



Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Logan House
Name of provider:	RehabCare
Address of centre:	Galway
Type of inspection:	Announced
Date of inspection:	29 November and 06 December 2018
Centre ID:	OSV-0003468
Fieldwork ID:	MON-0021791

About the designated centre

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

Logan House provides supported accommodation to people with an acquired brain injury and is based in a large city in the west of Ireland. The centre is located in close proximity to a range of shops and local amenities. Transport is provided so residents can avail of community based facilities and access amenities such as libraries, parks, hotels, cafe's, hairdressers, beauticians, shopping centres and cinema. The centre comprises of a large two storey house and one external apartment, which operates as five units, where up to nine people reside. The centre caters for residents with high, medium and low support needs. Each resident has their own bedroom (some en-suite) with share communal facilities, and there are two apartments with private kitchen/dining/sitting room, bathroom and bedroom. There is also a studio room available for residents. Some residents access day service options, where other residents like to choose their own daily activities. Access to allied health care professionals is available to the residents as required and includes; GP services, psychology and psychiatry services. The centre is managed by a person in charge, two team leaders, and team of social care professionals and assistant support workers. A sleepover staff is rostered for nights and the provider is crisis funding a waking night staff for additional support at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8
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How we inspect

To prepare for this inspection the inspector or 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
29 November 2018	09:00hrs to 17:00hrs	Thelma O'Neill	Lead
06 December 2018	10:00hrs to 17:30hrs	Thelma O'Neill	Lead
29 November 2018	09:00hrs to 17:00hrs	Catherine Glynn	Support
06 December 2018	10:30hrs to 17:30hrs	Catherine Glynn	Support

Views of people who use the service

The inspectors met with seven of the residents who live in the centre and had in depth conversations with four of the residents living in the service. Inspectors also received written feedback on the service from seven residents with the support of staff. Some residents reported that they were happy with the service, and the care and support they receive and the choices of social activities to engage in.

However, other residents expressed dissatisfaction with aspects of their daily routine, the staffing shortages in place which restricted their opportunities to participate in the wider community. Some residents also reported that they were not satisfied in the way in which complaints were managed, stating that their concerns were ignored or not dealt with to their satisfaction. While they were generally happy with the staff team, all of the residents spoken to complained about the constant change over of staff and the frequent use of agency staff working in the centre.

Capacity and capability

Inspectors found that the governance and management of this centre was poor, which was negatively impacting on the quality of life and safety of residents living in this centre.

Over the course of the inspection, the provider failed to demonstrate its capacity and capability to provide a safe and effective service. Inspectors found a number of serious risks on the first day of inspection which required the inspectors to change the planned focus of inspection and instead review a number of key high risk areas that were negatively impacting on the lives of the residents. These included safeguarding and protection, fire safety management and staffing. Because of the seriousness of the risks presented in this centre, the inspectors issued three immediate actions to the provider, requiring them to address these risks within a specific time frame as set by the Office of the Chief Inspector. During a second day of inspection, which was completed a week later, inspectors reviewed the actions taken by the provider in response to the immediate actions; however, the inspectors found that the provider had not satisfactorily addressed the concerns.

Overall, inspectors found that there was a lack of effective oversight by the provider in the governance and management of the centre. The provider had failed to complete a comprehensive assessment of each residents' health and social care needs and individual risks. Inspectors found that safeguarding concerns were not appropriately investigated and reported to the appropriate authorities in line with the organisations safeguarding policy. Furthermore, the provider had not ensured that the overall staffing arrangements were sufficient to ensure residents safety, and residents continued to be at risk of harm from peer to peer abuse. Fire safety measures were not adequate to address the immediate risks identified, as inspectors

found the measures taken were not been adhered.

Inspectors found that while the provider had a management structure in place, there was a lack of oversight by the provider of the effectiveness of the management team in discharging their responsibilities or accountability to deliver a quality service. For example, Inspectors were told by staff that they had reported issues to managers - in relation to residents' compatibility, staff retention, the excessive use of agency staffing, premises issues and residents' health issues; however, there was no evidence that their concerns were documented or acted upon.

While unannounced visits to audit the quality and safety of the service had been completed by the provider, as required by the regulations, inspectors found the actions identified in these audits had not not been satisfactorily addressed and the suitability and compatibility of residents living in this service had not been reviewed. This meant that the findings from these audits were not being used to improve the overall quality and safety of the service. Also, while there were support and supervision meetings taking place between the managers and the staff team, inspectors found the team leaders had no management training or training in performance management skills to ensure key staff indicators were being met.

Inspectors found that the provider's arrangements for staffing the service, were inadequate, with a lack of planning and organisation of the staff roster and a failure to keep records of who was working in the centre on a day to day basis.

Inspectors found serious peer to peer abuse had taken place in the centre and the provider failed to implement appropriate staffing levels as identified as being required within resident's safeguarding plans. When asked, the team leaders and the person in charge could not clearly tell inspectors what the current staffing needs assessment for this centre was. For example, the team leaders told inspectors that one resident required 2:1 support at all times when in the centre and another resident required 1:1 support. However, when inspectors discussed this with the person in charge, she said this level of staffing was not required, despite this level of support being documented in the resident's support plans. In addition, the system to record what staff supports each of the residents was receiving on a daily basis was ineffective as the staffing roster viewed on the day of the inspection was not accurate. Inspectors found that a comprehensive review of the current needs of each resident was required, in order to determine if the residents were being adequately supported at all times in the centre.

As a result, on the first day of inspection, Inspectors issued an immediate action requiring the provider to ensure the residents were protected from the risk of abuse. The provider subsequently sanctioned 1:1 staff from 8am to 12 midnight for one resident. On the second day of inspection, inspectors reviewed the provider's response to the urgent action and was told that the additional staff supports were now in place; however, the staff rosters did not show the increase in staffing and there was no evidence that this staff support was being provided as stated on the staff roster for the current week or the following week.

Inspectors were told by residents and staff that this centre has a high staff turnover and the person in charge confirmed that there is a recruitment and retention issue in this centre. The centre uses four different staffing agencies to supply the centre with the required allocated staffing but frequently they cannot supply the number of staff needed. Residents told inspectors that they did not like the constant use of agency staff and having to induct new people on their person care and support needs were and would rather try and do it themselves. This was not documented in the residents personal plans and/or risk assessments.

During the inspection a number of residents told inspectors that they were not happy with various aspects of the service. Some of the residents said that given the opportunity they would move to another service, because the managers and staff did not listen or address their concerns. In one example, residents had no access to television, one resident told the inspector their television wasn't working in their bedroom which they had raised with staff, the inspector also noticed that the television for the sitting room was sitting on the floor with a note stating "this television has been out of order since August". On review of the complaints records, there was no record of this complaints in the complaints log.

