

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Walk A
Centre ID:	OSV-0003403
Centre county:	Dublin 12
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Walkinstown Association For People With An Intellectual Disability
Provider Nominee:	Eamonn Teague
Lead inspector:	Karina O'Sullivan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	11
Number of vacancies on the date of inspection:	4

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 03 August 2016 09:00 To: 03 August 2016 22:00

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection

This was the third inspection of this designated centre. This inspection was completed to inform a registration decision and also to follow up on the previous actions required from inspections.

How we gathered our evidence

As part of the inspection the inspector visited the designated centre, this consisted of three houses, met with the seven residents who lived within two houses, seven staff members and the person in charge. The inspector viewed documentation such as, care plans, person-centred support plans, recording logs and policies and procedures. The inspector met and spoke with six residents. The inspector also had discussions with seven staff members.

Description of the service

This designated centre was operated by Walkinstown Association For People With An Intellectual Disability and was based in Dublin 6W, 16 and 24. One house was home to three residents and one resident on a respite basis, the second house was home to five residents and the third house was home to three residents. The provider had

produced a document called the statement of purpose, as required by regulation, this described the service provided. The designated centre aimed to provide supports to facilitate each person in achieving a self-determined, socially inclusive life as identified within the statement of purpose.

Overall judgments of our findings

Ten outcomes were inspected against. The inspector found six of the outcomes were found substantially compliant and four outcomes were found to be of moderate non-compliance. Improvement was required in relation to the resident mix in one house as some residents' lived experience was impacted upon by behaviours presented in this house. However, it was acknowledged the provider had a plan in place to comprehensively address this issue. Other areas of improvement included, emergency lighting, medication management and the information contained within residents' files.

The person in charged facilitated the inspection and was accompanied by the Director of residential services for the feedback session.

All inspection findings regarding compliance and non-compliance are discussed in further detail within the inspection report and accompanying action plan.

Section 41(1)(c) of the Health Act 2007. Compliance 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.

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector reviewed this outcome in respect of the complaints procedure, no other component was inspected against.

There was a complaints policy and procedure in place however, it was unclear who the nominated person was independent of the person nominated within the process to deal with complaints. This was to ensure all complaints were appropriately responded to and records maintained as specified under paragraph 34(3) of the regulations.

Judgment:

Substantially Compliant

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The inspector found plans relating to the wellbeing and welfare of residents required improvement. This related to the area of assessments and review of documents to ensure the current needs and wishes of the residents were reflected.

The inspector found improvements were required in both social and healthcare plans. The inspector viewed eight resident's files these consisted of a personal plan with personal outcome measures leading to social goals. Issues identified within plans included:

- Review and completion dates of some social and healthcare assessments were not recorded, in some of the plans viewed. Other plans were dated 2015 with no evidence of review.
- Review of some residents goals were not evident since April 2015.
- One resident had no goals on file, the reason provided to the inspector was due to the current needs of another resident within the house.
- Elements within residents plans were blank for example, timeframes, person responsible and the review date for the plan. The inspector found the system did not guide practice effectively.

Some residents spoken with identified to the inspector their goals and how these were progressing. One resident showed the inspector the gym they were attending and the classes they wished to participate in through accessing the gym's website.

The inspector found some resident's social care needs were identified and residents had the opportunity to participate in meaningful activities that were appropriate to their interests and preference. For example, participating in sporting events, holidays, leisure pursuits and cooking.

Resident's family members were consulted in relation to personal plans in line with resident's and family members' preferences. There was evidence for this maintained within resident's file.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspector reviewed this outcome in respect of the action identified from the previous inspection and found the action had been temporarily addressed. The storage of a hoist was now in the outside shed. The inspector discussed this with the person in charge who identified this was not a practical solution within the longer term. The person in charge identified plans were in place to rectify this by providing suitable storage facilities within the house.

During the inspection maintenance issues were identified in order to enhance the living environment for residents. These were identified to the person in charge; areas included the replacing of a bath panel and skirting board in one bathroom, mould evident in another bathroom and water marks on ceilings.

