Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

OVERVIEW REPORT

MONITORING AND REGULATION OF DISABILITY SERVICES IN 2020

November 2021

Safer Better Care

About the Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children, Equality, Disability, Integration and Youth, HIQA has responsibility for the following: HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Office of the Chief Inspector

  within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services —** Regulating medical exposure to ionising radiation.
- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

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A message from the Chief Inspector of Social Services and Director of Regulation

Mary Dunnion, Chief Inspector of Social Services and Director of Regulation

As we planned for 2020, we could not have anticipated the challenge that was to become the COVID-19 public health emergency. The pandemic resulted in a year like no other. All parts of society were affected, including the day-to-day lives of people with disabilities living in designated centres across Ireland.

At the outset of this report, I would like to acknowledge the high level of cooperation and measures taken to minimise the risk to residents in designated centres for people with disabilities, by residents themselves and their loved ones, staff, managers and the Health Service Executive (HSE) as funder of the services. While a very worrying time for all, residents and staff in centres showed great resilience and as a result, the level of infection in centres for people with disabilities was significantly less than that in other sectors of the healthcare system.

During 2020, as regulators, we adapted our approach to ensure that we were contributing to the national response to the pandemic. We took measures to support providers in their work to reduce the risk of COVID-19 infection to residents. We established an Infection Prevention and Control Hub which providers and managers of centres could contact for advice on implementing public health guidance to keep residents safe. We ran a series of webinars on infection control planning for managers and staff which were attended by over 1,400 participants. We also put arrangements in place to enable providers to quickly register isolation or treatment facilities for their residents who had a COVID-19 infection. In addition, our inspectors kept in regular contact with the persons in charge of every designated centre to ensure that they had access to the resources they required and were able to respond to the care and support needs of residents during the pandemic.

At the start of the pandemic, routine inspections were suspended for five weeks while we engaged with public health, to ensure we had appropriate infection control arrangements in place to minimise the risk of infection for residents, staff and inspectors. We then undertook a programme of inspections in centres where we had

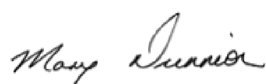
received information of concern that indicated risk to residents. Many of these inspections allowed us to provide assurances to residents, their families, providers and the public that appropriate arrangements were in place to manage the risk of COVID-19 infection. In a number of centres, we found that public health measures were not being implemented appropriately and inspectors required providers to take immediate action to address this to keep residents safe.

As highlighted in previous overview reports, the quality of a provider's governance arrangements ultimately leads to better outcomes for residents. Again, during the initial phases of the global pandemic, we found that providers who had better governance arrangements were often more effective at limiting the risk of transmission of COVID-19 in their services.

This year has demonstrated the need for all service providers to ensure that they are continually reviewing and testing their business continuity arrangements and contingency plans through simulated drills on a regular basis. A thorough analysis of the service's response and findings from these drills should inform updates to contingency plans to ensure the centre is better prepared and equipped for any future infection surges. As I write this message, while there are many positive signs for the future, such as progress on the vaccination programme, we all continue to be at risk from COVID-19. HIQA will continue to inspect designated centres through ongoing vigilance in relation to managing the risk of COVID-19 infection, but also considering how the quality of life and human rights of residents are protected and promoted in designated centres.

Finally, I would like to again pay tribute particularly to residents and staff in designated centres for their resilience in what have been extremely challenging times. In addition, the contribution of residents' loved ones, management and of the HSE in supporting providers must also be recognised.

I am hopeful that through all of our efforts, we will be able to return to enjoying life without the worry of COVID-19, in time.



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

From October 2021, Carol Grogan was appointed Chief Inspector of Social Services.

Introduction by the Deputy Chief Inspector of Social Services (Disabilities)

Finbarr Colfer, Deputy Chief Inspector of Social Services (Disabilities)

2020 was a very challenging year for everyone, but I am most conscious of the additional challenges that the pandemic brought for people with disabilities who live in designated centres. During the pandemic, our focus was on the day-to-day experience of residents and on the actions of providers to ensure that the risk of infection for residents was minimised.

