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:	Woodview
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	14 March 2024
Centre ID:	OSV-0002376
Fieldwork ID:	MON-0034138

About the designated centre

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

Woodview is a community based designated centre operated by St. Michael's House. The centre provides full-time residential care and support for up to six male or female adults with an intellectual disability. It is situated in a suburban area of Co. Dublin with access to a variety of local amenities such as a local shopping centre, hotel, a large park within a short walking distance, bus routes, and churches. The centre has a vehicle to enable residents to access day services, local amenities and leisure facilities in the surrounding areas. The centre consists of a large two-storey house with seven bedrooms. Residents in the centre are supported 24 hours a day, seven days a week by a staff team comprising of a person in charge, registered nurses, care assistants, and a social care worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Thursday 14 March 2024	09:30hrs to 17:45hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an announced inspection carried out in response to the provider's application to renew registration of the designated centre. The inspector had the opportunity to meet many of the residents living in the centre over the course of the day. The inspector used interactions with residents, observations of interactions between staff and residents, along with a walk-around of the premises and a review of documentation to inform judgments on the quality and safety of care.

The inspector was greeted by the person in charge and two residents on arrival to the centre. The person in charge informed the inspector that they were rostered as front-line staff and would be supporting residents until additional staff came on duty later that morning. The inspector observed the person in charge and staff on duty actively supporting the residents with their busy morning routines which included assisting residents to get up and dressed, assisting with their breakfast and administering medications. When the additional staff arrived, the person in charge met with the inspector and facilitated the inspection for the remainder of the day.

Many residents in this house communicated using a variety of modes including speech, sign language and gestures. One resident shook hands with the inspector on arrival and then was assisted to the kitchen to engage in an activity of their choosing. Another resident was getting ready to attend their day service. The inspector saw that staff on duty were knowledgeable regarding residents' communication modes and responded quickly to residents' requests. For example, one resident signed to staff that they wished to go to sleep on the couch. Staff assisted the resident to transfer to the couch and made them comfortable with a blanket and pillow.

The inspector sat in the kitchen for a period of time and had the opportunity to meet other residents. One resident had been in the accident and emergency department the night before the inspection due to an identified health care issue. The resident had received treatment and had been discharged back to the care of the centre. The inspector saw staff going to the pharmacy to acquire the resident's newly prescribed medications. The inspector also saw staff preparing modified fluids and assisting the resident to take fluids in a gentle manner which was upholding their dignity.

The inspector saw that there were issues with storage in the designated centre. Residents presented with a variety of health care needs for which they required staff support, medications and various aids and appliances. The inspector saw that there were many mobility aids stored in the main corridor of the centre. The inspector was told that storage was an issue in the centre and that this was reflected in the provider's audits. The inspector observed there was insufficient space in the medication room to store all of residents' prescribed supplements. For this reason, a locked cupboard which contained a medication fridge had been installed in one of

the sitting rooms. The lack of suitable storage posed a risk to the safe storage of medications and, to the evacuation arrangements. This will be discussed later in the report.

Residents in this centre each had their own bedroom which was decorated in line with their personal preferences. Bedrooms were generally clean and well-maintained although there was a build-up of mould around some bedroom windows. Residents had access to a large accessible bathroom and a smaller shower room. Both of these were well-maintained although two aids were seen to block access to the shower in the smaller shower room. The inspector was told that these aids were moved to the hallway when residents were showering.

Residents had access to a large kitchen and dining room and a smaller sitting room. Upstairs, several unoccupied bedrooms were used to neatly store personal protective equipment (PPE), surplus intimate care products and archived documents.

A large back garden was available to residents. One resident was seen enjoying the garden in the afternoon on their return from day service.

The inspector noted there were sufficient staff on duty on the day of inspection to meet residents' assessed needs. Staff were seen to provide care in a manner that respected residents' privacy and dignity. For example, one resident required one-to-one care as they were at risk of falls. The inspector observed that they were assigned a staff member to support them. This staff member waited outside this resident's bedroom when the resident chose to spend time there alone. This allowed the resident to have time alone while staff remained easily accessible to assist the resident with mobilising.

