Overview of 2016 HIQA regulation of
social care and healthcare services

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

April 2017

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent authority established to drive high-quality and safe care for people using our health and social care services in Ireland. HIQA's role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.

HIQA aims to safeguard people and improve the safety and quality of health and social care services across its full range of functions.

HIQA's mandate to date extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has statutory responsibility for:

Setting Standards for Health and Social Services — Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.

Regulation — Registering and inspecting designated centres.

Monitoring Children's Services — Monitoring and inspecting children's social services.

Monitoring Healthcare Safety and Quality — Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.

Health Technology Assessment — Providing advice that enables the best outcome for people who use our health service and the best use of resources by evaluating the clinical effectiveness and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion and protection activities.

Health Information — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information

Contents

Overview of 2016 HIQA regulation of social care and healthcare services

As required under Section 37(2)(b) of the Health Act 2007 (as amended) (referred to in this report as 'the Health Act'), this overview report is the report of the regulatory activities of the preceding year — in this case, 2016 — of the Chief Inspector of Social Services and the Health Information and Quality Authority (HIQA).

HIQA exercises all of the regulatory powers through its regulation Directorate and the Office of the Chief Inspector, as set out in the Health Act. There are four distinct pillars delivering programmes of regulation in HIQA:

- Disability Services (Adults and Children)
- Older People's Services
- Children's Services
- Healthcare.

Whereas in previous years each regulatory function within HIQA published a separate report of its monitoring and regulatory work over the preceding year, this report sets out all of HIQA's regulatory activities in 2016.

The report contains an executive summary, the findings of each of the four pillars and what work the Regulation Directorate will carry out in the coming years. The appendix includes an overview of the Regulation Directorate of HIQA.

The chapters covering each pillar give an outline of the overall findings in their respective sectors. They cover the thoughts of the people who use services, the themes that have emerged through monitoring and inspection programmes, and where HIQA believes improvements are required.

We have taken the decision to identify centres where we found examples of good practice throughout this report. This is to facilitate shared learning across organisations.

Examples of poor practice are also identified in order to heighten awareness among providers of what poor care looks like. Where poor practice was identified during our monitoring and inspection programmes, we took steps to address this through our escalation and enforcement procedures.

It should be noted that findings on inspection reflect what is found at a moment in time; services can fluctuate between demonstrating good levels of compliance and poor compliance.

Foreword

HIQA will be 10 years in existence in 2017. Our Regulation Directorate was initially tasked with monitoring regulations and Standards in nursing homes and hospitals. By the end of 2016, this work had expanded to include designated centres for children and adults with disabilities and a range of other children's services.

Since our inception, our inspection teams have carried out thousands of inspections and spoken to an even larger number of people who use services. This overview report is intended to give an account of our work in 2016, and it will highlight challenges and opportunities across the range of health and social care services that we regulate.

Our findings show that many people are receiving a good quality service. This is reflected in the positive feedback we hear while on inspection, in our inspection reports and in the trend of improving compliance in certain areas.

However, there remain a significant number of children and adults who are not receiving a service appropriate to their needs and preferences. In 2016, we found poor governance, inadequate safeguarding measures, a lack of clear policy direction and or timely implementation of policy, and poor accountability, particularly in terms of how those funding services assured the best use of public money.

We have taken appropriate enforcement action where we have found poor care and outcomes for people who use services. We always place the lives of residents living in the designated centre to the fore when deciding on what course of action to take in such circumstances, and the range of our response are set out in this report. We will not hesitate to promote and protect the rights of such vulnerable people.

As a learning organisation, we regularly review our systems and processes to ensure our regulatory activity is responsive and evidence-based. Thematic monitoring programmes were an important component of our work in 2016. The feedback on these types of inspections — in terms of their value as a quality improvement tool — is positive, and we will look to increase the number of these types of inspections in the coming years.

The Regulation Directorate underwent a significant structural reform in 2016, which is detailed in an appendix of this report. We also continued with the review of our Authority Monitoring Approach, which aims to bring greater consistency to our work while improving our internal processes.

Looking forward, it is anticipated that HIQA will be required to take on additional responsibilities in the coming years that will result in more services being subject to regulation. In 2017, we will start a programme of registration of children's special care units, while we are also preparing for the introduction of the regulation of medical exposure to ionising radiation in 2018.

HIQA will continue to work with the Department of Health and other stakeholders on the formulation of legislation which will introduce a system of licensing for all public and private hospitals. We recently completed in-house research on how new and emerging models of care are challenging the definition of a designated centre. It is hoped that the findings and recommendations arising out of this research will inform the debate on how we deliver better and safer social care services into the future.

Mary Dunnion
Chief Inspector of Social Services and Director of Regulation,
Health Information and Quality Authority

Executive summary

This report reviews the work of HIQA's Regulation Directorate (encompassing the Office of the Chief Inspector) in 2016. During the year, our inspection teams saw clear links between good governance of health and social care services and better outcomes for those using services. Continuing challenges facing services which were identified during 2016 include:

- an ageing population profile
- delayed access to acute and community healthcare services
- a service dominated by hospital care, as opposed to a more integrated health and social care service
- staff recruitment and retention difficulties
- being able to provide more community-based accommodation and services for people with disabilities
- gaps in services for at-risk and vulnerable children
- gaps in the regulation of services for people with disabilities and older people.

In this context, the establishment of the Committee on the Future of Healthcare is a welcome development. Based on its experience of monitoring and regulating services over a 10-year period, HIQA is also engaging with the Department of Health with a view to suggesting amendments to the Health Act 2007. Throughout 2016, HIQA contributed to a Department of Health working group on licensing of acute healthcare services with a view to assisting in and informing the development of the necessary legislation.

These ongoing dialogues present a timely opportunity to consider how Ireland as a nation can reform health and social care services to meet the country's individual and population needs and ensure that quality, safety and protection are at the centre of what is delivered. HIQA also welcomes the proposed introduction of regulation of home care services in Ireland. When introduced, this will bring regulatory oversight of this area of care for the first time in this country.

The importance of good governance

A consistent theme throughout all of our regulatory activities is the critical importance of good governance and management when providing a service. The Health Act 2007 and its associated regulations — and various national standards — provide a governance framework that can be used by providers to assure themselves that they are providing safe and good-quality services.

This includes:

- the 'fitness' of service providers as defined in the regulations
- the skills and experience required of persons in charge and persons participating in management
- clarity in terms of authority and accountability, and
- effective lines of communication.

The data HIQA generates from its business intelligence functions, as described throughout this report, demonstrates the importance of good governance.

Invariably, where we find services that are well managed, we also find residents and service users who enjoy a good quality service that protects and promotes their rights. Good governance also means

having a positive attitude to regulation and using inspection findings as a quality improvement tool. On the other hand, poor governance leads to poorer quality outcomes for residents and people using services.

In line with its regulatory remit and its commitment to ongoing improvements to the quality of services provided to residents and others, HIQA will soon be introducing new and more detailed processes to assess, on an ongoing basis, the fitness of service providers and service managers. In our experience, this focus, along with good governance and accountability, delivers the best outcomes for people using services.

Safeguarding

Safeguarding is a key component in providing health and social care services and as such is reflected in regulations and nationally mandated Standards. It is defined as measures which are preventative and protective in respect of the health, human rights and wellbeing of people who use services. These measures enable children and at-risk adults to live free from abuse, neglect, harm and exploitation. HIQA continues to encounter services where safeguarding is not sufficiently strong and comprehensive.

Government policy has directed regulation of services into areas where there are clearly identified vulnerabilities for people in receipt of those services. These include residential services to people who are older, dependent, have a disability or are children who — because they are deemed at risk of harm and or abuse — are in the care of the State. During the course of our work, we continue to identify other service types where we believe similar vulnerabilities exist. In some instances, gaps or deficiencies in current legislation result in people who may be vulnerable in regulated services being left without adequate protections.

Legislation introduced in 2016 strengthened the requirements for service providers to ensure that their staff are appropriately vetted. However, services were still not taking the issue of Garda Síochána (Ireland's National Police Service) vetting sufficiently seriously and were thereby failing in their legal responsibility to safeguard residents.

In addition, in a range of disability services we found that leadership and practice in recognising, preventing and protecting people from harm was deficient. While challenges in providers' ability to safeguard are manifested in some instances by failure to protect residents from peer-to-peer abuse, in other instances we would assess the absence of person-centred care and institutional practices as a form of system abuse and neglect.

Regulation of services provides a level of protection through the requirement of providers to maintain compliance with regulations and standards and through the use of periodic inspection by HIQA. However, HIQA believes that the area of safeguarding needs to be further strengthened by introducing legislation which would enshrine adult safeguarding in law and acknowledge the State's responsibility to protect those who may be at risk.

In line with HIQA's corporate objective to influence policy and the way in which decisions on the funding and provision of services are made, the Authority has worked as the State's regulator in tandem with other bodies to identify and address legislation and policy gaps on adult safeguarding. The introduction of such legislation would enhance the suite of other legislation aimed at promoting and protecting the rights of people who may be vulnerable.

Accountability

Allied to the importance of good governance is the need for accountability when providing services. Providers should be accountable to service users and also to those who fund the service. This is why the concept of commissioning is worthy of further consideration in the Irish context. A well-established practice in other countries, commissioning refers to a strategic process of identifying a population, community or individual service need; buying that service; and monitoring its quality on an ongoing basis.

While service providers are ultimately accountable for the quality of the service they provide, its funders should also play their part. The State distributes large sums of funding to various organisations to provide a service on its behalf. However, there is often insufficient oversight of how this money is used or on the outcomes it achieves for service users. Providing such an oversight framework for Ireland has the potential to deliver a range of benefits including better experiences for those using services, improved service planning, greater accountability, better value for money and greater efficiency. HIQA acknowledges the preliminary work done by the Health Service Executive (HSE) on developing such a framework.

The value of thematic inspections

Through our inspection and regulatory activities, HIQA seeks to monitor compliance with regulations and national standards in those services it regulates. However, as well as monitoring compliance, it increasingly sees the value in promoting the use of best practice and evidence-based care. This is achieved through a quality improvement approach which engages with service providers in a positive way to enhance a specific area of their service for the benefit of people using those services.

An important way to do this is by what are termed 'thematic' inspections looking at specific aspects of care. These types of inspections focus on a particular aspect of the regulations and standards that have a real impact on people who use services. In 2016, we carried out thematic inspections in hospitals and nursing homes on issues such as dementia care, nutrition and hydration, antimicrobial stewardship and medication safety.

The feedback that we received from our stakeholders on the various thematic programmes was very positive. HIQA inspectors have also noted a sustained improvement over the past number of years in the thematic areas that were chosen for review.

The capacity to undertake programmes of thematic inspection in designated services depends on the resources needed to carry on HIQA's statutory functions of registering and regulating designated centres. At present, designated centres must renew their registration with HIQA every three years. This requires a significant amount of work for those services and HIQA, both in terms of inspection days and administrative processing.

HIQA believes that the three-year cycle does not represent a wise use of resources. Removing the requirement to renew registration would allow the Authority greater flexibility in terms of carrying out thematic inspection and quality improvement work and focusing resources in the areas of highest risk. HIQA is engaging with the Department of Health on this matter, and it will continue to do so in the context of a review of the Health Act 2007.

Overview of inspection and monitoring findings

Our inspection teams take every opportunity to speak with people who use services. HIQA values feedback from relatives, friends and advocates. In general, many of the people we spoke with in 2016 were satisfied with their service and felt that they were receiving good care. However, there were still a considerable number of people who told us that they were not satisfied; that the services were not person-centred; and that services were failing to meet their needs. HIQA has sought to include the voice of people who use services throughout this overview report as in the Authority's view it is often one of the best indicators of the quality of services.

People with disabilities

The experience in residential services for people with disabilities is somewhat mixed. While many are receiving a quality service and enjoying a good standard of living, a significant number of people are experiencing a quality of life that is well below that which would be expected for citizens in this 21st Century Ireland. These people have been living over a long period of time in institutionalised services that do not promote person-

centredness and where abuses of their rights have happened. In some instances HIQA has assessed the care being provided as unsafe.

During 2016, HIQA inspectors saw situations where people had been placed in services that were not appropriate to their needs. This practice often results in increased risk to the safety of these people and the people they live with. HIQA continued to see routines and practices that were determined by the needs of staff — as opposed to residents' needs — in more densely populated settings, as well as in some community-based houses. As a result, and in order to protect residents, the Office of the Chief Inspector took enforcement proceedings against a number of providers and will continue to act to promote and protect the rights of residents.

Nursing homes

HIQA's experience in older people's services, where it is in its third cycle of registration, is that regulation is now well established. Most service providers are demonstrating a good understanding of the regulations and standards and are responsive to findings of regulatory non-compliance.

Notwithstanding this, we continue to encounter difficulties in terms of how outdated nursing home buildings impact on residents' privacy and dignity, and their right to be safe while in long-term residential care. During the year, the deadline for compliance with the relevant physical environment standards was extended by the Minister for Health to the end of 2021.* HIQA is working with all nursing home providers that have substandard premises to ensure that they are developing plans which will address these shortcomings in advance of the deadline.

In relation to safeguarding, HIQA inspectors found that some providers did not have sufficient measures in place to comply with Garda Síochána vetting requirements. These preventative measures are enshrined in legislation and regulations and play a key role in safeguarding residents.

* *Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016 – S.I. no. 293 of 2016*

Healthcare services

The country's public acute hospitals continue to experience well-publicised challenges to the provision of high-quality, safe care. This is impacting on patients in a variety of ways, for example: lack of access to necessary treatments due to lengthy waiting lists; substandard and outdated physical infrastructure; antimicrobial resistance and emergency department overcrowding. In 2016, HIQA's healthcare team focused on a number of inspection programmes looking at specific aspects of care, called thematic inspections. This approach sought to promote improvements to patient safety and standards of care in key areas.

In addition, the team reviewed the degree of progress being made at the Midland Regional Hospital, Portlaoise (Portlaoise Hospital), Co Laois following the recommendations of HIQA's statutory investigation published in May 2015. HIQA also conducted a follow-up review of progress made by publicly-funded ambulance services, following on from a comprehensive review conducted by the healthcare team in 2014.

In reflecting on the learning from both of these follow-up reviews, it is evident that while a significant amount of improvement in such services may be driven locally, in some instances only substantive decision-making at a national policy level will truly address key areas of outstanding risk for patients. In the absence of such decision-making, efforts to improve services for patients can only partially make progress.

Meanwhile, inspections looking at specific aspects of care in hospitals around the country further reinforced the view that there is both variation in the effectiveness of local management practice, and an inequitable distribution of resources between and among hospitals and hospital groups. This highlights the need for a clear vision on how Ireland provides hospital services into the future.

Children's services

The children's team in HIQA has statutory responsibility for monitoring and inspecting a range of different services against national quality standards and regulations. Its findings show that once children had access to a child protection or alternative care service, most received a good service. There is some good work being done on supporting children to access educational opportunities and in maintaining contact with their birth families.

However, more work is needed to ensure all children receive a service that is appropriate to their assessed needs. There continue to be gaps in services in terms of children being allocated a social worker. The information and data provided to HIQA by the Child and Family Agency (Tusla) showed that of the 25,034 open cases (cases that require an intervention), one in five cases (21.6%) remained unallocated to a social worker at the end of 2016.

These metrics do not include unallocated adult cases related to retrospective allegations of abuse. The absence or delay in completing assessments due to the lack of an allocated social worker presents a potential risk to children. This also delays a conclusion being reached for adults who may have had false or unfounded allegations made against them.

Escalation and enforcement

Most services regulated by HIQA demonstrate a positive attitude to regulation and are committed to improving the quality of their service. Where HIQA finds poor services, it has a duty to act in the best interests of service users and in compliance with the requirements of the Health Act. To this end, the Office of the Chief Inspector has a range of enforcement powers available in both disability and older people's services.

In the first instance, the Office of the Chief Inspector will always seek to work with providers to bring their service into compliance with regulations. In all cases, the Chief Inspector places the lives of residents living in the centre to the fore when deciding on what course of action to take. If the Chief Inspector does not see sufficient improvement or is concerned about the fitness of the provider and or persons participating in management, then further steps can be taken, up to and including:

- requiring the service providers to develop an action plan to achieve compliance
- issuing time-bound warnings
- placing conditions on a provider's registration
- cancelling a centre's registration and or the prosecution of persons specified within the Health Act.

During 2016, the Chief Inspector issued 11 notices of proposal to refuse the application to register and cancel the current registration status of designated centres for people with disabilities. Further to this, the Chief Inspector issued two notices of decision to cancel the registration of two disability services operated by the same provider. Ultimately, the provider withdrew their appeals to the Chief Inspector's notice of decision, which resulted in the Health Service Executive (HSE) taking over the running of three of this provider's centres.

In older people's services, the Chief Inspector issued 21 warning letters to providers regarding the level of non-compliance found in their

designated residential centres for older people or nursing homes. In addition, a total of 38 centres had restrictive conditions applied to their registration. Examples of restrictive conditions included: limiting admissions to a centre; limiting the number of beds in a specified room; and requiring a provider to adhere to a specified improvement plan.

Submissions and complaints

HIQA welcomes and encourages feedback from all informed and interested parties, including service providers who may dispute some of our findings or judgments. In order to address these issues, and to promote fair and transparent regulation, HIQA operates a structured submissions' process for providers of services. This process provides an opportunity for us to review and improve our processes and to regulate in a fair and transparent way.

In 2016, we received a total of 17 submissions. Eight of the submissions were resolved at Stage 1 of our process, where an inspector manager reviews the material submitted. Nine submissions were appealed to Stage 2 which involves review by a panel of managers from outside of the Regulation Directorate.

Learning for the Regulation Directorate following these submissions included:

- clearer reporting and description of issues associated with safeguarding residents and managing suspicions or allegations of abuse
- less emphasis on the findings of previous inspections and more information being provided on findings from the inspection being reported
- ensuring our staff understand and adhere to the standard operating procedure for submissions
- re-emphasising the importance of maintaining good communication between providers and inspection teams.

HIQA is aware of the important role complaints play in ensuring that people can raise issues of concern. Through our regulatory work, HIQA monitors how service providers manage the complaints they receive. As such, HIQA encourages service providers to take complaints seriously and to regard them as an opportunity for quality improvement.

