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:	Walk D
Name of provider:	Walkinstown Association For People With An Intellectual Disability CLG
Address of centre:	Dublin 12
Type of inspection:	Short Notice Announced
Date of inspection:	10 June 2021
Centre ID:	OSV-0005492
Fieldwork ID:	MON-0032754

About the designated centre

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

Walk D comprises two houses (one five-bedroom house and a one-bedroom bungalow) located in suburban areas of South Dublin. The centre provides full time residential care and support for up to 6 adult residents who have intellectual disabilities. Walk D can also support residents with non-complex health care needs, and mental health support needs. Residents are supported by a team of direct support workers, who are managed by a local team leader and a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 - 2015 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 10 June 2021	10:00hrs to 18:30hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

The inspector was advised of the views and experiences of the residents through speaking with them and through questionnaires the residents filled prior to the inspection.

Residents commented positively regarding the support they received and their relationship with the staff of the designated centre. They commented that staff supported their independence and encouraged them to get involved in social and recreational activities in accordance with their choices, interests and personal relationships. They identified to whom they could bring any concerns or issues they may have with the house or supports.

Residents were involved in a range of hobbies and community activities such as cycling, playing football, going for walks in the local parks, getting involved in exercise groups, attending live music sessions and volunteering in interest groups and political events. The residents told the inspector what they had planned for the day and also commented that they enjoyed pursuing their interests alone or with preferred staff members.

To reduce movement between locations as an infection control measure, the inspector attended one house in person. The house was clean, comfortable and suitably decorated, and residents had opportunities to personalise their bedroom space. Residents had unrestricted access to all parts of their house and areas were set up for their needs, including a ventilated area to smoke or vape, and a garage in which to store bicycles. The house had suitable and spacious shared areas including a pleasant back garden, and the house was within walking distance to local shops, parks, and bus and tram routes. Residents could come and go from the house as they pleased.

In the months prior to this inspection, two service users were supported to transition out of the designated centre into private accommodation. The inspector found detailed, person-centred records on how the provider supported the service users with this goal at their pace and based on their choices. At the time of the inspection one resident was accommodated in each of the two houses that made up this designated centre. Both residents commented that they preferred living in their own private space. One resident was in the process of exploring options for living in accommodation not managed by a social care provider and was being supported in the steps towards this goal with their keyworker. The inspector observed positive interactions between staff and the resident over the course of the inspection, and staff displayed a good knowledge of the residents and their individual supports, interest and personalities.

The next two sections of this report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the safety and quality of the service being

provided.

Capacity and capability

The service was led by a person in charge and a team leader. The centre had a clearly defined governance structure in place with arrangements for management contact when the person in charge or team lead was not available. There were no vacancies in the designated centre and the centre had a relief panel available. The inspector reviewed a staffing roster which reflected the times worked by each member of core and relief staff, as well as identifying where each person was based for that shift. In many instances, staff split their time between supporting residents in the designated centre, and working in other services outside of same. The primary reason for this was to provide community outreach support for residents who had recently transitioned out of the service, using personnel who were familiar to them. The provider advised that this arrangement would be revised based on future admissions to the designated centre. The description of staffing resources (with whole time equivalents) listed in the statement of purpose dated May 2019, had not been revised to reflect this change in staffing resources assigned to the designated centre, for the direct support staff as well as the person in charge. However, the provider was assured that the staffing complement was sufficient for the number and needs of residents currently in the centre, including assessment and control measures against risk related to times during which there were no staff present in the centre.

The inspector reviewed a sample of staff supervision records with their respective line managers. The matters discussed in these meetings evidenced meaningful opportunity for staff to raise concerns, express interest in career development opportunities and discuss how they could most effectively support the resident with whom they worked closest to support their goals and projects. For new staff, an induction checklist was outlined to be completed before people commenced in their role. The inspector reviewed a sample of personnel files which included required information on reference checks, qualifications and vetting by An Garda Síochána.

The provider had identified a suite of training which was required for all personnel in this service, those required under the regulations, and training and skills identified by the provider as required to provide safe and effective support for the specific health and social needs of residents living in this centre. This was particularly important as for the majority of time residents received support from one staff member at a time. The inspector found that many of the staff either had no record of attendance at mandatory training, or were overdue for a renewal session by over a year outside the timelines set out by the provider. Examples of these included the safe administration of medication, support for residents with autism, supporting residents with behavioural needs, safe moving and handling, infection control, and safeguarding of vulnerable adults.