Staff were also observed supporting residents with their evening meal. Staff were very quick to respond to residents' communications. For example, one resident pulled at their apron to indicate that they were finished their meal and staff immediately offered to assist with removing the apron.

While the inspector saw that there were sufficient staff on duty on the day of the inspection who were providing care to residents in a kind and caring manner, the inspector was also told by staff, and by family members who had completed residents' questionnaires, that the inconsistent staffing arrangements were unsettling for residents and presented challenges to the delivery of good quality care. Family members emphasised the importance of a stable and familiar staff team to their loved ones who lived in the designated centre. This will be discussed further in the capacity and capability section of the report.

Overall, this inspection found that residents were in receipt of a good quality of care with some areas that required improvement. Staff were endeavouring to provide person-centred care which was meeting residents' assessed needs. However, there were considerable constraints on the staff team due to staff vacancies and the reliance on a large number of relief and agency staff to fill these posts. Additionally, there was a need for a review of the storage facilities in the centre to ensure that aids, appliances and medications were stored in a safe manner.

Capacity and capability

This section of the report sets out the oversight arrangements and how effective they were in ensuring a good quality and safe service. The inspector found that, while there were clearly defined management systems, there were a number of staff vacancies which were impacting on the delivery of a quality service. There was a high reliance on relief and agency staff which was resulting in poor continuity of care for residents.

There were a number of vacancies in the centre at the time of inspection. These were being filled by relief and agency staff. The inspector saw, on reviewing the rosters, that there was a high number of relief and agency staff coming into the centre in the months preceeding the inspection. This was not supporting continuity of care for the residents.

The inspector saw that staff and family members had expressed concerns regarding the impact of the inconsistent staffing arrangements on the well-being of residents. For example, some residents struggled to sleep when there were unfamiliar staff on duty. The inspector was told that, at times, there were staff skill-mix deficits. For example, some relief or agency staff were not qualified to drive the centre's bus or to administer required medications in the community. This resulted in residents being unable to access day service or the community on those occasions.

The staff who were employed permanently in the centre were found to be well-trained and were knowledgeable regarding the residents' needs. Staff were seen to support the residents in a gentle and caring manner. Family members spoke positively about the permanent staff team in the residents' questionnaires. However, it had been identified by the provider that there was a considerable impact on the staff working in the centre due to the current staffing resource constraints and arrangements.

The inspector was informed that the provider was endeavouring to recruit staff however, at the time of inspection, there were funding restrictions which impacted on the recruitment process. While recruitment of permanent staff was identified as a required action on the provider's audits, there was no defined time-frame set out for when this would be completed.

The person in charge had set management days during the month and on other days was rostered on as a front-line staff. The inspector saw that the centre was busy on the day of inspection and the person in charge was actively required in order to provide for residents' assessed needs. It was documented in the provider's audits that the staff vacancies had an impact on the oversight arrangements as monthly data reports and the centre's quality enhancement plan had been postponed in 2023 in order to allow the person in charge to concentrate on the day-to-day delivery of care.

The staffing arrangements in the centre required enhancement in order to ensure that residents were in receipt of a good quality service which was not only meeting their assessed needs but which was supporting residents to access activities and education in line with their individual preferences.

Regulation 14: Persons in charge

The designated centre was run by a person in charge who was suitably qualified and experienced. They were employed in a full-time capacity and had responsibility solely of this designated centre. The person in charge demonstrated a thorough understanding of the service and the residents' needs and were knowledgeable regarding their regulatory responsibilities.

Judgment: Compliant

Regulation 15: Staffing

There were a number of staff vacancies in the centre at the time of inspection.

The inspector reviewed the planned and actual roster and saw that there was a high reliance on relief and agency staff in order to complete the roster. For example, in February of this year, 39 relief and agency staff were required to fill vacant shifts. This was not supporting continuity of care for the residents.