In turn, HIQA takes the same approach to complaints that it receives about its own work. Wherever possible, it seeks to resolve complaints at the earliest opportunity. Learning from complaints is also shared throughout the organisation anonymously, including with the Executive Management Team and HIQA's Board. In 2016, HIQA received a total of 11 complaints relating to the regulation of services. These, in line with HIQA's complaints policy, were fully investigated and responded to. Where relevant, learning is shared across the organisation and with complainants.

Looking ahead

The regulatory powers of HIQA and the Office of the Chief Inspector are expected to be extended into other sectors in the coming years. HIQA will continue to work with the Department of Children and Youth Affairs to commence the registration and inspection of all children's residential centres provided by Tusla, and providers in the voluntary and private sectors.

HIQA will be planning for the transfer of responsibilities from the Department of Health to HIQA, under new legislation, for the regulation of medical exposure to ionising radiation, which is scheduled to start in 2018. Another important future development in HIQA's regulatory work will be the proposed introduction of a licensing system for public and private hospitals. It is intended that the licensing system will introduce a framework of regulation for hospitals which will be overseen by HIQA, providing similar powers of inspection and enforcement available in nursing homes and residential centres for people with disability.

Throughout 2016, HIQA contributed to a Department of Health working group on licensing with a view to assisting in and informing the

development of the necessary draft legislation as a precursor to the introduction of new legislation. We also welcome the early indication of the Government's proposals for the regulation of home care services. This will introduce regulatory oversight for the first time of the quality and safety of this type of care for vulnerable older people and people with disabilities in their own homes.

As a learning organisation, the Authority regularly reviews its systems and processes to ensure that it is fulfilling its statutory responsibilities as effectively and efficiently as possible. HIQA encourages and welcomes feedback on its work from people using services. It also welcomes feedback from service providers and the general public. HIQA also carries out research to ensure its regulatory practices and development of standards are evidence-based and are in line with international best practice.

This research included an analysis of other jurisdictions' programmes of regulation in social care services as compared to Ireland's current model. The model in Ireland is centred on the definition of a designated centre in the context of services for older people and people with disabilities.

HIQA's experience of regulating services and our analysis of regulation in other countries has shown that there are new and emerging models of care in Ireland that do not meet the definition of a designated centre. As such, there are a significant number of service users outside of the protections of a regulatory framework.

HIQA believes reform is needed in how it registers and regulates services in order to respond to the various existing and emerging models of care being seen in Ireland today and into the future. The Authority intends to work with the Department of Health and other relevant stakeholders with a view to advancing reform in this area.

Conclusion

People are entitled to expect access to safe, good quality services that meets their needs in a timely, caring and effective manner. There is much good work being done in Ireland's health and social care services, and HIQA has sought to highlight this throughout this report and in individual inspection reports. As outlined within our Strategic Plan published in 2016, we believe that improvements within Ireland's health and social care services can only come about through collaborative effort between all relevant stakeholders. HIQA recognises that there are many challenges facing service providers. For example, the difficulties in recruiting staff and the need for increased resources and capital investment.

Notwithstanding these challenges, our findings show that improvements in the quality and safety of services can be delivered from the replication of good practice across services, application of evidence-based standards and guidelines, and constructive engagement on the outcomes of self-assessment or third-party assessments such as those carried out by HIQA's teams. We hope this report will help to foster a culture of shared learning across service providers with the ultimate goal of improving outcomes and experience for people using services.

HIQA will continue to work with all stakeholders to address the many challenges facing the country's health and social care services and to plan effectively for the future.

Chapter 1 - **Disability services**




Chapter 1 - Disability services

Key points

Voice of the resident
While many residents tell HIQA that they are receiving good care, there are still a significant number who described limited opportunities for activities, low staff numbers and poor physical environment standards.

Governance
Inspection findings support the view that governance is key in delivering a high-quality service. Where HIQA finds poor care, it is ultimately caused by poor governance and management.

Safeguarding
HIQA continues to encounter services that are not adequately providing prevention or protection from harm or abuse for residents.

Institutional practices
Some services continue to operate under outdated practices which are institutional in nature and not person-centred and in themselves may be harmful or in breach of residents' human rights.

New and emerging models of care
Some services are providing new and innovative care services which do not meet the legal definition of a designated centre. This has potential to create gaps in the protection of service users.

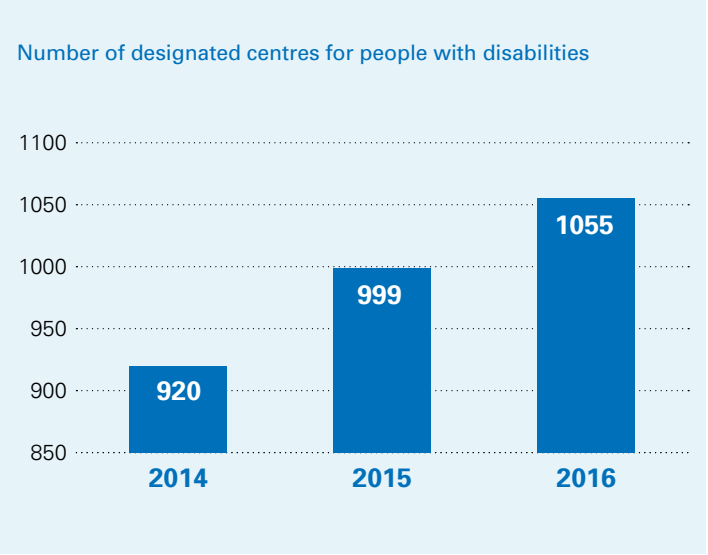
Introduction

Through its regulatory work during 2016, a number of key themes about residential services for people with disability emerged. This section of the report focuses on those areas. Residential services for people with disabilities are undergoing a period of major adjustment and transition as the Health Act and associated regulations give providers a common governance framework with which to evaluate their services.

In addition, ongoing activity in relation to implementing the policy of people with disabilities moving from institutionalised congregated settings into community-based services is also bringing about changes and challenges within the sector. In fact, these challenges and the general lack of preparedness within the sector for regulation resulted in the Minister for Health extending the deadline for registration to 2018.

By the end of 2016, there were 1,055 designated centres for people with disabilities, compared to 999 in 2015 (see Figure 1). Of these, 701 centres had been registered because their providers demonstrated compliance with the relevant regulations. As such, compliance demonstrates a commitment to providing residents with a safe place to live and a good quality of life.

Figure 1. Number of designated residential centres for people with disabilities in 2014, 2015 and 2016



At the start of 2016, following a process of internal restructuring within the Regulation Directorate, the Designated Centres for Disability pillar was established within HIQA. This meant that there was now a dedicated team with responsibility for regulating the quality and safety of designated residential centres for adults and children with disabilities across Ireland. Through its regulatory activity, this team worked to ensure that quality in designated centres was improved, that people were being safeguarded and that care was person-centred.

The team consisted of the Deputy Chief Inspector of Social Services, five inspector managers — one of which has a programme and quality assurance brief — and 26 inspectors; and five regulatory officers who

also have an inspection remit. An inspector manager and team of inspectors and regulatory officers cover four assigned geographic areas, called the East Area; Dublin, Wicklow and Kildare Area; the West Area; and the South Area.

As the Government continues to prepare for the ratification of the United Nations Convention on the Rights of Persons with Disabilities, through its work, HIQA and other agencies are making an important contribution to these preparations. HIQA aims to promote, protect and ensure that people with disabilities living in residential services enjoy the human rights and fundamental freedoms to which all citizens are entitled.

In doing so, the Designated Centres for Disability team is committed to improving the way in which it engages with people who use services and the way in which it reflects their views of services in inspection reports.

Good practice

Service provided by the Daughters of Charity

A campus setting provided services for a large number of residents. Inspectors found that the provider had taken effective measures to improve the safety and the quality of life for residents on the campus, despite the challenges of the physical environment of a congregated setting.

On the initial inspections, there had been historically accepted, institutionalised staff practices in place which had compromised the privacy and dignity of residents. These practices had not ensured adequate consultation with residents or their representatives, involved institutionalised daily routines for residents and inadequate support to ensure residents had meaningful days. Individual personal planning with residents had been of a poor quality.

However, while the physical environment continued to be a challenge, the provider has taken effective actions to improve the quality of life for residents in the congregated setting. During the most recent inspections, the provider had reviewed the governance and leadership within the campus to improve the focus on the individual support needs of residents. The staff skill-mix and staffing rosters had been reviewed and changed to ensure the best outcome for residents in a challenging physical environment.

Staff had been provided with training on developing meaningful personal plans for residents, and inspectors saw these being implemented. Overall, the provider had successfully improved outcomes for residents, and had enhanced their quality of life as much as possible — despite the challenges of a large congregated setting.

One resident stated during an inspection:

"I love living where I live because of the facilities in the area like the hairdresser, beautician and the local shops. The staff in all of these places know me and are friendly towards me."

The voice of the resident

It is HIQA's view that service users are often the best source of information on the performance of a service. That is why our inspectors spend time listening to and observing residents and, where appropriate, speaking with their relatives and advocates during inspections. We also review resident satisfaction questionnaires which are sent out prior to an announced inspection. For a variety of reasons, HIQA recognises that not all residents wish to offer feedback or meet with inspectors and we fully respect this right.

In 2016, a total of 735 inspection reports on residential centres for people with disabilities were published. During these inspections, inspectors spoke directly with 2,183 residents about their services. Speaking with them provides an insight into what it is like to live in these centres. In addition, inspectors observed residents' daily routines. On average, almost three out of four (73.5%) of all residents who were in centres at the times of inspection chose to meet with inspectors.

During these meetings, residents' feedback proved invaluable to the inspection teams in assessing what it is like to live within each particular designated centre. Most residents who spoke with inspectors said that they liked living in their homes, that staff were kind and supportive, and that they felt safe. Some residents chose to share their experiences about what added to their quality of life. These experiences included participating in a variety of activities both at home and in the community. This included being involved in the running of their home, selecting meals for the weekly menus and accessing employment and educational opportunities.

Some residents were unhappy with life within their respective designated centres. They highlighted difficulties caused by limited access to activities, low staff numbers, the challenges of living with others, limitations with the premises and that some centres closed each weekend. In other instances, some residents told inspectors that they felt they were not listened to in relation to their desire to self-medicate, or in terms of the use of closed-circuit television (CCTV) within their home, which they believed was intrusive.

Such feedback gives valuable insights about the lived experiences of residents, and it informs the assessment of the service provider's effectiveness in delivering a good quality service. We also welcome feedback from residents through a range of other formats and meetings. For example, during 2016, HIQA staff were invited to attend a residents' advocacy group; to give a presentation and engage in a discussion at a different group; and received correspondence from another residents' advocacy group. Our staff also welcomed residents from three different designated centres to a national meeting of the HIQA disability team in December 2016.

HIQA acknowledges that while its inspectors are assessing the quality of a service, these services are also people's homes. During meetings with HIQA staff, residents spoke about what it was like to experience an inspection. This feedback has helped the Chief Inspector to refine the inspection

processes while continuing to achieve the objective of inspection and regulation within people's homes. Additionally, these channels of communication have allowed our staff to reassure residents that the aims and objectives of regulation are to ensure that residents are receiving the care and support that they are entitled to, and which regulation requires.

The Office of the Chief Inspector is committed to further developing HIQA's programme of engagement with service users in 2017, including further engagement with residents' advocacy forums. Additionally, the Authority is committed to reviewing its inspection reports to increasingly reflect the views and experiences of residents.

Good practice

Service provided by Ability West

Inspectors observed a positive situation where the ongoing review of the individual support plan for a resident with complex and intensive support needs resulted in significant improvements in the safety of the service and the quality of life for this resident.

Because of the assessed risks to the wellbeing and safety of the resident, specific restrictive measures had been implemented which included limitations on engagement with peers and restricted access to certain parts of the resident's home.

However, the provider had identified a risk of social isolation as a result of these measures. The provider introduced a programme to allow the resident to engage in day-to-day activities with the support of staff, and incrementally introduced the resident to activities that had been previously curtailed as a result of risk.

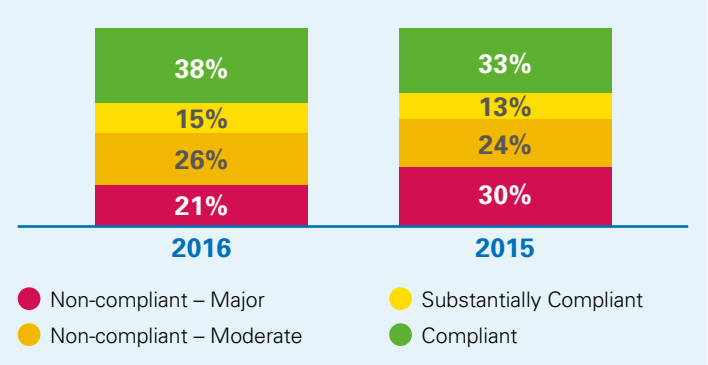
Inspectors saw how the provider had ensured a safe service for the resident, while also ensuring that staff continued to review the situation and seek to reduce the level of restrictions that the resident was experiencing. As a result, very significant improvements in the quality of life for the resident were observed.

Accountability, leadership and management

Critical to meeting the requirements of the United Nations Convention on the Rights of Persons with Disabilities is effective leadership and management within disability services. This requires the establishment of governance arrangements that enable service providers to assure themselves that the rights of residents in their care are protected and promoted.

In general, during 2016, our staff found most providers had appropriate governance and management arrangements in place. One of the core outcomes that HIQA assesses on inspection is 'Governance and Management'. Centres increasingly complied with this inspection outcome in 2016, compared to 2015 (see Figure 2). The percentage of inspections where there was compliance with this outcome rose from 33% to 38%. In addition, there was a significant reduction in major non-compliances with this outcome, down from 30% in 2015 to 21% in 2016.

Figure 2. Compliance with governance and management



A key indicator of a good service is where service providers are proactive in terms of identifying areas for quality improvement. Another indicator of a good provider is where they take effective and sustained action to address any issues that have been identified and ensure a positive outcome for residents.

However, while many providers have a quality improvement agenda, HIQA has also found that some providers depend on the findings of inspections in order to address shortcomings. HIQA staff identified a number of centres where the provider was providing an unsafe or poor quality service and where the provider was unable to take proactive and effective action to improve their services. In these situations, HIQA take a stepped approach to enforcement. Throughout 2016, disability service providers were required to attend 153 meetings with the Office of the Chief Inspector to account for their failure to meet their regulatory responsibilities.

When such interventions are unsuccessful, the Office of the Chief Inspector will then take the first step towards cancelling the registration of centres by issuing a notice of proposal to cancel their registration. In 2016, in line with the provisions in the Health Act, the Chief Inspector issued 11 notices of proposal to refuse the application to register and cancel the current registration status of designated centres for people with disabilities. If these notices had been taken to their conclusion, this would have meant that these centres would have had to cease operating within a set time frame.

However, in most instances, in response to these notices, providers make representations to the Office

of the Chief Inspector setting out the actions they are taking to improve the standards of their services. Nonetheless, where a provider fails to make a representation or fails to take effective or appropriate action, the Chief inspector then issues a notice of decision to cancel the registration of a centre. This is the final decision of the Chief Inspector and the provider may only appeal the decision to the relevant district court.

In 2016, the Irish Society for Autism appealed to the district court in relation to notices of decision to cancel the registration of two of its centres. Both appeals were withdrawn in court by the provider prior to a full hearing. Later, the registrations of the two aforementioned centres along with a third centre operated by this provider were cancelled and, in accordance with the requirements of the Health Act, the HSE took over the operation of these centres.

At the time of writing, a further provider had submitted an appeal to the district court in relation to a notice of decision to cancel the registration of a centre which had been issued in December 2016.

Oversight by funders of services

In HIQA's experience, there is a need for more effective accountability to ensure a more transparent, fair and effective use of public money to provide health and social care services in Ireland. Service providers are primarily responsible for ensuring they deliver a service that is safe and provides people with a good quality of life. However, there is also a responsibility on the funder of those services, primarily the HSE, to ensure that public money is being used to deliver good quality, safe services.

HIQA supports the HSE's initiative during 2016 to review and strengthen the service level agreements it has in place with providers of residential services to people with disabilities. HIQA advocates the further development of those arrangements. While these measures should result in greater accountability, HIQA believes a more fundamental review of service funding is needed. In this context, a formal accountability framework, similar to a commissioning-model approach, needs to be developed.

HIQA is of the view that such a model would support more effective service configuration, the implementation of national care programmes and more effective oversight of services.

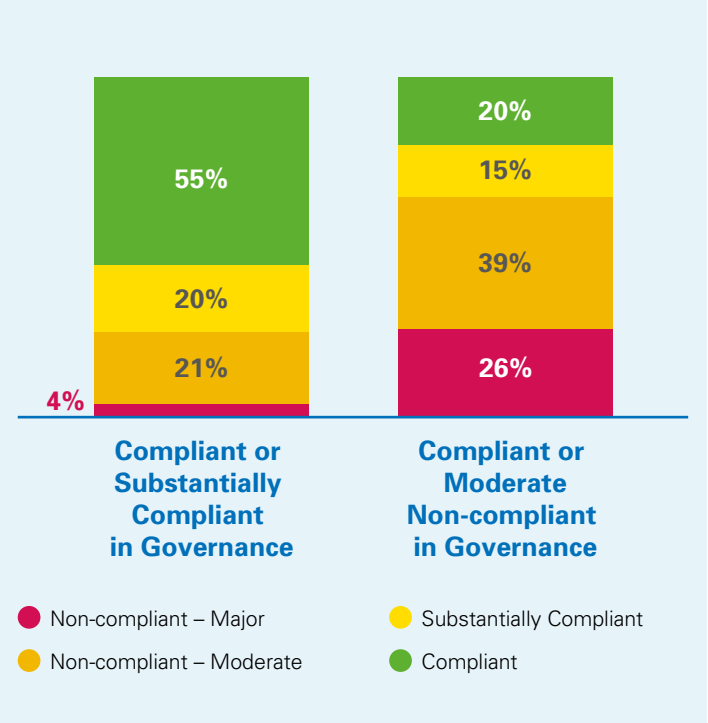
Safeguarding

The National Safeguarding Committee, in its Strategic Plan 2017–2021,[1] defines safeguarding as the means to protect people's health, wellbeing and human rights, and to enable people to live free from harm, abuse and neglect. It states that it is fundamental in achieving high-quality social support services.

