Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

## Issued by the Chief Inspector

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| Name of designated centre: | Logan House |
| Name of provider: | The Rehab Group |
| Address of centre: | Galway |
| Type of inspection: | Unannounced |
| Date of inspection: | 06 October 2025 |
| Centre ID: | OSV-0003468 |
| Fieldwork ID: | MON-0047485 |

## About the designated centre

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

Logan House is a designated centre run by The Rehab Group. The centre can cater for up to seven male and female residents, who are over the age of 18 years and who have an acquired brain injury. The centre is situated on the outskirts of Galway city and is centrally located to cafes, restaurants and other local amenities. The centre comprises of one building which contains staff offices and five separate apartments. Here, residents have their own bedroom, some en-suite facilities, bathrooms and kitchen and living areas. A communal courtyard is also available to residents to use as they wish. Staff are on duty both day and night to support the residents who live here.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 7 |

## How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

**1. Capacity and capability of the service:**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

**2. Quality and safety of the service:**

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Monday 6 October 2025 | 10:00hrs to 17:30hrs | Mary Costelloe | Lead |

## What residents told us and what inspectors observed

This unannounced inspection was carried out to assess the provider's compliance with specific regulations. The provider had notified the Chief Inspector of a number of safeguarding incidents which had occurred in the centre in recent months.The Chief Inspector had also received information which raised specific concerns regarding the unsuitability of accommodation and ineffective communication systems between different areas of the service which impacted upon the quality and safety of care for a resident in the service. The findings from this inspection indicated that issues raised in relation to ineffective communication systems highlighted in the unsolicited information received by the Chief Inspector were found to be upheld. The findings also indicated poor compliance with the regulations reviewed including governance and management, staffing, communication, risk management, safeguarding, assessment and personal planning.

This inspection was facilitated by the person in charge who had been recently appointed to manage the day-to-day operation of the service. The inspector also spoke with four staff members who were on duty. During the course of the day, the inspector met and spoke with four residents, one with whom they spoke with for an extended period of time and with one family member who was visiting the centre.

The designated centre comprised of a large two-storey detached building located in residential area on the outskirts of a city. The building contained four separate apartments, two of which were single occupancy and two shared occupancy. There was also a separate single occupancy self-contained apartment located on the grounds and a shared patio area to the rear of the apartments. Each apartment had a kitchen and living area, either one or two bedrooms, some had an en suite toilet and shower and separate bathroom facilities were also provided. There was a staff office and separate sleep over room available to staff within the main building. Each apartment was furnished and decorated in a homely style to the personal taste of each resident. Apartments were decorated with personal photographs, artwork, memorabilia and furniture of their choosing. Each apartment was provided with adequate personal storage space. One apartment was designed to meet the needs of a resident using a wheelchair. It contained an accessible kitchen with height adjustable cooker and food storage cupboards, sensors to open doors, remote controlled window blinds and an intercom system so that they could communicate with staff in the main building. However, the personal alarm system which the resident required to contact staff in the event of a fall or other emergency was found to be ineffective on the day of inspection. The systems in place to ensure that this system was fit for purpose were inadequate. The records reviewed showed that the system was being checked twice daily with no issues being identified, however, a review of the system on the day of inspection showed that it was not working as intended which posed a risk to the resident. The person in charge undertook to review this system and the protocols in place to ensure that staff were alerted and could attend to the resident immediately in the event of an emergency.

There were seven residents who were living with an acquired brain injury accommodated in the centre. They predominately required support in the area of social care and positive behavioural support. Some residents had assessed health care needs, in relation to their elimination and nutrition, and only required minimal support from staff with this aspect of their care. Some residents were very independent and were in employment, some regularly attended organised group activities and others preferred to organise their own individual schedules. Each resident had their own weekly planner setting out their planned activities for the week.