The inspector was told that the staff vacancies were impacting on the quality of care. It was reported that, on occasions, residents could not access the community or day services due to a lack of appropriately qualified staff.

It was reported by staff, at staff meetings, that some residents were finding it difficult to sleep at night without familiar staff on duty and that there had been incidents where required duties, such as cleaning, had not been properly completed when there were relief or agency staff on duty.

Staff reported in the provider's annual review from 2023 that the staff vacancies were impacting on their ability to provide a good standard of care. The person in charge also highlighted through their supervision meetings of the challenges of working with inconsistent staffing.

Judgment: Not compliant

Regulation 16: Training and staff development

There was generally a good level of compliance with mandatory and refresher training. The inspector saw that all staff were up to date with required safeguarding training and with fire safety.Two staff required refresher training in Infection Prevention Control (IPC) and one staff required refresher training in feeding, eating drinking and swallowing (FEDS).

The person in charge reported that, due to staff vacancies and subsequent constraints on their management hours, not all staff had received the required number of supervision sessions as set out by the provider's policy. The inspector reviewed the staff supervision records and saw that most staff had received at least three supervision sessions within the past 12 months. A staff supervision schedule was in place for 2024 which detailed that staff would have four supervision sessions as required by the provider's policy.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider submitted a copy of their certificate of insurance along with their registration renewal application. The provider had effected a contract of insurance which mitigated against harm to the residents.

Judgment: Compliant

Regulation 23: Governance and management

There were defined management structures in place in the centre. The centre was run by a person in charge who reported to a service manager. Regular meetings were held between the person in charge and service manager in order to ensure that risks relating to the quality and safety of care were escalated to the provider level.

The provider had in place a series of audits which were completed in consultation with residents, families and staff. These audits included the required six-monthly unannounced visits and an annual review of the quality and safety of care as well as additional audits in areas such as infection prevention and control (IPC).

A review of these audits showed that the high reliance on relief and agency staff was of concern to families, staff and senior management and, that it was recognised that the centre was insufficiently resourced to ensure delivery of good quality care in

line with the statement of purpose.

There were some enhancements required to audits to ensure that they were effective in driving service improvements. For example, the six monthly unannounced audit in October 2023 identified that the hallway of the centre was cluttered with assistive equipment however there was no time frame within which this would be addressed and the same issue remained as a required action on the six monthly audit in February 2024.

The provider's audits had also not identified some of the risks seen on this inspection for example, unsafe storage of sharps and the presence of mould in some bedrooms. Improvements were required to ensure they comprehensively identified risks in the centre and took action to address these.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A statement of purpose was maintained in the centre. This had been recently reviewed and contained all of the information as required by the Regulations.

Judgment: Compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived there. While residents were in receipt of care which was meeting their assessed needs, there were some improvements required, particulary in relation to storage facilities for residents' aids and medications.

Residents living in the centre had varied assessed health care needs. The inspector saw that residents had access to the required health care professionals and supports in order to meet those needs. Many residents were also prescribed mobility aids, medications and nutritional supplements. While the designated centre was laid out in a manner that promoted accessibility there was a lack of suitable storage for mobility aids when they were not in use.

The medication room was observed to be too small to hold all of residents' prescribed medications with additional storage space for some items observed in the residents' living room space. The medication room required review and enhancement as it was posing a risk to some aspects of the safety of care in the

centre, for example sharps were not stored in a safe manner.

The designated centre was a large double-story building located in a busy suburb of Dublin. Most of the residents' bedrooms were located on the ground floor with only one resident being accommodated upstairs. This was due to the assessed mobility needs of most of the residents. Vacant bedrooms upstairs were used to store surplus intimate care products, personal protective equipment and archived documents. The inspector saw that residents' bedrooms were decorated in line with residents' preferences and had adequate storage for residents' personal possessions.

The majority of residents' mobility aids were stored in the main hallway of the centre when they were not in use. The inspector was told that this ensured that the aids were easily accessible to staff and residents when they required them. However the storage of aids in the hallway had the potential to impact the safe evacuation of the centre in the event of an emergency. One resident's bedroom opened on to this hallway and was used as their route to an emergency exit. The potential for aids to obstruct this exit and impede a safe evacuation had not been considered and risk assessed.

