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 May 2025
Centre ID:	OSV-0001783
Fieldwork ID:	MON-0047061

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 27 May 2025	08:30hrs to 13:30hrs	Alanna Ní Mhíocháin	Lead
Tuesday 27 May 2025	08:30hrs to 13:30hrs	Anne Marie Byrne	Support

What residents told us and what inspectors observed

The inspection was unannounced and was conducted due to the Chief Inspector of Social Services receiving information of concern relating to the provider's governance and oversight of designated centres. Overall, though inspectors found good personal planning and safeguarding arrangements in the centre and that the provider had implemented systems for the oversight of the quality of the service, this inspection found that significant improvement was required in a number of areas in this centre. There were failings found in relation to how the provider was responding to incidents that were continuing to occur. These required significant action by the provider to review and identify if additional controls and further input from multi-disciplinary teams were required to maintain residents' safety. Considerable improvement was required in relation to behavioural support and risk management. The provider had failed to adhere to the terms set out in their written agreements with residents. The provider had not implemented systems to ensure that the residents received the support they required to engage in activities that were in line with their interests.

This centre comprised of one building in a very 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 who had lived in this centre for a number of years. They required care and support from staff in relation to their personal and intimate care needs. Some residents had assessed health care needs, some had assessed communication needs, others were assessed as at risk of falls, some required positive behaviour support, and all required a certain level of supervision from staff when they were in their apartment. In addition, they each required staff support to access their local community to engage in the activities that they liked to do. They each liked having their own living space, and for the most part, lived independently of each other. They all attended day service, with two of the residents accessing this locally, and one resident attended a day service located on the grounds of this designated centre.

Upon the inspectors' arrival to the centre, all three residents were at home and were getting ready to head to their day services. The inspectors had the opportunity to meet with two of these residents. Residents had assessed communication needs and engaged with inspectors with the support of staff. Residents greeted the inspectors and appeared to understand staff when they explained to them why the inspector was in their home.

The inspection was facilitated by the person in charge and a member of senior management. In addition, inspectors met with two other staff members. Staff spoke of how residents liked gardening and had recently planted some flowers for the

summer months. They spoke of how they were required to check in to supervise one resident at intervals when they were alone in their apartment, and of the care and support that the residents required with their intimate and personal care needs. Staff were knowledgeable on the steps that should be taken should a safeguarding incident arise.

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

Capacity and capability

Overall, inspectors found that significant improvement was needed in relation to the provider's adherence to their written agreement with the residents. The provider had systems in place to monitor the quality of the service in the centre. However, improvement was needed to ensure that these systems identified all areas for service improvement and that incidents were managed appropriately. Staffing arrangements were suited to the residents' needs. Complaints in the centre were well managed and notifications to the Chief Inspector were submitted in line with the regulations.

Inspectors noted that the provider had not adhered to the terms outlined in residents' written agreements. Inspectors noted that one resident had an agreed amount of money outlined in their contract of care for personal spending and any purchase above this amount required discussion with the resident's family prior to purchase. Of significant concern, inspectors found that the resident had made two purchases of furniture in excess of this amount without the support of family. It was also not documented that the resident had been consulted about this purchase or if they had been supported to make this decision. The items of furniture had not been recorded on the resident's personal possessions log and they replaced existing items in the centre.

The provider had systems in place to monitor the quality of the service. This included the use of routine audits in the centre and unannounced audits of the service by the provider. Findings from audits were discussed at meetings between the person in charge and their line manager to ensure that the issues were addressed. Incidents in the centre were also reviewed and analysed. Where required, notifications of these incidents to the Chief Inspector had been completed in line with the regulations. However, improvement was required in relation to the routine audits in the centre to ensure that the information obtained adequately assessed the quality of the service. Improvement was also needed in relation to the review of incidents to ensure that steps were implemented to escalate issues and avoid reoccurrences.

The staffing arrangements were in line with the needs of the residents. The necessary number of staff were on-duty to ensure that the residents received the

support they needed. Information was shared with staff in the centre and between managers through regular meetings.