Residents spoken with were in good from and told the inspector that they were generally getting on well. They advised that they continued to be involved in planning their own schedules. One resident told the inspector how they enjoyed going for walks in the local woods and parks and were heading out for a walk later in the day. The inspector met with two residents as they were heading off for a walk and planning to visit the local supermarket to do some shopping. Another resident spoken with told of their plans to go for physiotherapy, and swimming later in the day. Some residents spoke of going to the local 'hub' and enjoyed partaking in group activities including baking and art. Residents had recently got together to attend a birthday celebration for one of their peers, had enjoyed a summer BBQ together and recently had gone bowling as a group. Each resident decided upon and planned their own weekly menus and told the inspector how they went shopping for groceries each week. Shopping lists and the weekly meal plans were displayed in each apartment as a reminder for residents.

There were normally three staff on duty during the day and evening time during the weekdays with four staff on duty at weekends. Additional staffing was provided by the outreach programme staff who supported three individuals for allocated hours each day. These staff supported some residents with meal preparation, personal care and to partake in social activities and outings of their choice. However, improvements were required to ensure that there were clear lines of authority and accountability, clear allocation of duties, as well as formal handover arrangements to ensure the safety and continuity of care and support for residents. This is discussed further under Regulation 23: Governance and management and Regulation 15: Staffing.

The centre was generally found to be well maintained and visibly clean throughout. The provider had invested in the premises and new windows had been recently fitted to the building. Internal improvements including repainting had also taken place. However, further enhancements were required to some external areas and further repairs were required in some apartments. The external areas including the plasterwork to the front wall and wooden gate required repairs. The garden areas were also in need of on-going maintenance. Damaged wooden flooring to the bedroom in one of the apartments required repair, raw wooden surfaces to one of the bathrooms required to be sealed to provide readily cleanable non-absorbent finishes and a stained and damaged shower curtain needed to be replaced.

While residents reported that they liked their apartments, one resident advised that they were unhappy with their current living arrangements as they felt isolated and

sometimes lonely due to the lack of interaction with their peers and with staff who were based in the main house. They advised that while they liked the size and spacious layout of their apartment, the current accommodation did not meet their needs due to lack of opportunities for social interactions particularly in the evenings and at weekends. Following a recent review of their care needs, it is the opinion of the multi-disciplinary team that the resident might be better facilitated in a residential setting that is shared with other service users and with staff present. The provider was aware of this need and there had been on-going meetings with the funding provider with a view to seeking alternative suitable accommodation.The person in charge outlined that a referral process to an alternative provider was currently in progress. The inspector also met with a family member of the resident who advised that they continued to advocate on behalf on the resident to ensure that their assessed needs in terms of suitable alternative accommodation was provided. They confirmed that they were being kept updated regarding the referral process.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents life.

## Capacity and capability

The provider needed to ensure that there were clearly defined management arrangements in place that identified the lines of authority and accountability, and detailed responsibilities for all areas of the service. Management arrangements in place required improvement to ensure that the service is safe, appropriate to the residents needs, consistent and effectively monitored. The findings from this inspection indicated non compliance's in governance and management, staffing, communication, risk management, safeguarding, assessment and personal planning.

The provider had appointed a new person in charge. The person in charge worked full-time and was based in the centre during the weekdays. They had been appointed to the role in the past two weeks and were still getting to know residents, staff and the service. They acknowledged that several aspects of the service required improvement and confirmed that some of these had already been identified through their own observations and review of processes. They expressed agreement with the findings of this inspection and demonstrated a commitment to addressing the issues raised. They were supported in their role by a team leader and a second team leader had been appointed and was due to commence in post. The person in charge outlined how there were plans in place that team leaders would work on alternative weekends to ensure oversight of the service. There were also on call management arrangements in place for out-of-hours and at weekends.

Residents in the centre were supported by both residential and outreach staff teams. However, ambiguity in accountability and authority arose due to both staff

teams reporting to separate managers. This had several potential impacts on the quality and safety of care and support provided to residents including a risk or uncertainty around decision making responsibilities which could lead to delays in addressing residents needs. There was lack of a coordinated communication system between both staff teams, which posed a risk to the continuity and effectiveness of support to residents.

