Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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:	Unannounced
Date of inspection:	31 January 2019
Centre ID:	OSV-0003468
Fieldwork ID:	MON-0025786

About the designated centre

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

Logan House offers accommodation and support to individuals with an acquired brain injury. The service accommodates both male and female residents between the ages of 18-65. The centre consists of two buildings which are divided into five apartments. Units one and two provides accommodation for four residents on the ground floor, whereas unit three and four accommodates four residents on the first floor. A further unit five comprises of a separate one bedroom apartment to the rear of the house. Unit five is used by residents availing of respite care at the centre, who have limited support requirements. Levels of support provided to residents vary across the five units during the day and there was two staff on duty at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
31 January 2019	10:30hrs to 18:00hrs	Thelma O'Neill	Lead
31 January 2019	10:30hrs to 18:00hrs	Catherine Glynn	Support

Views of people who use the service

There were three residents in the centre on the day of the inspection. Inspectors spoke with two residents who told them that they were happier at the centre since it had a new management team. Residents also said that they felt listen to by the management team and that their complaints were addressed in a timely manner. However, residents did say that there were still areas where they would have liked to see improvements at the centre, but acknowledged that this was happening and would take time.

Capacity and capability

This inspection was completed as a follow-up, risk based inspection to a monitoring event carried out on the 29 November 2018. The inspection in November 2018 had identified a significant number of non-compliance with the regulations which impacted on the quality of care and support provided to residents. A provider meeting was called on the 13 December 2018 to issue a warning letter to and advise the provider of the serious risks to residents identified during the inspection. Following the meeting, the provider was required to respond in writing, stating how they would bring the centre back into compliance with the regulations.

The provider submitted written assurances in response to the warning letter as well as a robust compliance plan. These included a change in the management team in the centre and assurances that regular updates would be submitted to the senior management team on a weekly basis. The Health Information and Quality Authority were advised that the majority of the actions identified would be addressed by the 31 January 2019.

Inspectors reviewed the actions taken by the provider since the last inspection and found the provider had appointed a new management team to review the operational management and quality assurance systems in the centre. Although the actions from the previous inspection were not fully complete, inspectors did find that the centre's compliance rate had improved in a number of areas and the centre was moving towards compliance, albeit not within the agreed time lines.

A new person in charge and an integrated service manager had been redeployed from other service areas within the provider organisation to strengthen the governance and management of the centre and bring its practices into compliance. Inspectors found that changes in management structure had enhanced the leadership and governance of the centre and had made a positive impact on the

care and support provided to residents at the centre on a daily basis.

The new person in charge was based full-time at the centre, and was suitability skilled and qualified to manage the centre. The provider had also appointed an integrated service manager to support and assist the person in charge in the governance and management of the centre. The integrated service manager was experienced in the leading and managing teams and was responsible for the governance and management of several designated centres within RehabCare.

The provider's new management arrangements had ensured following the last inspection, that a full review of practices at the centre and their impact on the quality of service experienced by residents had occurred at Logan House. Following the review's completion, the provider had developed a quality improvement plan to address identified findings and bring the centre back into compliance with the regulations and improve the lived experience of residents at the centre. The review had examined areas such as staffing levels, premise issues, complaints management, fire safety risks, safeguarding and risk management and inspectors found that improvements in these areas were evident since the last inspection. However, further action was required by the provider to ensure full compliance with the regulations.

Inspectors found that the service was safer for residents, but the compatibility of residents living together in this centre remained an issue, as the accommodation provided did not fully meet the care and support needs of residents. However, inspectors were made aware that the provider had an agreed plan in place to address compatibility concerns and reconfigure the centre in manner that would best suit both residents' health and safety and care needs.

The management of received complaints had been improved since the last inspection.The provider's commitment to addressing residents' complaints about the centre was shown through the Chief Executive Officer meeting with all of the residents at the centre following the last inspection. In addition, a meeting was held with each resident and their representatives to capture and discuss their views on the service provided. Residents had also be facilitated to meet with an independent advocate. Inspectors found that following the last inspection, residents' complaints were being addressed; however, some received complaints did not have all associated actions documented such as who was responsible for ensuring the complaint was addressed and whether the complaint was resolved to the resident's satisfaction.

