Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Logan House
Name of provider:	RehabCare
Address of centre:	Galway
Type of inspection:	Short Notice Announced
Date of inspection:	03 June 2020
Centre ID:	OSV-0003468
Fieldwork ID:	MON-0029518

About the designated centre

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

Logan House provides supported accommodation to people with an acquired brain injury and is based in a large city in the west of Ireland. The centre comprises of a two storey house and one external apartment to the rear of the premise. The centre operates as five units, where up to seven people reside. The centre caters for residents with high, medium and low support needs. Each resident had a private bedroom (some en-suite) with shared communal facilities, and there are two apartments with kitchen/dining/sitting room, bathroom and bedroom. Some residents access day service, where other residents like to choose their individual daily activities. The centre is located in close proximity to a range of shops and local amenities. Transport is provided so that residents can avail of community-based facilities and access amenities such as libraries, parks, hotels, cafes, hairdressers, beauticians, shopping centres and cinema. Access to allied healthcare professionals is available to the residents as required and includes; G. P. services, psychology and psychiatry services. The centre is managed by a person in charge, three team leaders, and team of social care professionals and assistant support workers. Residents are supported by staff during the day in response to their assessed needs and currently a sleep over staff is rostered for nights to ensure residents support needs are met as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 3 June 2020	11:15hrs to 17:45hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was completed within the parameters of the Covid 19 pandemic, associated restrictions and measures based on national guidance to reduce the risk of the introduction and transmission of infection. For example three residents who normally reside in the centre, had in consultation with family and staff, temporarily returned home given the impact of pending restrictions such as travel and visiting restrictions. The centre is subdivided into five units and again in the context of infection prevention and control the inspector did not enter these individual units and remained in one area of the centre. All residents were invited to engage if they wished with the inspector and one of the three residents expressed an interest in meeting with the inspector. This conversation started with discussion of the impact of Covid 19 on daily life and routines and in particular the duration of the restrictions and their impact, for example limited excursions into the community and then the changes that were experienced such as queuing and physical distancing. There was a little anxiety but overall a sense of being safe and protected in the centre. There was discussion of life pre Covid, discussion of home and place of origin and hope for the future, hope for greater independence and purpose in life and opportunity to pursue and enjoy meaningful and purposeful employment. At intervals during the day the inspector had opportunity to observe staff and residents engage; this engagement was easy and equitable.

Capacity and capability

Overall the inspector found that the provider had enhanced the governance structure of this centre and the centre was operated and managed to ensure that residents received a safe, quality service that was appropriate to their needs. The support and care that residents received was effectively monitored; staff were confident that progress had been made since the last inspection but there was acknowledgement that there was scope for further improvement. This would concur with the findings of this Health Information and Quality Authority (HIQA) inspection. Some delay had occurred in some planned actions in the context of the impact of the Covid 19 pandemic.

An additional team leader had been appointed to support the person in charge in the operation and oversight of the service; the local management team therefore consisted of three team leaders and the person in charge who reported to the integrated services manager. These management resources provided for consistent oversight, supervision and support. While there was recent change to this management structure accessible, collaborative and supportive working relationships were reported.

The staffing levels on the day of inspection reflected the reduced occupancy of the centre and other changes made in response to infection prevention and control requirements. For example, two staff teams each supported by a team leader were in operation and worked opposite each other. In addition, relief staff and agency staff were not currently utilised so there was no crossover of staff between services. Having reviewed the staff rota and having discussed staffing arrangements with the person in charge, the inspector was satisfied that previous failings identified on inspection had been addressed by the provider. Recruitment had been successful and a core staff team was in place with no reported vacancies. When relief and agency staff had been utilised the rota indicated that consistency and continuity for residents was considered with the same small number of staff named on the rota. However, the provider should as part of its quality improvement plan give further consideration as to how it staffs the waking night staff post through agency rather than consolidating it into a regular contracted post. Staffing will be referred to again in the next section of this report in the context of risk management.