While staffing levels appeared adequate to meet residents needs, there was insufficient clarity regarding how tasks were allocated and who held responsibility for specific care and support. Some residents felt that while staff responded to requests for support, their approach was more focused on completing the task than on engaging with residents as individuals. Communication books in residents apartments were not reliably maintained, some had not been updated for over a week while others lacked sufficient detail to support effective information sharing. Some daily notes reviewed for individual residents were also poorly documented, lacked detail, and did not always reflect the individualised support provided or the residents' experiences. This lack of consistency in completing the communication books and daily notes had potential to impact on the continuity of care, information sharing among staff so that they could respond appropriately to changes in a residents well being, behaviour or support needs.

While the provider had systems in place for reviewing the quality and safety of care including an annual review and six monthly provider audits, the inspector noted that actions identified as a result of some reviews had not been acted upon and therefore had not led to service improvement in those areas. The most recent provider led audit completed in July 2025, included actions relating to safeguarding and record keeping such as the completion of daily notes. However, there was no evidence in the team meeting minutes reviewed that these actions had been discussed with staff, therefore, there was a missed opportunity to discuss issues, share learning and bring about service improvements.

The provider had submitted an assurance report in June 2025 in response to information of concern received by the Chief Inspector. However, the inspector found that some of the information provided in the response in relation to the operation of an effective personal alarm communication system used by a resident was inaccurate in that the system was not working and checks being completed on the system were ineffective. Records reviewed on the day of inspection indicated that this system was being checked twice daily with no issues being identified or reported by staff. This impacts upon the credibility of the providers governance systems and also compromised the safety of the resident. On the day of inspection, the personal alarm system was not functioning as described, which posed a risk to the resident who may not be able to summon help in the event of an emergency or lead to delays in staff responding to urgent situations such as falls, medical issues or safeguarding incidents. This issue had been raised by the resident and their family member and had been ongoing for several months.

## Regulation 15: Staffing

Improvements were required to ensuring there was sufficient clarity around tasks allocation and staff responsibilities and to ensuring that residents received continuity of care and support. Communication books and daily notes were not reliably maintained, poorly documented, lacked detail, and did not always reflect the individualised support provided or the residents' experiences. These inconsistencies had potential to impact upon the continuity of care and information sharing among staff.

The staffing rosters reviewed for 29 September to 12 October 2025 showed that there were normally three staff on duty throughout the day and evening-time with two staff on duty at night-time (one staff on active duty and one staff on sleep over duty). There were normally four staff on duty at weekends. Some residents also had allocated hours of support from the outreach staff team during the day. The person in charge outlined that three staff members were on extended leave and how these shifts were being covered by regular relief and agency staff. Improvements were required to staff rosters to ensure that the full names and role of each staff member was included and to ensure that the staff member in charge of each shift was clearly identified. The person in charge showed the inspector the new staff roster template which they planned to implement which would address these issues.

Judgment: Not compliant

## Regulation 23: Governance and management

The provider needed to ensure that there were clearly defined management arrangements in place that identified the lines of authority and accountability, and detailed responsibilities for all areas of the service. There was ambiguity in accountability and authority, as two staff teams who provided support to residents, reported to different line managers. This had several potential impacts on the quality and safety of care and support provided to residents including a risk or uncertainty around decision making responsibilities which could lead to delays in addressing residents needs. There was lack of a coordinated communication system between both staff teams, which also posed a risk to the continuity and effectiveness of support to residents. The existing management systems required review to ensure the service is safe, responsive to residents' needs and effectively monitored. Gaps in governance were noted across areas including staffing, communication, safeguarding, risk management, assessment and personal planning.

The provider submitted an assurance report in response to regulatory concerns, however, it was found that some of the information provided within the report was inaccurate. This undermines confidence in the providers governance and oversight arrangements.

Given the number of safeguarding incidents notified to the Chief Inspector in recent months, there was lack of evidence of an holistic approach been taken to the

oversight and management of safeguarding to ensure staff reflection, learning and encouragement of a culture of openness. The minutes of recent staff meetings and residents house meetings were reviewed, and indicated that safeguarding or recent safeguarding incidents had not been discussed with staff or residents.

While systems were in place to review the quality and safety of care, including internal audits, actions identified through these reviews had not been implemented. For example, actions due in July 25 relating to safeguarding and record keeping remained outstanding. There was no evidence that these issues had been adequately discussed with staff or used as learning opportunities to improve the quality and safety of the service.

