15: Staffing

The centre had no vacancies in the staff team with no agency usage across any of the locations. Where shifts required cover due to planned and unplanned leave, this was sourced from a panel of regular relief staff or permanent staff working additional hours. This ensured continuity in terms of regular staffing across each of the three locations. The provider had planned and actual rosters in place that were the responsibility of the person in charge to maintain. Rosters for the month of September were reviewed on the day of inspection.

Staff interactions were observed to be professional and person centred. Staff who met with and spoke to the inspector in all three locations were knowledgeable of the assessed needs of the residents. The inspector found that staff in one house who were managing a challenging environment required greater input from the provider level.

Staffing levels in this one house had recently been increased with the addition of an extra sleep over shift, however, the inspector was not provided with evidence that this increase was a direct response to an additional resident who had recently moved into the centre or as a response to ongoing compatibility and safeguarding issues identified during the inspection in this house. The registered provider had yet to finalise a plan for the extra resources with the person in charge informing the inspector that the shift pattern worked by the additional staff was subject to review and possible change.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider ensured that the staff teams in each location had been in receipt of training that was identified as mandatory in their policy. The person in charge maintained a training log in the designated centre as part of their review and oversight processes. Staff across all three locations had completed trainings such as first aid, manual handling, safeguarding, fire safety and awareness, medication, positive behaviour support and human rights.

However, the inspector found that staff were not provided with the skills to care for residents with specialist care needs and this resulted in negative outcomes for residents as discussed later in the report. In all three premises of this centre was a resident cohort with significant mental health diagnosis and specific requirements for staff in supporting residents with their diagnosis. In each premises residents had a dual diagnosis of mental health conditions that required significant staff supports. The inspector found that staff were not in receipt of any form of formal training to manage and support residents with such diagnosed conditions.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector reviewed key governance and management documents such as the providers annual review, provider unannounced six monthly audits, team meeting minutes, management team meeting minutes and incident forms across the three locations in the centre. Following review of these documents and conversations with management, staff and residents the inspector was not assured that the systems in place were effective in identifying and resolving ongoing concerns. The inspector found significant concerns in relation to the management of resident compatibility, residents' finances and safeguarding which had not been identified by the provider through their own internal auditing processes.

The inspector reviewed the provider's six monthly unannounced inspection reports. A recent provider inspection took place in August 2025; however, the previous inspection should have been completed in March 2025 and had not taken place. This is not in line with the regulation, as only one unannounced audit had taken place in a 12 month period.

On review of the most recent provider led unannounced inspection regarding one house, while the provider had quantified the number of incidents reported they had failed to escalate these concerns already regarding compatibility of residents and significant ongoing behavioural and safeguarding incidents that had been highlighted in completed incident review forms. For example two incident report forms reviewed by the inspector from February and July 2025 outlined a resident indicating to staff they wanted to hurt themselves with a sharp object. These incidents were not highlighted in the provider's audit, no actions were identified as required from the review of incident reports and these incidents were not subject to a serious incident review.

A further review of incident forms highlighted incidents where a resident engaged in frequent and significant behaviours of concern. These incidents were not reported to the Chief Inspector as safeguarding concerns where other residents were often witness to and impacted by the incidents. Local reviews of the incident forms were insufficient in terms of escalation, for example one incident review form observed by the inspector showed the risk reduction section noted as "N/A".

The inspector reviewed team meeting minutes at all levels of governance in the centre. Local team meetings from one house were reviewed for August and September 2025. Neither meeting discussed the ongoing safeguarding nor were resident compatibility issues highlighted. Incident review forms were not discussed despite the serious nature of incidents. The inspector reviewed the minutes of the most recent meeting of the senior management team in the centre, incident forms, outcomes from a multidisciplinary team meeting were not discussed or given a proportionate escalation.

In another house, the inspector reviewed information on resident's finances' and was not assured on the oversight systems in place regarding one resident and with the providers own pathways to managing resident finances as outlined in their admissions and finance policies.

While it is acknowledged that the resident wishes to be independent in their financial affairs, the registered provider has no system in place to ensure this continues to be the will and preference of the resident. The resident had recently transitioned to the centre. On reviewing the provider's admissions policy to ascertain the requirements pre-admission regarding finances, the policy only signposts to the providers finance policy. On review of the finance policy, the policy states that each resident much have a bank account in their own name, but the resident has a joint account with a representative .