Regulation 14: Persons in charge

The person in charge worked full time and was responsible for managing two designated centres and one individual service. She was a qualified social care professional with experience of working in and managing services for people with disabilities. The person in charge was supported by two team leaders in the centre.

However, due to the level of non-compliance noted during this inspection and the lack of effective oversight, evident in the failure to implement the provider's policies, recommendations from audits or actions arising from safeguarding plans; the inspectors found that this arrangement was insufficient and was not ensuring the effective operational management of the centre.

Judgment: Not compliant

Regulation 15: Staffing

The provider failed to ensure that there was appropriate staffing arrangements in the centre to meet the residents' care and support needs and to ensure that they were protected from the risk of harm and abuse. Staff rosters did not reflect the actual staff on duty in the centre during the day or at night. Inspectors noted that while staff were rostered to work in the centre, they were actually working in another service. Furthermore, there was no up-to-date record being maintained of who was working the waking nights in the centre, as these shifts were being staffed by a recruitment agency.

Judgment: Not compliant

Regulation 23: Governance and management

The inspectors found that the provider and person in charge had failed to ensure that the policies and procedures for safeguarding, managing complaints and staffing of the centre were being implemented. In addition, the provider had failed to ensure that actions arising from unannounced visits to the centre were being effectively implemented, this meant the provider was failing to learn from incidents and drive quality improvements in the service.

The provider had appointed managers to govern and oversee this centre. However, the inspectors found that the management systems in place lacked corporate or operational leadership and accountability. There was an evident failure by the management team to take responsibility for managing and responding to risk, lead an effective service and put in place a consistent staff team that was knowledgeable and responsive to residents' care and support requirements.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had developed a statement of purpose. While this included all of the requirements as prescribed in Schedule 1 of the regulation, the inspectors found that it did not describe the level of service being offered in the centre accurately, including the arrangements and number of staff that would be on duty in the service at all times.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Residents made several complaints both verbally and in the written questionnaires to the inspectors during the two days of inspection. The inspectors reviewed these complaints, which the residents advised had previously been raised in the centre and found they they had not been logged as complaints and had not been addressed. These related to social activities and access to the kitchen and cooking facilities, as well as staffs' responsiveness to residents requests.

For example, residents had raised concerns about staff sitting in the sitting room

using their personal phones while working and ignoring the residents. One resident told the person in charge in front of the inspectors that they did not trust the person in charge or staff to act on their complaints or to make a complaint to, as nothing would be done to address their concerns.

Judgment: Not compliant

Quality and safety

Overall, the resident's quality of life and safety was found to be poor. Many residents living in this centre reported that they were unhappy and that they did not feel supported to raise concerns about their experiences of living in the centre.

Inspectors found significant risks and non-compliance's in a number of areas inspected, of particular concern the provider had failed to safeguard residents or others from the risk of abuse and failed to ensure that there was adequate staffing maintained in the centre to meet the changing needs of the residents. In addition, fire doors continued to be held open by furniture in the upstairs apartment following the urgent action being issued.

Inspectors found the quality and safety of care being provided was inadequate in relation to; fire safety, staffing, and safeguarding. Current practices and procedures were not adequate and the provider and person in charge had failed to appropriately identify and managed these risks.

Some aspects of the risk management process were supporting positive risk taking and supporting residents' autonomy with regard to meaningful social inclusion. A number of residents in the centre had presented with high risk behaviours, such as; physical damage to the premise, peer to peer abuse and verbal and physical aggression towards staff, which posed a serious threat to the safety of all residents and staff in the centre. As a result the team leaders had decided that additional staffing had to be present at all times, when certain residents were present. However, this practice was not consistently implemented and was not documented in the residents' personal files, behaviour support plans or plans of care as being a need.

Some residents displayed behaviours of concern which had resulted in a number of restrictive practices in use in the centre; however, the residents did not have appropriate positive support plans in place to ensure appropriate preventative and reactive strategies were in place. In addition, inspectors found that these restrictions were not all documented in the restrictive practice log and had not been reported to the office of the chief inspector as required by the regulations.

Staff on duty on the day of inspection had training in safeguarding of vulnerable adults. However, there were a number of safeguarding risks that were not being appropriately managed and, as a result, the provider had failed to adequately

safeguard residents from the ongoing risk of harm or abuse. For example, on the first day of the inspection, inspectors found that a very significant safeguarding issue had not been managed or referred to the HSE safeguarding team or other agencies appropriately by the provider, as a result the provider was required to take immediate action in order to safeguard this resident. The provider was notified that due to the nature of these concerns that the office of the chief inspector had immediately referred the matter to the HSE safeguarding team and to other relevant organisations. However, due to the sensitive nature of this concern no further details will be discussed in this report.

On the second day of the inspection, the inspectors reviewed the provider's response to the urgent safeguarding concern found that while some actions had been taken, including completing referrals to relevant agencies and holding a case review, that other actions had not been suitably addressed. For example; the actions identified by the management team as a result of the case review had not been documented in the resident's safeguarding plans as agreed. Also a concern regarding a vulnerable adult had not been appropriately investigated and the national safeguarding policy had not been appropriately implemented as required.

In addition, inspectors found that the provider had failed to ensure that the residents' changing healthcare needs were subject to regular review. For example; in relation to diabetes management, falls management, and food and nutrition. This posed a risk to residents and staff as the provider was not ensuring that healthcare tasks were being delivered on the basis of up-to-date information.

Inspectors found that the quality and safety of care in this centre was not being adequately monitored or subject to regular audit. This meant that there was no mechanism in place to assess the ongoing quality of the service being provided to residents. This failure meant that residents' concerns were not being effectively listened to and acted upon, that residents were not being kept safe at all times and that residents' were not being adequately support to lead good and meaningful lives.

Regulation 12: Personal possessions

Inspectors reviewed the system in place for managing household expenses and the management of communal bills and found that there was robust system in place that was well managed. Inspectors were told that all of the residents manage their own money.

However, inspectors reviewed the systems of how the staff determined the residents ability to managed their personal money and found that the residents' did not have a financial capacity assessment completed, so staff were not aware if residents were capable of managing their financial affairs independently. Inspectors found one case where a resident was at risk of financial abuse in the community due to a lack of capacity around financial management which is currently under investigation by the appropriate authorities.

Inspectors reviewed the residents' access to their personal possessions and found that one resident did not have full access or control of their clothes. The person in charge told the inspector that the resident had behaviours of concern around their clothes and that their clothes were being stored in another apartment and given to them as required. However, the provider had failed to ensure that this restriction of access was documented in their behaviour support plan, was with the residents consent or on the restrictive practice register.

Judgment: Not compliant

Regulation 13: General welfare and development

Some residents were very independent and had active lives but some residents told the inspectors that they were bored living in the centre and had limited links with the local community. Other residents told inspectors that they had no meaningful daily or evening activities and that they found this difficult. Residents said they had limited access to education, training or meaningful social activities.