Further oversight and improvements were required to personal planning documentation and to ensuring that residents received support to achieve their identified personal goals.

Judgment: Not compliant

## Quality and safety

As discussed under the capacity and capability section of this report, deficits in the overall governance and management of the centre, as well as staffing, communication, risk management, safeguarding, assessment and personal planning impacted negatively on the quality and safety of care in the service.

Improvements and oversight were required to ensure that there were coordinated communication systems in place between both staff teams. The inspector found that the service did not have a consistent or structured system for communication between staff teams including the absence of formal handovers. There was also an absence of reliable daily notes and communication logs. This posed a risk to the continuity of care, with potential negative impacts on the safety and well-being of residents. It also made it difficult to assess that care and support was being delivered in line with individual plans, preferences and assessed needs. Furthermore, the absence of reliable daily notes undermined accountability and oversight.

Safeguarding incidents reported to the Chief Inspector were being managed in line with safeguarding procedures and polices. All staff had completed training in safeguarding of vulnerable adults. However, there was a lack of evidence of broader proactive approach been taken to the oversight and management of safeguarding.

The inspector reviewed the files of two residents. There were recently updated comprehensive assessment of needs completed. Care and support plans were in place for all identified issues. The support plans in place were found to be clear and informative. There was evidence of regular review from a multidisciplinary team including physiotherapist, behaviour support specialist, psychiatry, dentist and

opthalmology. However, further oversight and improvements were required to personal planning and associated documentation, to ensure that residents were supported to pursue their individual chosen goals, and to ensure that updates regarding the progress of achieving those goals was evidenced.

While the provider had a risk management system in place, it failed to mitigate a specific risk to an individual resident, specifically the ineffective operation of a personal alarm. There were no clear protocols or staff responsibilities established for monitoring the house mobile telephone alerts generated when the alarm was activated. Assurances submitted by the provider with regard to the effective workings of the system were found to be inaccurate and the daily checks carried out on the system by staff had failed to identify any issues with the system.

The premises was generally laid out to meet the number and needs of residents, however, the provider needed to progress plans to provide alternative suitable accommodation for a resident to meet their specific needs in order to improve their quality of life and well-being.

## Regulation 10: Communication

Improvements were required to ensure that each resident is assisted and supported at all times to communicate in accordance with their needs and wishes and to ensure that the individual communication supports required by each resident are supported by staff.

There was no effective communication system in place for a resident who was a wheelchair user and lived in their own apartment which was separate from the main house in the event that they needed to contact staff in an emergency.

A resident spoken with advised that there were times when they found it difficult to understand verbal communication with some staff and they also felt that some staff did not understand them which led to feelings of isolation and the inability to express their needs.

Judgment: Not compliant

## Regulation 17: Premises

The premises was generally laid out to meet the number and needs of residents, however, the provider needed to progress plans to provide alternative suitable accommodation for a resident to meet their specific needs in order to improve their quality of life and well-being. New windows had been recently fitted to the building and internal improvements including repainting had also taken place. However, further enhancements were required to some external areas and further repairs

were required in some apartments. The external areas including the plasterwork to the front wall and wooden gate required repairs. The garden areas were also in need of on-going maintenance. Damaged wooden flooring to the bedroom in one of the apartments required repair, raw wooden surfaces to one of the bathrooms required to be sealed to provide readily cleanable non-absorbent finishes and a stained and damaged shower curtain needed to be replaced.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

Improvements and further oversight were required to the systems in place for the management and on-going review of risk in the centre. The provider had failed to mitigate a specific risk to an individual resident, in that their personal alarm system was not working effectively. This posed a serious risk to the resident who may not be able to summon help in the event of an emergency or lead to delays in staff responding to urgent situations such as falls or medical issues. This concern had been raised by the resident and their family member and had been ongoing for several months.

Assurances submitted by the provider with regard to the effective workings of the system were found to be inaccurate and the daily checks carried out on the system by staff were ineffective and had failed to identify any issues with the system.

