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 B
Name of provider:	Walkinstown Association For People With An Intellectual Disability CLG
Address of centre:	Dublin 12
Type of inspection:	Unannounced
Date of inspection:	11 August 2021
Centre ID:	OSV-0003404
Fieldwork ID:	MON-0033660

About the designated centre

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

Walk B comprises three houses in South Dublin, each located in a suburban area. The centre can accommodate up to seven residents, and provides care and support to adults with an intellectual disability. It can also support residents with additional support needs, such as non-complex health care and positive behaviour support. The centre is staffed by a team of direct support workers, and each house has its own team leader, who reports to the person in charge.

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 - 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
Wednesday 11 August 2021	10:20hrs to 17:30hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

The inspector met with three of the six residents living in this designated centre as well as speaking with staff directly supporting them. The inspector also observed residents coming and going from the house to attend day service and to local services and amenities as they wished. The inspector found examples of how residents were supported to pursue their own interests and routine and observed friendly, engaging interactions between residents and staff through the day.

It was clear to the inspector that staff knew the residents well and were knowledgeable on their communication styles, personalities, interests and personal news. Where required, the staff could support the residents to chat with the inspector on their experiences living in this designated centre without speaking on their behalf. Staff and residents had a good rapport and it contributed to a comfortable and homely atmosphere in the designated centre. Consistency and continuity of staffing was important for the residents living here and the inspector found examples of how new staff members would be gradually introduced to the service to ensure that the resident was comfortable and happy with any changes or transitions to their care and support.

One resident lived alone in one of the three houses which made up this designated centre and did not wish to participate in the inspection. The inspector found evidence indicating how this resident had been supported to live independently with reduced staff support, to develop their self-sufficiency and activities of daily living such as cooking, grocery shopping, regular exercise and recycling, and agree the structure of their staff support with them. The staff were available by phone whenever the resident needed them.

The residents all lived in single-occupancy bedrooms which were personalised based on their wishes, painted and decorated with personal photographs, artwork and items from favourite football teams. Residents who smoked had a safe, sheltered area in which to do so. Each house had access to a vehicle to support residents to pursue their preferred routine and outings.

Residents were supported to stay in contact with friends and families during the social restrictions required due to the COVID-19 pandemic. Residents showed the inspector examples of how residents kept in contact with each other by sharing videos and participating in sports challenges such as walking competitions. Some residents had participated in online education courses on cooking, computers and sewing. Some of the residents had lived in the community for a long time and were known to the local businesses and neighbours. Day services had recommended for those who attended them, and some residents kept themselves busy with outings to the zoo, tidy town projects and community art courses. One resident showed the inspector how they celebrated a milestone birthday while in quarantine, and how they had been supported to celebrate it with their friends, staff members and family. Residents went to the local pubs, shops, parks and cafes independently or with staff

supporting. Residents commented that they got along well with the staff and had a good relationship with their families, seeing them as extensions of their families.

Residents stated that they would feel comfortable speaking with the staff or manager if they felt unsafe or dissatisfied in their home. The inspector found examples of where matters had been raised and the outcome of the investigation fed back to the resident, and whether or not they were satisfied with the result. One resident expressed a desire to move out of their house and live alone, and the provider was in the initial stages of seeking suitable locations and funding for this to happen.

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 inspector found that this designated centre was appropriately resourced for the number and assessed support needs of the residents. The service provider maintained an appropriate oversight of the operation of the service and were regularly apprised of events and incidents related to the centre. The day-to-day operation of the service was delivered by a competent team of staff and management whose allocation and shift pattern were appropriate for the residents' assessed support requirements and preferences. Some gaps were identified in staff training and in the completeness of notifications to the chief inspector.

The designated centre was led by a person in charge, with a team leader assigned to each of the three houses to manage the day-to-day running of the local team. The person in charge was knowledgeable of the residents and routinely spent time in each house to engage with the staff team and the residents. The members of the core and relief staffing teams met during the inspection evidenced good familiarity with residents' personalities and communication styles, and positive, engaging interactions were observed during the day. The residents spoke highly of the staff members and had a good relationship with them and their families, with one resident stating that they considered them part of their own family.

At the time of the inspection there was a small number of staffing vacancies. Interviews to fill these were complete and staffing rosters indicated how the impact of said vacancies was mitigated through staff working additional shifts, or a small number of regular members of the relief panel working in the service. In the sample of weeks reviewed, it had not been necessary for the provider to employ the services of agency to ensure staffing complement was met. In addition, the person in charge had composed suitable support guidance for both the incoming personnel and the residents affected, to ensure an appropriate introduction and provide

reassurance to the resident that their support delivery would continue as planned.

