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:	Galtee View House
Name of provider:	St Joseph's Foundation
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	21 February 2023
Centre ID:	OSV-0001826
Fieldwork ID:	MON-0038250

About the designated centre

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

St Joseph's Foundation provides a range of day, residential and respite services in North Cork and Limerick. The centre provides a home to 10 residents and is based in a community setting in county Limerick. The centre mainly provides care and support to residents who have high support needs, while some residents also had changing complex health care needs. The centre is a purpose-built bungalow with a variety of communal day spaces including a large sitting room, visitor's sitting room and beauty room. There was separate large open plan kitchen and dining room. All rooms were bright, spacious and comfortably furnished. Many of the bedrooms and bathrooms had assistive devices to support residents to transfer more easily. The centre is in a tranquil setting with large garden spaces.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
Tuesday 21 February 2023	10:15hrs to 15:00hrs	Laura O'Sullivan	Lead
Tuesday 21 February 2023	10:15hrs to 15:00hrs	Lucia Power	Support

What residents told us and what inspectors observed

Galtee View house was a purpose built bungalow located on the outskirts of a rural town in Co. Limerick. Currently the centre provides 24hour support to eight adult presenting with an intellectual disability. The centre presented as a warm and homely environment. Each resident had their own room which they were supported to decorate in accordance with their interests and personal preferences. One resident proudly showed an inspector their bedroom and family photographs. This resident also showed the inspector around the centre. It was noted during this walk around that the function of some rooms did not match the floor plans in place. For example, a prayer room was being used as a sensory/soft play area. This was an action from a previous inspection.

This was an unannounced inspection. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector adhered to these throughout the inspection. The centre was found to be clean with effective measures in place to promote a safe environment.

The inspectors had the opportunity to meet and speak with a number of residents during the day. One resident had transitioned to the centre since the previous inspection. They told the inspector they were very happy in the centre and staff were always lovely to them. They felt safe in the centre and could speak to someone if they were not happy. They showed the inspector their new room which they had made their own since moving in.

An inspector visited the residents in the dining room when they were having lunch. A chatty atmosphere was resent with staff chatting with residents about their day during the mealtime. Residents told the inspector the food was lovely in the centre. Staff were observed offering the residents choices throughout the mealtime.

Activation observed during the course of the inspection was found to be limited and focused on in house activities. When a number of resident went for a walk this consisted of going to the letter box to collect post, which was within the ground of the house setting. This was further evidenced in documentation reviewed with community involvement minimal in the centre. This had been highlighted during governance communication with a requirement for increased staffing levels requested. No action had been out in place to address this.

Interactions between staff and residents in the centre was observed to be jovial and respectful in nature. The members of the management team present were known to residents and all engagements were observed to be positive in nature. Since the previous inspection the person in charge had introduced a number of measures to assure resident rights were paramount in the centre. This included the facilitation of access to independent advocates as required. Residents had been supported through recent bereavement in the centre.

The next two sections of the report present 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 service being delivered to each resident living in the centre

Capacity and capability

This was an unannounced inspection completed of designated centre Galtee View house. The centre had previously been inspected in September 2022 where a high level of noncompliance with the regulations and Health Act 2007 was evidenced. Following the inspection the registered provider had entered a period of escalation and submitted a response of actions which would be completed to address identified areas of non-compliance. It was evidenced however, during this inspection that a number of actions had yet to be addressed within the allocated time-line. These will be discussed with the report.

Since the last inspection there had been a change in the organisational governance structure of the centre. The provider had appointed a suitably qualified and experienced person in charge to oversee the day to day operations of the centre. They held governance over two centres located in close proximity to each other. The person in charge had an awareness of the needs of the residents and the centre. Since commencing their role within the centre they had introduced a number of actions such as a review of residents rights and on site monitoring schedule. The person in charge reported directly to the person participating in management. Where an area requiring attention was identified this was escalated by email to the person participating in management. This included current staffing levels and the impact on community activities, need for review of individualised personal plans and updating of the statement of purpose, While these has been escalated no response had been received from management.

The registered provider had not ensured a number of regulatory required actions had been completed. For example at the time of the inspection an annual review of service provision was not in place for 2022, with no plan evidenced for this to be completed since January 2021. The most recent six monthly unannounced visit to the centre had been completed in October 2022. While a number of audits had been completed these had not been used to identify areas of non-compliance and to develop actions to address these. For example, a finance audit completed in August 2022 had not identified non-compliance to the organisational policy within the centre, a care plan audit completed in September had identified the need for improvements in personal plan but this remained outstanding. This action had also been addressed in previous inspections completed by the Health Information and Quality Authority.

