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:	Short Notice Announced
Date of inspection:	04 November 2025
Centre ID:	OSV-0001783
Fieldwork ID:	MON-0048234

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
Tuesday 4 November 2025	08:35hrs to 14:00hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

Significant failings in relation to the governance and management of this service were identified on inspection. The provider had identified the supports required by residents in relation to their personal and social needs. However, these supports had not been implemented by the provider. The provider's failure to implement the necessary supports for residents to engage in meaningful activities was a repeated finding on the last three inspections of this centre. 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.

Western Care Association was inspected under a targeted inspection programme that commenced in March 2023 due to concerns about the governance and oversight of centres and its impact on the wellbeing and safety of residents. This centre was last inspected on 27 May 2025. At that time, four regulations were found to be not compliant. This showed that significant improvement was required in relation to the governance and management of the service to ensure that the needs of residents were met and to ensure the residents' safety. Due to the level of non-compliance, the provider was required to attend a warning meeting where a warning letter was issued outlining that the provider was required to come into compliance. 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. The purpose of this inspection was to review the implementation and effectiveness of that compliance plan.

This was a short-notice announced inspection as this centre is in a rural location and staff are not on-site for a number of hours during the day while residents attend day services. The inspector contacted the person in charge via telephone the evening before the inspection and arranged to meet at the centre the following morning.

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.

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.

The inspector had the opportunity to meet with all three residents on the day of inspection. Two residents indicated that they did not wish to speak with the inspector and this was respected. One resident spoke briefly with the inspector about going on the bus and some of their interests.

In addition to the person in charge, the inspector also met with two staff members. Staff spoke about the supports required by residents to engage in community activities. They spoke about residents who required the support of two staff when accessing the community. Staff knew that residents had behaviour support plans in place and spoke about some of the strategies that they used when supporting residents to manage their behaviour.

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

Significant improvement was required to the governance and management systems in the centre. The systems in place to monitor the quality of the service were not adequate or effective. Through previous inspection compliance plans, the provider had committed to implementing new oversight arrangements to ensure that service improvement initiatives were completed and monitored. However, it was noted that although the provider had obtained support from members of the multidisciplinary team, recommendations and strategies to support residents had not been initiated. The provider had failed to implement adequate governance arrangements to ensure that the residents received the necessary supports to meet their assessed personal and social needs. This resulted in residents being offered limited opportunities to engage in activities that they enjoyed in the community or in the centre.

The provider had reviewed their written agreements with residents and these were found to be in line with the regulations.

Regulation 23: Governance and management

The governance and oversight of this service required significant improvement. The provider did not have adequate systems in place to monitor the service and identify areas that required improvement. Where issues were identified, agreed actions were not implemented or were not effective. The provider had committed to a number of actions in relation to the governance of the service following findings from previous inspections of this centre on 16 September 2024 and 27 May 2025. The inspector

found that these actions had not been implemented or completed by the day of the current inspection in line with the provider's agreed timelines.

The provider had committed to implementing a system where residents were offered choices in relation to their daily activities, personal activities and social activities. The provider's behaviour support service and speech and language therapy service had completed sessions with staff to identify activities that the residents might enjoy and ways to offer choices to residents. The inspector reviewed the report in relation to this project and it stated that these sessions had been completed between January and March 2025. On the last inspection of this centre, there was no definite plan in place to implement these recommendations. In response to this finding, the provider had committed to implementing an activity tracker to ensure that residents were offered choices. The provider had committed to reviewing this tracker on a weekly basis to ensure that residents were supported to participate in activities in line with their interests. The inspector reviewed the daily activity trackers for two residents from 1 October 2025 to 26 October 2025. This review found that the choices offered to residents were not recorded. In some cases, this section of the residents' daily record form was blank and no information was recorded. In other cases, the daily record sheets documented routine tasks completed by residents, such as, brushing teeth, doing laundry, putting their feet up. It did not record whether the residents had been offered an opportunity to engage in social or personal activities. It was also not clear how the residents had been offered choices, despite advice from a speech and language therapist in relation to the use of objects of reference to ensure that residents could express their choices. The inspector found that the provider's overview of this system had not resulted in residents being offered choices in relation to the social activities. This will be discussed further under regulation 13: general welfare and development.