Judgment: Not compliant

Regulation 17: Premises

The design and layout of this premise did not meet the current needs of the residents living in this centre and required a comprehensive review of the facilities and its current use was required. On a walk around of the centre inspectors found:

1. There were accessibility issues for one wheelchair user in and around the centre, such as, accessing the the entrance and hallway doors, as they did not have automatic door openers in place.

2. Kitchen facilities were not wheelchair accessible, as the sink, kitchen cupboards and hob were too high for wheelchair users to reach, and the resident had specifically requested cooking activities to be part of their personal goals.

3. There was inadequate accessible space in the residents bedroom who was a wheelchair user and inspectors saw the resident had difficulty mobilising around their room.

4. A standing frame for one resident was stored outside in another apartment, as there was inadequate space to store the equipment in the residents' bedroom and their was concern regarding its use outside due to uneven surfaces.

5. One resident did not have a headboard on their bed and their bed was pushed up

against a radiator, putting them at risks of suffering an injury.

6. Residents had no bedside lighting, which posed a risk at night to some residents with mobility issues after the main lights were switched off, should they chose to move around their rooms.

7. Two televisions in the upstairs apartment were out of order. One television had a note stating it had been out of order since August and the second television, had no access to television channels.

8. Inspector's found that some of the residents bedrooms/apartments were not clean, for example; kitchen cupboards, ovens, fridges, apartment floors and toilets were unclean on the day of inspection. While there were cleaning arrangements in place for communal areas, residents apartments were not adequately maintained. This was an action from the last inspection in 2017 and had not been addressed.

10. The floor boards in the main hallway were lifting which were a risk to residents with mobility issues and had not been addressed.

11. The exterior of the premises needs upgrading to ensure the back of the house, which was used as a evacuation point, provided suitably access and egress from the centre.

12. A fire exit from a residents' bedroom had a very steep ramp, which posed a risk to the resident (who was a wheelchair user) in the event of a emergency evacuation.

13. There were items stored in the protected escape stairs.

14. There were four filing cabinets stored in the hallways both upstairs and downstairs, these hallways were designated fire escape routes and these cabinets were reducing the available space to safely evacuate the centre.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents had different dependency levels around managing their food and nutrition. Some residents were very independent and others required staff support. Inspectors were told by residents that they were receiving sufficient food, but said they would like access to more food choices, access to snacks in the evening, and would like to have more access to the kitchen for cooking.

Inspectors found the management of one resident's nutritional needs required urgent review, as staff had placed restrictions on the resident's access to kitchen facilities, food and water - without appropriate support arrangements in place. There was no evidence in the resident's care plan, outlining the need for these

restrictions and staff spoken to did not have a clear understanding as to the residents healthcare needs. The decision to implement these restrictions and the ongoing use of these had not been subject to medical reviews, which was confirmed by staff who stated to inspectors that the resident had not been seen by a dietitian or other allied health care professionals recently.

Judgment: Not compliant

Regulation 26: Risk management procedures

There was a high level of risk in this centre and the provider had not demonstrated that this was being managed adequately. This was impacting negatively on the quality and safety of care provided to the residents. Inspectors found several residents had slips/ trips and falls over the past year. One resident in particular, had seven falls out of their wheelchair, but subsequently did not have a falls management plan put in place. In addition, the frequency and nature of these falls had not triggered a comprehensive multidisciplinary review to assess the cause and preventative measures that could be put in place to drive forward good falls management in this centre. In addition, individual risk assessments and the organisational risk register did not reflect many of the serious risks that were impacting on the resident safety in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

On the first day of the inspection, the inspector reviewed the fire safety procedures in this centre and found there were some good systems in place to protect residents from fire. A fire alarm and a range of fire fighting equipment; such as fire extinguishers, fire blankets and emergency lighting were available in the centre. Documentation viewed by the inspector showed that regular fire drills took place and residents could evacuate in a timely manner. However, during the walk around of the centre the inspector observed two fire doors being held open by a wooden door wedge and furniture, which was a serious risk of breaching fire containment measures in the event of a fire; as a result, an urgent action was issued to the provider to remove the door wedges and furniture and allow the fire doors to closed properly.

On the second day of inspection, inspectors reviewed the actions taken to address the urgent actions and fire risks in the centre and found that three door sensors had been ordered and were due to be installed on the 7/12/18, but inspectors found written evidence that the fire doors were consistently kept open by furniture for the

week following the immediate action being issued.

Inspectors also found that one resident who was advised not to smoke in their apartment due to their history of setting off the fire alarm was continuing to smoke in the apartment and did not have a support plan in place to help or educate the resident on the risks associated with smoking in the apartment.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had a health and social care assessments completed; however, some residents' support plans did not identify their current health and social care needs. In addition the details of the residents' healthcare conditions and their associated interventions were not included in their plans of care and were not being reviewed when their needs changed. For example, in four files reviewed, residents' support needs had increased due to a deterioration in their physical and mental health, but the residents did not have multidisciplinary reviews completed. This meant that the provider had failed to ensure that residents were able to enjoy the best possible health and social care, in line with best practice guidelines, at all times.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Inspectors reviewed incidents where behaviour that is challenging had impacted on the residents' quality of life. However, while there was evidence of behaviour that is challenging occurring in the centre, inspectors found that some residents did not have positive behaviour support plans in place and that some of the residents' plans (where these were in place) did not reflect the restrictions being implemented in response to managing the behaviours of concern. In addition, there were several restrictive practices in place in the centre that had not been identified as restrictions or approved by an independent restrictive practice committee.

Judgment: Not compliant

Regulation 8: Protection

Inspectors reviewed five safeguarding incidents of various types that had occurred in the centre, over the past five months and found that many of

these risks had not been appropriately reported, investigated or managed by the management team. As a result residents were not adequately safeguarded or protected, the provider was required to take urgent action on the first day of the inspection to address this.

On the second day of the inspection, inspectors reviewed the provider's response to the urgent action and were told by the person in charge that she had met with the senior managers and the designated officer to discuss the safeguarding risks. However, inspectors found that there was no evidence that the meeting took place, the actions agreed during the meeting or a timescale for when the actions would be implemented. For example, inspectors found residents' safeguarding plans had not been updated to include all risks for individual residents and that a comprehensive review of the residents files and safeguarding risks in the centre had not taken place.

Judgment: Not compliant

Regulation 6: Health care

While residents had access to healthcare professionals, such as their general practitioner, dietitian, speech and language therapist and occupational therapist - and many of the residents were independent in managing their own healthcare needs, some staff were not familiar with the residents' healthcare conditions or when they were last reviewed by their medical or allied health professional.