Two toileting aids were also stored in the shower of one of the bathrooms. In order for residents to use the shower, the aids were placed in the hallway. This further added to the obstacles in the hallway and posed a risk to the safe evacuation of residents. It was also not in line with best practice to promote accessibility and autonomy for residents as there was a requirement for aids to be moved before they could access the shower.

A medications room was available in the centre however it was insufficient to store residents' required medications and supplements. Due to the quantity of residents' supplements prescribed and the need for them to be readily available to staff, as they were used frequently, a locked fridge had been installed in a resident sitting room to contain the supplements. This was impacting on the homeliness of the centre. Additionally, a sharps box was stored in an unsafe manner in the medication room due to the lack of availability of suitable storage.

There were a number of restrictive practices in place in this centre due to the assessed needs of residents. The person in charge and the staff team had recently completed human rights training and this had prompted a review of the centre's restrictive practices. The staff team spoke positively regarding this review and their enhanced knowledge of restrictive practices. However, there was a need for residents' consent to these restrictive practices to be documented.

Overall, there were suitable fire detection, containment and extinguishing facilities. A restrictive practice was in place with regards to locking road-facing final exit doors. This had been risk assessed and suitable control measures were in place to mitigate against the risk of residents being unable to evacuate. One resident was known to refuse to evacuate on occasion. Further detail was required in their personal evacuation plan and on fire drill records to detail how staff should support the resident to fully evacuate in the event of an emergency.

In summary, while it was evident that residents had access to appropriate health

care supports and that the provider had systems in place to meet their assessed needs, there was enhancement required to the storage facilities in order to mitigate against risks to emergency evacuations and to ensure suitable storage of all medications and sharps.

Regulation 11: Visits

There were no visiting restrictions in the designated centre. Residents could receive visitors in line with their choices. Care plans available in residents' files detailed the supports in place to enable residents to maintain contact with their families and friends.

Judgment: Compliant

Regulation 17: Premises

The inspector saw that there was limited suitable storage space in the centre. The lack of storage was presenting a number of risks to the safety of the service. A number of residents had assessed needs for which they required aids to mobilise. Many of these aids and appliances were stored in the hallway of the centre. While there was sufficient room for residents to get by the aids on a daily basis, as they were stored in the main hallway of the centre, they posed a potential risk to the safe evacuation of the centre in the event of an emergency. This is detailed further under Regulation 28. The provider's own audits detailed that the hallway was cluttered however there was no clear action in place to address this issue.

One shower room, off the main hallway, was used to store two commodes. When residents wished to use the shower the commodes were moved into the hallway. This further added to the clutter and was not promoting accessibility of the shower for residents.

The inspector saw that there was insufficient space in the centre's medication room to store all of residents' prescribed supplements. For this reason a locked fridge had been placed in one of the sitting rooms. This did not contribute to a homely aesthetic. Furthermore, there was insufficient space in the medication room to ensure that sharps were stored safely. The sharps box was stored on a shelf above head height which posed a safety risk to staff when taking the box down.

The storage facilities in the centre required a full review by the provider to ensure that there was sufficient storage for medications and aids and that these were not posing a risk to staff and residents.

There was upkeep required to some aspects of the premises. This included:

- radiator covers required painting or varnishing to ensure that they could be effectively cleaned
- the kitchen counter and one cupboard required repair
- a sofa in the kitchen required replacement as the cover was damaged and could not be effectively cleaned
- mould was seen around some bedroom windows in the centre. This required treatment as it presented an IPC risk. The person in charge informed the inspector that they would clean it on the day of the inspection.