HIQA's experience is that where providers have strong governance and leadership arrangements in place, safeguarding measures are stronger. This is demonstrated in Figure 3 which shows how good compliance in governance and management outcomes is strongly associated with good

compliance in safeguarding. For example, 55% of services who complied with safeguarding outcomes had in parallel demonstrated compliance or substantial compliance with governance and management outcomes (35%). On the other hand, if a service had a major or moderate non-compliance with governance and management, only 20% of these services complied with safeguarding outcomes.

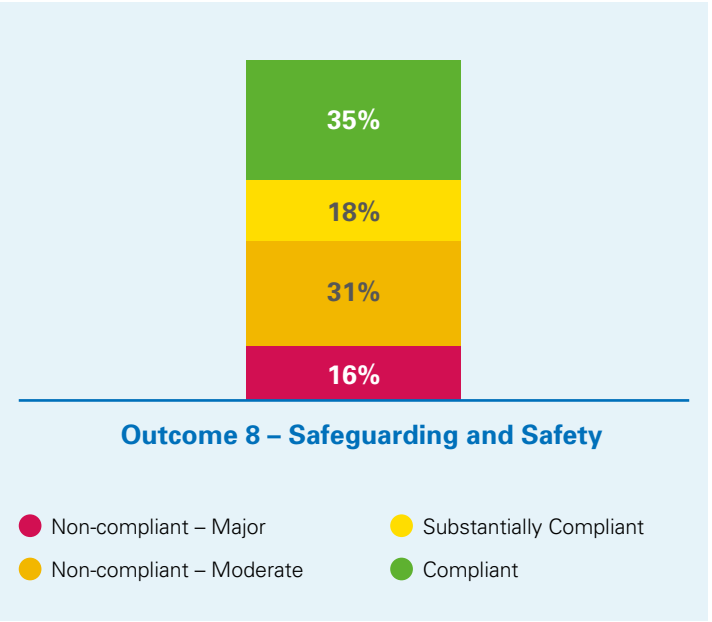
Figure 3. Compliance level in safeguarding relative to compliance with governance in designated centres for people with disabilities in 2016



However, adequate safeguarding for people with disabilities cannot solely depend on the governance arrangements of individual providers. HIQA is advocating for new safeguarding legislation that would make it a legal requirement to have adequate arrangements in place to safeguard all vulnerable people.

Protecting vulnerable people from the risk of abuse and quickly responding to any suspicions or allegations of abuse is an essential aspect of safeguarding. Overall, our staff found that there needs to be a continuing focus on keeping residents safe from the risk of abuse. During 2016, there continued to be a worrying level of non-compliance with our assessment of compliance with regulations aimed at achieving better outcomes on safeguarding (see Figure 4).

Figure 4. Compliance with safeguarding and safety in 2016



In 2016, inspectors also found that significant improvements were required to safeguard residents from the risk of injury or harm through peer-to-peer altercations.† Such incidents were often behaviour-related rather than abuse issues. However, inspectors found that some providers were failing to safeguard residents and failing to implement effective positive-behavioural support arrangements that minimised such behaviours and reduced risk to residents.

Inspectors have found that in centres where there are frequent and recurring peer-to-peer altercations, there has been a historical acceptance and ambivalence to such behaviour over a long period of time. In some centres, there are institutionalised staff practices with inadequate insight of the impact of those staff practices on the welfare of residents. Often, residents who are incompatible with each other are placed together, or residents who find it difficult to live with others are placed in an inappropriate living environment that does not meet their needs.

In some of those centres, residents have told inspectors that they are afraid; this has been borne out in inspectors' observations. While this situation tends to be more prevalent in large congregated settings, it has also been observed in some smaller, community-based houses.

† Peer-to-peer altercations occur when a resident causes, or threatens to cause, harm to another resident.

Good practice

Service provided by the Health Service Executive

In this centre, the provider offered short respite breaks to people with disabilities. Inspectors found that the provider had put very effective consultation and assessment processes in place to ensure that staff knew the residents well; ensured that the service could meet the support needs of residents; and planned activities around the preferences of residents.

Residents told the inspector about how the person in charge met with them on their arrival to ensure that the information in the centre was current and correct. They told the inspector that staff were aware of what they liked to do when they were visiting the centre. They also described a range of activities that staff supported them doing, including going shopping, having meals out and meeting friends in town.

Family members said that nothing was too much for staff, that they ensured residents had an opportunity to make choices and that staff ensured that the service was like a "home from home".

List of centres that achieved full compliance in 2016

Figure 5 (below) shows all of the designated centres for people with disabilities that achieved full compliance in all outcomes inspected by HIQA in 2016.

Figure 5. Disability services that achieved full compliance in a 2016‡ inspection

Registered provider	County	Centre's name
Ability West	Galway	Grangemore Services
Brothers of Charity Services Ireland	Cork	No.1 Fuchsia Drive
	Galway	Gort Supported Living Services
		Oran Services
	Waterford	Tory Residential Services Kilmeaden
Camphill Communities of Ireland	Kildare	The Bridge Community
Carriglea Cairde Services	Waterford	White Strand Respite Service
CoAction West Cork	Cork	Bantry Residential
COPE Foundation	Cork	Cork City North 15
		Cork City North 17
Daughters of Charity Disability Support Services	Dublin	Hansfield Group - Community Residential Service
	Limerick	Group A - Community Residential Service Limerick
		Group D - Community Residential Service Limerick
Dundas Ltd	Meath	The Mill
G.A.L.R.O.	Westmeath	GALRO Residential Mullingar
Gateway Organisation	Sligo	Newhaven
Gheel Autism Services	Dublin	Phoenix House
Health Service Executive	Laois	Portlaoise Area
	Louth	Sruthan House
		The Coastguards
	Meath	Avalon
		Caradas
		Glen Abhainn
		Ivy House
		Na Driseoga
	Westmeath	Le Cheile

‡ *The data is based on centres that had what are termed '10 outcome' and '18 outcome' inspections. Each of these centres would have had at least one of these inspections during 2016 and were assessed as being compliant or substantially compliant in all outcomes inspected. It should be noted that inspection findings reflect what was found in a centre on the day of inspection and findings can change over time.*

Registered provider	County	Centre's name
Muiríosa Foundation	Kildare	Community Living Area 23
	Laois	Community Living Area D
		Community Living Area J
North West Parents and Friends Association for Persons with Intellectual Disability	Sligo	Rathedmond Community Group Home
Nua Healthcare Services	Clare	Hempfield
Nua Healthcare Services	Cork	The Abbey
		Valley View
	Dublin	Winterfell
	Laois	Taliesin House & Log Cabins
		The Pines
	Louth	Rathdearg House
	Meath	The Lodge
	Westmeath	Tulla House
Redwood Extended Care Facility	Dublin	Cedarwood Lodge
	Meath	Ferndale
		Orchard Vale Apartments
RehabCare	Cavan	Cavan Accommodation
	Clare	Brookside Lodge
	Kerry	Kenmare Accommodation Service
	Meath	Navan Adult Residential Service
	Sligo	Sligo Supported Accommodation
	Tipperary	Supported Living Thurles
		Tus Nua
Resilience Healthcare	Cork	Ard Na Gaoithe
RK Respite Services	Tipperary	Northfields Respite Centre
St Catherine's Association	Wicklow	Haughton Lodge
St Christopher's Services	Longford	Children's Respite Service
St John of God Community Services	Dublin	St Augustine's
		Suzanne House
	Kerry	North Kerry
		St. John of God Kerry Services - Supported Living
	Kildare	St. John of God Kildare Service DC 11

Registered provider	County	Centre's name
St John of God Community Services	Louth	Ard Na Rithe
		Boyne Lodge
		Solas Na Gréine
	Meath	Shannon Villa
Sunbeam House Services	Wicklow	Drumcooley
Western Care Association	Mayo	Abbeydeale Residential Services
		Barr-an-Chnoc Residential Service
		Ceol na hAbhainn Residential Service
		Glade House Residential Service
		Pinegrove Residential Service
		St Stephen's Respite

Moving from congregated settings to the community

The move from congregated living to community-based models of support and care continues within residential disability services, in line with the HSE's 'Time to Move On' initiative. While some people with disabilities have moved, or are in the process of moving, to community houses or independent living, a significant number of people continue to live in congregated settings.

The full closure of all congregated settings will take time. However, in the interim, providers need to ensure that the rights of residents who continue to live in congregated settings are protected and that their quality of life and experiences are improved, while also ensuring that these services comply with regulations.

During 2016, the Designated Centres for Disability team continued to inspect congregated settings. In some of these centres, providers had attempted to re-organise the physical environment to improve the privacy of residents. However, in many instances, practices within these centres remained institutional in nature and were determined by staff routines rather than the needs of residents. For example, arrangements including:

- the communal laundering of residents' clothing
- centralised meal times and menu planning
- the use of physical and environmentally restrictive practices§(2)
- limited access to the community or educational and vocational activities.

§ A restrictive procedure is a practice that: limits an individual's movement, activity or function; interferes with an individual's ability to acquire positive reinforcement; results in the loss of objects or activities that an individual values or; requires an individual to engage in a behaviour that the individual would not engage in given freedom of choice.

Emerging models of service

An issue that has arisen from the transition away from congregated settings is the emergence of new models of service or existing services caring for vulnerable people that do not fit within the definition of a designated centre as contained in the Health Act. These types of services identified in Ireland include:

- personal assistants
- home care
- sheltered housing and assisted living
- respite care
- day care
- home sharing (placement with families).

As a result, some residents are moving to living arrangements that are not subject to regulatory oversight and these residents do not have the same legal protections as those protections provided to residents who live or had been living beforehand in registered designated centres.

Some people are being accommodated in centres that require significant levels of restrictive practices and controls. These measures are deemed necessary in cases where people are assessed as being a danger to themselves or to others in the community. The Chief Inspector is concerned that these models of service may fall outside the definition of a designated centre, and that the regulatory framework to protect residents in such living environments may be inadequate.

Submissions and complaints

In total, there were three submissions received from service providers who were dissatisfied with HIQA findings or regulatory judgments. On review, all three were resolved by the relevant inspector manager at Stage 1 of our submissions process. Aside from submissions, HIQA also received seven complaints relating to our disability service inspections. These were all processed according to our complaints policy.

Examples of poor practice found in various services for people with disabilities

- Notifications submitted to HIQA by the registered provider confirmed a constant failure by management to recognise and respond to persistent evidence of poor safeguarding practice. This meant that vulnerable people were subject to continual peer-to-peer abuse and persons with behaviour that challenges were not receiving appropriate behavioural support.
- The registered provider and persons in charge did not have effective governance and management arrangements in place to protect vulnerable people. As a result, unacceptable care practices were neither identified nor considered inappropriate. These practices manifested in a punishment custom which included the withholding of privileges and preferred foods.
- The service failed to ensure assessment arrangements in place to ensure the admission and integration of new residents to the designated centre were safe. This resulted in people experiencing peer-to-peer abuse and poor safeguarding practices in their home.
- Management failed to appropriately investigate reported incidents which meant that children and adults living in the designated centre were unsafe and continued to experience unmanaged peer-to-peer abuse. Staff were not confident in managing people with behaviour that challenges, and no training had been put in place to address this.
- There was a failure to address inappropriate staff practices which resulted in residents' mealtimes being determined by staff meal breaks as opposed to residents' preferences.
- The registered provider failed to ensure the physical environment was safe and that fire evacuation arrangements were effective. Furthermore, staff did not have fire evacuation training.

Chapter 2 - **Older People**




Chapter 2 - Older People

Key points

Voice of the resident
Most residents were satisfied with the service they received and were generally complimentary about staff.

Going beyond the regulations
The sector is in its third cycle of registration and HIQA anticipates that providers are now focused on achieving a level of quality above and beyond minimum compliance with the regulations.

Governance
Inspections found that complying with the governance outcome is the best indicator of quality across the whole service.

Safeguarding
Some services were not compliant with safeguarding requirements, particularly in the area of Garda Síochána vetting.

Privacy and dignity
HIQA continues to find centres where the physical environment does not protect or promote residents' privacy and dignity. While the Authority acknowledges that the revised deadline for meeting the physical environment regulations has been moved to 2021, HIQA believes that much needs to be done in these services in the interim to ensure that the quality of life, privacy and dignity of residents is improved.

Introduction

At the start of 2016, following internal restructuring within HIQA's Regulation Directorate, the Designated Centres for Older People pillar was established within HIQA. This meant that there was now a dedicated team responsible for regulating the quality and safety of designated centres for older people (nursing homes) across Ireland. Through its regulatory activity in 2016, this team worked to ensure that quality in nursing homes was improved, that people were being safeguarded, and that care was person-centred.

The Designated Centres for Older People team is responsible for overseeing 580 registered nursing homes with 30,396 registered beds. The team consists of the Deputy Chief Inspector, five inspector managers and 19 inspectors; and five regulatory officers who also have an inspection remit. The Designated Centres for Older People team is divided into four geographical areas: South; West; East; and the Greater Dublin Area.

The Chief Inspector's statutory remit underpins HIQA's inspection of nursing homes. The requirement to re-register each nursing home every three years significantly influences how the resources available to this pillar are deployed each year.

In 2016, 93 of the 580 centres required a renewal of registration. This is lower than other years and is a result of the cyclical nature of the registration process which sees registration applications fall mostly into the final year of the three-year registration cycle. For example, 238 centres are due for renewal in 2017 and 249 centres in 2018. This would revert back to 93 again for 2019 in the event that no new centres open or existing ones close.

The lower number of registrations in 2016 provided the Designated Centres for Older People team with a greater degree of flexibility in terms of allocating resources than in other registration-cycle years. As such, we increased our monitoring activities of nursing homes where there had been concerns about the level of regulatory compliance, and carried out more thematic inspections, which look at specific aspects of care in a centre.

Thematic inspections are designed to encourage and facilitate quality improvement within the sector. In 2016, HIQA focused on dementia care. People with dementia have very specific needs and there has been a lot of research carried out in recent years which seeks to improve the living environment for this vulnerable group. HIQA's dementia-themed inspections in 2016 (170 such inspections) were evidence-based and sought to identify areas for improvement in the care of residents with dementia.

Our staff welcomed the opportunity to focus on such quality improvement initiatives and the feedback from providers was also positive. The regulatory requirement to renew the registration of 238 centres in 2017 will reduce the number of quality improvement initiatives such as thematic inspections which can be undertaken by HIQA.

One resident told us:

"Whenever something is wrong with me, I am looked after."

The voice of the resident

One of the most important aspects of regulating nursing homes is obtaining feedback from residents and their families or advocates in order to gain an insight into everyday life in the centre. During inspection, this is achieved by inspectors talking with residents and relatives.

Prior to a registration inspection, nursing homes are provided with questionnaires which are to be distributed to residents and their family and friends. The completed questionnaires are made available to inspectors before the inspection takes place. Residents and their families are asked about all aspects of the care they receive, including issues around:

- activities
- their rights
- privacy
- healthcare
- standard of accommodation
- quality of food
- safety
- staff
- laundry facilities and
- complaints management.

Inspectors use this feedback as a guide to inform the inspections and to pay special attention to issues of concern to residents.

Another means of gaining insight into residents' experience, particularly for those with advanced dementia, is through observation. This is particularly important for thematic inspections focused on dementia. Inspectors discreetly observe and measure the interactions with residents and staff in order to assess if the care is person-centred and provided in a dignified manner.

Feedback from residents and their families was mainly positive about most aspects of living in a nursing home, although many residents expressed a wish to be cared for in their own homes. It is apparent that the quality and choice at mealtimes was important to residents, and several people gave examples of how their feedback on food and menu choices had been addressed by management.

Other important issues were the number of staff available to assist residents during the day and at night. During the 2016 inspections, several residents spoke of the kindness shown to them by staff, with one resident summing this up by stating that "they can't do enough for you". Other residents commented on staff being over-worked and residents having to wait on occasion to receive care.

Several residents spoke about the range of activities provided in the nursing homes, including gardening, baking, arts and crafts, exercise and music sessions, and the benefit of having pets in the centre. However, some residents and their relatives expressed a desire for more outings, activities and engagement with the local community. HIQA will continue to prioritise meeting with residents to hear their feedback as we believe their views are a rich source of information on how well a service is being run. Additionally, HIQA is committed to reviewing our inspection reports to increasingly reflect the views and experiences of residents.

Good practice

Consultation with residents

Meaningful consultation with residents and action in response to such consultation is a cornerstone to improving the quality of life for residents. Such meaningful consultation was evident in centres such as Middletown House, Wexford and Corbally House Nursing Home, Limerick. In these centres, residents were consulted with in relation to efforts to:

- maintaining personal life histories
- care planning
- planning for end-of-life care and
- organising activities.

Effective care planning on issues such as residents' wishes for end-of-life care had helped to prevent unnecessary transfers of residents from these centres to acute hospitals.

Regulation of nursing homes in 2016

In 2009, nursing homes became the first health and social care sector to be regulated by HIQA. The sector has experienced regulation for over seven years and is now quite familiar with the process. In fact, many registered providers are in their third cycle of regulation. Therefore, HIQA would anticipate that registered providers are now focused on improving their services beyond basic compliance with the regulations¶ and are working towards achieving widespread compliance with the National Standards.**,††

The revised *National Standards for Residential Care Settings for Older People in Ireland*[3] were introduced in July 2016. These revised National Standards place a stronger focus on, and are a framework for, the continual development of quality of life for residents and a person-centred approach to care for all residents. Providers are encouraged to implement the Standards, which describe what the nursing home should do to provide a good quality and safe service for people living there.

Improved standards of care were seen in nursing homes through the higher level of regulatory

¶ *The regulations currently in effect are entitled Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.*

** *The standards currently in effect are entitled National Standards for Residential Care Settings for Older People in Ireland.*

†† *While our inspection teams assess a centre's compliance with both the regulations and standards, we are only empowered to take enforcement action when regulations have not been complied with. Meeting the standards is viewed as demonstrating a level of quality which exceeds that required by the regulations.*

compliance found during our inspections in 2016. In total, HIQA completed 608 inspections of 494 centres, meaning that 81% of registered nursing homes were inspected in 2016. Of these, 72 centres demonstrated an excellent level of compliance with the regulations during the inspection (see Figure 6) by achieving a rating of compliant or substantially compliant in all areas inspected.