The inspector reviewed training records that were individualised to each staff employed. From these records the inspector saw that staff had access to a comprehensive programme of training that included mandatory training such as safeguarding and fire safety but also education and training that reflected the stated purpose and function of the service, staff roles, the assessed needs of residents and the Covid 19 pandemic. For example, in response to previous inspection findings members of the multi-disciplinary team (MDT) had provided training to staff on the care needs and the support required for persons with an acquired brain injury; staff had completed complaints management and supervision training. Staff knowledge and practice was further informed by regular and consistent input from the MDT; for example, occupational therapy and behaviour support. The delivery of some refresher training, particularly where physical distancing could not be maintained had been impacted by Covid 19.

Regular supervision for all grades of staff formed part of the providers systems of oversight. The person in charge was satisfied as to the regular frequency of the supervision in the context of the change that had been required in this centre. The supervision process that was described to the inspector was robust and meaningful and incorporated day to day practice, concerns and queries and personal and professional development for staff.

The inspector found evidence of good and improved complaints management procedures. It was clear from the complaint log that complaints management was understood by staff. For example if a resident raised a matter at the residents meeting, staff transferred and processed the matter under the complaints management procedure. The action taken in response and whether this was sufficient or not to resolve the matter to the residents satisfaction was clearly recorded. The person in charge described the operation of the formal complaints procedure; for example investigation by a person not directly related to the complaint and meetings with complainants.

The inspector reviewed the findings and action plan of the most recent provider internal review of the quality and safety of the service completed in December 2019.

This was a detailed and comprehensive review and action plan that had validated progress made but also identified areas where improvement was needed; these were also identified by this HIQA inspection and this would support the transparency of the review process and its regulatory basis. However, while the progress of the action plan was monitored, based on these HIQA inspection findings further action was needed for example in relation to risk identification and management. A further matter raised by the internal provider review was the status of the provider's long-term objective plan for the service as committed to in the assurances submitted to HIQA. Notwithstanding any recent delays as a result of the Covid 19 pandemic, this review needs to be agreed, explicitly planned and progressed as it has been committed to since mid 2019. In the interim residents needs have changed and decisions made in the context of shorter-term objectives may not now be the best decision, for example, the placement of residents within the centre. This will be referred to again in the next section of this report.

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. The person in charge was aware of their role and responsibilities under the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. It was evident from discussion with the person in charge that they consistently participated in the operation and oversight of the service. The provider had enhanced the resources available to the person in charge to support them in their work thereby ensuring more effective management and oversight.

Judgment: Compliant

Regulation 15: Staffing

The staffing levels on the day of inspection reflected the reduced occupancy of the centre and other changes made in response to infection prevention and control requirements. Having reviewed the staff rota and having discussed staffing arrangements with the person in charge the inspector was satisfied however that previous failings identified on inspection had been addressed by the provider. Recruitment had been successful and a core staff team was in place; when relief and agency staff were utilised the rota indicated that consistency and continuity for residents was considered with the same small number of staff named on the rota.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were provided with training that supported them to provide a safe and effective service to residents. Supervision to support staff in their work was understood and formally implemented at regular intervals. Supervision incorporated feedback from staff on learning gained from training completed and any further training needs.

Judgment: Compliant

Regulation 23: Governance and management

Notwithstanding any recent delays as a result of the Covid 19 pandemic, the provider's long-term objective plan for the service as committed to in the assurances submitted to HIQA needs to be agreed, explicitly planned and progressed as it has been committed to since mid 2019. In the interim residents needs have changed and decisions made in the context of shorter-term objectives may not now be the most appropriate decision, for example, the placement of residents within the centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Records seen indicated that residents and their representatives were aware of the complaint policy and procedures and how to access and use them as needed. Action was taken by the provider to address complaints. The team leader and the person in charge monitored the receipt of complaints and their management.