One of the houses within the designated centre was maintained to a very high standard in relation to cleanliness. The inspector was informed by one resident about their responsibilities for cleaning parts of their home and spoke about their employment as a cleaner in other locations within the organization. The resident clearly took pride in this work and valued their employment in this regard.

Judgment:

Substantially Compliant

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspector found the health and safety of residents, visitors and staff within the designated required improvement in order to be meet the requirements of the regulations and to ensure safe services for all. Improvements were required in the area of risk management, emergency lighting and fire containment. Emergency lighting and fire containment was also previously identified on inspections within this designated centre as only one house had emergency lighting installed.

Fire containment had been considered in two of the three houses within the designated centre, as these two houses had fire doors installed where required. However, within the

third house there were no fire doors and therefore, adequate fire containment could not be maintained within this house. There was also lack of evidence that appropriate actions were taken in response to issues identified during fire drills. The inspector found actions were not reflected within resident's personal emergency evacuation plans (PEEPs) for example, a drill dated 10 June 2015 resulted in a resident not leaving the house. The person in charge identified additional interventions were now in place however, these were not evident within the residents PEEPs. Issues highlighted in another house on the 27 February 2016, had no follow up actions recorded. Within one house a plan was to be established to evacuate the premises using alternative exists and to ensure all relief staff had taken part in a fire drill. The inspector asked to see the plan however, the person in charge was unable to provide the plan. No date was identified when this plan was to be completed. The inspector did see evidence where follow up was identified through one fire drill where the assembly point was moved and this was discussed at a team meeting.

The inspector viewed the system in place for routine checks and services of the fire detection, alarm system, and equipment being conducted by a fire professional. The fire alarms were checked on a quarterly basis by the maintenance department. The fire equipment was also serviced in June 2016 and will be completed annually as required by regulations.

The inspector viewed the risk management policies and procedures and found the organisational risk management policy in place this included the specific risks identified in regulation 26. However, the system within the designated centre required improvement in order to identify, examine and manage potential hazards in the designated centre. There was insufficient risk assessments for smoking and the regulation of water temperature within the designated centre.

Improvements in relation to individual risk assessments were also required for example, the inspector viewed a risk assessment dated 12 February 2014, no subsequent review of this risk was evident. Another risk assessment viewed was completed on 9 June 2014 and reviewed on 30 September 2015. This identified a resident could remain in the house alone for 75 minutes. The inspector also viewed a protocol in relation to this practice dated 1 October 2015. This document identified the resident could remain in the house alone for 135 minutes. The inspector found this system did not guide staff effectively.

The inspector viewed the emergency plan and found it contained sufficient detail to guide staff in the procedure to follow in the event of possible emergencies such as, flood or power outage.

The inspector viewed a number of accidents and incidents and evidence of learning from some incidents were evident. The inspector went through the process with one team leader and the person in charge and found clear follow up of two incidents and communication with the relevant stake holders.

There was a health and safety statement in place. There was a policy in place relating to the procedure staff should follow if a resident went missing from the designated centre.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector found measures were in place to protect residents from being harmed or suffering abuse. However, plans in place were not maintained up-to-date and did not reflect current practice. Improvements were required in the area of identifying and reviewing potentially restrictive practices.

The inspector viewed health and wellbeing plans for residents these outlined proactive and reactive strategies to reduce levels of stress for residents. Plans contained detailed information for example, specific phrases were identified for staff members to use to ensure a consistent approach. However, the inspector found the monitoring of behaviours required improvement in order to establish the effectiveness of interventions implemented. The inspector requested to view the recording and rating system in place for some behaviours and found the records maintained did not correlated with the plans. Two incidences viewed consisted of residents behaviour being rated using a numeric scale, the rating was inserted into the resident's daily notes. The inspector requested evidence of how staff members had calculated the numbers however, this was not available. The scales demonstrated within the resident's plans were not the scales used by staff members when completing daily notes. The inspector found this system did not guide staff effectively nor did this system provide effective monitoring of residents behaviour levels.