A complaints procedure was in place to allow the residents and family members to raise any issues relating to the quality of the service. This procedure was implemented when required.

Regulation 15: Staffing

The staffing arrangements were suited to the needs of residents.

The inspectors reviewed the rosters in the centre from 1 April 2025 to 27 May 2025. These showed that the number of staff identified by the provider to meet the needs of residents was on duty at all times. One additional staff member was available three evenings a week and at weekends. The purpose of these additional hours were to provide opportunities for residents to engage in social activities. The person in charge provided cover for one of these evening shifts per week. The person in charge reported that these hours were flexible and that additional staff could be rostered at other times to accommodate residents' schedules and activities. The review of rosters showed this flexibility with some staff rostered at different times at weekends.

The review of the rosters also indicated that there was a consistent team of staff working in the centre. This included the relief staff who provided cover for planned and unplanned leave. This meant that the staff were familiar to the residents and with the supports that should be implemented to meet the needs of residents.

The provider had completed an audit of staff files in March 2025. This audit was reviewed by inspectors and it showed that the provider had obtained the required information and documentation in relation to each member of staff, as outlined under the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The provider had systems in place to maintain oversight of the quality of the service, to share information, and to review incidents. However, improvement was required in relation to the quality of information obtained through audit and the identification of trends in incidents.

The provider maintained oversight of the service through audit. Inspectors reviewed the routine audits that were completed in the centre since the beginning of 2025. They found that the audits had been completed in line with the provider's schedule.

However, the quality of information obtained through the routine audits did not always ensure that areas for service improvement were identified and addressed. For example, the monthly financial audits contained actions to be completed, such as 'count all cash in wallets', rather than questions about the accuracy and effectiveness of the systems in use in the centre. In addition, the audits in the centre had failed to identify that resident's funds were used to purchase furniture in the centre without appropriate support from their family as outlined in their contract of care. This will be discussed under regulation 24: admissions and contract for the provision of services.

The provider also completed six-monthly unannounced audits of the service. Inspectors reviewed the most recent of these audits that had been completed in November 2024. Actions from these audits, routine audits, and previous inspections of the service were discussed at meetings between the person in charge and their line manager. This ensured that identified actions were addressed and progressed in line with the timelines set out by the provider.

Information was shared between centres and with staff in the centre through regular meetings. Inspectors reviewed the minutes of the most recent staff meetings in the centre, meetings between persons in charge, and meetings between managers of services within the locality. These showed shared learning between services and relay of information from senior management meetings.

Inspectors reviewed the incidents that had occurred in the centre since the beginning of 2025. Incidents were reviewed on a quarterly basis by the person in charge to see if there were any trends and if steps could be taken to avoid reoccurrences. However, this review had not identified the need to make a referral to the behaviour support service for one resident due to repeated incidents. This will be discussed further under regulation 7: positive behavioural support.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider had submitted notifications to the Chief Inspector in line with the regulations.

Inspectors reviewed the audit of notifications that had occurred in the centre during the first three months of 2025. These showed that any incidents that should be reported to the Chief Inspector had been submitted in line with the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a complaints procedure in place and the procedure was implemented in the centre.

Inspectors viewed the provider's complaints procedure. They noted that an easy-to-read version of the procedure was available to residents and this was kept in a location that was easily accessed by residents.

There was evidence that complaints were processed in line with this procedure. The inspectors' review of the minutes of a recent meeting between the person in charge and their line manager showed that a resident's complaint relating to a light in their bedroom had been resolved to the satisfaction of the resident.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The provider did not adhere to the written agreement between the resident and provider.

Inspectors reviewed one resident's most recent written agreement. This agreement had been signed by the provider and a family representative on behalf of the resident in April 2024. Inspectors also reviewed the records of the resident's personal spending for March, April and May 2025. Inspectors noted that the resident had made two separate purchases of large items of furniture in that time. The cost of these items amounted to almost €1400. The new items of furniture replaced existing items in the centre. The senior manager and person in charge were unable to provide documentary evidence that these purchases had been discussed with the resident or their family representative. This was not in keeping with the resident's written agreement that outlined that any personal spending over €200 would require consultation with the resident's family. The written agreement also specified that the resident would be provided with a furnished home. In addition, when inspectors viewed the resident's log of personal possessions, they found that these items were not recorded in this log.