In addition, we continued to focus on key indicators of safety and residents' quality of life, such as protection from risk of abuse, the quality of support being provided to residents and how residents' rights were promoted and protected, in the context of public health measures required to keep all citizens safe.

While there were outbreaks of COVID-19 infection in designated centres for people with disabilities which had a significant impact on residents, overall inspectors found that providers were vigilant in managing the risk of infection and responded quickly when there were infections.

There were a number of factors that contributed to managing the risk of COVID-19 in centres for people with disabilities. There was a high level of cooperation between the HSE and providers. The HSE's service level arrangements with providers ensured an established relationship between the HSE as funder and the providers. Providers reported that the HSE was responsive to issues that arose for providers during the pandemic. This included such measures as the HSE supporting providers to develop isolation and treatment facilities, as well as liaising with public health to clarify guidance on infection control arrangements specific to the disability sector.

In addition, inspectors also saw many examples of cooperation and support between providers which included the sharing of knowledge, experiences and resources. This approach by the sector was critical in minimising the risk to residents.

During this time, as the regulator, we met with provider representatives on a monthly basis to share information and to highlight areas of concern. The Chief

Inspector also provided information to the HSE about the reported daily infection levels within centres and highlighted centres where there were challenges in managing the risk to residents.

This overview report sets out the work and the findings of inspectors during 2020. It provides findings in relation to a number of key regulations that impacted directly on the safety and 8esponsib of residents. In the 2019 Overview Report, we provided a comparison between the experience of residents living in congregated settings[1] and those living in community-based housing. In 2020, while we found that there were improvements in compliance in congregated settings in areas such as safeguarding and positive behaviour support, there continues to be a significant variance in the level of non-compliance in congregated settings and a greater risk to residents in those settings compared to those in community-based settings.

During 2021, inspectors will continue to focus on the management of the risk of infection in centres. Inspectors will also focus on the everyday experience of residents and how their rights are upheld by providers during these times.

And hopefully, in time, it will be possible for residents and their loved ones, and for all of us to return to a somewhat more normal routine of daily living.

Finbarr Colfer
Deputy Chief Inspector of Social Services (Disability)
Health Information and Quality Authority

[1] Congregated settings are described as places where 10 or more residents live or residents are accommodated in a number of houses on the same campus in: *Time to move on from congregated settings - A strategy for community inclusion*. Dublin, Health Service Executive; 2011. Available online from: https://www.hse.ie/eng/services/list/4/disability/congregatedsettings/time-to-move-on-from-congregated-settings-%E2%80%93-a-strategy-for-community-inclusion.pdf.

Chapter 1. COVID-19 – The impact of the pandemic on people with disabilities

1.1. Introduction

The COVID-19 pandemic has had a significant impact on the lives of people with disabilities and on the regulation of designated centres for people with disabilities.

During 2020, the Chief Inspector took measures to ensure that regulation made an effective contribution to the public response to the pandemic. Some of these measures supported providers to respond effectively to risks to residents' safety during the pandemic. The measures also enabled and supported good communication with providers, the HSE, Public Health and the Government at each stage of the outbreak.

On March 10, the Chief Inspector of Social Services issued a response to the Government's announcement of a public health emergency. Providers were notified that routine inspections would be suspended briefly, while infection control arrangements were put in place to minimise the risk of infection to residents, staff and inspectors during inspection activity.

In addition, the planned programme of thematic inspections in both older peoples' services and disability services were cancelled. This initial response to the pandemic provided clarity to providers about the approach that the Chief Inspector was taking in relation to the inspection and regulation of centres.

An Taoiseach addressed the nation on 12 March 2020[2], setting out the government's plan to introduce restrictions to manage the impact of the pandemic on Irish society. Following this, the Chief Inspector wrote to all providers setting out the revised regulatory arrangements that would be put in place with immediate effect.

The Chief Inspector made adjustments to reduce the regulatory burden on providers, while they were making critical preparations to manage the risk of infection in their centres. For example, adjustments were made to the threshold for submitting statutory notifications to the Chief Inspector, including a temporary removal of the requirement for some notifcations. In addition, the Chief Inspector, decided to temporarily cease the publication of inspection reports.