The process of reviewing restrictions applied to residents was unclear, while there was a policy in place it was unclear if it was followed in some instances. For example; decisions made in relation to medications used to manage a residents behaviour. The inspector requested evidence of review as the documentation contained within the resident's file was not consistent. Within one part of the file a rights assessment plan was in place to reduce the medication for the resident. This was dated 16 February 2016 however, there was no evidence of this occurring and the person in charge also confirmed this was not happening. The inspector also found a devise was installed into

one house. This device alerted staff when the front door opened. The inspector requested to see evidence of why this intervention was in place and how often this was going to be reviewed. The person in charge identified this intervention was in place to support one resident and was decided with the Director of residential services. No evidence of a risk assessment or members of the multi-disciplinary team discussing this intervention. Nor was there a schedule to reduce and or review this restriction was evident within the resident's file. The impact of this device on other residents was also not recorded. The person in charge informed the inspector the organization's human rights committee did not identify this intervention as a rights restriction.

One resident spoke to the inspector and showed the inspector a letter they had written to the HSE (Health service Executive) outlining concerns they had in relation to their living environment. The letter detailed the daily impact the current resident mix has had on the resident. The resident identified high levels of stress and stated they could not leave their bedroom due to behaviours present in their home. Members of staff also identified incidences of behaviour negatively impacting on the safety and quality of lives of other residents. Another resident also identified to the inspector they chose to stay in their room as a result of the behaviour. The inspector viewed evidence of how this had impacted upon residents through an increase in the incidence of self-harm and other behaviours. The inspector discussed this situation with the person in charge who identified alternative accommodation was agreed for the resident within another organization. The person in charge was awaiting the other organisation to commence the implementation of this transition.

Intimate care plans were also in place for residents some viewed required to be updated.

There was a policy in place on the prevention, detection and response to abuse and staff had received training. The person in charge outlined the procedures to be followed should an allegation of abuse arise. Some residents also outlined who they would contact should this situation arise.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector found residents were supported to achieve and enjoy the best possible health. Improvements were required in relation to healthcare assessments and plans.

The inspector found improvements were required in relation to developing healthcare plans with appropriate steps outlined. An evaluation of the effectiveness of the plans devised as discussed in outcome 5 was also required.

The inspector viewed residents best possible health documents and healthcare needs and found that they were not reviewed annually or as required, for example one plan viewed was dated 04 February 2015.

The inspector viewed an epilepsy plan and found the information contained within the plan did not to match the prescription for the medication prescribed. The duration of minutes prior to the administration of medication once a seizure commenced was different in both documents.

Residents had access to a general practitioner, and to allied healthcare professionals including, psychiatrist, optician speech and language therapists and dentist.

Regarding food and nutrition some residents assisted staff in meal preparation and participated in menu planning in accordance with the resident preferences. Within one house the inspector and staff members were provided with a cake baked by one of the resident's. The resident discussed the process with the inspector and also provided written instructions in relation to the ingredients and method to bake this cake.

Judgment:

Substantially Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector found medication management policies and procedures were satisfactory and safe. Improvements were required in relation to the administration of p.r.n. (a medicine only taken as the need arises) medication and review of the some resident's person-centre medication plans.

The inspector viewed one p.r.n. medication within one house past the medications expiry date, another p.r.n. medication had no expiry date specified.

Residents had person-centred medication plans and assessment of capacity in place. Some of these plans required updating and review for example, one plan dated 27 June 2016. This plan contained inaccurate information in relation to the inclusion of a member of the allied healthcare team. The resident had not received care provision from this professional for nine months. The inspector was informed the information contained within the plan was not reflective of current practice.

Further guidance was also required for staff to effectively guide practice in relation to the administration of p.r.n. medication. Guidance was unclear for example, up to 5mg of medication was identified. The inspector found the document unclear and did not guide staff effectively in relation to the administration of this medication.

The inspector viewed some medication errors and found improvements were required to ensure learning was attained from the sample viewed

Administration recording sheets were in place for residents and a number of these were viewed by the inspector. These were found to be up-to-date and showed that staff administered and signed for medication.

The inspector viewed the training records and found all staff members had undertaken medication management programme.