In addition, inspectors found that where some residents had conditions such as diabetes, dysphagia, weight loss and mobility issues the provider had failed to ensure that a healthcare management plan was in place to guide staff in supporting residents with these conditions. This posed a potential risk to residents, for example, inspectors found that diabetes care was not being adequately managed by staff and they had not received training in diabetes management or the medications prescribed to manage this condition.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 6: Health care	Not compliant

Compliance Plan for Logan House OSV-0003468

Inspection ID: MON-0021791

Date of inspection: 29/11/2018 and 06/12/2018

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 14: Persons in charge	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 14: Persons in charge:</p> <p>Background</p> <p>RehabCare ensures that all PICs are suitably qualified and have the required experience required before appointing PICs to manage designated centres. PICs are supported by PPIMs to fulfil their duties.</p> <p>Action</p> <p>A new interim PIC commenced working in the service on the 17/12/2018. This individual has the relevant management qualification and experience required for the role. This arrangement will be place for the next three months pending the confirmation of a permanent PIC.</p> <p>A new Residential Services Manager will be appointed to the service. This person will have the relevant management qualification and experience required to fulfil the post of PIC for the centre. NF30 will be submitted in respect of the new permanent PIC. The PIC appointed as interim in December 2018 will remain in post to provide a full handover to ensure seamless continuity of service. This new appointment of a Permanent Residential Services Manager (Person In Charge) will be completed by 31.5.19.</p> <p>The interim PIC will formally write to all resident's families/ next of kin to inform them of the changes in service management. This was completed by the 21/12/2018.</p> <p>The NF30 was submitted in respect of the interim PIC to HIQA on 19/12/2018. Associated documents to be submitted by 29/12/2018.</p> <p>Members of the regional operational management team are currently providing direct support to the new interim PIC and staff team and are actively involved in the implementation of measures outlined in this plan. This support was formally put in place on 17/12/2018.</p>	
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing: Background

Staff are recruited to the service in line with organisational policy. The staffing levels provided in the service are based on the assessed needs of residents.

Actions

A Residential Services Manager (PIC) will be appointed to the service. This person will have the relevant management qualification and experience required to fulfil the post of Person in Charge for the centre. NF30 will be submitted in respect of the new permanent PIC. The interim PIC appointed as interim in December 2018 will remain in post to provide a full handover to ensure seamless continuity of service. This will be completed by 31.5.19.

A full staffing needs assessment will be conducted for all residents. Following the review of all residents' support plans, risk assessments and reassignment of apartments, the PIC and PPIM will fully review staffing levels to ensure the mix and skills of staff is appropriate to the assessed needs of residents. This will be completed in the context of the reconfiguration of the staffing model at the centre. This will be completed by 26.4.19

A new reconfigured model of staffing will be in place in the service appropriate to the number and assessed needs of residents, statement of purpose and the size and layout of the service. This will be complete by 31.5.19.

A review of the current roster will be completed. These necessary arrangements are being put in place to ensure that the appropriate staffing levels are in place going forward and that the roster is easy to understand with named staff members assigned to 1:1 duties easily identifiable. A shift coordinator will be identified and assigned for each shift. The PIC is maintaining oversight of the roster to ensure there is a copy of actual worked roster maintained in the service. This will be completed by 27/12/2018.

1:1 staffing in line with safeguarding plans are in place and will remain as per the requirement. This was completed by 30/11/2018.

Staff with the relevant training from other RehabCare services have been redeployed to work in this service in order to reduce the use of agency staff in the service. Any agency staff used in the service are regular staff with whom the residents are familiar. This was completed by 21/12/2018.

Following a review of staff capability, a focused training and development plan will be developed to enhance the quality of service delivered. This plan will be progressed in the first quarter of 2019 (31/03/19). This plan will be informed by the assessed needs of residents. The plan includes a suite of mandatory & refresher training, reflective practice and individual coaching.

A staff briefing took place on the 19/12/2018. These briefings are being continued regularly with the contents of this report along with the arising action plan and progress of same being discussed.

All staff will engage in reflective practice at team meetings which will be scheduled on a monthly basis. Staff will reflect on and share how training has impacted on their practice. This will be completed by 29.3.19 and ongoing.

Regulation 23: Governance and management	Not Compliant
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Outline how you are going to come into compliance with Regulation 23: Governance and management:
Background

Background

There is an operational line management structure in place to oversee the management of the service, this structure supports service delivery from local level to national level across the organization. The organization is committed to ongoing oversight completing unannounced visits every six months and conducting an annual review of the service. The Quality and Governance Directorate with subject matter experts are actively supporting the service on an ongoing basis in terms of risk management, medication, safeguarding, regulations etc.

Actions

A new PIC commenced working in the service on the 17/12/2018. This individual has the relevant management qualification and experience required for the role. This arrangement will be place for the next three months pending the confirmation of a permanent PIC for the service.

A Residential Services Manager will be appointed to the service. This person will have the relevant management qualification and experience required to fulfil the post of PIC for the centre. NF30 will be submitted in respect of the new PIC. The interim PIC appointed in December 2018 will remain in post to provide a full handover to ensure seamless continuity of service. This will be completed by 31.5.19.

During the week beginning December 17th a number of subject matter experts from across the organisation commenced providing an increased level of support to the service. This support was targeted at addressing specific concerns in this report in the first instance and subsequently will address longer term areas for improvement. This input was overseen by the covering ISMs and the Head of Quality and Practice Development & Research assigned to oversee the implementation of this plan from a Senior Management level. Evidence of this input has been documented, including findings and arising actions. These initial reviews were complete by 21/12/2018 and will continue in 2019.

The Head of Quality and Practice Development & Research from the Quality & Governance Directorate has been appointed by the providers Senior Management team to oversee and co-ordinate the completion of this action plan and to provide senior

operational management support for the service. This commenced on 15/12/2018.

Cover arrangements for the PPIM currently on leave have been implemented with the Integrated Services Manager from the regional management team appointed to support the service and the new PIC. A member of the Regional Management Team has been assigned to act as a Designated Officer in terms of the provider's responsibility for safeguarding residents from abuse. This arrangement commenced on 14/12/2018.

Members of a core oversight team from operations and the Quality & Governance Directorate have participated in daily conference calls. These have taken place during the week beginning December 17th to oversee the development and implementation of this plan. The CEO has been briefed on a daily basis.

Subject matter experts have been providing daily updates to members of the Core Oversight Group. Findings from their reviews and arising actions have been documented. This was completed by 21/12/2018.

The providers Senior Project Executive (Compliance) and an ISM from another region with support from the Director of Quality and Governance will complete a full internal audit before 10/01/2019.

The Board of Rehab were informed of this Inspection Report and subsequent meeting with the authority at a meeting of the board on 14/12/2018.

A copy of this inspection report was made available to the Board on 20/12/2018.