Following the last inspection of this centre, the provider had committed to ensuring that all staff completed training in a new module of neurodiversity training. The provider had committed that all staff in the centre would complete this training by 17 October 2025. The inspector reviewed the minutes of two governance and oversight group meetings that were held in August 2025 and September 2025. These identified that staff training needed to be completed by that date to meet the timelines of the last inspection's agreed compliance plan. The inspector reviewed the training records for this module for all eight staff in the centre. On the day of inspection, only one member of staff had completed the new neurodiversity training module. Three other staff members had training dates booked in December 2025. However, although four remaining staff members had registered for the course, they did not have any training dates confirmed. Again, this showed that the oversight and governance of the service was not adequate to ensure that service improvement actions were completed as planned.

The resourcing of the centre to meet the needs of residents required review. Routinely, the centre was staffed by two members of staff. Additional staff were on-duty to support residents with social activities on Tuesday, Wednesday and Thursday evenings as reported by the person in charge. An additional staff member was also on-duty for six hours on Saturday and six hours on Sunday. However, a review of resident's risk assessments by the inspector showed that one resident

required one-to-one support. The person in charge reported that one resident required the support of two staff when accessing the community. Due to residents' assessed needs, this meant that residents could not be supported to leave the centre with only two staff on duty. The person in charge reported that it was not possible for more than one resident to leave the centre at any one. This meant that residents had to take turns leaving the centre and only at times when staffing levels allowed.

On the previous inspection of this centre, it was noted that residents' property registers did not record all of the residents' belongings, as required. In response, the provider had committed to completing an audit of the residents' property registers by 17 July 2025. The compliance plan stated that this audit would be completed by the person in charge. However, on the day of inspection, this had not been completed. The inspector reviewed the property register for one resident and noted that it had last been updated in August 2022. It did not record that the resident had been reimbursed for the purchase of furniture as outlined in the provider's previous inspection compliance plan. When this was brought to the attention of the person in charge, they reported that new property registers had been completed, but that they were unaware of their location.

The quality of information obtained through audit has been noted as an area requiring improvement in this centre on three previous inspections in May 2024, September 2024 and May 2025. On the day of inspection, there had been no change to the audits used in the centre. For example, the financial audit remained ineffective at monitoring residents' finances. The inspector reviewed the ledgers of personal spending for two residents. For one resident, the inspector noted that there was a receipt for €183 for the purchase of clothes that was not recorded in the residents' ledger. This discrepancy had not been identified by the provider. This meant that the systems used to monitor the quality of the service and to safeguard the residents was not effective.

In addition to the above, the inspector also found that the provider failed to implement all elements of residents' behaviour support plan, to adequately respond to risk and to ensure that residents were supported to engage in meaningful activities. These findings will be discussed under regulation 7: positive behaviour support, regulation 26: risk management procedures, and regulation 13: general welfare and development, respectively.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider had written agreements with the residents that were in line with the regulations.

The inspector reviewed the written agreements for two residents. These outlined the fees that the resident would have to pay and the terms and conditions of residency. The agreements had been signed by a representative on behalf of the provider and on behalf of the resident.

Judgment: Compliant

Quality and safety

Significant improvement was required to ensure that residents received a good quality and safe service that met their assessed needs.

Through the input of members of the multidisciplinary team, including speech and language therapists, psychologists and the provider's rights review committee, a number of recommendations relating to the residents' assessed needs had been identified. Reports and behaviour support plans identified supports that the residents required to ensure that they could make choices and engage in meaningful and enjoyable activities. Recommendations relating to known risks for residents were also included in these documents. The provider's failure to implement these recommendations meant that residents were not supported to engage in activities that were in line with their interests. This negatively impacted on the residents' human rights and quality of life. It also meant that suitable control measures to reduce risks to residents had not been implemented.

Regulation 13: General welfare and development

Significant improvement was required to ensure that residents in the centre were supported to engage in meaningful activities that were in line with their interests and assessed needs. This regulation was found to be not compliant on the previous three inspections of this centre on 27 May 2025, 16 September 2024 and 1 May 2024. This regulation was again found to be not compliant on this inspection. This was despite the provider having identified that meaningful activities were important to the residents and having identified the ways that residents should be offered choices in this regard.

The provider failed to implement the actions that they outlined under this regulation in the compliance plan submitted for the previous inspection of the centre on 27 May 2025. These actions related to the use of a daily activity tracker and staff training in neurodiversity. The actions from the inspection on 16 September 2024 in relation to this regulation had also not been implemented. The centre was not adequately resourced to ensure that residents could be supported to engage in

meaningful activities. This has already been discussed under regulation 23: governance and management.