It is important to emphasise that compliance results are based on findings on the day or days of inspection. The centres which demonstrated high levels of compliance with the regulations varied in terms of their size, layout and location — but they share one vital aspect of care: good governance. We found that when there is a strong and consistent governance structure in place, then the outcomes for residents tends to be positive.

Figure 6. Nursing homes that achieved full compliance with the regulations during inspections in 2016‡‡

Carlow
Signature Care Killerig
St Fiacc's House
Cavan
Breffni Care Centre
Castlemanor Nursing Home
College View Nursing Home
Oak View Nursing Home
Sullivan Centre
Clare
Carrigoran House
Riverdale House
Cork
Blarney Nursing and Retirement Home
Bridhaven Nursing Home
Padre Pio House
St Joseph's Hospital
Teach Altra Nursing Home
Donegal
St. Eunan's Nursing Home
Dublin
Aclare House Nursing Home
Ardmore Lodge Nursing Home
Beechtree Nursing Home
Catherine McAuley House
Cherryfield Lodge
Cherryfields Housing with Care Scheme
Elm Green Nursing Home
Glenaulin Nursing Home
Holy Family Residence
Kiltipper Woods Care Centre
Mount Hybla Private
Mount Sackville Nursing Home
Galway
Ballinasloe Community Nursing Unit
Castleturvin House Nursing Home

‡‡ *The data is based on centres that had 10 outcome, 18 outcome or dementia thematic inspections. Each of these centres would have had at least one of these inspections during 2016 and were assessed as compliant or substantially compliant in all outcomes inspected. It should be noted that inspection findings reflect what was found in a nursing home on the day of inspection and findings can change over time.*

Galway
Mill Race Nursing Home
Moycullen Nursing Home
St Mary's Residential Care Centre
Kerry
Heatherlee Nursing Home
Riverside Nursing Home
Kildare
Cloverlodge Nursing Home
Curragh Lawn Nursing Home
Oghill Nursing Home
Parke House Nursing Home
Ryevale Nursing Home
Kilkenny
Drakelands House Nursing Home
Strathmore Lodge Nursing Home
Laois
Community Nursing Unit Abbeyleix
Limerick
St. Gobnait's Nursing Home
Louth
Aras Mhuire Nursing Facility
Mayo
AbbeyBreaffy Nursing Home
Claremount Nursing Home
Cuan Chaitriona Nursing Home
Queen of Peace Nursing Home
St. Attracta's Nursing Home
St. Brendan's High Support Unit

Meath
Millbury Nursing Home
Woodlands House Nursing Home
Monaghan
Mullinahinch House
St Joseph's Nursing Home
Roscommon
Abbey Haven Care Centre & Nursing Home
Aras Mhathair Phoil
Costello's Care Centre
Innis Ree Lodge
Tipperary
Acorn Lodge
Ashlawn House Nursing Home
Millbrae Lodge Nursing Home Limited
Waterford
Dunabbey House
Killure Bridge Nursing Home
Westmeath
Bethany House Nursing Home
Moate Nursing Home
Portiuncula Nursing Home
Wexford
Abbeygale House
Knockeen Nursing Home
Middletown House Nursing Home
New Houghton Hospital
Wicklow
Eyrefield Manor Nursing Home
Kinvara House Nursing Home

Of the 494 centres that were inspected by HIQA in 2016:

- 394 had one inspection
- 87 had two inspections
- 13 had three or more inspections.

HIQA inspectors may visit a centre more than once per year for a variety of reasons, including:

- to verify measures or improvements which the provider had previously committed to
- in response to information which was of concern, or
- if HIQA has serious concerns about the quality and safety of the service.

Centres that require three or more inspections are in the minority. However, it is a concern that any centre would require such a level of regulatory monitoring. The Chief Inspector considers a proactive approach by providers to quality improvement to be an integral characteristic of being a 'fit'[§§] provider in line with the regulations. A 'fit' provider continually measures its service in order to improve the lives of each resident and does not require a regulatory inspection to identify regulatory non-compliance.

§§ *The Office of the Chief Inspector considers fitness to be, among other things, the ability of the registered provider and their management team to: perform his or her role; ensure the delivery of a service that provides suitable and sufficient care that protects the persons' rights and promotes residents' wellbeing and welfare; comprehensively understands and complies with regulations and nationally mandated standards; has robust governance arrangements in place which include timely and responsive quality assurance processes to assure the quality and safety of the service that the provider is registered to provide.*

The action taken by the Office of the Chief Inspector in response to regulatory non-compliance depends on issues such as the number and degree of non-compliances, the centre's regulatory history and the fitness of the provider as defined in the regulations. Our stepped approach to enforcement offers a number of options for taking action against a provider. In the first instance, the Chief Inspector will typically invite a provider to attend a meeting where the regulatory team will outline its inspection findings to them and advise them of their statutory responsibilities.

The Office of the Chief inspector will also provide an opportunity for them to account for the levels of non-compliance. This approach often results in improvements being made in the centre. During 2016, if this approach was unsuccessful, the escalation and enforcement processes focused on two key measures: restrictive conditions and warning letters. Warning letters to a provider outline what regulatory non-compliances are of concern to the Chief Inspector and the consequences of not addressing these issues satisfactorily. Restrictive conditions are placed on a centre's registration and may include limits on admissions or restrictions on the number of residents that can be accommodated in specified rooms (see Figure 7).

Figure 7. Escalation regulatory activity for nursing homes in 2016

Number of centres	Escalation regulatory activity
60	Providers were required to attend a meeting with HIQA to account for the level of regulatory non-compliance
21	Warning letters were issued to providers
38	Centres had restrictive conditions applied to their registration

In circumstances of major regulatory non-compliances and risk, the Office of Chief Inspector is empowered to cancel the registration of a centre and or take prosecutions. These are measures of last resort and HIQA will always give providers ample opportunity to avoid such a situation arising. However, our ultimate responsibility is to the safety of residents and our actions are always guided by what is in residents' best interests.

The Health Act provides the legislative basis for the monitoring, inspection and registration of nursing homes against regulations and standards. As previously stated, it is expected that registered providers — who have been operating under a system of regulation since 2009 — should by now be moving their services beyond basic compliance with the regulations to meeting or exceeding the National Standards.

Good practice

Mealtimes

Some centres including Haven Bay, Co Cork, and Ocean View, Co Kerry, had involved residents in efforts to improve mealtime experiences for residents. In these centres, residents' experience of mealtimes were enhanced through audit and observational review to ensure that meals were served hot, were well presented and on time. Residents were also involved in menu design and participated in a cheese tasting event.

Privacy and dignity of residents

A key component of appropriate long-term care is ensuring that each individual resident's rights to privacy and dignity are vindicated. There is clear evidence from our inspection programmes that the design, layout and available space in some nursing homes are negatively impacting on residents' privacy, dignity and quality of care. This is a significant concern in some centres operated by the HSE, where the physical premises are ageing and in need of major refurbishment and or replacement.

In June 2016, the Minister for Health signed into law Statutory Instrument No. 293. This extended to the end of 2021 the deadline for complying with various regulations related to the physical premises in nursing homes. However, registered providers of nursing homes with ongoing premises issues are strongly encouraged to take a proactive approach to dealing with these issues and to ensure compliance by 2021.

The Office of the Chief Inspector is engaging with the HSE on an ongoing basis to monitor progress with the HSE's Capital Development Plan which aims to ensure that centres under the HSE's remit will comply with the regulations by 2021. A similar process of engagement with private providers is also underway to ensure that detailed and fully costed plans, with timescales, are in place to address any premises issues by 2021. Progress against these plans will be assessed as part of the Authority's ongoing regulatory activity.

In the interim, registered providers must ensure that every effort is made to ensure the privacy, dignity and wellbeing of residents is promoted and maintained, regardless of the physical limitations of the building. Where the current building pose challenges, registered providers must find alternative means to ensure that the living environment enriches the lives of residents. They must also ensure that the privacy, dignity and wellbeing for people living in residential care is respected and sustained throughout their lives.

Leadership, governance and management

Effective systems of leadership, governance and management are an essential requirement underpinning the regulation of nursing homes. A 'fit' provider as defined in the regulations has in place an effective system of leadership, governance and management including:

- a management structure that supports the delivery of safe care in line with legislation
- a well-structured system of governance which includes responsive quality assurance processes
- systems of appropriately delegated responsibility and accountability that supports those employed to manage the service
- adequate resources (including financial and human resources) to ensure the safe and effective running of the centre.

HIQA's programme of regulation in 2016 found that while the vast majority of registered providers have very effective systems of leadership, governance

and management in place, for others it remains a work in progress. The findings of HIQA inspection activity clearly demonstrate the relationship between good governance and overall regulatory compliance. Data gathered by HIQA shows that when a service achieves compliance with the outcome on governance, there are fewer major non-compliances across all other outcomes.¶¶

Safeguarding

A key aspect of HIQA's work is the protection of vulnerable residents. In the absence of adult safeguarding legislation in Ireland, HIQA currently relies on national safeguarding protocols in designated centres for older people. As previously explained, safeguarding is a term used to denote measures which protect the health, human rights and wellbeing of individuals. These measures enable at-risk adults to live free from abuse, neglect and harm.

Registered providers who are responsible for assuring the safe delivery of care must understand the principles of safeguarding and recognise what poor care looks like. Most registered providers are aware of key safeguarding issues such as ensuring that staff and volunteers have undergone Garda Síochána vetting in line with regulatory requirements and have received training in protecting vulnerable people from abuse. It is HIQA's experience that providers who have effective systems of leadership, governance and management also have effective safeguarding arrangements in place.

¶¶ *For this analysis, compliance meant achieving a rating of 'compliant' or 'substantially compliant' with the Governance, Leadership and Management inspection outcome. It shows that compliance in Governance, Leadership and Management resulted in an average of 0.13 major non-compliances in other outcomes. Similarly, compliance with the Suitable Staffing outcome led to an average of 0.25 major non-compliances in other outcomes. The data supporting this finding is based on what are termed in HIQA as 10- and 18-outcome inspections, carried out in 2016.*

Garda Síochána vetting

HIQA views Garda Síochána vetting as the first step in ensuring that residents in nursing homes are protected and safeguarded. This requirement is included in the Health Act, the Care and Welfare Regulations 2013 and the *National Standards for Residential Care Settings for Older People* (2016) — and the previous *National Quality Standards for Residential Care Settings for Older People in Ireland* (2009). To this end, providers have always been required to ensure that vetting disclosures are obtained for all staff and volunteers.

The enactment of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 (hereafter referred to as the 'Vetting Act') on 29 April 2016 provided additional legislation which strengthened the provisions around vetting. It is now an offence to employ somebody to care for vulnerable people, or to commence such employment after the date of commencement of the Vetting Act, without a vetting disclosure from the National Vetting Bureau of An Garda Síochána.

This means that as part of the recruitment process to determine if a potential new member of staff or volunteer is suitable to work in a centre, Garda vetting disclosures must be received and a judgment

made on them prior to finalising the recruitment of new staff and before new volunteers start.

HIQA's regulation of nursing homes since the enactment of this legislation identified that some registered providers have allowed staff or volunteers to start work after 29 April 2016 without the necessary vetting disclosures in place. The Chief Inspector considers any non-compliance with respect to Garda vetting of staff to be unacceptable and a poor reflection on the service provider's governance arrangements. The failure of a service provider to have in place safe recruitment and staffing arrangements places an already vulnerable group of residents at increased risk of harm.

The enactment of the Vetting Act means that registered providers have until 31 December 2017 to ensure that vetting disclosures are in place for all volunteers and staff employed in their service prior to 29 April 2016. This is a particular issue of concern for services that have staff in place for many years and who have never undergone Garda vetting.

Given the requirement to have such vetting in place by the end of 2017, HIQA strongly recommends that these services take a leadership role in advancing such an essential safeguarding issue and proactively secure the necessary vetting disclosure for all staff well in advance of the deadline of 31 December 2017. Vetting is an important element of ensuring a safe environment for residents and the Chief Inspector will take appropriate action if non-compliance is found in this area.

Good practice

Enhancing the physical environment

A number of nursing homes had enhanced the physical environment for residents with dementia through improved design principles. These initiatives recognised the need to personalise space, provide more homely environments and promote discussion and reminiscence through art, objects, music and activities.

In Bushmount Nursing Home, Co Cork, Esker Lodge Nursing home, Co Cavan, and Bethany House, Co Westmeath, inspectors found that colour, lighting and signage within the centres were used to help orientate residents. The use of tactile, sensory decorations, traditional furniture and memorabilia were also used throughout these centres to stimulate conversation and reminiscence.

Contracts of care

In 2016, we received a small number of queries and concerns from residents and their families regarding the fees that they were being charged in nursing homes. For example, residents and families questioned:

- being charged a daily 'HIQA' fee
- being charged for services that they did not wish to avail of, such as particular social activities
- being charged for accessing the services of a general practitioner (GP) when the resident had free access to a GP through a Medical Card or GP Visit Card
- having changes made to existing contracts of care without the input of the resident or their representatives.

Residents of nursing homes are not required to pay any fees to HIQA. Each registered provider is required by law to pay €500 at the time of registration or the renewal of registration (every three years) and an annual fee of €183 in respect of each resident for a full year. It is not acceptable that any registered provider would seek to pass this charge on to a resident, and HIQA has taken appropriate action where it has found this to be the case.

Registered providers must ensure that contracts of care are clear, unambiguous and contain full details of the services to be provided to the resident. It should also detail additional fees (if any) to be charged for these services. In essence, providers must ensure that contracts and charges reflect the requirements of the regulations and the standards and are in line with consumer protection law. This allows for greater transparency and prevents undue stress for residents and their families. Therefore, discussion should be held with residents and their family prior to admission on the additional fees to be charged to allow for informed decision-making and consent. This is particularly important in the context of the introduction of the Capacity Act.

Residents' finances

Robust procedures to demonstrate that residents' finances are managed and stored appropriately are also important issues in safeguarding. Providers are required to ensure that accurate records are maintained in respect of all deposits and transactions of residents' money and valuables.

In order to comply with best practice, providers should also adhere to HIQA's Guidance on Residents' Finances.[4] This guidance highlights specific processes to be followed when providers act as agents for social welfare payments. These include ensuring that monies are not spent on items or services that the resident is entitled to receive free of charge; lodging the balance of the payment to an interest-bearing account for the benefit of the resident as soon as possible after receipt; and keeping a record of all sums received and all transactions made in relation to the payment. This will allow providers to demonstrate clear audit trails of residents' monies and to ensure their assets are adequately protected.

Submissions and complaints

In total, there were 13 submissions received from service providers who were not satisfied with HIQA's inspection findings or regulatory judgments. Of the 13, five were resolved on review by the relevant inspector manager at Stage 1 of our submissions process. The remaining eight were appealed to Stage 2 of our submissions process, which involved review by managers from outside of the Regulation Directorate. Aside from submissions, HIQA received three complaints relating to its nursing home inspections. These were all processed according to our complaints policy.

Examples of poor practice found in various nursing homes

- The registered provider and persons in charge failed to effectively assess and appropriately address the needs of residents with dementia. There was no organised schedule to provide appropriate sensory and reminiscence activities for residents. Healthcare assistants did not have a defined role in helping residents.
- There was a failure to ensure arrangements were in place to ensure staff knew how to effectively communicate and care for older people with an intellectual disability. This meant that residents were rushed at mealtime, staff used language which was not age-appropriate and one staff member was heard to mimic a resident.
- The service failed to ensure that staff working in the centre understood the importance of care planning. This meant that residents and, if appropriate, their families were not involved in care planning decisions.
- The service failed to recognise, report and subsequently investigate an allegation of suspected abuse in line with its own safeguarding policy.
- The registered provider did not ensure that there were arrangements in place to comply with Department of Social Protection guidelines for those who act as a pension agent. This meant that residents' pensions were paid into a central account belonging to the centre rather than into individual accounts earning interest and in the residents' names.
- The registered provider and persons in charge did not ensure effective arrangements were in place to ensure that residents' progress and or deterioration was communicated effectively. This meant that residents' care was compromised as staff with responsibility for caring for residents did not always have the correct, up-to-date information to hand.

Chapter 3 - **Children's services**




Chapter 3 - **Children's services**

Key points

Voice of the child
There are many examples of good services where children feel safe and well supported. However, not all children received the service they required to meet their assessed needs.

Governance
The best leaders and managers create a culture of high aspirations for children in care.

Safeguarding
Safeguarding and child protection practices in alternative care settings showed improvement in 2016, but some services continued to have ineffective safeguarding measures in place to promote children's safety.

Introduction

The children's services pillar is responsible for HIQA's statutory function in relation to several types of children's services. These services include statutory children's residential centres and special care units, statutory and privately-provided foster care services, child protection and welfare services, and Oberstown Children Detention Campus in Co Dublin.

In 2016, the Chief Inspector reconfigured the manner in which it regulates services. As part of this reconfiguration, the monitoring of residential services for children with disabilities, which had been carried out by HIQA's children's team, moved to the disability pillar within HIQA. The children's team consisted of the Head of Programme, four inspector managers, 12 inspectors, one regulatory officer and one regulatory support staff member.

Oberstown Children Detention Campus is funded by the Department of Children and Youth Affairs, through the Irish Youth Justice Service and is managed by a board of management. The campus provides detention places to the courts for girls up to the age of 18 years of age and boys up to the age of 17 years of age, ordered by the courts to be remanded or committed on criminal charges.

HIQA decided to defer the 2016 inspection of the Oberstown Campus to early 2017 in light of an external review of the campus announced by the Minister for Children and Youth Affairs and the Chairperson of the Oberstown Campus Board of Management in September 2016. Representatives from the children's team have met with the two international experts undertaking the review.

The team conducted a review of the work of the National Review Panel, which investigates serious incidents, including deaths of children in care and known to the child protection system. The review was carried out against the principles outlined in the *Guidance for the Child and Family Agency on the Operation of The National Review Panel* (2014)[5].

Child protection and welfare services

The Child and Family Agency (Tusla) has responsibility to protect children and promote their welfare under both the Child Care Act, 1991 and the Child and Family Act, 2013. It does this by direct service provision and by funding other agencies to do so on its behalf. Child protection and welfare services are provided by Tusla in 17 service areas, located within four regions, nationally.