On agreement of this action plan with the authority, the providers Senior Project Executive (Compliance) and the Director of Quality and Governance will incorporate this plan into the organisations overall current action tracking process. This information will also inform the organisations existing rag system. Data from both of these systems will be provided to the CEO/COO and the Board on a Monthly basis until all actions arising have been addressed. This will be complete by 31/01/2019.

The PIC and ISM will develop a local action tracker for the service which will ensure that all actions identified in this report are continually monitored, progressed and reviewed.

The organisation will develop a strategic plan for the future of the service. This plan will identify immediate, medium and long term objectives for the service. This will be progressed and implemented in 2019.

The PIC and Integrated Services Manager (PPIM) will review the progress of the centre against the service quality improvement plan on a monthly basis. This will be completed ongoing from week commencing 4.3.19 for a 6 month period to 2.9.19.

The Integrated Services manager will report on the progress of the service to the Regional Operating Officer and to the core oversight team from operations and Quality and Governance on a monthly basis through conference calls. This will be completed ongoing from week commencing 4.3.19 for a 6 month period to 2.9.19. The need to continue post 6 month period will be reviewed at that point.

Following Internal and External announced and unannounced inspections, Annual reviews and Health & Safety Audits the PIC will follow up and ensure all identified actions are addressed in a timely manner. Review of all actions will be on the agenda at monthly progress meetings between the PIC and ISM. This will be ongoing from March 2019.

A schedule of consistent and effective staff supervision will be implemented in line with Rehab Group Supervision Policy. The effectiveness of supervision practices will be reviewed at monthly progress meetings between the ISM and PIC. This will be ongoing from March 2019

A monthly progress report against actions outlined in this service quality improvement plan will be provided to HIQA on a monthly basis.

Regulation 3: Statement of purpose

Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

Background

The Statement of Purpose and function for each designated centre outlines the purpose of the service, supports provided, staffing arrangements and all other matters as outlined in the Regulations. Statements of Purpose are frequently reviewed to ensure content is accurate and service delivery is in line with that specified in the statement of purpose.

Action

Statement of Purpose and Function has been revised to name the new PIC and to accurately describe the level of service being offered in the centre, including the arrangements and number of staff that are be on duty in the service at all times. This was complete on 20/12/2018.

Regulation 34: Complaints procedure

Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Background

All complaints are recorded on RehabCare online reporting system and the organisation's policy guidelines are followed locally. The Complaints Policy and Procedure is discussed regularly in house meetings, including what to do if the complainant is not happy with the outcome of their complaint. The procedure is clearly outlined and advertised in the house and all residents have signed this document as evidence of their involvement in its discussion.

Action

Six of the residents were offered an opportunity to meet with Rehab's Complaints Officer on the 20/12/2018. The remaining residents will be offered an opportunity to meet the Complaints Officer before 15/01/2019. The purpose of these meetings is to enable residents to express their concerns and complaints and to ensure residents are fully advised of the complaints process.

Following these meetings, any complaints arising were documented on the organisation's complaint management database and actions arising have been identified. Resolution of these complaints will be monitored by the Complaint's Officer until such a time as they are resolved to the satisfaction of the complainants.

On the 20/12/2018, the Complaints Officer met with staff on site and outlined the complaints management process to them.

A review of resident's documents/ files has commenced week beginning 17/12/2018, this was been substantially completed by 21/12/2018. This review will be fully completed by 15/01/2019. The review identified other potential complaints that had been documented in the service. This information was supplied to the Complaint's Officer in advance of meetings with residents on 20/12/2018.

The PIC supported by the ISM has invited individual meetings with each resident's family. These meetings will capture and record any outstanding complaints and inform service improvements and best practice, going forward. The requests for meetings were made with families by 21/12/2018 with a view to completing all meetings by 10/01/2019. Families have been provided with contact details for the PIC and ISM should they have concerns or queries in the interim period.

The advocacy officer will offer each resident the opportunity to avail and meet with an independent advocate external to Rehab. If residents wish to avail of this support, a referral will be made to the relevant organization. This was completed by 21/12/2018.

The Chief Executive Officer visited the service on the 18/12/2018. During the visit the CEO met with all residents and apologized to residents for their poor experience in the service and the quality of care they have been receiving. The residents expressed their concerns to the CEO who was accompanied by the Organisations Advocacy Officer.

All staff read and signed the code of conduct policy. All staff to be formally notified that any deviation from the policy in terms of using their mobiles whilst on active duty, will result in immediate disciplinary action. This was completed by 21/12/2018. The Code of Conduct has been raised with staff at staff briefings.

The Advocacy Officer, Complaints Manager, Designated Officer, and Confidential Recipient contact details and photos will be displayed on a communal notice board in the house. This was completed by 21/12/2018.

All complaints will be managed in accordance with Rehab Group Complaints policy and recorded on the organisations complaints management database.

The Team Leader will conduct an audit of Complaints on a monthly basis to ensure all complaints are being appropriately responded to and records of all complaints is maintained appropriately in the service. The PIC will overview this audit on a monthly basis.

An easy read guide to Complaints with photographs and contact details of key personnel will be available in the service. Residents will be offered the option of having the ISM phone number stored in their phones for easy access should they wish to appeal a complaint outcome.

A log of complaints will be devised for the purpose of capturing any expression of dissatisfaction by the resident, which will be addressed by staff on that day. Any expression of dissatisfaction that cannot be satisfactorily addressed will be managed through the Complaints procedure. The shift Co-ordinator will record in the daily handover when they have addressed a dissatisfaction/complaint so as to alert the PIC and team.

The Complaints process and key personnel including; Complaints Officer, Advocacy Officer will be reminded to all at House Meetings.

All staff will engage in a refresher training on Complaints Management. This will be completed by 29.3.19.

Complaints Management will form part of the agenda at all monthly team meetings. This will be ongoing from March 2019

The management of complaints will be reviewed at monthly progress meetings between the PIC and ISM. This will be completed ongoing from week commencing 4.3.19 for a 6 month period to 2.9.19. Complaints management will also form part of Supervision meetings at least every quarter.

All complaints will be escalated in accordance with RehabGroup Complaints Policy.

Regulation 12: Personal possessions	Not Compliant
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Outline how you are going to come into compliance with Regulation 12: Personal possessions:

Background

The organisation's policy on Service User's Finances informs staff practice in terms of supporting residents with their finances and ensuring their personal possessions are kept safely.

Actions

Each resident will undergo a financial capacity assessment with the Neuropsychologist. This will be completed for all residents by the 31.5.19

Implementation of the Safeguarding Plan in respect of the resident at risk of financial abuse was reviewed by the Quality & Governance Lead Social Worker and PIC on 19/12/2018.

Based on review by the Behaviour Therapist, the restriction in respect of access to clothes has been removed and the resident's clothes are now available to the resident. Guidance in respect of how the resident can be appropriately supported in this regard has been documented. This was completed by 21/12/2018.

All finances will be handled in the centre in accordance with Rehab Service User Finance Policy.