The inspector reviewed a sample of supervision records between staff and their respective line managers. The contents of these meetings included topics meaningful for staff support, including how keyworker goals could be met, opportunities to raise queries or concerns in the role, and assistance for staff through the challenges posed by the ongoing health emergency in the past year.

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. A report was generated on the day of inspection which the person in charge used to monitor their staff requirements, and this reflected that all staff had attended training in fire safety in recent weeks. However the inspector found that of the 14 staff in the records provided, 11 staff members either had no record of attendance at some mandatory training sessions, or were overdue for renewal of same outside the timelines set out by the provider. This included training in safeguarding of vulnerable adults, infection control, safe administration of medication, safe moving and handling, and skills for supporting residents with epilepsy, autism, or behavioural support needs.

There was an appropriate management structure for this designated centre, with a team leader allocated to each house who led the local staff team and reported to the person in charge of the entire service. The person in charge was supernumerary to the staffing complement and attended each house on a regular basis to engage with the residents and staff team. The provider retained oversight of the operation of the designated centre, and had conducted their annual report and six-monthly unannounced audit of the service as per the regulations, on December 2020 and April 2021 respectively. These reports reflected on achievements of the service in managing the COVID-19 pandemic, ensuring that residents remained busy and engaged where their routine was interrupted by the pandemic, and that they continued to have access to their healthcare professionals. The provider had identified areas in which the service would improve or develop, with some of the findings of this inspection also identified by the provider in their own audits. While the reports commented on how residents' social, health and personal needs were being met as per their support plans, there was limited evidence of how the residents' own commentary, experiences, suggestions and feedback on the service was collected for these reports.

Regulation 15: Staffing

There was a sufficient number and skill mix of staff to support the needs of the residents in this designated centre. Suitable contingency arrangements ensured that vacancies were covered while retaining continuity of support for residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had no record of attendance at some mandatory training, or had not received refresher courses within the provider's timeframes, in training required to support the needs of the residents in this centre.

Judgment: Not compliant

Regulation 21: Records

Some improvement was required in ensuring documents required under Schedule 4 of the regulations were complete and accurate, including the duty roster and records of attendance at staff training and development.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was limited evidence that the annual report of the designated centre had been composed with consultation from the residents and their representatives.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

While the provider had submitted quarterly returns as required, some items identified internally as restrictive practices were found not to have been included in these notifications.

Judgment: Not compliant

Quality and safety

Overall the inspector found that the provider supported residents to stay safe, pursue their preferred routines and interests, and have their preferences reflected in the structure of their support and independence. Resident supports and protections were suitable and kept under ongoing review, with required improvements related to the physical living environment of the house.

Though speaking with the residents and reviewing support plans and risk assessments, the inspector was assured that the residents had regular and as-required access to their doctor and the healthcare providers relevant to their assessed clinical and support needs. Notes and recommendations from clinicians such as the assistant psychologist, speech and language therapist and general practitioner were evident in resident support guidance. Following a number of accidents in the service, the centre had been visited by an occupational therapist who made recommendations on safety amendments to the house to reduce the risk of injury in the future.

Where residents expressed themselves in ways which may pose a risk to themselves, other people, or property, the inspector found detailed and person-centred guidance on proactive and reactive strategies to keep all those involved safe. This included how to maintain resident self-esteem and positive outlook, avoid potential sources of stress or over-stimulation, and the importance of maintaining a busy routine and healthy structure for eating, sleeping, exercise and self-care. These strategies were discussed with the resident, and there were regular meetings between the team leads and psychologist where required to ensure guidance was up-to-date and having the desired effect.

The centre utilised some restrictive practices to keep people safe from potential sources of injury or distress, including items being managed by staff until required, limits on access to specified community or media services, or devices to alert staff to certain events. These practices were reviewed regularly by a designated panel to ensure their purpose was clear and their continued use was effectively controlling the associated risk.

The inspector reviewed a sample of incident reports which were found to contain sufficient detail to identify actions and learning from the matter and, where relevant, refer the incident through the safeguarding or complaints process. The inspector found good examples of where allegations by residents were investigated, including instances were there were multiple aspects to the complaint which were broken down to determine which did and did not warrant further review or concern. The inspector was shown how the outcome of the matter was discussed with the person who raised it, and their satisfaction with the conclusion.

The centre was comfortable and the residents had personalised their living space to their preferences and interests. Residents had sufficient space in which to store their belongings, and outdoor space to smoke or play football. While the centre was clean, some areas of the centre required maintenance work, including wardrobes and kitchen cabinets which were damaged and peeling, and walls in need of surface repair for cracks to the plaster or paintwork. In addition to impacting negatively on the pleasant, homely, aesthetic of the designated centre, the peeling or rough

surfaces impacted upon the environment's ability to be effectively cleaned and sanitised.