Judgment: Not compliant

Quality and safety

The assessed needs of the three residents in this centre were well-known by a staff team that had supported these residents over a number of years. Although there were good practices found in relation to residents' assessment and personal planning arrangements, risk management and behavioural support, which were

fundamental aspects of care that some of these residents' received, required considerable review by the provider to ensure better and safer care was being provided.

There was a good incident reporting culture by staff in this centre, and each individual incident that was reported was subject to review by management. However, there was an overall lack of response from the provider to incidents that were re-occurring. A few months prior to this inspection, a resident sustained an injury on foot of one of these incidents; and despite similar incidents continuing to happen following this, the provider had not collectively reviewed these incidents to establish if additional safety measures were required to maintain this resident safe from a potential further injury. Furthermore, the repeated occurrence of these incident had not resulted in consideration being given to the re-assessment of the resident's behavioural support needs, with the current behaviour support plan for this resident providing very limited guidance to staff on how to respond to these particular incidents, and no protocol had been developed to guide staff as to how to assess and check the resident for injury, when these incidents did occur. The provider had also not utilised their own staff team meetings to raise these incidents for discussion, and there was also review required of how these incidents were being collectively risk-rated to reflect the potential risk of further harm or injury to this resident. In addition, improvements were found to be required to the overall assessment of risk in this centre, to ensure some risk assessments better guided on the specific controls required to mitigate against certain resident and organisational risks.

Although there were good practices found in relation to residents' assessment and personal planning arrangements, inspectors found that the provider had not satisfactorily addressed previous issues raised upon the last inspection of this centre in September 2024, in relation to one resident's social care arrangements.

There were good practices found in relation to safeguarding arrangements in this centre, which was a topic that was discussed individually with each resident as part of their key-working sessions. Staff who spoke with the inspectors were aware of how to identify, report and respond to any safety and welfare concerns, with no active safeguarding plans being required for this service at the time of this inspection. There were a number of restrictive practices that were in use, many of which were in the process of review. However, upon walk-around of this centre, an inspector did bring it to the attention of those facilitating the inspection to also include in this review an existing door alarm that was in place for a resident, to ensure it was fit for its intended purpose.

Regulation 13: General welfare and development

Significant improvement was required in order to ensure that residents were supported to engage in activities that were in line with their interests and that they were provided with opportunities for occupation and recreation. This regulation was

found to be not compliant on the previous inspection of this centre. Despite a number of initiatives undertaken by the provider, this regulation was again found to be not compliant on this inspection.

In response to the previous inspection report of this centre, the provider's behaviour support service and speech and language therapist had completed a number of sessions in the centre. Inspectors reviewed a report that outlined a summary of the supports that were provided by these professionals between January and March 2025. This showed that these professionals had completed six sessions with staff to develop ideas of activities that could be offered to residents. Supports for residents' communication had also been commenced. The speech and language therapist was due to visit the centre on 5 June 2025 to review the effectiveness of the communication supports. However, following these sessions, it was unclear what systems were now in place to ensure that residents were offered choices in relation to their daily activities. A review of a resident's records indicated that these actions had not been effective. Inspectors reviewed the daily records maintained for one resident for the month of April 2025. These records indicated that the resident engaged in limited activities. The records mainly recorded the resident's participation in household chores and walks in the vicinity of the centre. Records did not indicate if the resident was offered choices in relation to how they wished to spend their time. A review of the resident's personal spending for March, April and May 2025 also reflected these limited activities.