The policy also states that each resident who wishes to be independent with their finances must have a safe in their bedroom and will be encouraged to keep monies

in their safe. The resident does not have a safe in their room. Key financial documents for the resident such as pay slips or bank statements are not stored in the residents home and therefore no system in place for review of these key documents.

Judgment: Not compliant

Quality and safety

This section of the report reviews the quality and safety of the service provided to the residents. The inspector was not assured in one location that residents were in receipt of a quality and safe service. Provider led systems in place to regarding care plans and risk assessments were not sufficient in identifying ongoing concerns and did not guide staff practice in supporting residents with complex needs.

Safeguarding procedures needed review. There are ongoing safeguarding concerns in one location and safeguarding plans are not deemed as effective. Safeguarding plans also needed to ensure control measures were relevant to the person identified as vulnerable.

Behaviour support systems in one location also required review. Staff supports outlined were general in nature despite very specific behaviour patterns identified in incident forms.

A resident told the inspector about concerns they have in relation to not feeling safe and happy in their home. The resident spoke about feeling afraid and scared when a housemate is upset. The resident also spoke about feeling that staff were required to spend too much time with another peer to meet their needs which leaves the resident feeling unsupported at times.

Regulation 26: Risk management procedures

The inspector was not assured, in particular in one house, that the registered provider has effective systems in place to identify, assess or manage risk. The person in charge maintains a risk register in the designated centre as part of their oversight processes, which was reviewed by the inspector. Risks were found to be inappropriately scored given the volume of evidence, for example, one resident had a risk assessment in place for behaviours of concern. Despite the evidence gathered from incident forms and ongoing impacts to the resident and peers the risk was scored as a medium.

Control measures in the risk assessment for behaviours of concern were not found to be effective as the inspector found evidence that the number of incidents was increasing in both frequency and intensity.

A resident in one house had made it clear to the provider that they felt at risk in their home and this risk was not appropriately escalated or managed in corresponding risk assessments

There were no risk assessments in place regarding the risk of harm from others or a negative lived experience, despite overwhelming evidence that this is an ongoing risk in one location.

The inspector observed evidence that a resident in one location was engaging in continued self-injurious behaviour. This risk had not been identified by the provider and therefore a corresponding risk assessment had not been developed. This was of particular importance as it was evident that staff were resorting to measures that could not be deemed as safe practice in an attempt to manage ongoing incidents.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The registered provider had assessments in place that were subject to review from the relevant health and social care professionals. Residents assessed needs had been identified and corresponding care plans had been implemented. On the day of inspection, the inspector reviewed care plans for residents in each of the three premises.

Residents had meaningful goals in place in each of the three locations and where possible residents were supported to be independent as evidenced with residents gaining employment in their local communities.

However, with this being said, not all care plans were seen to be effective. Where these deficits were evident, reviews were not sufficient in terms of guiding staff practice, in particular regarding the mental health care requirements in each location and behaviour support plans in one house.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where a residents assessed need required, the provider had a behaviour support plan in place. The inspector reviewed positive behaviour support plans for residents in each location. The behaviour support plan in place for a resident in one house

required review in terms of its accuracy, use of relevant information and how it guides staff practice.

The inspector found incident review forms outlining specific behaviours of concern with one resident. The residents behaviour support plan did not discuss reactive or proactive responses for staff for each specific behaviour with the observed guidance general in nature.

As outlined in another section of the report, the behaviour support plan for this resident described incidents with a sharp object as an "isolated incident", this is despite a second incident taking place since the residents behaviour support plan was last reviewed. Due to this incident not being reviewed in terms of staff managing such incidents, a staff member potentially placed themselves in an unsafe position in attempting to manage this second incident.

The inspector also reviewed a scheduled multi-disciplinary team (MDT) meeting that took place in May 2025 regarding the ongoing concerns presented by one resident. At this meeting the local team highlighted that the resident's incidents had increased in frequency and intensity with the reactive strategies inconsistent in terms of resolving incident. At the time of inspection no follow up meeting had taken place despite ongoing evidence that the resident was continuing to engage in behaviours of concern that were impacting both the resident and their peers.

Judgment: Not compliant

Regulation 8: Protection

The registered provider did not have effective systems in place to identify, monitor or implement safeguarding practices as outlined in their own policy or national guidelines. The inspector reviewed safeguarding plans in all three locations, and met with and spoke to residents and staff in all three locations. Safeguarding plans in place in one house were not effective as incidents had continued to escalate in recent months.