Keyworkers will conduct a monthly review of all residents' plans to include a review of the supports required to manage their financial affairs and changes to their personal plan will be made as necessary. This will be ongoing from March 2019.

Regulation 13: General welfare and development

Not Compliant

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

Background

RehabCare is committed to ensuring that all residents are supported to maintain a good quality of general welfare and that residents are facilitated to engage with supports and in activities that contribute to their development and wellbeing.

Actions

The PIC and Team Leaders are overseeing a process whereby a detailed plan of meaningful activities in line with resident's preferences for both daily and evening activities will be scheduled on a weekly basis. This process commenced week beginning 17/12/2018 and is recorded on individual weekly planners, as required.

Staff will offer support to residents in terms of accessing these activities. Staff will record both offering and any decline from residents to participate in such activities. The shift coordinator will ensure that this is recorded and allocated to staff on duty on each shift. The shift coordinator signs off on the shift planner each evening to verify this support has been offered and facilitated.

A review of current keyworker allocation was completed by 21/12/2018 to ensure that each resident is assigned a member of the permanent staff team to be their key worker.

The process of screening the needs of each resident was initiated during week beginning 17/12/2018. This screening has been informed by current MDT supports and recommendations deployed in the service. A full review of needs assessments will be completed to ensure that long term support required by residents is identified is in line with their wishes, wants and desires. The reviews will involve input from relevant MDT

professionals in line with each individual needs.

A full and thorough review of all residents support plans is ongoing, the purpose of which is to ensure plans are responsive to resident's needs.

All keyworkers will be coached in their key working by the PIC to ensure best practice approaches to key working are adopted. All staff will engage in Effective Keyworker Training. This will be completed by 29.3.19.

The PIC and keyworkers will action any updates required to plans to ensure that each person has a robust, meaningful, aspirational plan that encompasses all elements of their lives and supports them to achieve independence both at the centre and in the community. Plans will be comprehensive and inclusive of all activities resident is engaged in e.g. day service, outreach supports etc.

PIC & Team leader will review current and planned action plans for residents at all supervision meetings

The PIC and PPIM will audit one randomly selected plan per month. The purpose of the audit will be to identify if activities offered and engaged in are in line with assessed needs of residents and their expressed personal plans. This will commence from 1 April 2019 and ongoing.

The team will engage in reflective practice at team meetings monthly. The team will be encouraged to reflect on activities offered to residents to challenge if activities are meaningful and in line with expressed needs of residents. This will be ongoing from February 2019.

Regulation 17: Premises	Not Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:

Background

The organization is committed to ensuring that the designated centre is decorated and maintained to a high standard. Residents are encouraged and supported by staff to input into the decor their own home.

Actions

The OT commenced an assessment of the premises on the 14/12/2018. This initial assessment focused on the wheelchair ramp. A further assessment is planned to review the accessibility of the kitchen facilities and the use of automatic door openers by the 08/01/2019.

The OT will review the bedroom of one resident on the 08/01/2019. Necessary adaptations to be made by 31/01/2019.

The OT will review the use of the walker on the 08/01/2019, with necessary adaptations

completed by the 31/01/2019.

An offer of a headboard has been made to one resident. They have declined this and stated that they do not want a headboard. This was completed by 21/12/2018.

Televisions as required have been provided for residents. This was completed by 21/12/2018.

Contract cleaners have been requested to do a full deep clean of the premises. This will be completed by the 24/12/2018 and repeated on 03/01/2019. During 2019, these deep cleans will continue on a quarterly basis.

PIC now ensures that all staff have been allocated cleaning duties per shift to maintain a clean home environment for residents and the system of recording completion of these duties is being consistently implemented.

The damaged floor boards in the hall have been replaced. This was completed by 18/12/18.

On the 20/12/2018, the PIC contacted an external painting contractor, who will power clean the exterior of the premises by 10/01/2019. The PIC also booked a repaint to the exterior of the house. This will be completed by the 31/03/2019.

A professional window cleaner will be engaged to clean the windows by 14/01/2019.

The fire exit from a residents' bedroom with a very steep ramp was reviewed by the OT on the 14/12/2018. The ramp will be further reviewed by a building surveyor on the 08/01/2019.

Items stored in the protected escape stairs were removed on 14/12/18.

Non fire proof filing cabinets stored in the hallways (both upstairs and downstairs) in designated fire escape routes, that were reducing the available space to safely evacuate the centre have been removed. This was completed by 14/12/2018. Fire Proof cabinets were removed by 21/12/2018.

The staff sleepover room will be relocated upstairs to allow for additional space in the office downstairs and to provide more suitable sleeping accommodation for staff. This was completed by 21/12/2018.

A programme of works is planned to address premises remediation works required. This programme of works is planned to be completed by 31.5.19. Fire remediation works will be prioritised within the programme of works;

- Reconstruct ramp at exit from bedroom in apartment 1 which is currently deemed unsuitable due to inappropriate gradient. Reconstruct threshold at bedroom exit to ensure safe exit of wheelchairs.
- Upgrade the ceiling above the corridor at first floor level to fire rated 'shaft wall'

standard with additional protection through fire rated slabbing on the underside of the ceiling and upper side of the ceiling tiles in the roof void.

- Install a fire rated attic access hatch.
- Assess fire doors where certification documentation is not available. Following the outcome of this a decision will be taken as to whether or not to replace all fire doors. Fire remediation works will include replacement of at least 3 fire doors. This will be completed by 31.5.19.
- Complete access audit and regularize DAC status with the local authority.
- A reconfiguration of upstairs apartment will include review of the bathroom facilities to identify if alternative bathroom options can be considered for male/female sharing considerations. This will be completed by 29.4.19

A reconfiguration plan for the centre will be implemented by the 29.4.19. The aim of the reconfiguration plan is to revise the design, layout and allocation of apartments to best suit residents & families expressed environmental needs and wishes. Residents will be fully consulted in all reconfiguration of the building and transitioning plans will be devised for each resident as appropriate.

Regulation 18: Food and nutrition

Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

Background

RehabCare is committed to ensuring that all residents are supported as required to access to food in line with their preferences. Residents are supported to be as independent as possible in this regard. Where required staff support residents to plan their, shop for and prepare their meals. Where specific dietary requirements exist input from an allied health professional is sought to support the resident and inform staff practice.

Actions

Full review of all food stored and available for residents was completed on 15/12/18.

Residents whom require support are now supported to develop a weekly meal planner that aligns with their dietary requirements and choices. This will be completed on a weekly basis and commenced week beginning 17/12/2018.

Timetable for appropriate access to the kitchen has been completed in consultation with the residents. This was completed by 21/12/2018.