On the day of inspection, the inspector asked the resident to activate the alarm system as a test, however, the alarm was not responded to by staff when activated. On activation of the alarm, a text alert is sent to the house mobile telephone which should alert staff. The inspector and the resident were advised that staff had not responded as the house mobile telephone was not being monitored at the time and the text alert was not heard. It was also noted that there were delays in alerts being generated to the house mobile telephone when the alarm was activated. There were no clear protocols or staff responsibilities established for monitoring the house mobile telephone alerts. The person in charge advised of the specific staff member on duty who had responsibility for ensuring that they monitored the phone for alerts. Later in the day, the inspector spoke with this staff member but they were not monitoring the telephone, they did not know where the telephone was located and they did not demonstrate an understanding as to why they should be monitoring the phone or of the risk posed to the resident in the event of an emergency.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

Further oversight and improvements were required to personal planning documentation and to ensuring that residents received support to achieve their identified personal goals. The inspector reviewed the files of two residents in detail. PCP (person-centred planning) meetings involving the residents, family members and key workers were due to be scheduled annually with the purpose of creating a personalised plan focused on the individual's goals, dreams, and aspirations. While individualised plans had been created, there were no progress updates documented and it was unclear if action plans in place had been progressed or achieved. Each resident had been assigned a key worker who was responsible for supporting them progress their goals and to meet with them to review progress on a monthly basis, however, it was noted from one file reviewed that the key worker meetings had not taken place in recent months. The inspector noted that the last PCP meeting for another resident had taken place in June 2024. However, there were no progress updates documented to show if this residents plan had been progressed, or achieved. The minutes from a recent key working meeting with this resident indicated that their goals set out in June 2024 had not progressed.

Judgment: Not compliant

## Regulation 8: Protection

There was lack of evidence of an holistic approach been taken to the oversight and management of safeguarding to ensure staff reflection, learning and encouragement of a culture of openness as well as ensuring that residents felt empowered to speak up. Safeguarding incidents reported to the Chief Inspector in recent months had been managed in line with safeguarding procedures and polices. The person in charge outlined that a number of trust in care investigations were still in progress but nearing conclusion. They undertook to submit an update to the Chief Inspector on the outcome of the investigations once completed. The findings from the most recent provider-led audit in July 2025 had outlined an action that safeguarding was to be discussed with the staff team at the July team meeting. A review of the minutes of team meetings indicated that safeguarding had not been discussed. A review of the minutes of recent house meetings with residents also indicated that safeguarding had not been discussed and safeguarding was not an agenda item on the meeting template.

Judgment: Not compliant

## Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Not compliant |
| Regulation 23: Governance and management | Not compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Not compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 26: Risk management procedures | Not compliant |
| Regulation 5: Individual assessment and personal plan | Not compliant |
| Regulation 8: Protection | Not compliant |

# Compliance Plan for Logan House OSV-0003468

## Inspection ID: MON-0047485

## Date of inspection: 06/10/2025

**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 | Not Compliant |

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

• Since appointment of the new Person in Charge (PIC), they have undertaken a full review of staffing systems, role clarity and communication systems across the service. These systems and clarity of roles have been communicated to the staff team on the 30/10/2025 at the October team meeting and minutes were shared with the staff team on 03/11/2025. The PIC will ensure that all standing team meeting agenda items are discussed robustly. The PIC will sign off on monthly team meetings minutes, ensuring they contain an accurate and detailed account of discussions at each team meeting.

• As part of the induction for new staff, roles and responsibilities will be clearly outlined in their induction phase. This will ensure all new staff are aware of their roles and responsibilities.

• Existing staff, through the process of Supervision, will be supported to understand their roles and responsibilities on an ongoing basis.

• A new rota template was implemented on 13/10/2025 which identifies the shift leader. It includes full staff names and roles. The new rota considers the appropriate staff skill mix and support required by each resident. In order to ensure the rota provides appropriate support to all residents, all support plans will be reviewed in conjunction with the PIC and TL by the 10/11/2025.

• Individual resident's daily notes template have been revised to reflect the daily support required by each individual resident and guide staff practice. This was completed on 03/11/2025.