Judgment: Not compliant

Regulation 26: Risk management procedures

Although the provider did have risk management systems in place, significant improvement was required in relation to the response to incidents that were occurring in this centre to ensure residents were maintained safe from harm. There were also some improvements required to how risk assessments were being completed, so as to ensure these were accurately demonstrating the specific measures that were in place to mitigate against risk in this centre.

A few months prior to this inspection, an incident occurred where a resident sustained a significant injury following a behavioural related incident. An inspector reviewed the incidents that had occurred in the months since that aforementioned incident, where it was identified that a number of similar incidents of this nature had continued to occur. Although the resident hadn't sustained further injury from the re-occurrence of these incidents, incident reports did state that the resident had at times reported pain following these incidents. Despite this, no protocol had been developed to guide staff on how to assess this resident for injury when these incidents occurred. In addition, this particular resident was identified as a falls risk, and restrictive practices had been put in place in response to their safety needs. However, a review of this measure was required to ensure it was fit for its intended

purpose, as is outlined under regulation 7.

Furthermore, there was a lack of recognition on the part of the provider to act upon the information that was being gathered through the continued re-occurrence of these incident reports, so as to review for any additional safety arrangements that may be required to be put in place to maintain this resident safe from further potential harm. A review was also required into how these incidents were being risk-rated, as many of them were individually risk-rated low in the absence of injury and based on the level of management required by local staff to respond these incidents. However, there was a lack of consideration given to number of these incidents that continued occur, to inform a an organisational specific risk-rating that reflected the potential harm to this resident, based on the quantity of incidents that had happened.

In relation to the communication of incidents that occurred in this centre, this also required review. Although regular staff team meetings were occurring, the minutes from the most recent meeting reviewed by inspectors did demonstrate that medication errors had been discussed, however, the repeated occurrence of the aforementioned behavioural incidents were not discussed with staff.

In relation to the risk assessment of residents' individual needs, there were also gaps found in relation to this. For example, where residents had risks relating to their elimination needs, nutritional and health care needs, risk assessments were not always in place for these. In addition, there was a risk register available at this centre; however, this required further review to provide better clarity on how the provider was responding to identified risks linked with some aspects of this service, so as to ensure the measures that were being implemented by the provider were captured in associated risk assessments.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider had arrangements in place for the re-assessment of residents' needs and had developed personal plans to guide staff on the level of support that each resident required. There was good input from multi-disciplinary professionals in relation to these re-assessments, as and when required, and residents were afforded an opportunity to be part of this process. Where residents required additional MDT review, this was scheduled accordingly for them. Advocacy services were available to this centre, when required, and the review of residents assessment and personal planning arrangements often formed part of the provider's own six monthly visits to this service.

Judgment: Compliant

Regulation 7: Positive behavioural support

Although the positive behaviour support needs of residents in this centre were well-known, there was improvement required to this aspect of the service.

As previously mentioned, a number of behavioural related incidents had occurred over a number of months, one of which had resulted in an injury to a resident. Although this resident had been reviewed by behaviour support specialist following this said incident, the provider had failed to recognise the requirement for a further re-assessment to be completed, given due regard to the number of similar incidents that had since then, continued to occur. There was a behaviour support plan in place for this resident that gave mention to the specific behaviour exhibited by this resident that had resulted in injury,however; no clear guidelines were made available in this plan to staff with regards to recommended reactive and proactive strategies, specific to this particular behaviour.

Some restrictive practices were in use in this centre, many of which were in place to maintain residents' safety; however some of these were observed to require review, to ensure they were fit for their intended purpose. Upon a walk-around of the centre, it was observed that there was a door alarm on one exit door out of a resident's bedroom that led out into a small hallway. Inspectors were informed that this resident had an assessed falls risk, and this alarm was in place so as to alert staff, should the resident get up at night. However, there was also a second door out of this resident's bedroom that entered into their en-suite, which did not have an alarm, meaning that should the resident get up at night to use their bathroom, staff may not be alerted. The provider was in the process of reviewing a number of restrictive practices at the time of this inspection, with those facilitating the inspection planning to also request this restriction to be included within that review.