There has been a review of restrictive practices in terms of their appropriateness to meet the resident's needs. This included a review of access to food, water and kitchen facilities. Following the review, the resident's behaviour support plan has been updated to provide staff guidance in relation to the use of same. The restrictions remaining including protocols and rationale for use have been updated and documented in the service. This was completed by 21/12/2018.

Resident's support plans will be updated as required to ensure residents support needs in terms of food, routines and meal preferences are identified. This will be complete by 31/01/2019.

A referral to a qualified allied health professional has been made in respect of one resident to evaluate their needs and determine appropriate support requirements. The referral was made by 21/12/2018. The review will take place by 31/01/2019.

Regulation 26: Risk management procedures

Not Compliant

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

Background

Background

RehabCare operate a robust risk management system. Processes are in place for the identification, assessment and review of risk to ensure adequate control measures are in place to manage all risks. Risk management practices aim to protect the safety and respect the rights of service users.

Actions

The Providers Health & Safety Officer supported by the Lead Health, Safety & Risk Manager completed a review of all incidents in the service since May 2018 and produced a report providing details of incidents and analysis of trends. This was completed by 17/12/2018.

This report was reviewed by the Lead Health, Safety and Risk Manager, Health and Safety Officer, PIC and ISM on a conference call on 20/12/2018. This review looked at each incident and trend in the service and identified any further required corrective actions.

The process of screening each residents needs was initiated during week beginning 17/12/2018. This screening has been informed by current MDT supports and recommendations deployed in the service. A full review of needs assessments will be completed to ensure that long term support required by residents is identified is in line with their wishes, wants and desires. These reviews will involve input from relevant MDT professionals in line with each individual's needs. This will be completed by 31/01/2019.

An MDT will be held for one particular resident to develop a Falls Preventative Strategy. An interim falls prevention risk assessment is in place. This MDT will be completed by 29.3.19.

A review of resident's documents/ files has commenced week beginning 17/12/2018. This was been substantially completed by the 21/12/2018. This review will be fully completed by 15/01/2019 and will inform actions required in respect of updating

individual risk assessments. Actions arising have been identified from this process.

A review of risk within the service commenced during the week beginning the 17th of December. This review will progress and will inform the update of the risk register. This review will be fully completed by 31/01/2019.

All risks will be managed in line with Rehab Groups risk management policy.

Risk assessment in respect of individual Road Safety will be reviewed by the Outreach Service Manager and Logan House PIC. This will be reviewed by the neuropsychologist. This will be completed by the 29.3.19

The PIC will review all incidents reports for the past 12 months and carry out a full assessment of the risk relating to each adverse incident in conjunction with the staff team and residents. This will be completed by the 29.3.19.

The PIC will share learning from outcomes of the above exercise with the team at the team meeting.

The PIC will engage in incident review meetings with the National H&S team and ISM twice annually or more frequently in the case of high risk incidents.

Risk Management will form part of the agenda at all monthly team meetings. This will be ongoing from March 2019

The management of Risks will be reviewed at monthly progress meetings between the PIC and ISM. This will be completed ongoing from week commencing 4.3.19 for a 6 month period to 2.9.19. Risk management will also form part of Supervision meetings at least every quarter.

Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Background

Within the service there are systems in place to ensure all fire equipment is serviced and in working order. Daily and weekly checks are completed to ensure exits are not obstructed etc. Each resident has an individual PEEP which identifies their support requirements in the event of a fire. A fire risk assessment is completed and regularly reviewed. Regular fire drills are facilitated to ensure there is adequate preparation in the event of a real fire.

Actions

The providers Lead Health, Safety & Risk Manager supported by the Health and Safety Officer completed a review of all fire procedures in the service. This included a review of all fire safety concerns raised in this report, service documentation in terms of fire safety including PEEPs and mobility support requirements. This was completed by 21/12/2018.

Additional measures and supports have been implemented to ensure that the resident is reminded not to put door wedges and furniture in access and egress points. This includes the application of a staff check and the use of visual prompts. This was completed by 21/12/2018.

A full annual health and safety audit which will include a further review of fire safety measures will place by the 15/01/19. This will be completed by the Lead Health, Safety & Risk Manager supported by the Health and Safety Officer.

A follow up review of all actions identified during the December and January reviews will be completed by the Lead Health, Safety & Risk Manager supported by the Health and Safety Officer by the 15/03/19.

Resident's risk assessment has been updated to reflect the support required from staff in terms of smoking and safety in the home. This was completed by 21/12/2018.

A programme of fire remediation works relating to fire detection and containment arrangements is agreed for the centre. This programme of works is planned to be completed by 31.5.19 and will include:

- Reconstruct ramp at exit from bedroom in apartment 1 which is currently deemed unsuitable due to inappropriate gradient. Reconstruct threshold at bedroom exit to ensure safe exit of wheelchairs.
- Upgrade the ceiling above the corridor at first floor level to fire rated 'shaft wall' standard with additional protection through fire rated slabbing on the underside of the ceiling and upper side of the ceiling tiles in the roof void.
- Install a fire rated attic access hatch.
- Assess fire doors where certification documentation is not available. Following the outcome of this a decision will be taken as to whether or not to replace all fire doors. Fire remediation works will include replacement of at least 3 fire doors. This will be completed by 31.5.19.
- Relocate fire detectors throughout the centre.

Regulation 5: Individual assessment and personal plan	Not Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

Background

There is an annual screening of Resident needs, this informs the support plan which identifies their support needs and guides staff practice. The Resident is also supported to have ongoing action plans which enable them to pursue their goals. Based on the

ethos of person-centred planning, support plans and action plans are developed in consultation with the resident. Plans are reviewed on an ongoing basis to review their effectiveness and there is formal review at minimum on an annual basis. The review looks at the effectiveness of the plan over the previous 12 months and encourages the resident to identify goals for the coming year.

Action

The process of screening the needs each residents needs was initiated during the week beginning the 17/12/2018. This screening has been informed by current MDT supports and recommendations deployed in the service. A full review of needs assessments will be completed to ensure that long term support required by residents is identified is in line with their wishes, wants and desires. The reviews will involve input from relevant MDT professionals in line with each individual needs.

A full and thorough review of all residents support plans is ongoing, the purpose of which is to ensure plans are responsive to resident’s needs.

The PIC and keyworkers will action any updates required to plans to ensure that each person has a robust, meaningful, aspirational plan that encompasses all elements of their lives and supports them to achieve independence both at the centre and in the community.

PIC & Team leader will review current and planned action plans for residents at all supervision meetings

The PIC and PPIM will audit one randomly selected plan per month. The purpose of the audit will be to ensure the effectiveness of current plans and to identify if activities offered and engaged in are in line with assessed needs of residents and their expressed personal plans. This will commence from 1 April and ongoing.

The PIC will review the agenda for each person’s annual plan to assure that plans are adequately reviewed and new plans are developed to the highest standard. PIC will attend all Annual Reviews.