Judgment: Not compliant

Regulation 20: Information for residents

A residents' guide was available in the designated centre. A copy had also been submitted along with the provider's application to renew the centre's certificate of registration. This was reviewed and was found to contain the information as required by the Regulations.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable fire detection, containment and extinguishing facilities in the centre. Fire equipment was serviced regularly and maintained in good working order. Some final exits in the centre were key locked due to a known risk. There was a risk assessment in place which detailed the control measures implemented to ensure residents could be safely evacuated. Some of these control measures included all permanent staff carrying a copy of the single key which was used to unlock all final exits.

The inspector saw that a large bin was stored outside a resident's bedroom window. This posed a potential risk to the spread of fire through the designated centre. The person in charge arranged for the bin to be moved to a more suitable location on the day of inspection.

A number of residents had assessed needs for which they required aids to mobilise. Many of these aids and appliances were stored in the hallway of the centre. While there was sufficient room for residents to get by the aids on a daily basis, as they were stored in the main hallway of the centre, they posed a potential risk to the safe evacuation of the centre in the event of an emergency. One resident was required to use this hallway as part of their emergency exit route in the event of a fire. The provider's own audits detailed that the hallway was cluttered however there was no

clear action in place to address this issue.

There was a known risk in the centre that one resident may refuse to evacuate the centre in the event of a fire. Further information was required in this resident's personal evacuation plan to detail the specific actions to be taken by staff if the resident refused to evacuate. Records of fire drills also required enhancement to detail exactly where residents were evacuate to, and if one resident was only evacuated to the hallway, to ensure that this was recorded and that there were appropriate plans and procedures in place to respond to the risk in the event of a real emergency.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Three residents' files were reviewed by the inspector. It was found that each file contained a comprehensive individualised assessment which had been recently reviewed and updated. This assessment was informed by the resident, their representatives and the multi-disciplinary team.

The assessment was used to inform care plans which guided staff in how to meet residents' assessed needs. Care plans were written in person-centred language and put the resident at the heart of their care.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a variety of health care professionals in line with their assessed needs. Records of attendance at appointments were maintained. Residents attended health care professionals both in the community and from the provider's own multi-disciplinary team. Residents also accessed public health screenings and regular screenings for their particular assessed needs.

Staff on duty were informed of residents' health care needs. Staff told the inspector of the measures that were in place to mitigate against the risk of residents developing pressure sores and to control for the risk of falls where there were known risks.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff in this centre had recently completed training in human rights. Staff had used this training to reflect on restrictive practices that were in place in the designated centre and to identify additional restrictive practices which had previously not been considered as such. For example, staff had identified that night-time checks were a restrictive practice with potential to impact on residents' rights to privacy and dignity.

The person in charge had requested that the provider support them to complete a review of the restrictive practices in the centre. This review was completed in advance of the inspection. The inspector saw that restrictive practices were submitted to the provider's rights monitoring committee for approval. There was one area identified for improvement in respect of restrictive practices. This was ensuring that residents were informed of restrictive practices which impacted on them and that their consent to these was received and documented.

The inspector saw that residents who required them each had an up-to-date behaviour support plan on their file which detailed proactive and reactive strategies to guide staff in assisting residents in managing behaviours of concern.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Woodview OSV-0002376

Inspection ID: MON-0034138

Date of inspection: 14/03/2024

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. The filling of vacancies for this center has been significantly delayed due to the HSE derogating process. HR to confirm again with the HSE if these derogations have been approved. 2. Recruitment campaign was launched specifically for the Centre with the closing date for applicants on 26th April and interview date set for 28th May. Pending HSE derogation approval, its hoped to have new staff in place by August approx. 3. While awaiting HSE derogation vacancy approval, staff in the unit will avail of extra hours to ensure consistency for residents. Four regular agency staff and four regular relief staff will continue to be block booked to ensure consistency of care for the residents. 4. Service Manager discusses the centres vacancies at monthly management meetings and area service team monthly meetings (ASMT). Service manager will raise the vacancy issue at the next ASMT on 1st May to explore possible transfer options from other Centres who are carrying less vacancies.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. All staff have completed IPC training and FEDS training	

2. PIC has scheduled all staff for four supervisions for 2024 as per policy

Regulation 23: Governance and management	Substantially Compliant

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

1. The PIC will continue to provide Strong and effective PIC roster management and governance in order to offset the impact of the nationwide HSE Recruitment Pause/derogation. While awaiting HSE derogation vacancy approval, staff in the centre will avail of extra hours to ensure consistency for service users. Four regular agency staff and four regular relief staff will continue to be) block booked to ensure consistency of care for the residents.