• The new shift planner implemented on the 03/11/2025 identifies the Shift Lead. It identifies specific staff responsibilities for completion of tasks, including daily notes, IPC & cleaning, safety checks relating to one resident and medication checks. Staff are also prompted to ensure, at the end of their shift, they have documented pertinent

information relating to safeguarding, complaints, incident reporting, fire, health and safety checks. The shift planning document now acts as key communication tool for staff. The implementation of the shift planning document and associated checks will be reviewed by the Team Leader and PIC as part of their regular audit checks.

• Recruitment is ongoing to fill vacant positions. A meeting was held with Talent Acquisition Team to make job adverts more specific to the needs of residents in Logan House, this was completed on 28/10/2025. In the interim, consistent and regular relief staff and agency are used who are aware of residents' assessed needs.

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| Regulation 23: Governance and management | Not Compliant |

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

• The Outreach Team hours provided to residents of Logan House will come under the management of the PIC in Logan House; this will be completed by 28/02/2026.

• In the interim, monthly governance meetings between the PIC, Team Leaders, and the Community Service Manager with responsibility for outreach will be held and recorded. Standing agenda items include safeguarding, keyworking, risk management, staffing, and residents' feedback, this commenced on the 23/10/2025.

• A new personal alarm system has been installed on 31/10/2025 to support the resident in the wheelchair-accessible apartment. The new system will immediately alert staff via internal alarm system, with a secondary system that will alert staff by mobile phone which will be on the staff person. This system has functionality, whereby the Emergency services will be dispatched by the monitoring company.

• The new personal alarm system will be tested daily and this will be highlighted on the daily task list. The PIC and Team Leaders will conduct checks as part of the weekly and monthly audits. The audit templates will be updated by the 05/11/2025.

• Staff and the resident have been given a demonstration on the use of the systems on the 31/10/2025 and on the 03/11/2025. A clear user guide is included in the resident's support plan and is displayed on the notice board in the main office and included in induction for all staff. This was completed on the 03/11/2025.

• A key-working meeting took place on the 28/10/2025 with the resident. An additional control measure was implemented that includes floor level stationary buttons at areas identified as a high falls risk for the resident. These are accessible in the bathroom, bedroom and the sitting room. This alerts staff in the main house. This was reviewed and agreed by the resident with the OT on the 31/10/2025

• A clear escalation procedure will be developed for staff; this will be completed by 04/11/2025. The procedure will guide staff on the steps they need to take, in the event that a fault arises with the system. This includes reporting to the PIC and the monitoring company. Staff have been advised to communicate any issues that arise out of hours, to the on-call manager.

• This service is currently engaged in the Providers own escalation process. The monthly governance calls include the PIC, PPIM, senior operational staff and senior staff from the Quality & Governance Directorate. The governance group reviews all actions and their progress to ensure sustained quality improvement, this includes identifying and addressing barriers as they arise. This group will remain in place until all actions in this compliance plan have been completed.

• The PIC and PPIM will review all actions from the most recent internal audit to ensure all actions have been thoroughly closed off, this will be completed by 14/11/2025. A consolidated action tracker is in place, this is used to track actions from internal reviews and this compliance plan. This tracker is monitored by the PIC and PPIM. Updates on progress will be provided to senior management and the governance group on a Monthly basis. The next scheduled governance group call is scheduled for 24/11/2025.

• The providers Board of Directors have been provided with a copy of this Inspection Report, this was completed on 21/10/2025.

• The provider is meeting with an external consultancy group with a view to them completing an independent review of areas of practices within Logan House; scheduled meeting on 07/11/2025.

| Regulation 10: Communication | Not Compliant |
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Outline how you are going to come into compliance with Regulation 10: Communication:
• The communication section of each Resident's support plans will be reviewed and updated. This will be completed by the 14/11/2025. The PIC will ensure that all staff have read and signed the updated support plans.

• The PIC will complete a SLT referral to the HSE and an internal Digital Assistive Technology referral by 10/11/2025 to support one resident with communication.