Registration Regulation 5: Application for registration or renewal of registration

The provider has applied to renew the registration of this centre, all of the required documents have been received within the appropriate time frame.

Judgment: Compliant

Regulation 14: Persons in charge

The newly appointed person in charge was based full-time in the centre and had the required qualifications, skills and experience necessary to manage the designated centre. The person in charge was engaged in the governance, operational management and administration of the centre on a regular and consistent basis.

Judgment: Compliant

Regulation 15: Staffing

A review of the staffing allocation in the centre had taken place and staff support was assigned to individual residents in-line with risk interventions such as safeguarding plans. Furthermore, residents were supported to attend personal appointments and participate in social activities. Inspectors found there was a more consistent and cohesive approach towards meetings residents' assessed needs following the last inspection. For example; night staffing arrangements had been allocated to both floors in the centre to ensure staff support was available when required. However, a staffing needs assessment had not been completed for all residents, and the staff roster did not accurately reflect the actual working hours of staff in the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had access to regular training opportunities, which promoted their knowledge and skills to support residents' assessed needs and reflected current developments in health and social care practices. However, inspectors found that there were deficits in residents' assessments and personal plans due to staff requiring more training in this area. Some staff also required refresher training in medication management skills and the management team advised inspectors that they were currently reviewing staff training needs at the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

Governance and management has improved since the last inspection. A new person in charge was in post as well as a new person participating in the management of the centre. A new support worker was also redeployed to provide support to the team leaders in the centre. The senior management team had also provided support in the form of assessments, reviews and training for the new management team and staff. A review of the staff skill mix had also taken place and the staff roster had been changed to ensure there was adequate staff support available to residents when required.

While there remains a significant amount of work to be completed, the current management team had demonstrated the capability and capacity to lead the team to achieve identified improvements at the centre in timely and effective manner. However, although assured by actions taken following the last inspection, the provider did not have a robust, time bound quality improvement plan in place for all activities proposed at the centre by the management team.

Inspectors also found that the provider had not ensured that adequate arrangements were in place to support, develop and performance manage staff at the centre and ensure they were equip to meet residents' needs.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was subject to regular review, reflected the services and facilities provided at the centre and contained all information required under the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

Improvements to complaints management at the centre had ensured that residents and their representatives were aware of their right to make a complaint as well as how to the centre's complaints officer and independent advocacy. Staff were knowledgeable on how residents' concerns were addressed at the centre, although complaints records did not fully document all actions taken in response and the complainant's satisfaction with the outcome.

Judgment: Substantially compliant

Quality and safety

The quality and safety of this centre had improved since the last inspection, however, a significant amount of improvements remained to be completed. Following last inspection, the provider had implemented a full review of the quality and safety of the service and found that a more robust enhanced quality assurance system was required in the centre. Inspectors found the the new management structure had enhance leadership and oversight of the centre which had a positive impact on the service delivery.

On this inspection, inspectors found that improvements had occurred in areas such as health care, managing personal possessions, access to food and drinks, general welfare and development, premise issues, infection control, positive behaviour support and restrictive practices. However, there were five key areas that required significantly more work to meet full compliance with the regulations. These related to risk management, safeguarding, fire safety management, individual assessments and premise issues.

In general the risk management practices were in-line with the organisational policies and procedures and staff were able to demonstrate to inspectors that there were effective risk management procedures in operation in the centre. However, based on evidence reviewed during the inspection, a further review of fall management arrangements at the centre to meet residents' needs was required.

The management team had taken measures to safeguard residents from being harmed or experiencing abuse. There was a safeguarding policy in place and all staff had received specific safeguarding training. This ensured that staff had the knowledge and skills to treat each resident with respect and dignity and to recognise the signs of abuse and or neglect. The provider continued to manage ongoing safeguarding risks at the centre, and this had improved since the last inspection with consistent staff supervision. However, inspectors found that not all safeguarding risks identified at the centre were appropriately documented to both guide staff practice and protect residents from harm.

The provider had completed residents' compatibility assessments and had plans to reconfigure the centre to provide more suitable accommodation, both from a safeguarding perspective, as well as meeting the residents long-term care and support needs.