Each resident living with the centre had a service agreement in place. During the inspection it was evidenced that these did not reflect the current supports being

afforded to the residents and required review. This included such areas as staffing supports in place, person nominated to support with finances and description of the centre. This was an ongoing area of non-compliance within the registered provider. On the day of the inspection assurances were requested to address this at an organisational level.

Since the previous inspection staff were facilitated to raise any concerns regarding the supports provide within the centre. The person in charge facilitated monthly staff meetings where a number of issues could be discussed. The person in charge had introduced an annual schedule for formal staff supervisions which were being completed in accordance with organisational policy. A training matrix had also been developed to ensure all staff were supported and facilitated to receive the required mandatory training. Where required an action plan had been developed to address outstanding training. This matrix is updated on a monthly basis.

The registered provider had not ensured that the appropriate staffing levels had been appointed to the centre to support the assessed needs of residents. It was noted on a number of occasions that community activities did not occur due to the staffing levels in place. Also, a no nurse protocol had to be activated on two occasions over a fortnight period. Staffing levels identified on staff rota were not reflective of the statement of purpose.

Regulation 14: Persons in charge

The registered provider had appointed a person in charge to the centre. They possessed the required experience and qualifications to complete their role.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had not ensured the number of staff allocated to the centre was in accordance with the residents assessed needs. While a staff rota was in place and maintained by the person in charge, this did not reflect the staffing levels set out in the statement of purpose.

Judgment: Not compliant

Regulation 16: Training and staff development

A training matrix had also been developed to ensure all staff were supported and

facilitated to receive the required mandatory training. Where required an action plan had been developed to address outstanding training. This matrix is updated on a monthly basis.

Systems were now in place to ensure staff were appropriately supervised in accordance with organisational policy.

Judgment: Compliant

Regulation 23: Governance and management

A clear governance structure had been appointed to the centre. However, on the day of the inspection governance oversight was not evident. While day to day monitoring of service provision was in place there was not adherence to compliance plan response submitted by the provider in response to previous inspections and escalation. On the day of the inspection provider assurances were sought in areas including contracts of service provision and adherence to policies such as personal possessions.

An annual review of service had not been completed for 2022 and while an unannounced visit had been completed this had not been used to identify and address areas of non compliance.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Each resident living with the centre had a service agreement in place. During the inspection it was evidenced that these did not reflect the current supports being afforded to the residents and required review. This included such areas as staffing supports in place, person nominated to support with finances and description of the centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

A statement of purpose had been developed, however this required review to reflect the current function of the centre, including the staffing levels and governance structure.

Judgment: Substantially compliant

Quality and safety

As stated previously this was an unannounced inspection completed of designated centre Galtee View house. At the previous inspection in September 2022 a number of areas of non compliance had been identified in the quality and safety of the service provided to residents in the centre. The person in charge had introduced a number of actions to address some areas of non-compliance. However, the registered provider had not implemented actions as set out in compliance plan response.

Residents in the centre were supported to achieve the best possible health. Since the last inspection residents now had increased access to health care practitioner where a GP visited the centre bi-weekly. Any recommendations from the GP were set out for staff to follow in a consistent manner. Where a new heath care concern was identified a multi-disciplinary review was completed to ensure a holistic approach to support. A review of end of life care was completed with a clear pathway now in place to support the resident in a respectful and dignified manner at times of ill health and end of life.

Residents were communicated with in a regular basis through house meetings. These were an opportunity to discuss such areas as complaints, safeguarding and meal choices. Residents were supported to obtain the support of an independent advocate as required. Since the previous inspection a new template had been developed to tack and monitor communication with the advocate on the residents behalf. This ensured a consistent approach to actions required. Following the death of residents' peers in the centre support had been obtained for both residents and staff from members of the multi-disciplinary team.

Each resident had been supported to have personal plan in place. However, as per previous inspection of the centre these required review to reflect the assessed needs of all residents. Annual reviews were not consistently completed to reflect the changing needs of residents and to reflect their current social and emotional needs. The need for review of all personal plans had been discussed at recent staff team meetings and the person in charge had escalated the requirement of additional support to complete this. The registered provider had not implemented measures set out in escalation correspondence to review all personal plans within an allocated time-line.