The inspector observed all medication was stored in a secure, locked cabinet in a locked area and the keys to access the medication cabinet were held securely by staff.

All staff members signature was present within the signature bank.

Stock checks were maintained within the designated centre on a weekly bases and the inspector crossed checked a number of balances and found these accurate.

The designated centre had written policies and procedures related to the administration, transcribing, storage, disposal, refusal, medication errors and transfer of medicines. Medication was supplied to the designated centre by a local pharmacist and medication was recorded when received and a stock check was carried out.

Judgment:
Substantially Compliant

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The inspector found the quality of care and experience to residents was monitored and developed however, improvements were required in relation to the following up of actions identified within internal audits.

The inspector requested to view the unannounced visits conducted on behalf of the provider these were available within the designated centre for 2015 and 2016 for each of the three house which formed the designated centre. The person in charge had complete an action plan for some of these visits and was in the process of completing actions for the most recent visits.

The person in charge completed audits within each of the three houses however, these were not fully documented for example, actions identified from audits were identified via email to the relevant staff member. However, no follow up was evident in relation to determining if these actions were achieved within a specified time frame.

An annual review of the quality and safety of care in the designated centre was conducted however, a copy of this was not available within the designated centre.

The inspector viewed evidence of staff members receiving regular supervision or reviews within the designated centre. The inspector viewed supervision between the residential manager and the person in charge this included topics such as, strategic planning, house planning, education and needs of residents. The inspector also viewed supervision between the person in charge and the team leader, areas discussed included budgets, staffing and plans for the house.

The inspector was informed by the person in charge that performance development reviews were completed twice a year.

The inspector found there was a clearly defined management structure with lines of authority and accountability identified. The houses within this designated centre were managed by a suitably qualified, skilled and experienced person in charge. The person in charge was knowledgeable about the requirements of the regulations and standards. This staff member was the person in charge for the whole designated centre. The

inspector found this was a suitable arrangement due a team leader in place in each of the three houses and the close geographical locations of each designated centre.

Team meeting had taken place and the inspector viewed minutes of these meetings items discussed included residents needs, health and safety and staff training. The person in charge also met with the Director of residential services, the inspector viewed minutes from these meetings in May and July. Areas discussed included clinical issues, risk assessments, staffing, quality assurance and operational planning. The team leaders also compiled weekly reports in relation to each house. The person in charge compiled this information into one report reflecting the whole designated centre. This report is sent to the residential manager to ensure all stakeholders are aware of what had occurred within the designated centre in a weekly basis.

Judgment:
Substantially Compliant

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Overall, the inspector found there was adequate numbers of staff members to meet the needs of the residents within the designated centre to deliver a safe service. The provider had implemented a temporary arrangement within one house, this included the allocation of extra staff members to ensure the assessed needs of resident's were maintained.

Improvements were required in relation to staff files, staff training and the information contained within the rota.

Four staff files were viewed and the inspector identified gaps in relation to the information required as outlined in Schedule 2. A full employment history was not evident within some files.

The inspector viewed training records for 15 members of staff and gaps were identified. Two members of staff required people moving and handling training. Other staff members required training in epilepsy management and safeguarding. The person in

charge provided assurances to the inspector these staff members would not be working in a lone worker capacity until training was completed.

The inspector viewed the actual and planned rota and found a coding system was required for example, RD, LN and PM was identified within the rota with no explanation provided as to what these abbreviations stood for.

The inspector observed staff engaging with the resident in a friendly and respectful manner.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector focused only on schedule 3 documents in relation to this outcome and found improvements were required in this area.

Records and documents viewed were not in accordance with Schedules 3 as listed in the regulations. A number of residents files viewed contained multiple versions of documents. The inspector found these plans could potentially mislead practice with outdated assessments and information. Elements within residents' files were also left blank without any expectation for the omission of information.

Judgment:

Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Karina O'Sullivan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Walk A
Centre ID:	OSV-0003403
Date of Inspection:	03 August 2016
Date of response:	15 September 2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

It was unclear who the nominated person, other than the person nominated in Regulation 34(2)(a), to ensure all complaints are appropriately responded to and a record of all complaints are maintained.