Not all doors in the designated centre were equipped to effectively contain the spread of flame and smoke in the event of a fire, including doors along evacuation hallways. However, areas of high risk such as kitchen and laundry spaces were equipped with self-closing, fire rated doors with smoke seals. Where one bedroom was located close to the kitchen, an external exit door was provided to facilitate direct evacuation. The provider was assured regarding the ability of all staff and residents to follow correct procedures in the event of fire. This included simulating high-risk scenarios such as night time or times when there were no staff present. The houses were equipped with firefighting equipment and emergency lighting which was subject to routine service and certification.

The inspector was advised of how staff and keyworkers facilitated residents to make their own choices and pursue their own routine, such as doing their shopping, household choices, exercise regimes and staying in contact with friends and family. Residents were supported to spend time alone in the house or in the community, taking their wishes and potential social or clinical risks into account. Residents' privacy, dignity and personal autonomy was respected, and the provider had composed summary guidance for staff regarding supporting residents to become accustomed to upcoming changes such as new staff joining the team.

Regulation 17: Premises

Parts of the designated centre were in need of maintenance work including surfaces which were peeling, cracked, or in need of paintwork.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Appropriate protocols and practices were in effect to manage risks related to COVID-19. Some improvement was required to ensure that surfaces could be effectively cleaned and sanitised.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While fire doors were present in the highest risk areas such as the kitchen and

laundry, not all rooms along evacuation routes were equipped to provide effective containment of smoke and flame in the event of fire.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector found evidence that residents were supposed to access their doctor and the healthcare professional relevant to their clinical support needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Detailed and person-centred proactive and reactive strategies were in place to provide guidance to staff on keeping residents and others safe during times of distress, frustration or anxiety.

Judgment: Compliant

Regulation 8: Protection

Residents were supported on how to stay safe from harm at home and in the community. Matters of concern reported to the management were investigated and referred to the appropriate external authorities.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to make their own choices, pursue their own routine and take positive risks in their home and community.

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 - 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 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Walk B OSV-0003404

Inspection ID: MON-0033660

Date of inspection: 11/08/2021

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: HR Officer, Learning and Development Officer and PIC will meet to review outstanding training gaps by 30th September 2021 PIC will schedule completion of outstanding training by 31st October 2021 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. By 30th of November 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 1st December 2021 PIC to have reviewed all records as identified in the inspection report relevant to Schedule 4 that were inaccurate or incomplete and ensure presents 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 biannual 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 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
PIC and Team leads will update current restrictive practices by the 30th October 2021.

PIC will ensure all restrictive practices are included in the quarterly returns to HIQA. Commencing on 31st January 2022.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
On the 17th of September 2021 the PIC will meet with the maintenance officer and identified the refurbishment works arising for the HIQA inspection.

The maintenance works will be uploaded onto the electronic planned maintenance system by 15th October 2021.

A schedule of maintenance work for the reminder of 2021 was agreed between the PIC and maintenance officer. 7th October 2021

The PIC and the team leader collaborated with the person supported over several weeks to identify their refurbishment preferences. 17th of September 2021, the 7th of October 2021 and the 22nd of October 2021

The PIC and the maintenance officer are reviewing on a fortnightly bass the status of the refurbishment works until the completion date of December the 31 2021.

The PIC and the maintenance officer will review the maintenance needs for 2022 and submit for budget approval by the 30th of November 2021.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection: The PIC will ensure the upgrade of surfaces identified in the HIQA inspection report as needing attention and included in the maintenance schedule for completion by 31 of December 2021. The PIC and the team leader collaborated with the person supported over several weeks to identify their refurbishment preferences. 17th of September 2021, the 7th of October 2021 and 22nd of October 2021 The person in charge in collaboration with the health care coordinator will carry out an infection prevention controlled teamed audit by December 31st, 2021.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: PIC will meet with maintenance to advise them of the findings of the HIQA inspection. 7th of Oct 2021 Costing for the required amendments for WALK B will be developed. 31st Oct 2021 PIC will add the costings to the 2022 budget for approval.31st Oct 2021 Once the budget has been approved a schedule of work will be developed. 31st March 2022

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	31/12/2021
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	31/12/2021
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the	Substantially Compliant	Yellow	01/12/2021

	chief inspector.			
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 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	31/12/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/03/2022
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following	Not Compliant	Orange	31/01/2022

	incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			