The provider had identified that it was important to the residents that they engage in meaningful activities and community-based activities. The inspector reviewed a document that had been developed for a resident. The document was entitled 'What's important to me?' It had been developed by the person in charge and was dated 15 September 2025. This document noted that the resident would benefit from more connection with the local community. It identified that the resident would achieve this by joining local clubs, having the opportunity to develop a social role within the community, and by having the opportunity to go to local pubs, cafes, restaurants and community groups. The resident's behaviour support plan also identified that meaningful activities were important to the resident. It stated that the resident should be offered a selection of local and familiar activities which allowed the resident to choose activities that they know and enjoy. However, the inspector's review of the resident's daily notes from 01 October 2025 to 26 October 2025 found that they had limited meaningful, social or community-based activities. In some cases, the residents' activities were not recorded at all. In other cases, the activities that were recorded were routine and not indicative of activities that were in line with their interests. For example, brushing teeth, doing laundry, elevating legs. On one Saturday in October, it was recorded that the resident was 'requesting bus', however, it was not recorded whether they had been supported to leave the centre and go on the bus that day in line with their request. The records indicated that the resident had been supported to go on one trip outside of the centre to the pharmacy from 1 to 26 October 2025. Other recorded activities were based in the centre.

The methods that should be used to offer choices to residents were outlined in a document from a speech and language therapist and in residents' behaviour support plans. The speech and language therapy report had been completed early in 2025 as part of the provider's compliance plan from September 2024. It recommended the use of object based cues and choices. One resident's behaviour support plan, dated September 2025, also outlined that the resident should be offered choices from object cues or an object reference board. It also stated that the resident should be presented with at least two choices. However, these systems for offering choice to the resident had not been implemented on the day of inspection and there was no definite plan to implement these systems. This was reflected in the residents' daily notes. The resident's daily notes from 01 October 2025 to 26 October 2025 were reviewed by the inspector. These notes did not record if the resident had been offered choices in relation to their activities. Again, the recorded daily activities completed by the resident were limited, for example, doing dishes, bringing out the bin. The notes indicated that the resident had left the centre on one occasion during that time period to complete personal shopping.

Judgment: Not compliant

Regulation 26: Risk management procedures

Significant improvement was required to ensure that risks to residents were assessed and appropriate control measures implemented. This regulation was found to be not compliant on the last inspection of this centre in May 2025.

The inspector reviewed the risk assessments that had been completed for two residents. The most recent risk assessments for these residents were dated 4 July 2025. However, both residents had new and updated behaviour support plans in place. One had been developed in August 2025 and the other in September 2025. The risk assessments had not been updated to reflect the new guidance outlined in the behaviour support plans. The risk assessments made reference to the old strategies used to support residents in their previous plans. This meant that the information to guide staff was not clear, accurate or up to date and therefore presented a risk of inconsistency in care practice being adopted by staff.

In addition, the provider had not implemented all of the control measures to reduce risks to residents that had been identified through the new behaviour support plans. For example, one resident was at risk of lying down on the road when out walking. The resident's behaviour support plan from September 2025 advised that staff should therefore carry a foldable chair when out walking to avoid this behaviour. This had not been implemented by the provider and, on the day of inspection, there was no definite plan to trial this strategy.

The provider had also not implemented all actions outlined under the compliance plan submitted following the last inspection of this centre on 27 May 2025. This plan indicated that all residents' risk assessments would be reviewed by the provider's psychology team from 24 July 2025 onwards. However, as noted above, two residents' risk assessments were dated 4 July 2025 and it was not clear from documentation if this review had occurred. Further, the provider had committed to reviewing risk assessments quarterly in light of any incidents that occurred in that quarter. Given that the risk assessments were dated July 2025, it was not clear if this review had taken place in line with this target timeline.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Significant improvement was required in order to ensure that the residents received the necessary support to manage their behaviour and that any restrictive practices in the centre were appropriate and used for the shortest duration of time. This regulation was found to be not compliant on the last inspection of this centre in May 2025.