Each keyworker will be scheduled to present at monthly team meetings on their key client to update the team on any pertinent information relating to their plans, changes etc. This will also include a presentation by the Outreach Keyworker to ensure seamless consistent sharing of information regarding shared key clients plans and goals. This is ongoing monthly from March 2019.

Regulation 7: Positive behavioural support

Not Compliant

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

Background

The organisation's Positive Behaviour Support and Restrictive Practices Policies guides staff practice when supporting Residents in this regard. Organisational policy requires that all staff must complete a 2-day MAPA Foundation course and an annual refresher thereafter throughout their employment with RehabCare. This training equips staff with the skills required to support residents who experience behaviours that challenge.

Behaviour management plans are in place where necessary and staff are knowledgeable and competent in the implementation of these plans. These plans are periodically reviewed and monitored to ensure they are meeting the needs of the Resident.

All restrictive practices must be approved by a Restrictive Practice Committee and are monitored and reviewed to ensure they are in place for the shortest duration possible.

Actions

A full review of restrictive practices and positive behavior support plans has been completed. This included a review of the restrictions identified in this report in respect to access to clothes, food, water and cooking facilities. As a result of this review restrictions on access to clothes and food have been removed. Updated behaviour support plans as required have been provided to guide staff practice on the appropriate supports to be provided for residents. This was completed by 21/12/2018.

Following this review revised protocols to guide staff practice in respect of the use of the remaining restrictive practices and rationale for their use have been developed. This was complete by 21/12/2018.

The support of an advocate will be provided for the resident as part of a further review of the remaining restrictive practices should they chose to avail of this. To be completed by 31/01/2019.

The Behaviour Therapist and PIC will review practices around the use of PRN medication to ensure administration in line with policies and procedures. This will be completed by 29.3.19.

The PIC will arrange for a full review of all psychotropic medication linked to PRN protocol.

The PIC and BT will conduct quarterly reviews of all Behaviour support plans and restrictive practices. This will be completed ongoing from February 2019.

Restrictive Practices & BSP will be agenda item for update communication at monthly team meetings by the keyworker to ensure a consistent seamless communication re same. This will be ongoing from March 2019.

PIC and ISM will review management of Restrictive Practices and Behaviour Support Plans at monthly progress meetings.

Regulation 8: Protection	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection:</p> <p>Background</p> <p>The organisation's policy on Safeguarding Vulnerable Adults which is in line with national HSE policy governs staff practice in this area. The organization has a zero tolerance policy to all forms of abuse and when issues arise the organization is committed to taking corrective actions to ensure all residents and staff are protected from all forms of abuse. All staff complete Children First and Safeguarding Vulnerable Adults training on commencement of employment and refresher sessions thereafter.</p> <p>Actions</p> <p>The required staffing levels to ensure the safety of all residents as per the current safeguarding plans are in place in the service and will be maintained. This has been in effect as of 30/11/2018.</p> <p>The providers Quality & Governance Lead Social Worker met with the outgoing PIC, new PIC and Designated Officer on the 19/12/18. The purpose of this meeting will ensure a full review of implementation of current plans and support the new PIC to become familiar with the implementation of each plan.</p> <p>A review of resident's documents/ files commenced week beginning 17/12/2018. This was substantially completed by 21/12/2018. Key worker meetings and house meetings and other relevant documents have been reviewed to ensure that all relevant safeguarding concerns have been identified. Actions arising out of this review have been agreed. This was completed by 21/12/2018.</p> <p>Minutes of the recent meeting between PIC, Senior Management and the Designated Officer have been clearly outlined and filed appropriately. This was completed by 21/12/2018.</p> <p>The PIC and ISM (DO) will review safeguarding plans at monthly progress meetings or more frequently should the need arise.</p> <p>Safeguarding plans will be reminded at staff team meetings to ensure any changes in safeguarding are fully communicated. This is in progress and will continue from February 2019.</p>	
Regulation 6: Health care	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 6: Health care:</p> <p>Background</p> <p>Background</p> <p>On an ongoing basis RehabCare supports residents to access support from healthcare</p>	

professionals in the local community as and when required. On an annual basis there is a screening of resident's healthcare needs to ensure that all needs are identified and appropriate support sourced and provided. Guidance for staff practice to support residents with healthcare conditions is documented in individual plans.

Actions

The process of screening the needs of each residents support requirements was initiated during week beginning the 17/12/2018. This screening has been informed by current MDT supports and recommendations deployed in the service. A full review of needs assessments will be completed to ensure that long term support required by residents is identified is in line with their wishes, wants and desires. The reviews will involve input from relevant MDT professionals in line with each individual needs.

Following the full assessment of resident's needs, a new support plan with details of health care support needs will be developed. In addition, any specific healthcare management plans or risk assessments will be further reviewed and or developed. This will be completed by 31/01/2019.

The Quality & Practice Officer (Registered Nurse) within the Quality & Governance Directorate has consulted with the Team Leader in the service and reviewed elements of the health related documentation. Priority needs for the development of healthcare management plans for three residents have been agreed. One of these was completed on the 21/12/2018 and the remaining two will be completed by the 10/01/2019.

Diabetes management plan and individual Medication Management Plan has been reviewed and developed for a resident with a diagnosis of diabetes on the 20/12/2018 by the organisation's Quality and Practice Officer (Registered Nurse) to guide staff practice. This was completed by 21/12/2018. Final sign off on this plan will be completed by the 15/01/2019.

An initial review of assessments for self-administration of medication was completed on 17/12/2018. Recommendations for actions from this review have been developed.

An initial review of medication practices was completed on 17/12/2018. Recommendations for actions from this review have been developed.

A full review of medication practices to be completed by the organisation's Quality and Practice Officer (Registered Nurse) will take place before 31/01/2019.

The PIC and ISM will review contractual arrangements with allied health professionals supporting residents at the centre to ensure timely and appropriate access to MDT supports. This will be completed in conjunction with Rehab Quality & Governance Directorate. This will be complete by 29.4.19.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	31/01/2019
Regulation 12(3)(a)	The person in charge shall ensure that each resident uses and retains control over his or her clothes.	Not Compliant	Orange	31/01/2019
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Yellow	31/01/2019
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	29/12/2018
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of	Not Compliant	Red	31/03/2019

	staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/03/2019
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	31/03/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Yellow	31/03/2019
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	31/03/2019
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.	Not Compliant	Orange	31/01/2019
Regulation	The person in charge shall	Not	Orange	31/01/2019

18(4)	ensure that residents have access to meals, refreshments and snacks at all reasonable times as required.	Compliant		
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/01/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/01/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	15/03/2019
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	20/12/2018
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	15/01/2019
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	15/01/2019
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health	Substantially Compliant	Yellow	31/01/2019

	care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	31/01/2019
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	31/01/2019
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	31/01/2019
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	31/01/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	21/12/2018