2. PIC & Service Manager to enquire with recruitment agencies to identify staff who may be interested in a block booking for 6 months approx.

3. The filling of vacancies for this center has been significantly delayed due to the HSE derogating process. HR to confirm again with the HSE if these derogations have been approved.

4. Recruitment campaign was launched specifically for the Centre with applicant closures set 26th April and interview dates set for 28th May.

5. Staff vacancies are identified to have an impact on ability to provide a good standard of care; however, evidence suggests that the impact is being offset by the committed PIC, permanent staff and regular agency staff who have worked exceptionally hard to maintain the high standards and quality of care during this current HSE Recruitment Embargo. The assessed needs of the resident are being met; this was evidenced on the day of inspection with all Assessments of Need and support plans relevant and in date, an All About Me and My life Meeting in place and goal tracking systems in place for every resident. There are regular residents meeting, staff meetings, evidence of comprehensive required clinical input and reviews. All residents have had holidays in line with their will and preference- more holidays booked for the coming months. All residents' goals were achieved in 2023.

6. PIC and Service manger have begun the re-introduction of the optional quality audits: Quality Enhancement plan (QEP) and Monthly data sheets.

7. As evidence on the day of inspection, the PIC will continue to carry out the governance and management role, such a finance audits, medication management audit, fire drills and fire checks, health and safety checks, risk register and restrictive practice audits etc.

8. Annual Report for 2023 was completed. the Service manager will continue to carry out unannounced Six-Monthly audits.

9. The PIC to ensure there is suitably qualified staff on shift to support with the planning and facilitation of community outings for the residents.
10. The PIC will continue to use their protected management time to ensure required paperwork is completed and maintained to its current high standard.

11. Sharps box has been moved and is now stored at safe accessible area

12. Cleaning of mould in highlighted areas has been addressed and added to the cleaning schedule to ensure consistent cleaning

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. The Providers Property surveyor is scheduled to make a site visit to Woodview to review the storage facilities within the Centre.

2. A risk assessment has been completed in regard to storage of hoists in the hallway.

3. A manual handling risk assessment has been completed for the use of the hoists

4. Commodes are cleaned following each use and so reducing the risk of any IPC concern (cleaning logs on place)

5. Commodes are stored in the main bathroom and when the resident in question wishes to use the shower; There is no impact on the residents' autonomy or independence when using the shower as resident can move the commodes themselves- they are fully independent in this area. Also, the resident in question has a preference for the main bathroom and chooses not to use the identified shower.

6. Medication fridge will be moved to the medication room. New fridge approved for purchase on 19th April.

7. Sharps bin has been moved to safe accessible place

8. New Sofa approved for purchase 23rd April.

9. The kitchen counter has been inspected by an external company and we are awaiting a quote for new countertop. PIC is currently liaison the TSD to confirm dates for countertop to be fitted.

10. Radiator covers have been painted.

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: 1. The Providers Property surveyor is scheduled to make a site visit to Woodview to review the storage facilities within the Centre. 2. Rubbish bin was moved on day of inspection and remains in recommended place 3. The providers fore officer has been scheduled to do as site visit to risk assess any fire evacuation risk associated with the storage of the hoist. 4. Resident personal evacuation plan has been reviewed to reflect emergency evacuation and care plan amended for fire drill evacuation	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: 1. Residents Rights plans of care have been reviewed and reflect how residents' consent to restrictions in place	

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.	Not Compliant	Orange	31/08/2024
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/08/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Substantially Compliant	Yellow	23/04/2024

	training, including refresher training, as part of a continuous professional development programme.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/08/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/07/2024
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/08/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/08/2024

Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	31/07/2024
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	31/08/2024