Judgment: Not compliant

Regulation 8: Protection

The provider did have safeguarding arrangements in place for this centre, with clear procedures to guide staff on how to identify, response, review and monitor any concerns relating to the safety and welfare of these residents. All staff had received up-to-date training in safeguarding, and this was a subject that was regularly discussed at staff meetings. Where safeguarding related incidents did occur, the centre was supported by a designated safeguarding officer to review these. There were no active safeguarding plans in place in this centre at the time of this inspection.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Forest View Apartments OSV-0001783

Inspection ID: MON-0047061

Date of inspection: 27/05/2025

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	Substantially Compliant

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

• Risk Management training for managers was delivered on 26.06.25 with all managers now tranfering there risk registers to the new Vi-Clarity system. The QSSI department will attend area team meetings to provide further training to managers on 10.09.2025

Finance audits will be trialled with the pilot group on Vi-Clarity system by 08.08.2025 & the agenda template for 6 weekly business meetings between Area manager and person in charge has been updated to include audits. Persons supported money policy will be shared and discussed at the next team meeting on 17.07.2025.

• The person in charge will ensure that any significant future spends by residents are discussed and agreed through circle of support meetings and are in line with the Individual service agreement and have a record of these meetings available for review.

• The person in charge has reviewed incidents for a 6 month period in relation to one person who has had repeated incidents and engaged with the behavioral support service who have assigned a member of the department to review and update PRMP'S, behavioural support plans and support the development of required protocols. They are scheduled to attend the service on the 24.07.2025 with a member of the Psychology team to begin the process of reviewing and updating all PRMP's and BSP's, support the development of required protocols and a review of restrictive practices with the person in charge.

• The person in charge has reviewed incidents for 6 month period and submitted an OT referral in relation to one person who has had repeated incidents requesting an environmental assessment. An initial OT visit Occurred on 09.07.2025 with a preliminary report sent to person in charge with recommendations being implimented.

• An overview of risk tool has been developed to be used in conjuntion with the Vi Clarity system and is being piloted within this service. This tool will be reviewed quarterly and correlates all service and personal risks and associated restrictions. This tool also links incidents to the relevant risk and restriction helping to identify any trends in incidents which may require the implimentation of additional measures or review of restrictions, helping inform and link updates of risk assessments and the service risk register.
• The Registered Provider will establish a Compliance Oversight Group,to meet quarterly to monitor progress of all actions towards compliance set out in the Compliance Tracker and to address/problem solve issues identified. (18/08/2025)

• A governance and oversight group for the service has been established consisting of the PIC, Area manager, member of senior management with representation from the following departments; BSS, OT and Psychology. Other disciplines will also be asked to input as required. This group will meet once a month to review and support the progress of all actions in the compliance plan with the first meeting scheduled for 05.08.2025

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:

• The Provider has reimbursed monies to one resident whose Individual Service Agreement was not followed when purchasing furniture items. An audit of spending/finance ledgers of all residents has highlighted similar instances, these have also been reinmbursed.
• The Person in Charge will complete a review/audit of all property registers by 17.07.2025.
• The revised Finance audits template/tool will be trialled with the pilot group on Vi-clarity system.
• The agenda template for 6 weekly business meetings between Area manager and PIC has been updated to include audits. Persons supported money policy will be shared and discussed at the next team meeting on 17.07.2025.
• PIC will ensure that any significant future expenses by residents are discussed and agreed through circle of support meetings and are in line with the Individual service agreement and have a record of these meetings available for review.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

• An activity tracker has been developed within this service and will be reviewed by the PIC weekly to ensure each individual supported has been supported to participate in activities in line with their interests.
• Targeted hours for each individuals social needs & trialling of activities are identified on a weekly basis with the PIC and team.
• Daily log template has been altered to allow for more documentation of activites

offered and if they were accepted or declined and will be reviewed by the PIC on a weekly basis.
• The Psychology Department has fully reviewed and updated the organisational neurodiversity training to be rooted in an embodied neuroaffirming practice.
• All staff to attend this training by 17.10.2025