Inspectors found that the residents were now actively participating in their local community and were supported to do so by a structured and varied plan of activities. One resident had commenced art classes and was regularly attending the gym and another resident told inspectors they were attending a local community

centre for activities. However, further assessments regarding residents long-term goals in areas such as employment or further education were required.

Fire safety management in the centre had improved since the last inspection. Automatic fire door sensors had been installed to ensure they would close in the event of a fire. There were also procedures in place for the management of fire safety equipment and fire training for staff in the centre. A building and fire risk assessment had also been completed by a competent person since the last inspection. The assessment had identified further fire safety works required at the centre, and the provider had sanctioned all required works to be undertaken and completed by the 31 May 2019.

The provider had ensured that residents had access to medical services to ensure that they received a good level of health care. All residents had access to allied health professionals; however, some residents were on waiting lists to access services such as physiotherapists and dietitians.

Regulation 12: Personal possessions

Residents had improved access to their personal possessions including personal finances following the last inspection. However, financial capacity assessment to further assess residents' support needs had not been completed in-line with the agreed time frame of the 31 January 2019.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Since the last inspection, residents were supported to participate in a range of activities in the community which they enjoyed. However, the provider had not completed a review into each residents' assessed needs, capabilities and interests to ensure that the activities on offer were in-line with individuals' personal plans and supported them to achieve independence both at the centre and in the local community.

Judgment: Substantially compliant

Regulation 17: Premises

In general the premise was clean and suitably decorated; however, storage remained an issue as equipment continued to be kept in the stairwell resulting in

a trip hazard.

Inspectors found that the design and layout of the premises continued to be an issue in meeting residents' assessed needs. Some of the rooms were not suitable to meet residents' environmental needs and did not provide adequate space for residents' to mobilise around the centre and for the storage of personal and work equipment. In addition, toilet facilities did not meet the needs of residents' living in the upstairs part of the premises.

The person participating in the management of the centre informed inspectors that a number of reconfigurations were being scheduled over the coming months to ensure the premises met the residents' needs and provide a safe and suitable living environment at the centre. However, inspectors were not provided with a clear time bound plan on when all identified renovation works would be completed at the centre.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents had increased access to food and drinks following the last inspection and residents' individual dietary needs were met. Residents were involved in meal planning and were supported to buy, prepare and cook their own meals.

Judgment: Compliant

Regulation 20: Information for residents

The provider had not put measures in place to ensure the residents' guide reflected all information required under the regulations.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had systems in place for the assessment, management and ongoing review of risk. However, some individual risks were not appropriately reviewed and managed such as those relating to falls management and road safety.

Judgment: Not compliant

Regulation 27: Protection against infection

Infection control procedures had improved since the last inspection. The provider had contracted a cleaning company to conduct an internal and external deep clean of the centre and a cleaning schedule was developed and implemented by staff on a daily basis.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had installed automatic fire door closures following the last inspection. However, a subsequent building and fire risk assessment had identified further fire safety measures to be undertaken at the centre relating to wheelchair access as well as fire detection and containment arrangements.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Although reviews had commenced into residents' personal plans since the last inspection, the provider had not ensured that they had been completed for all residents at the centre. Furthermore, in those personal plans sampled by inspectors, the person in charge had not ensured that personal goal records included time frames for achievement and staff responsible to support residents in the achievement of their goals.

Judgment: Not compliant

Regulation 6: Health care

Residents' healthcare needs were reviewed and residents had received allied health assessments since the last inspection, which had improved their health. However, some residents remained on a waiting list to see allied health professionals.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

A full review of restrictive practices in the centre had been completed and had resulted in residents having increased access to food and drinks in their apartments. Furthermore , a restriction regarding access to a resident's clothes had been removed and a support plan put in place to more effectively support the resident's needs. However, a review of the practices around the use of PRN medication was required to ensure that it is was only administered in-line with provider's policies and procedures and national best practice.

Judgment: Substantially compliant

Regulation 8: Protection

Residents told inspectors that they felt safer in the centre and staff confirmed to inspectors that action was being taken to protect residents. However, inspectors found some residents' safeguarding plans had not been appropriately updated and required further review.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Logan House OSV-0003468

Inspection ID: MON-0025786

Date of inspection: 31/01/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
• 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 current PIC 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.