Significantly, between January and September 2016, almost all children on the Child Protection Notification System*** had an allocated social worker. This contrasts with 2015 when significant gaps in social worker allocation to those children most at risk had been identified in data returned to HIQA by Tusla. However, at year's end, two children (0.02%)

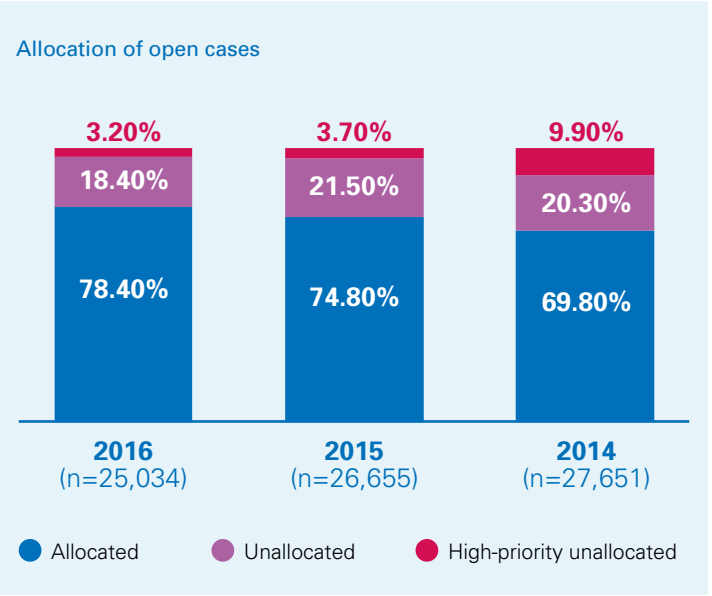
*** *A Child and Family Agency record of every child about whom there are unresolved child protection issues, resulting in each child being the subject of a Child Protection Plan (Children First, 2011).*

listed on the Child Protection Notification System did not have an allocated social worker.

As previously stated, children who had not received the service they required to meet their assessed needs continued to require attention in 2016. The data provided by Tusla at the end of 2016 showed a reduction in the number of unallocated cases, including high-priority cases. The data from Tusla also showed that more than a fifth of open cases had not been allocated a social worker.

These data provided by Tusla does not include unallocated cases related to retrospective allegations of abuse made by adults. The absence or delay in the completion of assessments due to the lack of an allocated social worker presents a potential risk to children and a delay in a conclusion being reached for the adults who have allegations made against them. Figure 8 illustrates the number of open unallocated cases year on year from 2014–2016.

Figure 8. Number of open unallocated cases year on year from 2014–2016*



** Source: Integrated Performance and Activity Report, Quarter 4, 2016 — Tusla.*

Good practice

Education — Tusla children's residential centres

In one children's residential centre, all of the children were attending school on a full-time basis in appropriate educational placements. The children were encouraged and assisted by staff to complete their homework. Additional educational supports were in place, for example grinds. The children in this centre were focused on completing State examinations, while educational achievements were celebrated.

In another centre, again all children were engaged in an educational programme. Staff advocated for children in order to get appropriate educational placements and tutoring when required. Staff supported children to attend school, some of which were located outside of the area. Children's educational progress and needs were regularly assessed, monitored and reviewed. The centre manager and staff were ambitious for children and aimed for them to proceed with third-level education or training. Children were in the process of completing State examinations and one young person was attending third-level education.

In 2016, the children's team started a review of the governance, leadership and management arrangements in place within Tusla to assure an effective, timely and safe child protection and welfare service. At the time of writing, this work is ongoing.

The voice of the child

During the course of HIQA inspections in 2016, inspectors met with 236 children, living in foster care (131), residential centres (98) and special care units (seven). These children talked to inspectors about their experiences in care and gave inspectors an insight into their day-to-day lives. Children talked about their social care workers, foster carers and their social workers and how they kept in touch with their families and friends. They described their experiences in school and the opportunities they had to participate in sports, hobbies and other recreational activities, which were similar to their peers.

The majority of children told inspectors that they felt safe, were well supported by their carer or social care staff, were listened to, and that they had someone to talk to if they had a worry or were upset by something. However, similar to findings in 2015, there was a lack of knowledge among some children about their right to access information held about them and how to make a complaint.

Alternative care services†††

Where children cannot live at home, alternative care services in the form of foster care or residential care are provided by Tusla, or it funds private providers to do so on its behalf. At the end of 2016, Tusla reported that there were 6,258 children in the care of the State[6]. Of those:

- 5,817 (93%) were in foster care
- 304 (4.85%) children were in mainstream residential care and
- 12 children were in special care.

In addition, 17 children, who required specialist services, were accommodated in care settings outside the State. A further 108 children were in other care facilities including detention, youth homeless services and other residential services. HIQA monitors and inspects the foster care services provided by both Tusla and private foster care providers. Of the children living in foster homes, 94% (5,456) were in Tusla placements and 6% (361) were in private placements.

Residential care is provided for children by statutory and non-statutory services. The children's team monitors and inspects the 35 statutory residential services‡‡‡ and the country's three special care units.§§§

††† *Alternative care services include children's residential services, foster care services and special care units.*

‡‡‡ *At the end of 2016, HIQA inspectors completed a census of the 35 children's residential centres. This census identified that there were 139 statutory residential beds available to accommodate children in care within 32 centres. Two other centres provided respite care and another was used as an assessment unit. By the end of 2016, 108 of the 139 residential beds were occupied.*

§§§ *The registration and inspection of these three units is due for commencement under section 41 of the Health Act 2007 during 2017.*

At present, Tusla is responsible for registering and inspecting non-statutory providers.

Child-centred services

Overall, children's rights were upheld and they enjoyed a good quality of life. Inspectors found that most children in care were treated with dignity and respect and were consulted with in relation to decisions about their lives. Many social care workers, in both residential and special care settings, built good relationships with the children in their care and made great efforts to support these children, some of whom had very complex needs.

Many foster carers made a concerted effort to build the confidence and ensure the wellbeing of the children living with them. Family contact was supported by foster carers, social workers and social care workers, in line with care plans. Foster care inspections did identify some areas for improvement. Services were still challenged to provide placements for children from different cultural, ethnic and religious backgrounds. In addition, foster carers and social workers did not always have sufficient information about the child's cultural and ethnic background to enable children to develop a positive understanding of their origins and backgrounds.

Complaints management was also an area that required improvement during 2016. Considering the high volume of work undertaken by Tusla across a wide range of services, the number of complaints recorded in residential centres and foster care service areas was low. Having a low number of complaints does not necessarily indicate a high level of client satisfaction. It can also indicate poor recording of complaints and or a culture that is unwelcoming of complaints.

Inspectors found that where social workers had, appropriately, managed complaints locally, there was no system in place to record this information centrally. Therefore, the potential to improve services from analysis of these complaints was not in place. In addition, complaint logs for centres and services did not always record the level of satisfaction of the complainant. Tusla implemented a new feedback and complaints process in September 2016, called 'Tell Us'. This process was being implemented in the final three months of 2016, a process which included the identification and training of complaints managers.

Good practice

Foster carer reviews — Fostering First Ireland (private fostering service)

This service had a well-developed system to carry out reviews of foster carers. Four independent reviewing officers compiled reports from the link social worker, children, foster carers and their families, social workers and the children's parents for the purpose of the review. A meeting was held with the foster carers to review their progress. The reviews were comprehensive, of a high standard and were in line with the regulations and standards. Additional reviews were carried out following incidents such as allegations, complaints and changes in a child's circumstances.

Safe and effective care

Good quality assessment and planning was in place for some children but not all. Inspectors identified significant risks in three residential centres and two foster care services in 2016. Improvements were required in the remaining residential centres and statutory foster care services in the areas of planning and quality of care.

Issues of significant risk related to:

- children being inappropriately placed
- children's needs not being met in the absence of child-in-care reviews taking place within the required Frequency; and
- poor preparation for leaving care and aftercare planning.

A number of children in residential care and a significant number of children in foster care did not have an up-to-date care plan during 2016. According to Tusla's data, of the children living in residential care, 99% (302 of the 304 children) had an allocated social worker at the end of 2016. However, 8% (443) of children in foster care had not been allocated a social worker to support them.

For any young person, the transition to adulthood can be difficult. For children in care, leaving care can be particularly overwhelming. Young people who do not receive the appropriate help and support can feel lonely and isolated, having lost the sense of belonging that their care had provided them with. Inspection findings showed that the support available for this cohort of young people was variable and that work with those preparing to leave care required more focus and improvement.

Many of our inspections found that children were being provided with opportunities to reflect on and manage their behaviour. Clinical specialists were available within some centres to support staff teams where there was an identified need. However, in a limited number of cases, some inspections found that there were poor or ineffective plans in place to inform staff practice in regard to behaviour that is challenging. In these centres, HIQA found that staff were not always able to respond proactively and in a planned manner to some children's challenging behaviour.

In addition, staff were often unable to manage the relationships between children to prevent them from harming each other. In special care units, while the incidence of physical restraint had reduced in some centres, the monitoring, oversight and recording of these incidents required improvement.

Similar to 2015 findings, limited numbers and types of foster care placements meant that matching children with suitable carers who could meet their needs was not always possible. This resulted in some placements breaking down, placing unrelated children in the same foster care placement, sibling groups not being placed together in line with their care plan and children being placed in private placements away from their local community.

The level of support to carers across statutory foster care services required improvement. While many

foster carers received good quality support and supervision, others did not have an allocated social worker. There were delays in the assessment and approval of a number of relative foster carers who had children placed with them, while some foster carers did not have an allocated link social worker to support the placement.¶¶¶

In addition, in three of the four statutory foster care services inspected, reviews of all foster carers did not take place in line with the national standards. This meant that updated Garda Síochána vetting and formal reviews of the foster carers' continued capacity to care for the children placed with them, did not take place.

Two of the three private foster care providers inspected exceeded up to four of the 19 standards, which related to:

- assessment and approval of foster carers
- the recruitment and retention of foster carers
- supervision and support of foster carers
- the provision of a quality educational support package to children.

Foster carers experienced continuity with link social workers and developed trusting relationships with the allocated link social worker. Child care planning and review processes were undertaken. However, the absence of up-to-date care plans impacted on some of the services' capacity to match children appropriately. A significant risk was found in one service in relation to safeguarding practices. Within this service not all child protection concerns were identified as such and were not always managed in line with Children First (2011)[7]. In addition, Garda Síochána vetting was not in place for all staff prior to commencing work for the service.

Good safeguarding and child protection practice in a children's residential centre or a foster care service ensures that children are cared for safely and that any threat to their safety is responded to quickly. This should be done in a way that respects the rights of all concerned, including those against whom allegations of abuse are made. Safeguarding and child protection practices within residential centres showed improvement in 2016 with this standard being met in 14 residential centres and one special care unit. Improvements were required in another of the special care units and two of the statutory foster care services.

Significant risks were identified in the remaining two statutory foster care services, four residential centres and one special care unit. These risks related to ineffective safeguarding practices to promote children's safety; allegations against staff not being investigated in line with relevant policies; and poor management of allegations made against foster carers.

Where significant risks were identified during inspections, these were escalated to Tusla or the private provider for immediate attention.

¶¶¶Tusla metrics at the end of 2016 identify that 19.25% (855) foster carers nationally did not have an allocated link social worker.

Good practice

Leaving and aftercare supports — Tusla Donegal Foster Care Service

There was a dedicated leaving and aftercare service in the Donegal area. Children told inspectors that the aftercare service was great and had helped them. They were aware of the supports that were available to them so that they could learn independent living skills. Courses for the children were wide-ranging and included practical training courses on cooking and domestic skills, money management and budgeting and parenting.

Referrals to the team were timely, facilitating the development of strong working relationships between staff and young people. The leaving and aftercare team were proactive and creative in accessing resources for their service. The team provided a drop-in service for young people who had left care and also conducted exit interviews for feedback on the service which was used to plan further developments.

Education

The majority of residential centres and foster care services met the standard on education. Inspectors found that great efforts were made to maintain school placements for children in care, particularly in foster care. Young people were being supported to apply for and attend third-level education.

Health and development

The health needs of children in care were largely being assessed and met. The most common issue that required addressing in residential centres related to medicines management and the absence of a national policy on, and staff training in, medicines management. During 2016, Tusla provided training in medicines management to centre managers and at the time of writing this was being extended to residential care workers in 2017.

Leadership, governance and management

The best leaders and managers create a culture of high aspirations for children in care. They provide strong oversight of practice and children's progress, while continually looking for ways to improve the service provided. Competent and confident staff are supported through training and supervision.

All of the centres or services inspected during 2016, including private foster care providers and special care units, needed to improve their management

systems, including risk management and oversight of care practices. Four centres and two foster care services were found to be operating with significant risk. These risks included:

- poor accountability
- ineffective management systems related to risk management and staff supervision
- inadequate oversight of care practices
- poor recording and reporting practices and
- a lack of capacity in two residential staff teams to provide consistently safe care.

Tusla did not have service level agreements in place with private foster care agencies, with the exception of emergency out-of-hours placements. While inspections found agreements in place related to individual children, these were not sufficient to ensure effective oversight of the overall quality, safety and effectiveness of the service being purchased. As highlighted elsewhere in this report, this finding underlines the key role played by the funder in ensuring good quality services and, in the opinion of HIQA, lends weight to the argument for a model of commissioning.

Staff training improved during 2016. A number of services and centres had completed a training needs analysis in conjunction with Tusla's workforce development unit, and a programme for training had been devised. A further development during 2016 was the ongoing development and implementation of a suite of national policies, procedures and guidelines to inform practice within foster care and child protection services.

However, additional national policies are required for residential care services. Staff in these services continued to work with a combination of regional and locally adapted policies, some of which had not been kept up to date to ensure they were fit for purpose. Other improvements required in residential care services related to gaps in mandatory training requirements and the need to ensure that the frequency of staff supervision reflected the requirements of policy.

The absence of an integrated information system within Tusla impacted on the capacity of managers to collate, manage and share information to support effective decision-making and promote continual improvement within the service.

Submissions and complaints

In total, one submission was received from a service provider who was not satisfied with HIQA's inspection findings and regulatory judgments. This matter was not resolved at Stage 1 of our submissions process and was referred to Stage 2 which involves review by managers from outside of the Regulation Directorate. Aside from submissions, HIQA received no complaints relating to the children's services team.

Examples of poor practice in various children's services

- Inspectors identified poor management and oversight of retrospective allegations of abuse against adults. This included delays in the service area assessing the risks and, when assessed, delays in dealing with immediate and high-risk cases.
- Ineffective arrangements in place to ensure a timely assessment process for relative foster carers to assess their suitability as carers. This meant that some assessments took between 12 to 16 months to be completed after the child was placed with the relative carers.
- Ineffective management and governance arrangements in place which meant that the monitoring, risk assessment, communication and supervision of children in a residential care setting was inadequate. This led to a collective failure across several levels of management to adequately recognise and appropriately respond to children in crisis.
- Children experienced institutionalised mealtime practices. While the units in one centre had cooking facilities, the meals offered were often repetitive with limited menu choices. Furthermore, children were not included in routine activities like assisting with preparing meals and had to queue with visiting personnel.

Chapter 4 - **Healthcare**




Chapter 4 - **Healthcare**

Key points

Governance
Effective governance and leadership were found to be critical in delivering a good service.

Variance across hospitals
In many of the monitoring programmes conducted by HIQA, significant variation in both practice and specialist staffing resourcing was found.

Planning and strategic direction
Much of the variation found during inspection indicated a need for more effective medium- to long-term planning and strategic direction at a local, regional and national level.

Voice of the patient
HIQA nutrition and hydration inspections found high levels of patient satisfaction with the food service in hospitals.

Introduction

The Irish healthcare system continues to experience significant challenges. These include difficulties around access to services; difficulty in recruiting and retaining certain key staff; and variation across hospitals with respect to capacity, capability and performance levels in a number of key patient safety areas that HIQA has monitored.

Furthermore, the healthcare system in Ireland remains largely focused on hospital care. While there is an acknowledgement that there is a need to rebalance services with greater provision in primary care, much remains to be done to make this happen.

In 2016, HIQA's healthcare team continued to monitor the implementation of the *National Standards for Safer Better Healthcare* (2012) (referred to in this section of the report as the National Standards) and the 2009 *National Standards for the Prevention and Control of Healthcare Associated Infection*.

It is important to highlight at the outset that the Health Act does not confer HIQA with the same powers of registration, inspection and enforcement as are available in some of the other areas it regulates. While HIQA does not have enforcement powers in healthcare, HIQA publishes healthcare monitoring reports to encourage sharing of learning and best practice, and for transparency. HIQA also identifies areas of high risk to service providers who are ultimately responsible for the quality and safety of the services they provide.

The National Standards apply to all public healthcare services (excluding mental health services) provided or funded by the HSE including, but not limited to:

- hospital care
- ambulance services
- community care
- primary care.

HIQA monitoring activities have been prioritised, on the basis of likely risk, towards the 49 public acute hospitals and publicly-funded ambulance services. The healthcare team's current programme allows for targeted monitoring in high-risk areas. The Authority identifies areas of high risk through:

- ongoing regulatory monitoring of services, including through inspections
- assessing information we receive from patients, members of the public and other relevant credible sources
- examining national and international evidence and best practice.

Information is crucial to the work carried out by the healthcare team. These sources inform both our regulatory response and ongoing planning and prioritisation of monitoring programmes.

The healthcare team consists of one Head of Programme, two inspector managers, seven inspectors, two regulatory officers and one programme support assistant.

The voice of the patient

Wherever possible, HIQA seeks patients' views as to how services are being provided. In 2016, HIQA included a patient satisfaction survey as part of its monitoring programme around patient nutrition and hydration. This revealed a high level of satisfaction with the quality of food served in hospitals. In addition, the monitoring programme in the area of medication safety in hospitals revealed that ensuring better patient awareness around their medicines before their discharge home from hospital may be a focus for ongoing quality improvement efforts.

In 2016, HIQA, in collaboration with the HSE and the Department of Health, continued efforts to roll out a survey of patients' experiences of their time in public acute hospitals. This comprehensive National Patient Experience (NPE) Survey, which will follow an internationally validated method, will be conducted for the first time during 2017. This survey will help to inform improvement in services for patients. It is HIQA's intention to use the information gained from this survey to inform future monitoring work.