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

1. Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

Please state the actions you have taken or are planning to take:

WALK will review the complaints policy and ensure inclusion of a nominated person to meet compliance with Regulation 34(3)

Proposed Timescale: 30/11/2016

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some residents did not have a comprehensive assessment conducted to reflect changes in the assessed needs and circumstances at a minimum on an annual basis.

2. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:

All Wellbeing plans in place will be reviewed and updated by the Team Leader, Team Coordinator and Assistant Psychologist.

A schedule for annual review will be established and maintained. Regular internal audits by the person in charge to be conducted, and communicated with the relevant staff.

Proposed Timescale: 15/10/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Assessments were not up-to-date for healthcare plans. The inspector was unable to determine if some residents assessed needs were being met.

3. Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:

All Composite Health plans and supporting documents in place will be reviewed and updated by the Team Leader, Team Coordinator and relevant Health care Professionals.

A schedule for annual review will be established and maintained. Regular internal audits by the person in charge to be conducted, and communicated with the relevant staff.

Proposed Timescale: 31/10/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some reviews did not assess the effectiveness of each plan and take into account changes in circumstances and or new developments within the resident's life and one resident had no goals on file.

4. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:

All Personal Outcome Measure (POMs) plans and supporting documents in place will be reviewed and updated by the Team Leader, Team Coordinator and relevant Health care Professionals.

A schedule for annual review will be established and maintained. Regular internal audits by the person in charge to be conducted, and communicated with the relevant staff.

Proposed Timescale: 30/11/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Some areas in the houses were in need of repair in relation to woodwork and paint work.

5. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:

The maintenance schedule for 2016 to be reviewed, to ensure that planned works are completed.

Works identified by the inspection to be targeted for immediate improvement.

Regular internal audits by the person in charge to be conducted, and communicated with the relevant staff, so that newly identified works are addressed by maintenance department.

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Suitable storage was not full addressed within one house.

6. Action Required:

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:

This as a scheduled work to be completed according to that schedule.

Proposed Timescale: 23/09/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Systems in place in the designated centre for the assessment, management and on-going review of risk required updating. The information contained within the documents were not reflective of current practice. While a comprehensive risk assessment had not taken place within the designated centre.

Individual risk assessments were not maintained up-to-date and did not reflect current practice.

7. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:

- i) Review and update all existing Risk Assessments, and establish schedule for their next review, with psychology department. 31st October 2016
- (ii) WALK to create new 'Risk Management Handbook' for the definitions of risk, and to govern the pathways for risk management; deliver and implement new system to all staff. 31st December 2016
- (iii) In specified house introduce a water temperature monitoring system, to ensure the already installed equipment is set and maintained at a safe level. 30th September 2016

Proposed Timescale: 31/12/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Emergency lighting was not in place within the designated centre.

8. Action Required:

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:

- (i) WALK to engage a contractor to submit costings for installation and signage. 30th September 2016
- (ii) WALK to submit to HSE funding for identified costings. 31st October 2016
- (iii) When funding confirmed, WALK to create schedule for work. Dependent on funding confirmation.
- (iv) WALK to inform service users; HSE and HIQA of implantation date. Dependent on funding confirmation.

Proposed Timescale: 31/10/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Adequate arrangements for evacuating all residents within the designated centre were not evident as some residents PEEPs were not reflective of current practice.

9. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:

All Personal Evacuation Egress Plans (PEEPs) plans and supporting documents in place will be reviewed and updated by the Team Leader, Team Coordinator and relevant Health & Safety staff.

Fire evacuation plan in FC to be updated. All locations to put review date for evacuation plans on an annual schedule for review and updating.

Identified relief staff who require local induction fire drill training to be trained.

A schedule for annual review will be established and maintained. Regular internal audits by the person in charge to be conducted, and communicated with the relevant staff.

Proposed Timescale: 31/10/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Adequate arrangements for containing fires was not evident within one house of the designated centre.

10. Action Required:

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:

(i) WALK to prepare costings for installation. 30th November 2016

(ii) WALK to submit to HSE funding for identified costings. 10th January 2017

(iii) When funding confirmed, WALK to create schedule for work. Dependent on when funding approved.