Judgment: Compliant

Quality and safety

Overall the inspector found that the appropriateness, quality and safety of the service that residents received was informed by a comprehensive assessment of

residents needs and wishes, consultation and engagement with residents and as appropriate their representatives and with the multi-disciplinary team (MDT). This provided assurance that the support provided was both individualised and evidence based. More robust risk identification and management would however have better assured the safety of all supports provided. The progression of the providers longterm objectives plan as mentioned in the first section of this report would also support the planning and progression of residents personal objectives, for example a desire for greater independence and purpose in life so that residents achieved the best possible quality of life outcomes.

The personal plan reviewed by the inspector was detailed and individualised. The plan was seen to be updated in line with any changes in needs; staff and residents engaged and residents participated in and had reasonable control over the care and support that was provided. The plan of support and reviews of the effectiveness of the plan were, based on records seen informed by regular and consistent input from members of the MDT.

The personal plan included the plan for pursuing resident's personal goals and objectives. Planning meetings were held; residents attended and contributed. Based on the conversation with residents, the goals in the plan reflected and respected resident needs and wishes. The person in charge was mindful of residents' long-term hopes and objectives and the need to consistently support residents to have access to and explore the appropriate avenues to pursue these objectives.

Staff were seen to be diligent in their monitoring of resident well-being and in seeking advice and support as needs changed; detailed records of these discussions and reviews were maintained by staff. Residents were seen to have access to the clinical support that they needed for example their General Practitioner (GP), physiotherapy, occupational therapy, psychiatry and behaviour support. There were times when residents choose not to avail of care or adhere to plans of support, these decisions were respected as were the actions taken by staff in response, such as negotiating with residents and seeking further advice and support from the MDT.

Records seen indicated regular input from the behaviour support team, for example in providing education and training to staff and seeking to analyse and understand why certain behaviours presented. Plans and protocols were developed from the findings so that certain behaviours might be averted and to support if possible better resident responses to certain challenges and situations.

There was a process based on assessed risk for the implementation of interventions that potentially had a restrictive component. Again based on records seen the rationale was resident and staff safety; decision making included the resident and the relevant clinician such as the occupational therapy or behaviour support team and was formally recorded.

The person in charge advised the inspector that there were no additional safeguarding concerns and that safeguarding plans and controls as they were needed continued to be implemented and monitored, for example one to one staff support. All staff had completed safeguarding training. The person in charge

described how given that residents had independence and control over aspects of their lives, staff sought to work with residents through the delivery of specific programmes, ongoing discussion and reflection to develop resident knowledge, understanding and awareness of risk and their skills for self-protection.

It was evident that staff were vigilant to the risk posed by Covid 19 to resident and staff well being and measures had been taken to prevent the introduction and onward transmission of infection. Residents were spoken with and understood the risk and the need for protective measures. Staff supported residents to return home if they choose to and could do so and maintained contact with them while at home. Staff supported residents to safely access community services as needed, for example to go to the pharmacy, and residents were educated in the use of hand hygiene products and face masks. The provider had established a centralised Covid 19 response team that co-ordinated and disseminated public health guidance and advice to each service. Based on practice seen this advice was based on public health guidance such as screening of staff well-being, reduced footfall, the use of facial masks and viral testing for residents and staff. All staff had completed accredited updated infection and prevention and control training including hand hygiene, breaking the chain of infection and using personal protective equipment (PPE). The person in charge confirmed that staff had access to adequate stocks of PPE.

Measures to protect residents from the risk of fire such as the fire detection and alarm system and the emergency lighting were inspected and tested at the required intervals; the annual testing of fire fighting equipment was due. Previous inspections had identified the need for remedial fire safety works; this was not explored in its totality but there was documentary evidence that fire resistant door sets had been inspected and remedial works had been completed. All staff had completed fire safety training and residents and staff participated in simulated drills or evacuated in response to any activation of the fire detection system. Each resident had an individualised personal emergency evacuation plan (PEEP), the plan included any obstacles to safe and effective evacuation including inconsistent resident response to staff request to evacuate; there was a protocol to be followed by staff if this occurred.