Reflecting on the current state of the health service

A number of key influencing factors which impact upon current healthcare provision in Ireland emerged through HIQA's healthcare monitoring programmes in 2016. These include:

- a health service largely focused on acute hospitals, as opposed to a more desirable integrated health and social care service
- a recognition that primary care services remain underdeveloped in Ireland
- a health service which is seeing an ever increasing, year-round level of demand for services, driven by an ageing population with increasing and more complex needs and increasing treatment options through technological advances
- rate of occupancy of acute hospital beds consistently greater than 85%, the level that is recognised internationally as being a tipping point beyond which patient flow through hospitals, including emergency departments, becomes severely impacted[8,9,10,11]
- increasing waiting lists for elective (pre-planned) surgery
- difficulty in recruiting and retaining front-line staff and some senior specialist and managerial staff
- a legacy of required investment that was postponed due to reduced budgets in recent years.

HIQA inspection teams frequently encounter instances where services are not in a position to meet the National Standards due to a period of sustained under-investment and a lack of resources. The HSE has also been undergoing a period of structural reform which has seen changes to management structures and reporting arrangements across services. This reform has included the:

- formation of seven hospital groups
- creation of nine community health organisations.

The findings from HIQA's monitoring programme, and the remainder of this chapter, should therefore be considered within the context of the various challenges outlined above.

Good practice in healthcare services

Portiuncula University Hospital, Saolta West/ North West Hospital Group

This hospital had set up a nutrition steering committee and had implemented a number of quality improvement initiatives. Patients were being screened and re-screened weekly for their risk of malnutrition.

Menu plans were individualised to meet patients' preferences, and mealtimes were changed to reduce non-essential interruptions during them. Policies were developed, and staff training on nutrition and hydration was structured.

Overview of monitoring work conducted by HIQA in healthcare settings

During 2016, the healthcare team monitored the health service in a number of different ways. It completed two high-level service reviews which aimed to determine the level of progress achieved following on from previous work conducted in 2014 and 2015:

- a review — published at the end of 2016 — of progress made at the Midland Regional Hospital, Portlaoise, in implementing recommendations in HIQA's investigation report into this service in 2015[12]
- a review to assess progress made in addressing high-risk safety concerns identified in HIQA's 2014 report into pre-hospital emergency care (ambulance) services.

We also monitored compliance with the National Standards through the design and implementation of monitoring programmes which focused on a number of key thematic areas looking at specific aspects of care. These themes were based on findings from previous regulatory work by HIQA and international evidence outlining their importance as key elements in ensuring the overall quality and safety of care provided to patients.

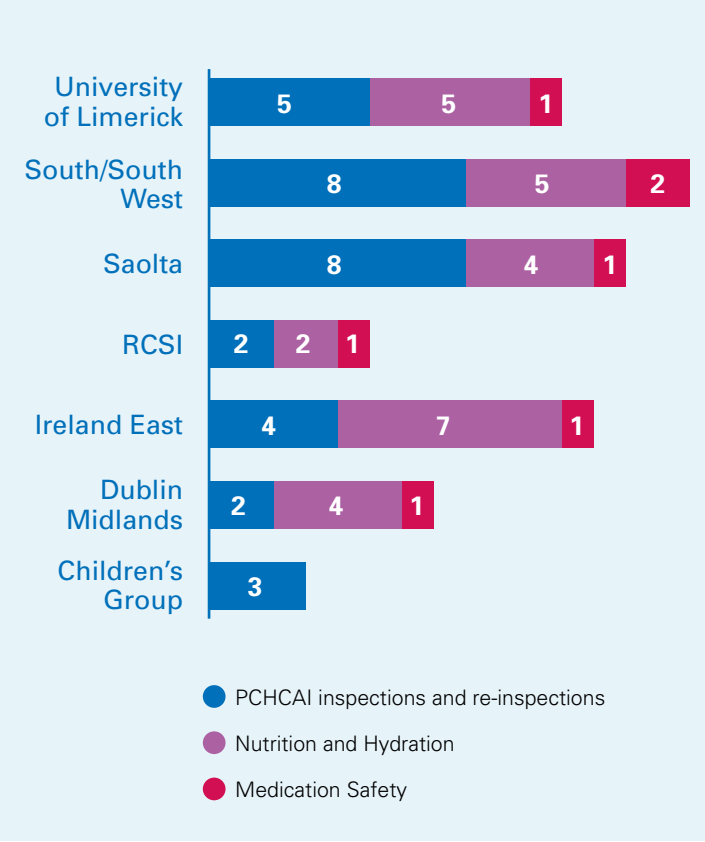
Monitoring against these thematic inspection areas also provided a broader insight into the governance arrangements for the quality and safety of services, including multidisciplinary and interdepartmental cooperation and coordination. These thematic reviews, which included 66 individual inspections in

the country's 49 acute public hospitals, included the following:

- monitoring of infection prevention and control practice against the *National Standards for the Prevention and Control of Healthcare Associated Infection* (2009)
- a national review of antimicrobial stewardship in public acute hospitals
- monitoring of how hospitals ensure that inpatients' nutrition and hydration needs are best met
- monitoring of the governance of medication safety in hospitals (see Figure 9).

In addition, both the antimicrobial stewardship programme and the initial phase of the nutrition and hydration programme saw the publication of an overview report. Both these reports aimed to distil the overall learning from individual inspections to inform a composite, high-level view of how public acute hospitals were collectively performing in each area.

Figure 9. Number and type of healthcare inspections carried out in each hospital group in 2016



Summary of high-level findings from thematic monitoring programmes

In keeping with the findings from HIQA's healthcare team in previous years, 2016 showed substantial variation in performance in the thematic areas monitored, and considerable scope for shared learning across hospitals. This work continued to highlight the importance of strong and effective leadership, governance and management arrangements in supporting hospitals with the implementation of the National Standards.

Nutrition and hydration

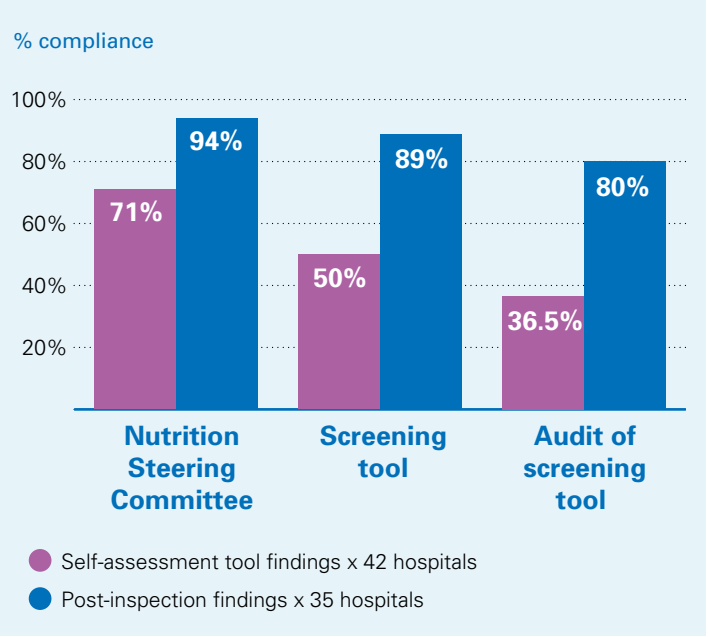
During 2016, areas of good practice and improvement initiatives by both front-line staff and at hospital-group level were identified in relation to nutrition and hydration care for patients.

In May 2016, HIQA published its *Report of the review of nutrition and hydration care in public acute hospitals*[13] which presented the findings of the initial monitoring programme. Four key areas for improvement were identified:

- hospitals should have a nutrition steering committee in place
- patients should be screened for the risk of malnutrition on admission
- hospitals must audit compliance with all aspects of patients' nutritional care
- and hospitals should engage with patients about food variety and choice in order to improve patients' experience of hospital meals.

Following the first phase of announced inspections, the healthcare team began a second phase of unannounced inspections between June 2016 and December 2016. Reports of the findings for each hospital are available on HIQA's website. During the unannounced inspections, HIQA found that most public acute hospitals had started to improve nutrition and hydration care provided to patients. This is measured against the information that was provided in a self-assessment tool issued by the healthcare team in August 2015 as part of this monitoring programme, and as highlighted in Figure 10.

Figure 10. Percentage differences in relation to information submitted by hospitals in the self-assessment tool in 2015 and findings during HIQA's nutrition and hydration inspections in 2016



Speaking with patients is an important component of HIQA's monitoring approach. During this programme, we spoke with 239 patients in the 22 hospitals inspected to seek their views in relation to nutrition and hydration. The team found that the majority of patients were satisfied with the meal choices offered during their hospital stay.

While some hospitals had well-established quality improvement initiatives relating to nutrition and hydration, others were in the process of developing such programmes.

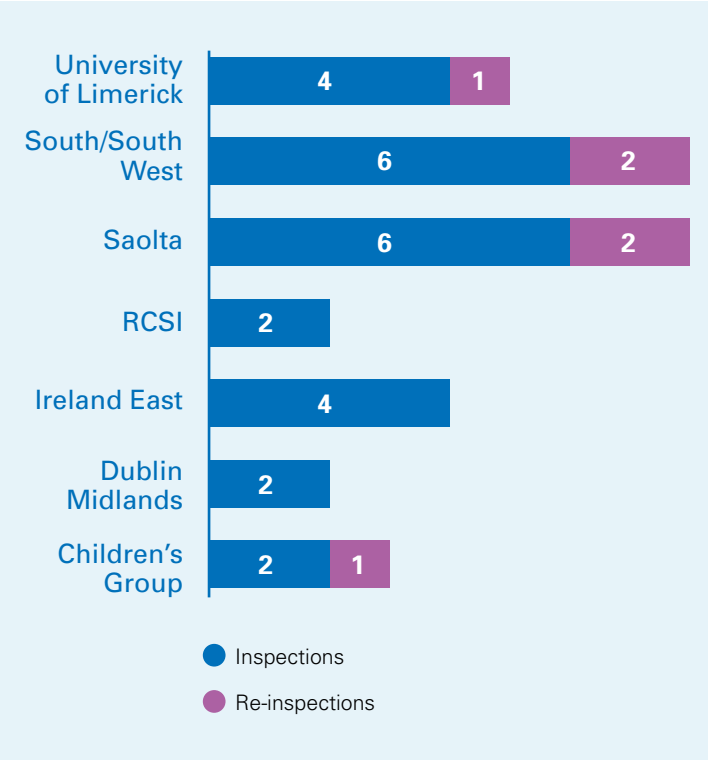
Prevention and control of healthcare-associated infections

This monitoring programme focused on the effective implementation of three of the standards for the prevention and control of healthcare-associated infections:

- Standard 3 which relates to environment and facilities management
- Standard 6 which relates to hand hygiene
- Standard 8 which relates to invasive medical device-related infections.

With the exception of a small number of hospitals, this programme of inspections demonstrated that many practices needed to improve relative to HIQA's findings in 2015. Indeed, in a number of hospitals, high risks were identified and escalated to relevant management for mitigation. High risks were primarily identified in relation to decontamination facilities for reusable invasive medical devices,**** hospital hygiene, and control measures around aspergillosis and legionellosis.

Figure 11. Number of inspections and re-inspections in each hospital group in 2016 in relation to the prevention and control of healthcare-associated infections



During the monitoring programme on the prevention and control of healthcare-associated infections, opportunities to improve were identified in many

**** *A reusable invasive medical device is an object which is used for diagnostic or therapeutic purposes which penetrates or breaks the skin or a body cavity.*

hospitals in relation to hospital infrastructure, maintenance and hygiene issues. HIQA acknowledges that the infrastructure and design in many older hospitals did not always easily support the implementation of best practice in relation to infection prevention and control. Notwithstanding these challenges, the findings indicated that better management, oversight and additional resources were required in some hospitals to overcome this problem.

Although a commitment to improving hand hygiene compliance was demonstrated in all hospitals, some hand hygiene compliance audit results showed that hospitals needed to maintain management focus in this area to improve and sustain good hand hygiene practices. It was evident that infection control care bundles, safe injection practices and healthcare-associated infection surveillance systems were being implemented. However, these needed to be progressed and fully embedded in all hospitals.

Medication safety

The healthcare team started announced medication safety inspections in November 2016. The purpose of these inspections was to determine if hospitals had effective arrangements in place to protect patients from harm related to medication usage. The design of this programme was supported by an external expert advisory group.

Between November and December 2016, the healthcare team conducted seven medication safety inspections in the first phase of the monitoring programme. It found that there was significant variation in relation to medication safety in all seven hospitals inspected. Some hospitals were able to demonstrate mature medication safety programmes, which had been established over a significant period of time. Other hospitals had made little progress in advancing medication safety programmes that would match up to international best practice. Good performance in this area resulted from:

- effective leadership
- multidisciplinary involvement
- senior management oversight and support which extended to actively seeking assurance around the hospitals' approach to ensuring medication safety
- adequate specialist personnel and information technology (IT) supports.

Antimicrobial stewardship

Prior to starting its medication safety monitoring programme, HIQA completed its national review of antimicrobial resistance in public acute hospitals.

The level of antimicrobial resistance now being detected worldwide in some instances leaves clinical staff with a very limited choice of medicines that they can use to try to treat people. Healthcare systems need to take measures to prevent the emergence and spread of multidrug resistant organisms as resistance to antimicrobials has begun to outpace the discovery of new antimicrobial medicines in some parts of the world.[14,15] The World Health Organization has declared resistance to antimicrobials to be a 'major global threat' to

healthcare.[16] In this regard, the healthcare team completed a review of antimicrobial stewardship in 49 public acute hospitals in Ireland and published the final report in July 2016.

The report[17] found that the implementation of best practice in managing and using antimicrobials varied across the country. In general, larger hospitals performed better in response to investment. Some smaller hospitals, defined as Model 3 hospitals, did not have safe and sustainable measures in place to protect patients. A number of smaller Model 2 hospitals had no antimicrobial stewardship programmes in place. These hospitals required further investment or sharing of resources across their respective hospital groups to effectively implement these programmes. It is notable that many of the findings from this review are similar to those that were subsequently identified in HIQA's medication safety monitoring programme.

A crucial component in achieving success in relation to antimicrobial stewardship, and indeed any aspect of complex care, is effective leadership, accountability and management. The report found that more effective national planning, governance and coordination was required to ensure that the Irish health system is prepared for an emerging global healthcare challenge. HIQA notes that a national action plan to address this threat is due to be completed by the Department of Health in 2017. This is a much needed and welcome development that should be supported by all relevant stakeholders.

Good practice in healthcare services

Our Lady's Children's Hospital, Crumlin, Dublin

Our Lady's Children's Hospital, Crumlin has consistently exceeded the HSE's national target for hand hygiene compliance.

The hospital had a comprehensive infection control educational programme in place for staff. It had also successfully embedded a set of infection prevention care bundles and audit into routine practice.

HIQA also observed good senior management oversight of hospital hygiene in the clinical areas inspected, and good performance in maintaining hygiene standards.

Overview of learning from high-level reviews of services, and potential applicability to the wider health system

Findings from thematic reviews conducted up to and including 2016 by HIQA — in particular the antimicrobial stewardship review — show that effective local and national medium- to long-term service planning is required to ensure consistently high performance. Furthermore, a systematic approach to determining the needs of patients and people using services is critically important to ensuring uniformly good practice across hospitals.

HIQA's monitoring work in Irish public acute hospitals shows that these hospitals can demonstrate good practice and high-quality care, but there is also significant variation in care across those hospitals. This is driven by a range of factors, including:

- a legacy of underfunding in some areas
- outdated staffing arrangements
- incomplete or poorly implemented reconfiguration efforts
- and developments in service provision driven through leadership at a local level, rather than through more informed national strategic planning.

In 2016, HIQA's healthcare team conducted two high-level, follow-up reviews to determine progress achieved following the HIQA investigation in the quality and safety of services at Midland Regional Hospital, Portlaoise (Portlaoise Hospital), and the HIQA review of the publicly-funded pre-hospital emergency care providers (the National Ambulance Service and Dublin Fire Brigade).

The Portlaoise Hospital investigation report was published in 2015; the pre-hospital emergency care report in 2014. Both follow-up reviews identified elements of good practice along with scope for improvement. However, in examining the totality of findings from these reports, a number of common themes emerged which may be worthy of consideration in terms of promoting service improvement across the health system as a whole.

Firstly, it was evident in the period prior to the follow-up reviews that both services had improved to a degree, including improved senior management support for both services at regional and national level within the HSE. However, it should also be noted that in both instances, despite improvements being well underway, the two service areas have a long road to travel to fully address all of the issues identified for improvement in the 2015 and 2014 reports. Additionally, in both services, HIQA found that key strategic decision-making around the future direction of services at a senior level was urgently needed to sustain and further develop those improvements already achieved.

In each situation, services had improved following increased funding and increased staffing levels. In particular, Portlaoise Hospital had improved the quality of care and patient safety monitoring. This was assisted and enabled by:

- improved governance and reporting lines, including a rationalisation of the number of committees in the hospital
- investment in sufficient extra staff to help develop local infrastructure for improved audit, management of complaints, incident investigation and other allied tasks.

HIQA's overall experience in monitoring public acute hospitals would suggest these hospitals can learn from the experience at Portlaoise Hospital and therefore potentially improve their services. In addition, setting up more formalised links with the Coombe Women and Infants University Hospital in Dublin helped to improve maternity care at Portlaoise Hospital.

This cooperation had begun to yield benefits for patients at Portlaoise Hospital in terms of standardising care with a larger centre, improved synergies associated with greater economies of scale, and in aiding with recruitment of hospital consultants through joint appointments. In a hospital system such as Ireland, which is widely dispersed and serves a predominantly sparsely populated rural population, much can also be learned from the benefits of this type of cooperation between large and small hospitals.

Good practice in healthcare services

Mater Misericordiae University Hospital, Dublin

The hospital had established governance arrangements in addition to systems, processes and practices to support medication safety. It was evident that this had been progressed over a significant period of time, driven by effective local leadership and executive management support and resource allocation. Moreover, measures implemented by the Hospital's board to actively seek assurance in relation to medication safety, a known area of high risk to patients in acute hospitals, were notable.