The provider retained a system of oversight of the operation of the designated centre, and had completed the annual and six-monthly audits of the service as required by the regulations, most recently in April 2021. Where areas were identified as in need of improvement or development, a time-bound plan of action was set out, and the inspector found examples of where these objectives had been completed or were progressing in line with said timelines. However some of the findings on this inspection had not been identified by these reviews. It was also unclear in the annual and six-monthly report how residents contributed their feedback and suggestions on the service.

Some of the information required to evidence compliance with regulations and adherence to provider policy were not available for review during the inspection, or were not current; these will be referenced under the relevant sections below.

Regulation 15: Staffing

The provider was assured that there was suitable staffing resources in place to support the residents in the house, and that appropriate protocols were in effect for times in which there were no staff present in the house.

Judgment: Compliant

Regulation 16: Training and staff development

There were significant gaps in training provided to staff in areas including support for people with autism, safe administration of medication, and safeguarding of vulnerable adults.

Judgment: Not compliant

Regulation 21: Records

Some of the information required to evidence compliance with regulations and adherence to provider policy were not available for review during the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

Some areas requiring improvements in the designated centre had not been identified through the provider's own annual and six-monthly review processes. It was unclear how the residents contributed their feedback, suggestions and experiences to the annual report of the service.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Each resident had a written and signed agreement with the service provider which outlined the terms, conditions and fees associated with living in the designated centre.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose had not been updated to reflect the changes in staffing complement for the designated centre which had occurred when some residents continued to be supported by the team dividing their time between the designated centre and another setting.

Judgment: Substantially compliant

Quality and safety

Residents in this designated centre received appropriate levels of support for their identified needs, had controls and protections in effect to keep them safe from general and specific risks, and were supported to pursue meaningful social, recreational and life enhancement opportunities. The residents spoke positively of their house, staff support and their ability to pursue their preferred routine and activities, and each resident had multiple projects and personal goals in progress which were supported by their respective keyworkers. Some areas for improvement were identified regarding the consistent and complete recording of support evaluations, goal progression, risk review and assessments of support levels, with evidence of contribution from and discussion with the resident.

The inspector reviewed a sample of support plans in place for residents. The inspector found these plans overall to be detailed, personal to each resident and

with guidance to staff on how to support the relevant need, and reflective of residents' preferred routines and interests. However, the provider had not ensured that a comprehensive assessment of the personal, social and healthcare needs of residents was carried out on at least an annual basis to inform and update these support plans. Support plans were not subject to a review which evaluated that the plans were accurate, up to date, and were having the intended effect or outcome, with contribution and participation from the resident and the relevant health professionals. The effect this had in the sample of plans reviewed included plans not taking recent changes in support needs into account, not reflecting advice from recent clinical appointments, and plans guiding staff on support measures where it was unclear if such supports were still required. It was also not clear how support plans were being made accessible to residents or discussed with them, to facilitate them to contribute to their review.

Residents enjoyed a life in the service which facilitated them to exercise their choice, independence and positive risk-taking. The provider was assured regarding resident safety when home alone or when out in the community without staff accompaniment, balancing the provider's responsibilities to keep people safe, against the wishes and capacity of the residents. Residents got involved in local community events, music and fitness groups and community recreation, and had easy access to public transport routes. Residents also had multiple life development goals in progress with which they worked on alongside their keyworker. Goals included independent life skills around literacy, cooking, money budgeting, and attaining paid employment opportunities. Examples such as these contributed towards a long-term goal of enhancing self-sufficiency in a more independent living space. Each of these objectives included records of steps taken towards the respective goals, and where the keyworker was investigating opportunities which could be relayed back to the resident to consider. While some improvement was required to ensure the progress notes summarised all the good work done by the resident and the keyworker, the inspector found that positive progress was being made on these goals and projects, and their continuation had not been negatively affected by COVID-19 pandemic or associated social restrictions.

The inspector reviewed risk management practices in the centre, and found that risk relating to the residents, the house and the service in general were kept under review with control measures outlined. Centre-specific measures were detailed to control risks related to safety from harm or abuse, procedures if residents are absent for extended periods without contact, or staying safe during an emergency event. As this was a service in which residents were supported individually by sole workers, risk assessments were in place to ensure residents and staff were safe, and who could be contacted out of hours in an emergency situation. The provider maintained an incident log which clearly outlined the nature of incidents and the actions taken to respond to them, with the ability to flag specific types of incidents to external reviewers such as the psychologist for their input. Some improvement was required to ensure that the post-incident review process was consistently followed to use incidents as an opportunity for future learning and to review the relevant risk controls and support plans. In the sample reviewed the inspector found examples of incidents which were not typical but which had not been used to update the relevant guidance, and examples in which the relevant health professional had

suggested action but it was unclear if this had been given effect.