However, while risk identification, assessment and management was evident and informed many areas reviewed there was scope for improvement to ensure and assure the safety of the support and services that residents received. For example, staff raised concerns in September 2019 following difficulties encountered during an unplanned night-time evacuation. However, the pathway of the objective assessment of the risk that was conveyed by staff, of escalation and response including any additional controls to reduce the risk and maximise resident safety in the event of fire was not evident. A similar finding emanated from the internal provider review of December 2019. Staff reported that it had been escalated, controls did include a protocol for staff to follow as mentioned above and the risk was identified and logged in the risk register. However, a repeat full drill had not been completed until March 2020 during which the resident did evacuate. It was not evident in the context of the residual risk if the residents continued placement on the first floor and the potential for relocation to the ground floor to reduce the risk

associated with possible failure to evacuate had been considered. In addition while there was no evidence available to the inspector that staffing levels were not adequate, decisions and changes made to staffing arrangements including nigh-time staffing were not supported by an explicit assessment of any associated risk including any additional impact on known evacuation risks. This risk assessment should then inform the review of the PEEPS. There was a further risk directly related to a specific and changing resident need that staff had appropriately responded to when it presented. However, while there was a comprehensive range of risk assessments based on assessed needs there was no risk assessment completed for this specific need. This was needed to assess likelihood of reoccurrence, to guide staff and to ensure that the controls needed to ensure resident safety were in place.

Regulation 26: Risk management procedures

While risk identification, assessment and management was evident and informed many areas reviewed there was scope for improvement to ensure and assure the basis for and the safety of the support and services that residents received. The findings of this inspection in this regard related to staffing decisions, evacuation procedures and residents assessed needs.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had responded and implemented effective measures to reduce the risk of the introduction of and the onward transmission of infection in the context of the Covid 19 pandemic.

Judgment: Compliant

Regulation 28: Fire precautions

Overall the provider had effective fire safety arrangements to protect residents and staff from the risk of fire. However, all remedial infrastructural works required were not all validated on this inspection and evacuation procedures are referenced in the improvement necessary in risk management procedures.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The personal plan was developed based on the findings of a comprehensive assessment; the plan and its effectiveness was the subject of regular review and update as needed by staff in consultation with the resident and the wider clinical team. The inspector was assured that staff sought to provide residents with the care and support that they needed for their well-being while balancing the decisions and choices made by residents.

Judgment: Compliant

Regulation 6: Health care

Staff assessed, planned for and monitored residents healthcare needs. Residents had access to the clinical support that they needed. If a resident declined care, this was recorded as was the follow-up action taken by staff in the interest of resident well-being.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were occasions when residents may have been challenged by events or circumstances and that resulted in behaviour of risk largely to themselves. The behaviour and how to support the resident was detailed for staff in plans and protocols. The approach was therapeutic and informed by the appropriate clinicians such as the GP and behaviour support.

Judgment: Compliant

Regulation 8: Protection

There was no new safeguarding concern advised to the inspector. Staff had completed training and residents were supported to develop their understanding of safeguarding risks and their skills for self-protection.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Logan House OSV-0003468

Inspection ID: MON-0029518

Date of inspection: 03/06/2020

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • In light of COVID-19, the next 6 monthly provider review will have an alternative format, whereby the PIC will compete a self-assessment and an internal auditor will carry out a desk based audit on this information. A verification meeting between PIC/Auditor will take place thereafter. This is to limit additional footfall in the service. The process will commence by June 30th 2020. • The long-term objectives planning meeting has been rescheduled to September 2020 due to COVID-19. In the interim, PIC/ISM/ROO will review the service model and consider if other placements within the designated centre address changing needs by 31st July 2020.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • The evacuation procedure, PEEPS and staffing needs risk assessment have now been updated to reflect the current staffing levels as a result of the reduction in residents currently residing in the designated centre. • Going forward, in advance of residents returning to the designated centre, the staffing level will be reassessed and modified as per the residents needs and the evacuation	

procedure, PEEPS and staffing needs risk assessment will be updated.

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 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/07/2020
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Substantially Compliant	Yellow	26/06/2020

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			