Since the last inspection of this centre, new positive behaviour support plans had been devised for residents. The inspector reviewed the plans that had been developed for two residents. These had been developed by two psychologists. They

were informed by a review of the incidents for the previous 12 months. Information from staff and the person in charge was also used in developing these plans. The plans gave clear guidance to staff on how to respond to residents when they were calm, anxious or presenting with challenging behaviour. The plans contained numerous recommendations about strategies that could be used to support residents with their behaviour and avoid possible escalations. The inspector noted that not all of the strategies had been implemented and on the day of inspection, there was no plan for these strategies to be implemented. For example, one resident's plan advised the establishment of a visual activity schedule, the use of transition songs when changing activities, a body map so that the resident could point to the place on their body where they felt pain, and a sensory box. None of these had been trialled with the resident despite the plan being in place since 18 August 2025.

Significant improvement was required to ensure that the provider adequately reviewed the use of restrictive practices in the centre to ensure that they were the least restrictive option in use for the shortest duration of time. The inspector reviewed documents for two residents entitled 'consent for the use of restrictive practice'. These documents were dated 8 July 2025. These documents outlined the restrictions in place for each resident, the reason for their use and there was a section where consent was sought for their use. This section had not been completed for either resident and there was no documented reason why this had not occurred. In addition, not all restrictive practices were recorded in this document. For one resident, a sensor under their bed was in use on the day of inspection. This was not listed in their restrictive practice documentation.

These findings had not been identified by the provider. The provider's rights review committee attended the centre in August 2025. A one-page document for each resident was developed following this on-site visit. This had not identified the gap in documentation as noted above by the inspector. In addition, though the rights review committee had made recommendations about the reduction in the use of some restrictions, this was unclear and not sufficiently specific to guide staff. For example, for one resident, the committee recommended to reduce the use of a guard that prevented the resident from opening their seat belt and to update the committee. It was not specified how this practice should be reduced, when and by whom. On the day of inspection, the seat belt guard remained in place and there was no plan to trial a reduction in this restrictive practice.

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 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Forest View Apartments OSV-0001783

Inspection ID: MON-0048234

Date of inspection: 04/11/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC and the staff team reviewed the use of available social hours at a team meeting on November 20th and agreed on how they will be used more flexibly to allow for more opportunities for social outings for the residents in line with their will and preference. This will be reviewed weekly by the PIC and PPIM

A review of the daily log structure will take place in conjunction with the psychology department to ensure choice and social opportunities are captured accurately. A discussion between the person in charge and the Senior Clinical Psychologist took place on December 4th to include documentation of the use of object-based and visual cues in line with choices and activities offered. This new template will commence in the service on 15th December 2025.

Input from the psychology department in the use of visual cues within the service has been received. The Senior Clinical Psychologist met with named staff on November 25th 2025 for initial discussions. This will be monitored through weekly checks by the PPIM of the activity tracker and revised daily logs and followed by monthly review with the Senior Clinical Psychologist. Initial sensory assessments were completed by the OT department on November 24th with reports received for each resident. A referral has been submitted on 8th December 2025 to the OT department for a full sensory profile for one resident as recommended by the OT.

Neurodiversity training took place December 4th and three staff who were on the waiting list attended. Three remaining staff who are yet to avail of the training will complete in February 2026, which is the next date the training will be provided.
Actions from 16 Sept 2024 and May 2025 have been completed.

The PPIM will review activity trackers on a weekly basis commencing on 12th December 2025.

Residents risk assessments have been reviewed on 5th December 2025 which identified that two residents can go out at the same time by using additional local service transport. The use of additional local service transport commencing 9th December 2025.

Previous property registers have been archived and current property registers in place in residents IP folders. Current property register reviewed on 10th November 2025 to include reimbursement of purchase of furniture.

This service will be included as a pilot site for the roll-out of the financial audit module on Viclarity, commencing January 2026

PPIM will have focused business meetings weekly with the PIC to monitor, evaluate and assure that all actions are progressed and completed. Where there are issues, the PPIM will escalate them. Commencing 12/12/25

The PPIM will have a specific focus on Forest View and a number of other services in the location; this will be reviewed in two months. Commenced 8/12/2025

A provider nominee will visit every week as support and assurance to the provider. This arrangement will be reviewed at the end of February 2026. Commenced 4/12/2025

The Governance and Oversight Committee will continue to function on a monthly basis where the PIC, PPIM and provider nominee will give an update on progress within the designated centre. The membership of the Committee will be extended to incorporate other staff with a role in supporting the service
An additional focused provider unannounced will be undertaken to assess the progress of this action plan.