The inspector reviewed open safeguarding plans in one house and found that one safeguarding plan in place was submitted in regard to a particular resident as the vulnerable person, yet, the control measures in place spoke only of the person allegedly causing concern. This was brought to the attention of the person in charge and an immediate review was commenced by the provider's social work team.

Significant safeguarding and protection concerns, were identified in one house. In conversation with the inspector, frontline staff outlined safeguarding as the main challenge in terms of working in the centre and described an environment that

requires significant management in terms of where residents are and ensuring to keep a positive outlook for residents.

One resident who spoke with the inspector spoke about not feeling safe in their home. The resident detailed a number of examples of times where they felt unsafe, and these incidents were both verbal and physical in nature with the resident stating they happened "a few times". The resident stated they "are not happy here". The resident also spoke about how staff are needed to support another housemate which left the resident feeling that staff are not in a position to provide the supports they need. These claims from the resident were supported by incident review forms and conversations with staff.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Prosper Fingal Residential Service 1 OSV-0003398

Inspection ID: MON-0039656

Date of inspection: 15/10/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: (1) The draft plan, to ensure staffing levels, skill mix and shift patterns meet the needs of all residents, and in particular, residents right to live in a home where they are safe, was reviewed on 26th November by the staff team, MDT, Area Manager and residents. This informed decision making by SMT on the staffing mix, which was completed on 2nd December 2025. (2) The effectiveness of this staffing plan will be reviewed after four weeks by the PIC and SMT and changed if deemed insufficient.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: (1) As an initial action, directed training / guidance will be provided to each residential house staff team with particular concentration on mental health diagnoses of existing residents and appropriate supports for same. (2) Registered provider will review the existing internal training provided regarding mental health. (3) In the medium-term, research to be conducted to identify external training options in the area of Mental Health to help staff support the mental health needs of residents, and implement same.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
(1) The registered provider will discuss findings from the HIQA inspection, including those related to governance and management, with the Board of Directors and Quality & Risk Board Committee, and ongoing regular feedback will be provided to both of the above.
(2) An internal cross-organisation working group led by the CEO's Office has been established to progress actions related to the inspection findings.
(3) The registered provider will continue the review of incident management in Prosper, with reference to current processes, oversight, frequency of monitoring, escalation and review.
(4) The registered provider has reviewed reporting arrangements between the PIC and Area Manager. Arising from this review, any incidents which represent a safeguarding concern will be escalated to the Area Manager and MDT, who will further escalate if required.
(5) The registered provider will schedule, and undertake, unannounced audits to the residential services with increased frequency. Reports from these audits will be escalated, as appropriate, to SMT and the Board.
(6) The registered provider will ensure that the staff member undertaking the six-monthly unannounced audits reviews incidents and notifications made to HIQA prior to the visit and uses the report to escalate issues / ensure follow up action as required.
(7) The agenda for residential staff team meetings will be updated to ensure discussion takes place during staff team meetings about all incidents related to safeguarding, behaviours of concern, resident compatibility issues and mental health.
(8) Staff will continue to be facilitated by the PIC to raise concerns about the quality and safety of care and support provided to residents through multiple channels including staff team meetings and supervision.
(9) All stakeholders will be reminded of their responsibilities for resident's finances as outlined in the Prosper Residents' Finances Policy.
(10) The measures outlined in the Residents' Finance Policy, found to be lacking, will be secured for the one identified resident in Ballustree Lodge, so that supports provided are in accordance with this policy.

Regulation 26: Risk management procedures	Not Compliant

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

(1) The residential services' risk register will be reviewed on a quarterly basis to ensure risks are scored appropriately and are reflective of incidents and impacts reported.
(2) The individual risk management plans (IRMP) for all residents have been reviewed to ensure they include risk of harm from others / negative lived experience and/or risk of self-injurious behavior and/or risk arising from behaviours of concern, should this be the case.
(3) The IRMPs for all residents will be reviewed after any incident that they are involved in or witnessed, to ensure scoring is appropriate and where control measures are found to be ineffective that this is escalated to the PIC and relevant support person/s e.g. Area Manager, Designated Safeguarding Officer, Health & Safety Officer.
(4) The IRMPs for all residents will be reviewed annually thereafter in line with the Personal Planning Process.
(5) All stakeholders will be reminded of their responsibilities for individual risk management as outlined in the Prosper Risk Management Policy.
(6) Residential staff will receive training / support in how to write up, score and review resident IRMPs in accordance with the Company Risk Management Policy, SOP 6.3.4.
(7) Appendix 1 in the Company Risk Management Policy (Non-exhaustive List of Potential Risks to include on an IRMP) will be updated to include self-injurious behavior.