• A new personal alarm system was installed on 31/10/2025 to support the resident in the wheelchair-accessible apartment. The new system will immediately alert staff via internal alarm system, with a secondary system that will alert staff by mobile phone which will be on the staff person. This system has functionality, whereby the Emergency services will be dispatched by the monitoring company.

• The new personal alarm system will be tested daily and this will be highlighted on the

daily task list. The PIC and Team Leaders will conduct checks as part of the weekly and monthly audits. The audit templates will be updated by the 05/11/2025. Staff and the resident have been given demonstrations and taken part in the use of the systems on the 31/10/2025 and on the 03/11/2025. A clear user guide is included in the resident's support plan and is displayed on the notice board in the main office and included in induction for all staff. This was completed on the 03/11/2025.

• A key-working session took place on the 28/10/2025, with the resident. An additional control measure was implemented that includes floor level stationary buttons at areas identified as a high falls risk for the resident. These are accessible in the bathroom, bedroom and the sitting room. This alerts staff in the main house. This was reviewed and agreed by the resident with OT on the 31/10/2025

• A clear escalation procedure will be developed for staff; this will be completed by 04/11/2025. The procedure will guide staff on the steps they need to take, in the event that a fault arises with the system. This includes reporting to the PIC and the monitoring company. Staff have been advised to communicate any issues that arise out of hours, to the on-call manager.

• In order to ensure appropriate support, the new rota considers the skill mix of staff and ensures the needs of residents are been met.

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| Regulation 17: Premises | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
• Maintenance issues are logged on the maintenance log and reviewed as part of the Team Leader weekly and PIC monthly audits. This was discussed with/communicated to all staff on the 30/11/2025 at the October Team Meeting.

• Repairs to flooring, bathroom, external plasterwork, wooden gate and garden maintenance works will be completed within 01/05/2026.

• Three residents are in the process of being referred to an alternative provider. The PIC and PPIM will continue to work in conjunction with the HSE to ensure all residents are appropriately placed. Regular meetings will be held between Rehab Group and HSE until this process is completed. This will be completed by 01/09/2026.

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| Regulation 26: Risk management procedures | Not Compliant |

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| Outline how you are going to come into compliance with Regulation 26: Risk management procedures:<br>• A new personal alarm system was installed on the 31/10/2025 to support the resident in the wheelchair-accessible apartment. The new system will immediately alert staff via internal alarm system, with a secondary system that will alert staff by mobile phone which will be on the staff person. This system has functionality, whereby the Emergency services will be dispatched by the monitoring company.<br><br>• The new personal alarm system will be tested daily and this will be highlighted on the daily task list. The PIC and Team Leaders will conduct checks as part of the weekly and monthly audits. The audit templates will be updated by the 05/11/2025. Staff and the resident have been given demonstrations on and taken part in the use of the systems on the 31/10/2025 and on the 03/11/2025. A clear user guide is included in the resident's support plan and is displayed on the notice board in the main office and included in induction for all staff. This was completed on the 03/11/2025.<br><br>• A key-working meeting took place on the 28/10/2025, with the resident. An additional control measure was implemented that includes floor level stationary buttons at areas identified as a high falls risk for the resident. These are accessible in the bathroom, bedroom and the sitting room. This alerts staff in the main house. This was reviewed and agreed by the resident with OT and PIC on the 31/10/2025<br><br>• A clear escalation procedure will be developed for staff; this will be completed by 04/11/2025. The procedure will guide staff on the steps they need to take, in the event that a fault arises with the system. This includes reporting to the PIC and the monitoring company. Staff have been advised to communicate any issues that arise out of hours, to the on-call manager.<br><br>• In conjunction with the resident, a further system was implemented that include floor level stationary buttons at areas identified as a high falls risk by the service user. These are located in the bathroom, bedroom and the sitting room. These are in accessible to the resident should they fall. These buttons alert staff in the main house who can then respond immediately. This was completed on the 31/10/2025 and is monitored and checked daily and through weekly and monthly audits.<br><br>• Daily checks of fall prevention equipment recommended by the Occupational Therapist including railings and wheelchair mechanisms are being completed.<br><br>• A weekly falls response drill will also be completed to assess staff's response as well as identifying any issues that may delay the response time. Any required actions will be implemented immediately to address same.<br><br>• A reassessment of one residents needs in relation falls was completed by the Occupational Therapist on 31/10/2025 that included preferences in relation to independent transfers for this resident. The resident's individualised risk assessment to be updated on the 04/11/2025 including the recommendations from OT review on the 31/10/2025. | |

• A review of the service's risk management framework has been completed which includes the risk register, risk assessments, local safety statements, business continuity plan and local risk management procedures. The review was communicated at the team meeting on 30/10/2025.