Where these additional oversight measures show that agreed practices are not followed, organizational policies will be followed to address the deficit.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The PIC and the staff team reviewed the use of available social hours at a team meeting on November 20th and agreed on how they will be used more flexibly to allow for more opportunities for social outings for the residents in line with their will and preference. This will be reviewed weekly by the PIC and PPIM

The A/CEO has approved an additional 12.5hours support per week. The PIC and PPIM are to develop a plan for the use of these hours to enhance opportunities for residents to participate in meaningful activities and development. Approved on 8/12/2025

Input from the psychology department in the use of visual cues within the service has been received. The Senior Clinical Psychologist met with named staff on November 25th 2025 for initial discussions. This will be monitored through weekly checks by the PPIM of the activity tracker and revised daily logs and followed by monthly review with the Senior Clinical Psychologist. Initial sensory assessments were completed by the OT department on November 24th with reports received. A referral for a full Sensory Profile for one resident was submitted on 8th December 2025 following recommendations from the OT.

Neurodiversity training took place on December 4th and three staff who were on the waiting list attended. Three remaining staff who are yet to avail of the training will complete in February 2026, which is the next date the training will be provided.

The PPIM will review activity trackers on a weekly basis commencing on the 12th December 2025.

A review of the daily log structure will take place in conjunction with the psychology department to ensure choice and social opportunities are captured accurately. A discussion between the person in charge and the Senior Clinical Psychologist took place on December 4th to include documentation of the use of object-based and visual cues in line with choices and activities offered. This new template will commence in the service on 15th December 2025.

The Provider will organize a workshop with the staff team focused on values and culture in practice (30/01/2026)

A review of the residents What's Important To Me document will take place to ensure it is accurately capturing the priorities for each individual in line with recommendations from MDT reports. This will be completed by December 19th 2025.

PPIM will have focused business meetings weekly with the PIC to monitor, evaluate and assure that all actions are progressed and completed. Where there are issues, the PPIM will escalate them (Commencing 12/12/2025)

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PRMPs will be reviewed in line with the updated Behaviour Support Plans with guidance from the psychology department. Any amendments required to the Risk

Register will also be completed to reflect the review of these documents. Any previous guidance in the residents' risk assessments will be archived. This will be completed by December 19th 2025. All personal risk management plans will be reviewed and aligned with risk register on Viclarity as part of a coordinated follow up training event for Forest View and the day services aligned to Forest View on 22nd January 2026

A review of walking routes for one resident took place on November 20th following discussions with the staff team and Senior Clinical Psychologist which eliminates the need for a foldable chair, which will be reflected in the updated Behaviour Support Plan.

Actions from previous inspection on 16 Sept 2024 and May 2025 have been completed.

The overview tracker of incidents is in place in the service to monitor any increase in incidents which would highlight the need to review risk assessments for each resident. The PPIM will review the quarterly incident analysis commencing on 12th December 2025.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The psychology department met with staff in the service to discuss behaviour support plans on November 25th and have given guidance on the use of visual aids. This will be reviewed by the PPIM weekly, followed by a review by the Senior Clinical Psychologist monthly. Sensory assessments began for each resident on November 24th with initial reports received on November 26th. A referral has been submitted for a full sensory profile for one resident on 8th December 2025 following recommendations from the OT. Trial period commencing 15th December 2025 for use of transition songs and use of a body map for one resident. This will be included in the monthly review by the Senior Clinical Psychologist.

Consent forms signed by family have been received on 4th December 2025. In line with ADM legislation, the Provider will explore how residents will be engaged with to give their own consent (30 January 2026)

The log of restrictive practice was reviewed on 24th November 2025 for one resident to include the use of a sensor under their bed.

A review of all restrictive practices within the service took place on 24th November 2025 to ensure all are recorded in the logs.

Initial guidance has been given on the reduction of a restrictive practice currently in place in the service. A referral has been submitted to BSS to assist in reducing the

restrictive practice for the individual on December 5th, 2025.
All updated rights checklists will be sent to the Rights Review committee for review at the meeting in January 2026.

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	01/03/2026
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	01/03/2026
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	01/03/2026

	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.	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	22/01/2026
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 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates	Not Compliant	Orange	28/02/2026

	intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			