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:
(1) The Positive Behaviour Support Plans in Knock Cross were reviewed and updated to ensure staff guidance on how to respond to behaviours of concern is sufficient. This was completed on 24th November 2025.
(2) The Mental Health and Wellbeing Support plans for all residents, who require this support, will be reviewed and updated to ensure staff guidance on how to support a resident's mental health care requirements is sufficient, which should also in turn inform the mental health training review outlined in Regulation 16.
(3) Residential staff will be reminded of the requirement to informally review personal and individual support plans on an ongoing basis and to carry out a review more frequently than annually, if there is a change in a resident's needs or circumstances.
(4) Through key working, residential staff will identify, record and implement person-centred activities / strategies to enhance resident mental health / wellbeing and compatibility and reduce the amount of time residents spend with other residents, if this is their desire. This has commenced.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
(1) All internal stakeholders will be reminded of their responsibilities for positive behavior as outlined in the Prosper Positive Behaviour Support Policy.
(2) The Clinical Manager supported by MDT will continue to review all incidents where a potential behavior of concern has been identified and will take action in response to identified behaviours of concern in accordance with the Prosper Positive Behaviour Support Policy.
(3) Prosper's policy on Positive Behaviour Support is under review with reference to the inspection findings.
(4) The Positive Behaviour Support Plans in Knock Cross were reviewed and updated to ensure staff guidance on how to respond to behaviours of concern is sufficient. This was completed on 24th November 2025. Should any new proactive or reactive strategies be identified, or should any new behaviours of concern arise, a further review will take place by the PIC and relevant support person/s e.g. Area Manager, Designated Safeguarding Officer, Health & Safety Officer.
(5) The registered provider will continue to liaise with external stakeholders in support of one identified resident in Knock Cross e.g. advocates, GP, HSE MHID team.
(6) The frequency of MDT meetings has been increased for Knock Cross house (MDT held on 24th November 2025; with two more scheduled).
(7) Where evidence exists that incidents of behaviours of concern are increasing in frequency and/or intensity or where proactive or reactive measures are found to be ineffective, a multi-disciplinary team meeting/s to address the issue will be scheduled without delay.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
(1) A review of the Safeguarding Policy has been commenced to capture the impact of safeguarding issues on all involved parties in a safeguarding incident, both the instigator and the affected vulnerable person/s.
(2) All internal stakeholders will be reminded of their responsibilities for safeguarding as outlined in the Prosper Safeguarding Policy.
(3) All reported safeguarding incidents will continue to be reviewed and responded to by the Designated Safeguarding Officer in accordance with company and national policy.
(4) The Safeguarding Plans in Knock Cross will be reviewed and updated to ensure staff guidance on how to keep all residents safe is sufficient. This has commenced.
(5) The Safeguarding Plan/s of resident/s in Knock Cross will be reviewed after any incident that a resident was involved in or witnessed and where control measures are found to be ineffective this will be escalated to the PIC and relevant support person/s e.g. Area Manager, Designated Safeguarding Officer, Health & Safety Officer.

(6) Where evidence exists that control measures in a Safeguarding Plan are found to be ineffective, the Designated Safeguarding Officer will review the Safeguarding Plan and where required, a multi-disciplinary team meeting/s to address the issue will be scheduled without delay.
(7) The resident in Knock Cross who stated to the Inspector that they are not happy there is being supported by the PIC and Senior Social Worker on a regular basis to review the supports in place, provide information and reassurance.
(8) All residents in Knock Cross will be assured of the measures the registered provider is implementing to keep them safe and will be encouraged to continue to speak up if they do not feel safe.
(9) Residents in Knock Cross are being supported to take part in separate activities from one another where they so wish.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	14/01/2026
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	28/02/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	28/02/2026

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	28/02/2026
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a	Not Compliant	Orange	28/02/2026

	copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.			
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	28/02/2026
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	28/02/2026
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall	Substantially Compliant	Yellow	16/03/2026

	take into account changes in circumstances and new developments.			
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Substantially Compliant	Yellow	16/03/2026
Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes.	Substantially Compliant	Yellow	16/03/2026
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.	Not Compliant	Orange	28/02/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/02/2026
Regulation 08(3)	The person in charge shall initiate and put in place an	Not Compliant	Orange	28/02/2026

	Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			