Crucially, for maternity services in Portlaoise, patient safety was aided by a greater alignment of required resources with the number of births there. Similarly, while the National Ambulance Service is further from where it needs to be to match its resources to growing service demand, it now has a much clearer understanding of what it needs to do to improve services — due to both the 2014 HIQA review and the work of a HSE-commissioned National Capacity Review. This improved awareness is allowing it to plan with much greater certainty as to how and where resources need to be allocated.

In considering this point, a common theme that emerges is the importance of clarity when planning services, where the level of services required is determined through a detailed and transparent approach. The follow-up review of pre-hospital emergency care found that an improved approach to service planning nationally had greatly aided the service. In contrast, ongoing indecision around future plans for services in Dublin had stymied progression.

Improved planning of services by the National Ambulance Service has been significantly informed in part by a National Capacity Review which determined scientifically the required amount of resource needed to meet pre-determined levels of service, based upon internationally benchmarked norms. The National Capacity Review, allied to improved planning around workforce needs and staff development, has been a major step forward for the service. While deficits in resourcing levels were identified through this process, the fact that these are now clearly articulated and understood represents a key base upon which to secure further planned improvements.

In its submission to the Joint Oireachtas Committee for the Future of Healthcare, HIQA again re-emphasised the importance of better service planning by setting up a commissioning model for health services, and better decision-making around resource allocation, through health technology assessment (HTA). The learning from both HIQA reviews and HIQA's wider thematic monitoring approach supports this view. The Authority's work also highlights the need for clear policy direction with respect to some services as a prerequisite for sustainable improvement.

Submissions and complaints

There were no submissions regarding the findings or judgments of the healthcare team. Aside from submissions, HIQA received one complaint relating to the healthcare team which was processed according to our complaints policy.

Examples of poor practice in various hospitals

- Several model 2 and 3 hospitals failed to effectively implement an antimicrobial stewardship programme.
- Serious deficiencies were found in one hospital's arrangements to ensure surgical instruments were safely decontaminated in line with the HSE Code of Practices.
- The hydration needs of patients were not adequately met in one hospital. Patients who were unable to walk did not have access to fresh drinking water.
- Inadequate arrangements were in place to ensure the effective monitoring and evaluation of medicines management during some inspections. HIQA also found inadequate policies, protocols and guidelines in place to support staff to safely prescribe and administer medications.
- Poor cleaning, supervision and storage arrangements were found in some inspections. This meant that some clinical areas inspected were dirty and unnecessarily cluttered.

Looking ahead

During 2017, the programme for the registration and re-registration of residential centres for people with disabilities and older people will continue. Older people's services are in their third cycle of registration and some disability services will be applying for the first renewal of their registration. HIQA intends to increase the number of inspections into specific aspects of care (thematic inspections) in designated centres that it conducts in order to improve care in key areas.

Meanwhile, HIQA's children's team will continue to monitor compliance in child protection and welfare services, foster care services, children's residential centres and special care units. It is expected that registration of special care units will start in 2017 which for the first time will also give the Authority powers of enforcement in this specific area of care.

In 2017, the healthcare team will begin planning for the regulation of medical exposure to ionising radiation in line with an EU directive. Monitoring in this area will start in 2018. Its thematic monitoring work will continue and be developed in medication safety, prevention and control of healthcare-associated infections, and nutrition and hydration (nutrition and hydration is due to conclude in April 2017).

In addition to the regulatory work planned for the four Regulation Directorate pillars within HIQA, the Directorate's Business Team and HIQA's Regulatory Practice Development Unit are engaged in a number of projects which focus on the future direction of regulation. There are three key pieces of work which the Regulatory Practice Development Unit is focusing on:

- proposed licensing of hospitals
- an analysis of the regulation of health and social care services and the definition of a designated centre
- HIQA's approach to monitoring, called the Authority Monitoring Approach.

Licensing

As referenced elsewhere in this report, HIQA's current role in relation to healthcare services is limited to monitoring and reporting activities, but there is no registration function or related enforcement component. The Department of Health is currently working on proposals to establish a licensing system for public and private hospitals. The Department drew up a draft general scheme for licensing and invited stakeholders to participate in a related working group during 2016.

The draft general scheme envisages that HIQA will be the licensing authority and will be responsible for monitoring compliance with forthcoming regulations. In order to inform its own deliberations on the challenges posed by licensing hospitals, during 2016, HIQA researched how such regulation is being carried on in a number of other countries.

HIQA analysis of regulation elsewhere

HIQA's analysis in 2016 focused on the regulatory systems in 16 jurisdictions internationally. The principal findings were as follows:

- All jurisdictions in those regions have some form of regulation of the public and private hospital sectors. The terms used to refer to this regulation differs. For example, it is licensing in the USA (where accreditation also occurs); it is certification in France; and registration in England.
- Some countries, such as Wales, Sweden and the Netherlands, have 'state-led' regulation, that is to say an independent public body is responsible for carrying out monitoring and enforcement activities. Other countries, such as New Zealand, Australia and the USA, have a

model that allows third-party accreditation and or auditing agencies to carry out much of the monitoring activity.

- There were differences in some countries in relation to enforcement powers. For example, in Wales, Northern Ireland and Scotland, the regulators' enforcement powers differed depending on whether the facility was public or private.
- The 'regulatory reach' in each country differed significantly. Some regulators were solely responsible for regulating hospital services and other clinical settings. Others had a much broader reach that covered services such as general practice, dental services, home care services, primary care and mental healthcare services.
- Differences were also noted in how services were licensed or registered. Some regulators registered a service once and did not require such registration to be renewed. Others had differing lengths of time for the expiry of a licence or registration. These were usually not longer than five years.
- The manner in which regulations and standards were devised also differed. However, invariably, the state was responsible for developing regulations and standards. There was a significant degree of variation in the interaction between professional self-regulation and state-led regulation. For example, in the Netherlands, each professional body was responsible for devising guidelines for its specific discipline, which would then be monitored by the regulator.

There were a number of key recommendations made in the HIQA research paper. For example:

- the value and sustainability of a three-year cycle of licensing should be reconsidered
- policy-makers should consider the implications for enforcement actions against public and private providers
- consideration should be given to the potential role of third-party accreditation agencies.

In addition to this research, HIQA also developed a 'scenario-testing' paper which sought to outline how the measures in the draft general scheme would impact on the hospital sector in Ireland. HIQA welcomes in principle the introduction of stronger regulation in the hospital sector in Ireland and will continue to engage with the Department of Health working group, as and when required, throughout 2017 and beyond.

Exploring the regulation of health and social care services

The focus of all regulation in adult social care, as set out in the Health Act, is what is termed the 'designated centre'. This relates to the physical location where care and support to older people and people with disabilities are provided. The definition in the Health Act is based on a model which delivers care and accommodation, primarily in a long-term residential setting.

Since HIQA started regulation of residential social care in 2009, its inspection teams have encountered a range of different service models. Increasingly, HIQA inspectors are finding that some services, particularly in relation to people with disabilities, do not meet the definition of a designated centre, as set out in the Health Act. As a result, such services are outside of HIQA's regulatory remit.

In late 2016, HIQA researched the concept and definition of a designated centre in the context of new and emerging models of social care in Ireland. The research considers all of the different models of care in Ireland today, both for people with disabilities and for older people. It gives a brief overview of how such models are regulated in other countries.

The countries analysed in HIQA's review are: England, Scotland, Wales, Northern Ireland, New Zealand and Australia; and the province of British Columbia in Canada. The research sought to outline the legislative context for regulation in these jurisdictions and to describe how the

different models of care are defined. The following are some of the key findings from the research:

- Compared to regulation structures in those countries studied, Ireland stands alone in its lack of regulation of various types of social care.
- Other types of services identified in Ireland include:
    - — home care
    - — sheltered housing and assisted living
    - — respite care
    - — short-stay or convalescence or step-down
    - — day care
    - — home sharing (placement with families)
    - — personal assistants.
- While all of the above are providing services in Ireland to people who may be vulnerable, there is currently no regulatory oversight of them.
- Some of the reviewed systems regulate 'services' as opposed to 'centres'. This means that service providers must be registered to provide a designated service, as opposed to the physical location that the care is carried on.
- The Care and Social Services Inspectorate in Wales is in the process of moving to a service-based model: 'Whilst providers would still be required to identify the place(s) at, from or in relation to which a service is being provided, the new system would only require individuals or organisations to register once with the regulator. If a provider wishes to provide further services or the same service from different places then they would apply to vary their initial registration.'[18]
- Many regulators have distinct sets of regulations devised specifically for certain models of care. For example, the Regulation and Quality Improvement Authority (RQIA) in Northern Ireland has nine sets of regulations which each apply to a specific sector (for example: nursing agencies, nursing homes, day care, residential care homes). In England, the Care Quality Commission (CQC) has 'fundamental standards' as baseline standards which apply to all social services that it regulates. The CQC will apply certain sections of these standards to particular services depending on what sector it is regulating.

Authority Monitory Approach (AMA) Review Project

This HIQA project was set up in 2015 to review in full all processes and procedures involved in the assessment and regulation of health and social care services within the remit of the Authority, called the Authority Monitoring Approach. This is a significant undertaking and underlines HIQA's commitment to continually reviewing and improving the way it does its work.

Throughout 2016, internal and external stakeholder engagements took place in many strands, including:

- workshops on regulatory strategy
- focus groups with regulatory staff, internal and external stakeholders
- pilot testing of new inspection methodology tools in eight designated centres
- the piloting of monitoring events to test revised methodology and support tools across four centres for people with disabilities and four nursing homes.

As a result of the project, HIQA has revised its registration notification and application forms along with associated guidance and provider roadshows. HIQA's provider portal website has also been developed with extended functionality due to be rolled out to the project in 2017 in order to support disability service providers in submitting statutory notifications.

In 2017, the project team in HIQA will continue to revise in-house regulation and monitoring procedures, provide training to staff, engage with our extensive stakeholder groups and upgrade our information communications technology (ICT) system. This project will run until early 2018 when new processes and procedures will be in place.

Conclusion

HIQA will be 10 years in existence in 2017. In this time, the organisation has matured, taken on new responsibilities, and has learned a great deal about effective regulation and about the provision of health and social care services in Ireland. This report gives an overview of what HIQA's inspection teams found in those health and social care services regulated and monitored by the Authority in 2016.

HIQA acknowledges that there are many factors which contribute to a service's ability to comply with their respective regulations and Standards, some of which are outside of the control of the providers of those services. The difficulties with recruiting and retaining staff have been well documented and continue to be a stressor on the delivery of a range of services. This also impacts on existing staff in terms of their ability to provide a quality service, and deal with increased workload and low morale.

Further to this, capital expenditure is required to increase capacity in the acute sector and upgrade and modernise the physical infrastructure in the social care sector. The relative lack of investment in the past number of years has impacted on service providers' ability to comply with the regulations and meet standards. Any significant investment of this nature should be done in a planned, coordinated fashion with a view to meeting the population's present and future needs.

Through our regulatory findings, in general, the people using services that spoke to our inspection teams felt that they were in receipt of a good service and that they felt safe. Our inspection teams found improved compliance in a range of areas and found that most providers had a positive attitude to regulation. Notwithstanding these positive findings, there are areas of concern that require a concerted effort to put right.

There are four key recurring themes throughout this report which are worthy of further mention:

1. Governance.
2. Safeguarding.
3. Policy-making and decision-making.
4. Accountability for funding.

Governance

Firstly, there are repeated references to the importance of good governance and the impact it has on people who use services throughout this report. A service achieves compliance in governance when it has in place an effective governance structure with clear lines of accountability. Service managers need to demonstrate fitness and be aware of their responsibilities and to whom they are accountable. Rather than reacting to poor inspection findings, a well-run service will pro-actively seek out areas for improvement by regularly monitoring and reviewing all aspects of the care they provide.

Our data in relation to the four areas we monitor and inspect shows that effective governance leads to better compliance across all of the regulations and Standards that we inspect against. For example, Chapter 1 shows the relationship between compliance levels with governance and the corresponding compliance levels with the safeguarding outcome. In recognition of the critical role played by good governance in delivering a quality service, HIQA will soon be introducing a new and more detailed process for assessing the fitness of service providers.

Safeguarding

Secondly, the issue of safeguarding appears frequently in this report. It is a central feature and basic requirement of any service that it takes appropriate measures to protect and promote the dignity and rights of potentially vulnerable service users. However, we continue to find services that are failing in their basic duty to protect and safeguard those vulnerable people that they care for. It is evident in some services that institutionalised staff practices mean that people are not cared for in a safe manner.

Staff do not always recognise poor safeguarding practice and some staff are resistant to improving their professional practice. Some recent legislative developments — the enactment of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and the introduction of the Assisted Decision Making (Capacity) Act 2015 — have the potential, if effectively implemented, to improve the area of safeguarding. While these measures are welcome, HIQA believes the legal framework could be further strengthened by introducing legislation that would enshrine adult safeguarding into law.

Policy-making and decision-making

Thirdly, this 2016 overview report shows there is a requirement for clear national policy direction, policy implementation and timely decision-making in terms of health and social care services. This was a key finding in both of the reviews conducted by the healthcare team in 2016 in relation to the country's ambulance services and the services at Midland Regional Hospital, Portlaoise. In this light, the plan to develop a long-term vision for the health service in the form of the Committee on the Future of Healthcare is a welcome development.

Accountability for funding

Finally, this report underlines the need for greater accountability in terms of the use of public monies that fund services. While service providers are ultimately responsible for the quality of the service they provide, there should also be an onus on those who fund services to check to ensure people receive a quality service and that value for money is being obtained. To this end, the report recommends the introduction of a commissioning model for health and social care services in Ireland, and it argues that such an approach should be considered as a means of improving how services are planned, designed, sourced and delivered. HIQA acknowledges the preliminary work being done in this area by the HSE.

Disability services

The regulation of disability services is still a relatively new phenomenon for service providers. Our inspectors have found many good services that are person-centred and which are providing people with a good quality of life. Our data shows that compliance in many key areas is improving and, as the sector becomes more familiar with the regulations and the National Standards for Residential Services for Children and Adults with Disabilities, we expect this trend to continue.

The move from congregated settings to community-based living continues, albeit at a slower than desirable pace. This move presents challenges to service providers, but our inspectors have seen many examples of people having an improved quality of life as a result.

Unfortunately, there are still a significant number of people living in residential centres for people with disabilities that are not fit-for-purpose, where practices are institutionalised, and where vulnerable people living there are not adequately safeguarded. While increased funding and resources are necessary elements of addressing these failings, there is also a need to address outmoded staff practices, inappropriate placements and poor governance arrangements.

Older people

Nursing homes have been regulated by HIQA since 2009. Service providers are now quite familiar with the process and what constitutes a good quality service. In fact, we now expect to see providers move beyond basic compliance with the regulations and moving their services towards fully meeting the *National Standards for Residential Care Settings for Older People in Ireland* (2016).

Our findings in 2016 show a generally good level of compliance across the nursing home sector. Residents who speak to our inspection teams are mostly complimentary about staff and the manner in which they are cared for. However, we continue to encounter challenges in key areas such as maintaining residents' privacy and dignity, non-compliance with the National Vetting Bureau Act 2012, inappropriate arrangements to manage residents' finances and contracts of care.

Children's services

We found a lot of evidence of good practice in 2016 in relation to services for children. There is a lot of good work being done in terms of access to education and maintaining contact with families. Many social workers, social care workers and foster carers were able to build good relationships with children in the face of some very challenging and complex situations.

However, gaps were evident in children being allocated a social worker. The latest available data from Tusla showed that more than a fifth of open cases had not been allocated a social worker. There were further challenges in terms of care planning, safeguarding, aftercare planning and providing placements for children from different ethnic, cultural and religious backgrounds.

Delays in carrying out timely assessment and approval of relative foster carers was identified as a significant risk. In addition, reviews of all foster carers did not take place in line with the National Standards. This meant that updated An Garda Síochána vetting and formal reviews of the foster carers' continued capacity to care for the children placed with them did not take place.

Healthcare services

While the country's hospitals faced ongoing challenges, our inspections found many examples of good care delivered by committed staff. During the course of the year, the healthcare team conducted inspections in a range of areas: prevention and control of healthcare-associated infections, medication safety, nutrition and hydration. Findings in these inspections differed across the country. Indeed, the inspections showed a significant degree of variation between hospitals in the same group.

There is significant scope for greater shared learning across hospitals. There is also a need for an improved approach to planning of services both locally, regionally and nationally. In some instances, monitoring by HIQA also found that an absence of timely decision-making and implementation at a policy level had hindered the progression of services beyond a certain point. Therefore, efforts are required at every level to try to improve services for patients.

Looking ahead

In 2017, the Regulation Directorate will continue with its programme of registration and inspection of designated centres for older people and people with disabilities. There will also be additional registration responsibilities taken on in children's services. The healthcare team will continue with its thematic inspection programmes and begin preparations for the introduction of the regulation of medical exposure to ionising radiation.

It is likely that HIQA will take on additional regulatory functions over the coming years, such as the licensing of hospitals and the regulation of home care. As such, we have conducted research in a range of key areas of relevance to the future direction of regulation and look forward to contributing to the development of policy in these areas. We also consistently review our own internal processes, and our work on the Authority's Monitoring Approach will continue in 2017 with a view to being operational in 2018.

Summation

To sum up, in 2016 we found many instances of good quality care across all of the services we monitor and inspect. However, there are significant challenges in terms of governance, safeguarding, policy development and implementation, and accountability. It is HIQA's considered view that improving governance practices in services would lead to an improvement in the quality of lives of all those who use services. Safeguarding is a basic function of any health or social care service and all service providers needs to take this responsibility seriously. The absence of a clear plan for the future of the health service continues to impact on the delivery of services and reform is clearly needed in this area. Aligned to this is the lack of accountability across our health and social care services, and HIQA is advocating the introduction of an accountability framework which would address these issues.

HIQA will continue to work in collaboration with all other stakeholders to address these complex issues in the coming years with the ultimate goal of improving the quality and safety of services for all.