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[2] Statement by An Taoiseach on Measures to tackle COVID-19 https://www.gov.ie/en/speech/5a280b-statement-by-an-taoiseach-on-measures-to-tackle-covid-19-washington/ Accessed: 2 March 2021

The Chief Inspector also updated providers on revised arrangements for the renewal and registration of designated centres. The Chief Inspector changed and simplified the process for providers to quickly add buildings to their centres for the isolation or treatment of residents who had a COVID-19 infection.

The Chief Inspector was notified of the first confirmed case of COVID-19 in a designated centre for people with disabilities on 23 March 2020. On that date, the Chief Inspector wrote to all providers and required them to review their infection prevention and control plans for each individual centre to ensure that they had effective arrangements and resources to respond to any suspected or confirmed incidence of COVID-19 infection.

From 27 March 2020, the Chief Inspector implemented a series of ongoing regulatory assurance telephone calls by inspectors to each designated centre. 7,116 calls were made during this time and they were used to monitor and assess the providers' preparedness for potential outbreak and management of COVID-19 in each designated centre. The Chief Inspector, in the interests of public safety, also required providers to submit daily updates on confirmed or suspected cases of COVID-19 infection in each of their centres.

In May 2020, following consultation with Public Health, risk-based inspection activity resumed. The process for these inspections was amended to ensure appropriate public health measures were used by inspectors to minimise the risk of infection to residents, staff and to inspectors themselves. These inspections focused on the provider's overarching governance and management arrangements during a pandemic, their infection prevention and control measures in the centre, risk management processes and their staffing arrangements.

1.2. Support for providers in responding to the COVID-19 pandemic.

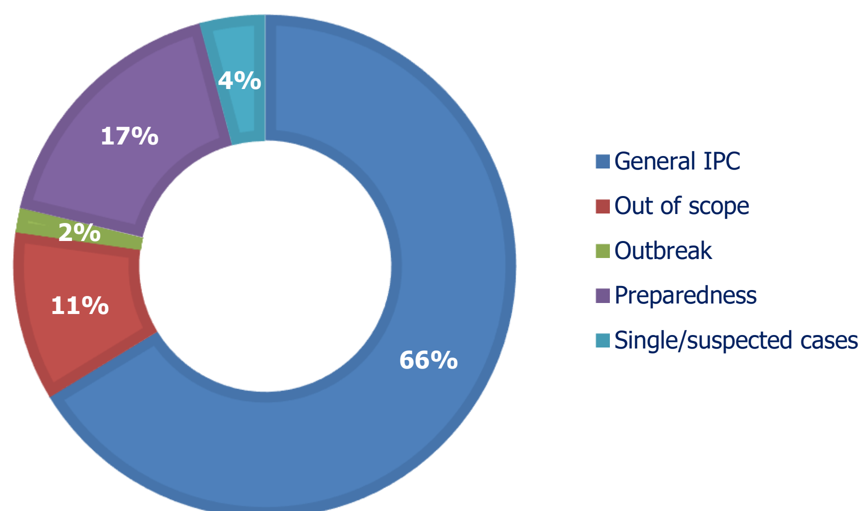
At the beginning of April 2020, the Chief Inspector established an Infection Prevention and Control Hub (the Hub). The Hub was developed to provide a single point of contact to give providers and staff, support and guidance in their implementation of public health measures in designated centres.

Between 6 April 2020 and 10 July 2020, the Hub managed and responded to 617 infection prevention and control queries, of which 31% (191) related to disability services.

The graph below shows that general infection prevention and control queries accounted for the majority of queries received relating to disability services (66% or

128 queries), while post-outbreak advice accounted for the smallest number of queries (2% or three queries).

Figure 1: Percentage of disability service-related queries by category



All enquiries made to the Hub were logged and where the person enquiring indicated that there were challenges to effective infection prevention and control measures in a centre, such as difficulties with staffing or with access to personal protective equipment (PPE), the issue was escalated to the Health Service Executive (HSE).

1.3. Preparedness for managing COVID-19: Assurance calls

As cases of COVID-19 began to emerge in designated centres for people with disabilities, the Chief Inspector implemented a system of regulatory quality assurance telephone calls with providers and persons in charge to determine and assess the overall strength of their contingency arrangements, their preparedness and their proposed tactical and operational responses in the event of an outbreak of COVID-19 in each centre.