(iv) WALK to inform service users; HSE and HIQA of implantation date. Dependent on when funding approved.

Proposed Timescale: 10/01/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Behaviour support plans or health and well being plans were not maintained up-to-date therefore, staff members did not have relevant documented information to guide their practice.

11. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:

All Wellbeing plans in place will be reviewed and updated by the Team Leader, Team Coordinator and Assistant Psychologist.

A schedule for annual review will be established and maintained. Regular internal audits by the person in charge to be conducted, and communicated with the relevant staff.

Proposed Timescale: 15/10/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The process in relation to restrictive practice was unclear within the designated centre as some restrictions were referred to the human rights enhancement committee while other were not.

Evidence of review of restrictions in place within the designated centre was not evident.

12. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:

WALK to review the Terms and Reference of the Human Rights Enhancement Committee (HREC).

WALK to review the current system of safeguarding; create new system and implement same.

Proposed Timescale: 31/12/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Residents within one house did not fully utilise communal rooms in the house such as, the sitting room. Instead residents stayed in their bedroom due to the current mix of residents within the house.

13. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:

WALK and other organization to agree and implement transition plan for one identified service user.

Service User affected by current mix of residents to be offered alternate space with own access, within the existing service - post transition of other identified service user.

Proposed Timescale: 30/11/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Some resident's healthcare plans were not reviewed at least annually.

Information contained within epilepsy plans did not match the medication prescribed for the resident.

14. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:

All Composite Health plans and supporting documents in place will be reviewed and updated by the Team Leader, Team Coordinator and relevant Health care Professionals.

All plans to be revised to reflect that the 'Kardex' is the lead document – all other documents to refer to the Kardex and not in themselves contain specific prescription information.

A schedule for annual review will be established and maintained. Regular internal audits by the person in charge to be conducted, and communicated with the relevant staff.

Proposed Timescale: 31/10/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

p.r.n. medication within one house was past the medications expiry date.

Some p.r.n. medication had no expiry date specified.

Some residents person-centred medication plans required updating.

The administration of some p.r.n. medication required further guidance to guide staff effectively and consistently.

15. Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:

All Medication plans, PRN protocols and supporting documents in place will be reviewed and updated by the Team Leader, Team Coordinator, Keyworkers and relevant Health care Professionals.

Regular checks on medications to ensure they are valid. Introduce expiry dates on all prescription labels from pharmacy; and mark blister packs for current week.

Proposed Timescale: 31/10/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Follow up on actions from audits completed was not evident for all audits.

16. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

WALK to create new schedule of internal audits which measures activity according to the regulations and standards.

Audits to be communicated to the relevant staff, with action plans; and followed up in Team Meetings.

Proposed Timescale: 30/10/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some gaps were evident in relation to the information and documents as specified in Schedule 2 for staff members.

17. Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:

HR are asked to close all gaps in staff files for DCA.

Proposed Timescale: 31/10/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Planned and actual staff rota was present however a coding system was required.

18. Action Required:

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:

Team Leaders to install a clearly identifiable code in roster folder, which will apply to all subsequent planned and actual rosters.

Proposed Timescale: 15/10/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some members of staff required mandatory training.

19. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:

(i) All staff to receive essential training in Safe Administration of Medications (SAMs), Occupational First Aid, Fire Awareness, Safe Guarding Vulnerable Adults. 31st December 2016

(ii) All staff to receive remainder of mandatory training: WALK induction, Studio III, Patient Moving. 2017 training calendar cycle

(iii) As required staff to receive training in Personal Outcome Measures (POMs), Epilepsy. 2017 training calendar cycle

Proposed Timescale: 31/12/2016

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A number of resident's files viewed contained multiple versions of documents.

Outdated assessments and information was contained within resident's files.

Elements within resident's files were also left blank.

20. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:

All service user's files to be reviewed. Duplicate or multiple documents or expired documents to be removed and archived.

All sections of service user files to be completed and available.

Proposed Timescale: 31/12/2016