• Risk management has been added to the team meeting agenda as a standing agenda item to ensure staff awareness and understanding of same.

• Staff will complete training in areas such as person handling, vehicle clamping and safeguarding, this will be completed by 28/02/2026.

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| 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:
• Outstanding PCP meeting will take place on 13/11/2025. Following the meeting, a plan and associated action plans outlining personal goals, supports required and measurable outcomes within a specific timeframe will be developed; this will be completed by 28/11/2025. Key working meetings will take place monthly and progress of plans will be reviewed at these meetings. This will be monitored in the Team Leader weekly audits and the monthly PIC audits.

• All support plans and action plans will be reviewed by the PIC by the 14/11/2025 to ensure they are in line with the individual's goals, objectives and accurately reflect their will and preferences. Progress of the action plans will be reviewed as part of the weekly and monthly audits.

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| Regulation 8: Protection | Not Compliant |

Outline how you are going to come into compliance with Regulation 8: Protection:
• Safeguarding is a fixed agenda item for staff at every team meeting and supervision session. Safeguarding is a fixed agenda item for residents at every key working session and house meetings. This will encourage a staff reflection and a culture of openness.

• Safeguarding was reviewed with residents as part of the house meeting on October 19/10/2025.

• The new shift planner template includes a daily prompt to staff to ensure any

safeguarding incident has been accurately reported and recorded. The shift leader is responsible to ensure the completion of same.

• An education pack will be developed in an appropriate format to support residents and staff to understand abuse and ensure a culture of disclosure is promoted within the service. This will be explained to residents via key-working sessions, this will be completed by 30/11/2025.

• Clear Safeguarding escalation structures were explained to staff at the October Team Meeting on 30/10/2025.

• Qualified Safeguarding Vulnerable Persons Trainer attended the team meeting on 30/10/2025 to deliver a safeguarding workshop on responsibilities and reporting procedures. The session has been documented in the minutes of the October Team Meeting and minutes were shared by the PIC with the staff team on 03/11/2025.

• All staff to be retrained in Safeguarding Adults at Risk of Abuse and HIQA National Standards for Safeguarding Adults via HSELand, this will be completed by 30/11/2025.

• Trust in care investigations nearing completion will be reviewed by the Provider and outcomes submitted to HIQA upon finalisation.

## 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 |
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| Regulation 10(1) | The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes. | Not Compliant | Orange | 14/11/2025 |
| Regulation 10(2) | The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan. | Not Compliant | Orange | 14/11/2025 |
| 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 | Not Compliant | Orange | 03/11/2025 |

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| | than full-time basis. | | | |
| 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 | 13/10/2025 |
| 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. | Substantially Compliant | Yellow | 01/09/2026 |
| Regulation 17(1)(b) | The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. | Substantially Compliant | Yellow | 28/02/2026 |
| Regulation 23(1)(b) | The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for | Not Compliant | Orange | 28/02/2026 |

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| | all areas of service provision. | | | |
| 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 | 04/11/2025 |
| 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 | 28/02/2026 |
| Regulation 05(4)(b) | The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes. | Not Compliant | Orange | 03/11/2025 |
| Regulation 05(6)(c) | The person in charge shall ensure that the | Not Compliant | Orange | 28/11/2025 |

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| | 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 assess the effectiveness of the plan. | | | |
| Regulation 05(6)(d) | 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 take into account changes in circumstances and new developments. | Not Compliant | Orange | 28/11/2025 |
| Regulation 08(1) | The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. | Not Compliant | Orange | 30/11/2025 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Not Compliant | Orange | 03/11/2025 |