Residents within the centre were not supported to achieve their personal goals where set. One resident whose goal related to swimming had attend twice since the beginning of the year. Activation was focused within the house rather in the local and wider community. One residents recorded activity on the day of the inspection was walking to the gate to the collect the post. Goals in place were not evidenced to

be individualised in nature and reflected activities that were already part of residents' daily routines.

Regulation 12: Personal possessions

Residents had access to their own monies and records were been maintained by the provider for all expenditure. The person in charge highlighted that resident bank cards were been held centrally. Management of finances was not in line with the providers own policy and this required review, this is actioned under contracts of care and governance and management.

Judgment: Compliant

Regulation 13: General welfare and development

The registered provider had not ensured residents were supported to participate in meaningful community activation in accordance with thier interests and needs.

Judgment: Not compliant

Regulation 17: Premises

The centre was a large purpose built bungalow. The function of a number of rooms within the centre were not reflective of the declared floor plans in place. This was an outstanding action from a previous inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had been supported to have personal plan in place. However, as per previous inspection of the centre these required review to reflect the assessed needs of all residents. Annual reviews were not consistently completed to reflect the changing needs of residents and to reflect their current social and emotional needs.

Judgment: Not compliant

Regulation 6: Health care

Residents in the centre were supported to achieve the best possible health. Improvements were identified in such areas as end of life care and access to health care professionals.

Judgment: Compliant

Regulation 9: Residents' rights

The centre was operated in a manner which was respectful to the rights of residents. Since the previous inspection residents were communicated with pertaining to the operations of the centre. Access to independent advocates was supported and facilitated.

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 (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	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Galtee View House OSV-0001826

Inspection ID: MON-0038250

Date of inspection: 21/02/2023

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: To regain compliance with Regulation 15 the Statement of Purpose and in particular the staffing ratio will be reviewed to reflect the correct staffing levels and ensure there is no discrepancy between the two. The registered provider will ensure that the number of staff allocated to the centre does reflect the residents needs and will support the residence through the use of relief and agency staff to cover sick leave/ annual leave etc.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To come into compliance with Regulation 23 assurances regarding the contract of service and policy re personal possessions have been provided to Hiqa. A procedure re personal possessions has been reviewed, updated and communicated to staff. The contract of care has been reviewed and updated and an addendum has been included which identifies the current CEO. The annual review for 2022 has been completed and is available in the centre. Annual reviews going forward will be completed in line with regulation and available for inspection.	

Regulation 24: Admissions and contract for the provision of services	Not Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: To ensure compliance with Regulation 24 the contracts of care are being reviewed to ensure that they reflect the supports being afforded to the residents particularly in the areas of staffing, support with finances and description of the designated centre.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Statement of Purpose will be reviewed to reflect the current function of the centre as well as the staffing levels and governance structures. This will be updated at least yearly or more frequently as required to reflect any changes.	
Regulation 13: General welfare and development	Not Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: To comply with Regulation 13 the Person in Charge will implement an activity chart to plan, track and ensure that residents will be supported to access meaningful community activities.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: To comply with Regulation 17 an updated floor plan will be submitted to HIQA outlining the current functioning of all rooms in the residence. Changes to the use and functioning will be reflected in the Statement of Purpose.	

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: Residents personal plans will be reviewed annually to reflect the changing needs of the residents to comply with Regulation 5. Personal plans will be included in our quality KPIs.	

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	26/06/2023
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	21/04/2023
Regulation 17(1)(a)	The registered provider shall ensure the premises of the	Substantially Compliant	Yellow	26/06/2023

	designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
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 all areas of service provision.	Not Compliant	Orange	21/04/2023
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	15/05/2023
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	28/02/2023

Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Not Compliant	Orange	12/05/2023
Regulation 24(4)(b)	The agreement referred to in paragraph (3) shall provide for, and be consistent with, the resident's needs as assessed in accordance with Regulation 5(1) and the statement of purpose.	Not Compliant	Orange	12/05/2023
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	21/04/2023
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and	Not Compliant	Orange	15/05/2023

	circumstances, but no less frequently than on an annual basis.			
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	01/06/2023
Regulation 05(6)(b)	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 conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	15/05/2023
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a	Not Compliant	Orange	15/05/2023

	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	15/05/2023
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Not Compliant	Orange	15/05/2023