Regulation 26: Risk management procedures	Not Compliant

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

The Registered Provider has reviewed and updated the Risk Management Policy to include guidance on, and signposting for, all of the specific risks identified in Regulation 26, to include control measures and mitigating actions in place, including the following risks:
• Unexpected absence of any resident
• Accidental injury to residents, visitors or staff,
• Behaviours of concern (to include aggression and violence)
• Self-harm.
The Registered Provider has provided training in the understanding of Risk Management to 7 Areas. In addition, all of those Areas have live risk registers. Further engagement and support to understand the concept and system of Risk Management will be delivered to Area Teams over the coming months. The next phase includes community supports and Senior Management / Department Heads to develop Risk Registers for each department and the Corporate Risk Register. 19/08/25.

The revised Risk Management Policy will be issued 01/09/2025

• The person in charge has reviewed incidents for a 6 month period in relation to one person who has had repeated incidents and engaged with the behavioral support service who have assigned a member of the department to review and update PRMP'S, behavioural support plans and support the development of required protocols. They are scheduled to attend the service on the 24.07.2025 with a member of the Psychology team to begin the process of reviewing and updating all PRMP's and BSP's, support the development of required protocols and a review of restrictive practices with the PERSON IN CHARGE.

• The Rights Review Committee are scheduled to carry out a visit to the service on 11.08.2025

• Restrictive practice training is being delivered to managers within the area on 25.07.2025

• The PIC has reviewed incidents for 6 month period and submitted an OT referral in relation to one person who has had repeated incidents requesting an envirenmental assessment. An initial OT visit Occurred on 09.07.2025 with a preliminary report sent to person in charge with recommendations being implimented.
• The person in charge has scheduled time at staff meeting for Named staff to provide

an update on the person they support , this will include general welfare, goals and incident. person
• An overview of risk tool has been developed in this service to be used in conjuntion with the Vi Clarity system and is being piloted within this service. This tool will be reviewed quarterly and correlates all service and personal risks and associated restrictions. This tool also links any incidents to the relevant risk and restriction helping to identify any trends in incidents which may require the implimentation of additional measures or review of restrictions, helping inform and link updates of risk assessments and the service risk register.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• The person in charge has reviewed incidents for a 6 month period in relation to one person who has had repeated incidents and engaged with the behavioral support service who have assigned a member of the department to review and update PRMP'S, behavioural support plans and support the development of required protocols. They are scheduled to attend the service on the 24.07.2025 with a member of the Psychology team to begin the process of reviewing and updating all PRMP's and BSP's, support the development of required protocols and a review of restrictive practices with the person in charge.

• The person in charge has reviewed incidents for 6 month period and submitted an OT referral in relation to one person who has had repeated incidents requesting an environmental assessment. An initial OT visit Occurred on 09.07.2025 with a preliminary report sent to person in charge with recommendations being implimented.

• The Rights Review Committee are schduled to carry out a visit to the service on 11.08.2025

• Restrictive practice training is being delivered to managers within the area on 25.07.2025

• Risk Management training for managers was delivered on 26.06.25 with all managers now tranfering there risk registers to the new Vi-Clarity system. The QSSI department will attend area team meetings to provide further training to managers on 10.09.2025
• The Psychology Department has fully reviewed and updated the organisational neurodiversity training to be rooted in an embodied neuroaffirming practice. This approach is based on the promotion of the latest psychological evidence, with a focus on a bespoke, person-first approach, using inclusive language and honouring human rights. The updated training specifically aims to move towards accepting and understanding neurodiverse differences as a valid way to be in the world, shifting the focus on adapting the environment interactions with the person to align better with their unique needs.
• All staff to attend this training by 17.10.2025

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	17/10/2025
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	17/10/2025
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'	Substantially Compliant	Yellow	10/09/2025

	needs, consistent and effectively monitored.			
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Not Compliant	Orange	17/07/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	10/09/2025
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	17/10/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive	Substantially Compliant	Yellow	11/08/2025

	procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			