• The Rota will be staffed appropriately to ensure that staffing levels are maintained. Copies of planned and worked rotas will be available in the centre and will reflect the actual working hours of staff in the centre. The rota will identify the Shift Co-ordinator assigned to every shift. The rota will continue to be planned 4 weeks in advance. This will be completed by 31.5.19

Regulation 16: Training and staff	Substantially Compliant

development	

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• A full review of staff capability and training needs will be undertaken as part of the reconfiguration of the staffing model at the centre. This will be completed by 26.4.19

• A focused Staff Training and Development plan developed to build the capability of staff will continue to be customised to ensure best match to meeting the training needs of staff at the centre. 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.

Training will include: -
Fire Safety Training
Risk Assessment training
Restrictive Practices
Positive Behaviour Support Planning
Safeguarding & Allegations
Safe Administration of Medication Assessment
MAPA
Managing Behaviours that Challenge
Refresher on Regulations
Food Safety Management
Safe Moving and Handling
Managing Complaints
Report Writing
Person Centred Planning & Best Practice in Key working
Brain Injury Awareness

• The PIC, Team Leader, Support Workers and Care Workers will complete a Distance Learning Cognitive Rehabilitation Training programme in conjunction with Braintree UK.

• All staff at the centre will have completed training outlined by the 28.6.19.

• Thereafter the PIC will ensure all staff receive training including refresher training within the required timeframes. The PIC will audit participation in staff training on a monthly basis.

• 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	Substantially Compliant

management	

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

• 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 current PIC will remain in post to provide a full handover to ensure seamless continuity of service. This will be completed by 31.5.19.

• 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.

• 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.

• Team Meetings will be held monthly in the centre. The Integrated Services Manager will attend team meetings on a bi monthly basis. This will be ongoing from March 2019.

• A focused Staff Training and Development plan developed to build the capability of staff will continue to be customised to ensure best match to meeting the training needs of staff at the centre. This plan will be informed by the assessed needs of residents.

• 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 34: Complaints procedure	Substantially Compliant

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

• 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 the Complaints Policy.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

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

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

Outline how you are going to come into compliance with Regulation 17: Premises:
• 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.
• This plan will see the number of beds available in the service reduce to 7. The current TLU on site will form part of the suite of apartments occupied by residents of Logan House. The reconfiguration of the building will eliminate the male/female sharing arrangement in apartment one. Residents will be fully consulted in all reconfiguration of the building and transitioning plans will be devised for each resident as appropriate.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
• The residents guide will be fully and comprehensively reviewed against the regulations to ensure completeness of all information contained within. This will be completed by the PIC in conjunction with the residents and team by the 29.3.19.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• All risks will be managed in line with Rehab Groups risk management policy.

• 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.

• 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 April 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

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• 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.

• 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

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• 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 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• 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.

Regulation 7: Positive behavioural support	Substantially Compliant

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

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Designated Officer, in conjunction with the PIC and Senior Social Worker,

Safeguarding Lead have conducted a full review and update of all safeguarding plans.

• The PIC and ISM (DO) will review safeguarding plans at monthly progress meetings or more frequently should the need arise.

• 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.

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.	Substantially Compliant	Yellow	31/05/2019
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Yellow	29/03/2019
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in	Not Compliant	Orange	29/03/2019

	accordance with their interests, capacities and developmental needs.			
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/05/2019
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	Yellow	31/05/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	28/06/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet	Substantially Compliant	Yellow	31/05/2019

	the aims and objectives of the service and the number and needs of residents.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/05/2019
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	31/05/2019
Regulation 20(2)(b)	The guide prepared under paragraph (1) shall include the terms and conditions relating to residency.	Substantially Compliant	Yellow	29/03/2019
Regulation 23(1)(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	31/05/2019

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	28/06/2019
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	29/03/2019
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in	Not Compliant	Orange	31/05/2019

	place.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/05/2019
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.	Not Compliant	Yellow	02/09/2019
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	29/03/2019
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	Not Compliant	Yellow	29/04/2019

	or by arrangement with the Executive.			
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.	Substantially Compliant	Yellow	29/03/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	04/03/2019