The designated centre was suitably equipped to detect, contain and extinguish fire. All internal doors and the central stairway were equipped to effectively contain flame and smoke and could close automatically. The house was equipped with emergency lighting and evacuation maps to aid a swift exit. The provider conducted practice evacuation drills to identify areas of potential delay, and from these achieved consistently low times and were assured that that the house could be evacuated efficiently at any time. Secondary external exits to the assembly point were available should the primary exit route be compromised.

The inspector reviewed a sample of medication records and found that medicines were administered in accordance with the times, methods and dose sizes prescribed by the general practitioner. Guidance was available for staff to advise of acceptable windows of variation from exact times prescribed. For medication administered on a prn basis (administered as and when required) guidance on the circumstances of its use was explained. Medication was stored in a secure location and subject to stock checks to ensure a sufficient supply was available. Residents had access to a pharmacy and were supported to take responsibility over their own medications in accordance with their level of support requirement, however in instances where a resident independently self-administered medication, the provider did not have evidence available demonstrating that they had completed an assessment of resident capacity and how they were assured that the level of independence had not changed.

Regulation 13: General welfare and development

Resident were supported to pursue meaningful opportunities for recreation, education, employment and life enhancement goals, with key working staff supporting the residents in achieving their long and short term objectives.

Judgment: Compliant

Regulation 17: Premises

The premises of the designated centre was suitable in design, layout and features for the residents, and was kept in a good state of maintenance.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

The inspector found evidence detailing how residents who had recently transitioned out of the service were supported to visit and make decisions regarding their new home.

Judgment: Compliant

Regulation 26: Risk management procedures

Some improvement was identified by the provider regarding reviews, actions and learning following adverse incidents in the designated centre, including responding to recommendations made where incidents were referred to third parties.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The premises were clean and sufficiently equipped with features to prevent and control spread of infection. Staff and residents were supported to stay safe during the ongoing health emergency.

Judgment: Compliant

Regulation 28: Fire precautions

The designated centre was suitably equipped to contain, detect and extinguish fire. The provider had systems to be assured that evacuation could be achieved efficiently in the event of emergency.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Medications were appropriately stored and were administered in accordance with prescribed times and doses.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider had not ensured that a comprehensive assessment of the personal, social, and health care needs of residents was carried out on at least an annual basis. Review of resident support plans was not accompanied by evidence that the review had assessed the effectiveness of the plan in consultation with the resident and the relevant health and social care professionals.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for Walk D OSV-0005492

Inspection ID: MON-0032754

Date of inspection: 10/06/2021

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: a) HR Officer, Learning and Development Officer and PIC will meet to review outstanding training gaps by 20th August b) PIC will schedule completion of outstanding training by 30th September c) PIC to plan for remaining staff training due for completion in 2021. All identified training needs for 2021 will be complete by 31st December 2021. d) By 31st August HR Officer, Learning and Development Officer and PIC will identify why gaps arose and plan to address issues to ensure no reoccurrence.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: By 31st October PIC to have reviewed all records as outlined in Schedule 3 and ensure presence of same.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and	

management:
In the next bi annual self-assessment in 2021 (by 31st October 2021) and in the 2021 Annual Review (by 12th February 2022) there will be explicit reference to reflect the voice of the service user – their experiences, suggestions and feedback – and how outcomes are assessed.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
By 31st August, PIC will amend the Statement of Purpose to reflect the required quantum of service and the ability for this to vary.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
a) By 31st August 2021, PIC will have confirmed the completion of IRF reviews as per action highlighted in Annual Report 2020.
b) By 30th September PIC will have reviewed IRF and Risk documents with specific reference to resident plans to ensure plans reflect learnings.
c) PIC will schedule a monthly review of IRFs.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
a) By 31st October PIC will have explored with Residential Dept team the Personal Plan system within the service, with specific reference to how Personal Plans can illustrate: (i) the comprehensive assessment undertaken (ii) the participation of the resident in the plan and its reviews (iii) the effectiveness of the plan
b) By 31st December, any agreed changes to the Personal Plan system will have been

implemented by PIC
c) PIC will schedule and undertake quarterly reviews of Personal Plans
d) By 30th September PIC will ensure there is accessible version of Personal Plans for residents.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	30/09/2021
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/10/2021
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	Substantially Compliant	Yellow	12/02/2022

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	12/02/2022
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.	Substantially Compliant	Yellow	30/09/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/08/2021
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	31/07/2022
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an	Not Compliant	Orange	31/10/2021

	appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	31/12/2021
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in	Substantially Compliant	Yellow	31/12/2021

	needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	31/12/2021