References

1. National Safeguarding Committee. Strategic Plan 2017–2021. Dublin: National Safeguarding Committee; 2016. Available from: http://safeguardingcommittee.ie/wp-content/uploads/2016/12/NSC-Strategic-Plan-2017-2021.pdf. Accessed on: 7/3/2017.
2. Health Information and Quality Authority. Guidance for Designated Centres - Restraint Procedures. Dublin: Health Information and Quality Authority; 2014. Available from: https://www.hiqa.ie/sites/default/files/2017-01/Guidance-on-restraint-procedures.pdf. Accessed on: 20/03/2017.
3. Health Information and Quality Authority. National Standards for Residential Care Settings for Older People in Ireland. Dublin: Health Information and Quality Authority; 2016. Available from: https://www.hiqa.ie/sites/default/files/2017-01/National-Standards-for-Older-People.pdf. Accessed on: 7/3/2017.
4. Health Information and Quality Authority. Guidance for Designated Centres - Residents' Finances. Dublin: Health Information and Quality Authority; 2014. Available from: https://www.hiqa.ie/sites/default/files/2017-01/Guidance-on-residents-finances.pdf. Accessed on: 23/2/2017.
5. Department of Children and Youth Affairs. Guidance for the Child and Family Agency on the Operation of The National Review Panel 2014. Available from: https://www.dcya.gov.ie/documents publications/20141204GuidOperationofationalReviewPanel.pdf. Accessed on: 12/4/2017.
6. Tusla. Integrated Performance and Activity Report - Quarter 4, 2016. Dublin: Tusla; 2017. Available from: http://www.tusla.ie/uploads/content/Q4_2016_Integrated_Performance_and_Activity_Report_Final.pdf. Accessed on: 7/3/2017.
7. Department of Children and Youth Affairs. Children First: National Guidance for the Protection and Welfare of Children. Dublin: Department of Children and Youth Affairs; 2011. Available from: https://www.dcya.gov.ie/documents/Publications/ChildrenFirst.pdf. Accessed on: 12/4/2017.
8. Jones R. Hospital bed occupancy demystified and why hospitals of different size and complexity must run at different average occupancy levels. British Journal of Healthcare Management. 2011; 17(6): 242-8. Available from: http://www.hcaf.biz/2011/Hospital_occupancy.pdf. Accessed on: 9/2/2017.
9. Kuntz L, Mennicken R, Scholtes S. Stress on the ward: Evidence of safety tipping points in hospitals. Management Science. 2014; 61(4): 754-71. Available from: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.831.6162&rep=rep1&type=pdf. Accessed on: 9/2/2017.
10. Blom MC, Jonsson F, Landin-Olsson M, Ivarsson K. Associations between in-hospital bed occupancy and unplanned 72-h revisits to the emergency department: a register study. International journal of emergency medicine. 2014; 7(1): 1-6. Available from: http://link.springer.com/article/10.1186/s12245-014-0025-4. Accessed on: 9/2/2017.
11. Keegan, Dr A. Hospital Bed Occupancy [Online]. 2008. Available from: http://www.adf.com.au/publication-3-hospital-bed-occupancy-. Accessed on: 9/2/2017.
12. Health Information and Quality Authority. Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise Dublin: Health Information and Quality Authority; 2015. Available from: https://www.hiqa.ie/healthcare/focus-quality-safety/investigations/portlaoise-hospital. Accessed on: 9/2/17.

13. Health Information and Quality Authority. Report of the review of nutrition and hydration care in public acute hospitals. Dublin: Health Information and Quality Authority; 2016. Available from: https://www.hiqa.ie/system/files/Review-nutrition-hydration-hospitals.pdf. Accessed on: 9/2/2017.

14. Valencia R, Arroyo LA, Conde M, Aldana JM, Torres M-J, Fernández-Cuenca F, et al. Nosocomial outbreak of infection with pan–drug-resistant Acinetobacter baumannii in a tertiary care university hospital. Infection Control & Hospital Epidemiology. 2009; 30(03): 257-63. Available from: https://www.repositoriosalud.es/bitstream/10668/1672/1/Valencia_Nosocomial.pdf. Accessed on: 9/2/2017.

15. Falagas ME, Bliziotis IA. Pandrug-resistant Gram-negative bacteria: the dawn of the post-antibiotic era? International journal of antimicrobial agents. 2007; 29(6): 630-6. Available from: http://www.sciencedirect.com/science/article/pii/S0924857907000192. Accessed on: 9/2/17.

16. World Health Organisation. Antimicrobial Resistance - Global Report on Surveillance. Geneva: World Health Organisation; 2014. Available from: http://apps.who.int/iris/bitstream/10665/112642/1/9789241564748_eng.pdf?ua=1. Accessed on: 9/2/2017.

17. Health Information and Quality Authority. Report of the review of antimicrobial stewardship in public acute hospitals. Dublin: Health Information and Quality Authority; 2016. Available from: https://www.hiqa.ie/publications/report-review-antimicrobial-stewardship-public-acute-hospitals. Accessed on: 9/2/2017.

18. Department of Health and Social Services. Regulation and Inspection of Social Care (Wales) Bill - Explanatory Memorandum incorporating the Regulatory Impact Assessment and Explanatory Notes. Welsh Government; 2015.

Appendix 1

HIQA's Regulation Directorate

HIQA exercises all of the regulatory powers through its regulation Directorate and the Office of the Chief Inspector, as set out in the Health Act 2007. There are four distinct pillars delivering programmes of regulation:

- Disability Services (Adults and Children)
- Older People's Services
- Children's Services
- Healthcare.

At the beginning of 2016, HIQA reconfigured the way in which it organised its staff and regulatory functions (see organisational structure, Chart 1). Formerly, teams of inspectors worked across several functions. For example, an inspector may have been responsible for monitoring nursing homes as well as residential centres for people with disabilities. The reconfiguration now means that teams work exclusively in their own respective pillars thereby enabling the effective pooling of knowledge, skills and experiences within the teams.

In addition, the inspection teams working on residential services for people with disabilities and older people have also been geographically aligned with the Health Service Executive's (HSE's) new community healthcare organisations.

The primary responsibility of each of the pillars is to monitor services for compliance with the various regulations and to check if services are meeting nationally mandated standards. Through its thematic inspections, HIQA's role is also to promote quality improvement. While HIQA plays a part in promoting improvement across these services, it is ultimately the responsibility of service providers to ensure that people using services are safe and that residents have a good quality of life.

Disability and older people's services

The Office of the Chief Inspector within HIQA has been regulating residential services for older people since 2009. Regulation of residential services for adults and children with disabilities started in 2013. Both these pillars have similar functions in terms of registration, inspection and enforcement. HIQA inspects these services to monitor compliance with the relevant regulations and national standards.

HIQA inspection teams are authorised to enter centres, speak with residents, interview staff and management, and examine documentation. Inspections can be announced or unannounced. On completion of an inspection, a report is usually published (publication may be delayed if HIQA is involved in enforcement proceedings) and made available on the HIQA website. If HIQA finds that providers are not complying with regulations and or there is a risk to the safety and welfare of residents, it has a range of escalation and enforcement options available to it. These include:

- requiring the service providers to develop an action plan to achieve compliance
- issuing time-bound warnings
- placing conditions on a provider's registration
- cancelling a centre's registration and or the prosecution of persons specified within the Health Act.

Children's services

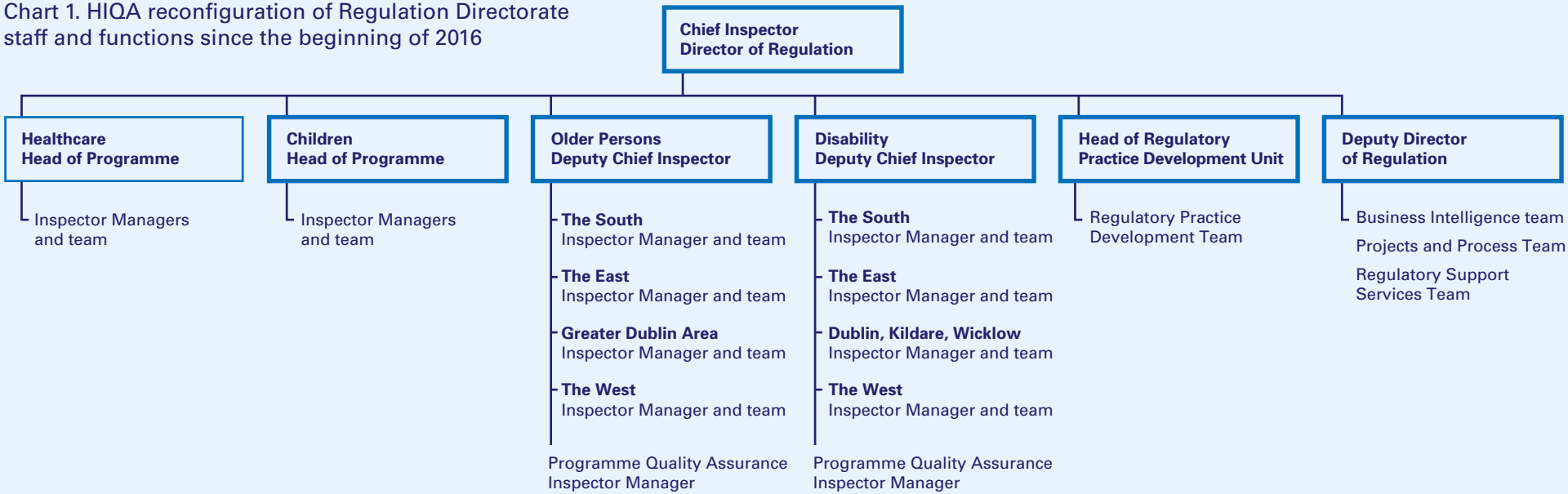
The children's team in HIQA inspects foster care, special care units, detention schools, statutory residential centres and child protection and welfare services. Each type of children's service has its own statutory framework that gives authority to HIQA to monitor the service using nationally mandated standards. HIQA inspection teams are authorised to enter and inspect all of the above services and to produce reports of their inspection findings. There are currently no enforcement powers in relation to these services.

However, service providers are presented with the findings of inspections so that they may develop action plans to implement safety and quality improvements. In order to promote quality and safety in the provision of services to children, the team assesses if a service provider has all the elements in place to safeguard children and provide them with a high-quality service. Where risks are identified, HIQA will seek assurances from service providers that they are protecting children through mitigating these risks.

Healthcare

Monitoring by HIQA of the implementation of standards in the acute healthcare sector started in 2009. Activity in this pillar has been concentrated on the acute healthcare sector and is based on the mandated *National Standards for Safer Better Healthcare* (2012) and the *National Standards for the Prevention and Control of Healthcare Associated Infections* (2009). Under the Health Act, HIQA is authorised to enter public hospitals and other healthcare services, with or without notice, for the purpose of monitoring compliance with these standards.

Chart 1. HIQA reconfiguration of Regulation Directorate staff and functions since the beginning of 2016



Healthcare inspection teams follow a thematic approach which means they focus on particular areas of patient care, such as medication safety or nutrition and hydration. Most inspection reports are published †. However, HIQA has no enforcement powers in relation to its monitoring work in healthcare. Under Section 9 of the Health Act, the healthcare team is also tasked with carrying out investigations or reviews against standards.

Support services

In addition to the four regulatory pillars as outlined, there are two HIQA teams that support our regulatory activity: Regulatory Support Services and the Regulatory Practice Development Unit. Regulatory Support Services provide the business and administrative support for all of HIQA's regulatory activity. This includes:

- business intelligence
- business planning
- project management
- corporate reporting
- processing registration applications
- providing administrative support to inspection teams
- receiving and processing notifications and information from the general public in the form of concerns.

The aim of the Regulatory Practice Development Unit is to coordinate the development of regulatory practice and methodological approaches within the directorate. It facilitates training, professional development and mentorship to support the delivery of confident and competent regulatory practice. The unit also includes the Regulatory Prism Integration Team who supports the development and implementation of HIQA's electronic information management system, which is called Prism.

† Some hospital reports are combined together to give an overview of a particular theme. For example, the healthcare team published a nutrition and hydration overview report in May 2016 which outlined the findings relating to 13 unannounced inspections. The hospitals in this report were anonymised.

During 2016, the Regulatory Practice Development Unit provided support to the Regulation Directorate by devising methodologies, developing policies and providing in-house training to new and existing staff. In addition, the unit provided information-sharing sessions for providers and stakeholders on various aspects of regulation.

Monitoring compliance and enforcement

HIQA gathers, processes and analyses large amounts of information on an ongoing basis. This information may come from:

- inspection activity
- notifications which service providers are required to send to HIQA
- concerned people using services or members of the public
- a selection of key performance indicators relating to acute healthcare services and children's services from the HSE and the Child and Family Agency (Tusla).

In 2016 HIQA's business intelligence function was further developed to provide meaningful information relevant to managers and inspection teams' decision-making activities. This information supports planning and scheduling of inspections, the effective management of the inspection process as well as monitoring against HIQA's system of internal controls. This information is used to inform and assure responsive regulatory activity.

We employ a 'case holder' model which means each inspector is responsible for monitoring a designated caseload of centres. All information about a particular centre is received and processed by the case holding inspector. This allows HIQA's teams to build a regulatory profile of each service and enables them to plan inspections accordingly.

We have several types of inspections:

- **Registration inspections:** these are carried out when HIQA receives an application from a service provider to register — or renew the registration of — a designated centre. Registration inspections are always announced. This is done to provide an opportunity for carers and families to meet with inspectors if they so wish. It is also necessary to ensure that the appropriate management personnel are present on the day of inspection. A registration inspection looks at all of the 18 outcomes in our assessment framework. They typically take two days to complete.
- **Monitoring inspections:** HIQA carries out monitoring inspections on an ongoing basis to assess the level of regulatory compliance within a service. These inspections will usually be unannounced and can be carried out at any stage of a centre's registration cycle.
- **Risk-based inspections:** HIQA teams will carry out a risk-based inspection if they have reason to believe that there is a risk to the health, safety or welfare of the residents or service users. For example, a risk-based inspection may be started after receiving information from a concerned person. Risk-based inspections will normally be unannounced and will usually focus on a small number of outcomes.
- **Thematic inspections:** these types of inspections are intended to promote quality improvement in a particular area of care (for example, dementia care or nutrition and hydration). In advance of the start of a programme of thematic inspections, the Authority will ask service providers to complete a self-assessment questionnaire and action plan. The majority of our healthcare inspections are thematic.

Findings from all of the above inspections help us to assess the level of compliance within a service and also inform our registration decisions.

HIQA has adopted a common 'Authority Monitoring Approach' in order to carry out its functions as required by the Health Act. The Authority's Monitoring Approach aims to ensure consistency across all of its functions in terms of how it manages risk and makes regulatory judgments.

Most services regulated by HIQA demonstrate a positive attitude to regulation and are committed to improving the quality of their services. Where HIQA finds poor services, it has a duty to act in the best interests of service users and in compliance with the requirements of the Health Act. To this end, the Office of the Chief Inspector has a range of enforcement powers available in both disability and older people's services. In the first instance, it will always seek to work with providers to bring their service into compliance with regulations. If the Chief Inspector does not see sufficient improvement or is concerned about the fitness of the provider and or persons participating in management, then further steps can be taken, up to and including cancelling the registration of the centre.

HIQA has a range of internal processes which govern how it manages services of concern, and it has adopted a stepped approach to escalation and enforcement. Its inspectors, inspector managers and other staff must:

- identify risks to residents, children and patients
- assess the level of risk
- plan and take regulatory actions
- monitor the effectiveness of such actions in reducing risks.

In cases where nursing home services or residential services are considered high risk or are under consideration for cancellation and or refusal of registration, they are placed on our Regulatory Risk Register. Regulatory Risk Register meetings are convened fortnightly and consider all of the services on the register.

The Regulatory Risk Register is chaired by the Director of Regulation/ Chief Inspector who holds ultimate responsibility for all decisions made in respect of services that are monitored and regulated by HIQA under the Health Act. Senior managers, inspector managers and other relevant regulatory managers and staff are in attendance.

The objective of the Regulatory Risk Register is to ensure that there is sufficient oversight of high-risk services and that these risks are managed in the best interests of the people using services and in line with our statutory remit.

Stakeholder engagement

As a national organisation, HIQA interacts with a range of statutory, voluntary and private organisations in carrying out its work. For the Regulation Directorate, this means engaging with the Department of Health, Department of Children and Youth Affairs, the HSE, the Child and Family Agency (Tusla) and representative groups on an ongoing basis.

In addition, the Authority has been invited to attend the Health Committee in the Houses of the Oireachtas to discuss a variety of issues related to health and social care services. HIQA also hosts regular information events with service providers on how it regulates services and to update them on future developments. Finally, and most importantly, HIQA engages with residents and service users to provide them with information and to hear how HIQA's work impacts on them.

In its Corporate Plan 2016–2018, HIQA has committed itself to help protect and safeguard service users and to strive to improve the country's health and social care services. The Regulation Directorate plays a critical role in promoting these important objectives.

Appendix 2

Inspections of designated centres for older people and people with disabilities are organised according to outcomes. There are a total of 18 outcomes with a slight variation across services for older people and services for people with disabilities. This reflects the differences in the revelant regulations. The outcomes are as follows:

Designated centres for older people

Outcome 1: Statement of Purpose
Outcome 2: Governance and Management
Outcome 3: Information for Residents
Outcome 4: Suitable Person in Charge
Outcome 5: Documentation to be kept at a Designated Centre
Outcome 6: Absence of the Person in charge
Outcome 7: Safeguarding and Safety
Outcome 8: Health and Safety and Risk Management
Outcome 9: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints Procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' Clothing and Personal Property and Possessions
Outcome 18: Suitable Staffing

Designated centre for people with disabilities

Outcome 1: Residents Rights, Dignity and Consultation
Outcome 2: Communication
Outcome 3: Family and Personal Relationships and Links with the Community
Outcome 4: Admissions and Contract for the Provision of Services
Outcome 5: Social Care Needs
Outcome 6: Safe and Suitable Premises
Outcome 7: Health and Safety and Risk Management
Outcome 8: Safeguarding and Safety
Outcome 9: Notification of Incidents
Outcome 10: General Welfare and Development
Outcome 11: Healthcare Needs
Outcome 12: Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the Person in Charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and Documentation

Published by the Health Information and Quality Authority.

For further information please contact:
Health Information and Quality Authority
Dublin Regional Office
George's Court
George's Lane
Smithfield
Dublin 7
D07 E98Y

Phone: +353 (0) 1 814 7400
URL: www.hiqa.ie

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