These calls were made to each designated centre on a fortnightly basis, continued throughout the first wave of COVID-19 and into the beginning of the second wave of infections. During this time, there were 7,116 calls made to providers and persons in charge of designated centres.

While it was clear from these early telephone calls that the vast majority of service providers had taken steps to review their infection control procedures and their contingency arrangements, a number of key areas of concern began to emerge.

These were escalated by the Chief Inspector to the HSE, Public Health and the Department of Health.

- ***Congregated Settings and Infection Control***

  Providers of larger, campus-based or congregated settings reported more rapid outbreaks in COVID-19, both in resident and staffing populations. In one example, a number of residents living in a single unit who each had their own bedrooms, were all found to have a COVID-19 infection. In another example, after one confirmed case was reported on the campus, an outbreak was declared due to a high number of staff and a number of residents being reported as having suspected cases of COVID-19.

- ***Stock management and supply of PPE***

  In early engagement with centres, inspectors found that there were variations in the ability of different providers to meet the demand for PPE. For example, some providers ensured that there was a constant delivery and supply of PPE to each designated centre, managed centrally with regular reviews of stock levels to ensure that a minimum level of stock was available. However, other providers struggled to maintain this approach, particularly where they were endeavouring to supply a number of large campus-based settings and community-based day services from the same supply.

- ***Staffing resources / Service continuity***

  During 2020, inspectors found non-compliance in the level of staffing resources in just over 11% of all designated centres that had an inspection that year. At the commencement of the quality assurance telephone calls, inspectors found a number of examples where providers had failed to adequately ensure through their contingency planning that they had access to or had retained sufficient staff to maintain continuity of service. This became particularly critical where providers had staff who were no longer able to work across more than one centre, or where staff were required to self-isolate.

- ***Access to, and the deployment of, extra capacity and suitable isolation facilities***

  As the number of cases of COVID-19 began to increase, a number of providers reported that they had insufficient capacity to ensure the effective isolation and management of an outbreak. In some centres, residents could not access a single use bathroom or were sharing other facilities, such as their bedroom. Some residents found it challenging to be isolated in their bedroom for up to 14 days and would leave their rooms on a regular basis.

The ability to access and create additional capacity for the sole purpose of isolation and recovery for people with COVID-19 became a significant issue and critically one that the Chief Inspector recognised very early in the pandemic. On the 12 March 2020, the Chief Inspector made changes to the process for applying to increase the overall size of a designated centre by adding additional premises.

On the 31 March 2020, the Chief Inspector set out the arrangements and actions that needed to be taken by providers in the event of an emergency situation requiring them to access an additional premises.

1.4. Key learning for the sector

Analysis is yet to be completed, both nationally and internationally on the overall preparedness, management and response to the global pandemic. However, while in the main inspectors found that many providers responded quickly, some early learning is emerging.

- **Planning and preparation** – Regular testing of the COVID-19 management plan for the centre must become a core component of a centre's risk management plan. Thorough analysis of the centre's response and findings from testing their plans should inform any changes that would support better preparation for any future outbreak. Such testing will be a key factor in ensuring gaps in resources, knowledge and resilience are identified and resolved in advance of a future outbreak or major incident.

- **Good governance** – Providers who have consistently ensured they have comprehensive governance and oversight systems in place have demonstrated better capacity to effectively manage COVID-19 in their centres. It has been challenging for providers to prevent outbreaks of the disease, however, where outbreaks did occur in centres which were well managed, these centres tended to have better infection control systems in place, better supplies of critical resources and timely or immediate access to additional staffing resources to support continuity of service and isolation arrangements where required.

- **Reponsive regulation** – The absence of emergency provisions to support the sector in opening up additional capacity at short notice remains a critical weakness in the current legislation. The ability and agility the regulator has demonstrated in adapting and responding to this emerging crisis, despite this

gap in legislation, has proven critical in the management and oversight of this public health emergency in designated centres for people with disabilities.

1.5. Acknowledgements

COVID-19 has had a significant impact on the lived experiences of people all around the world. For people with disabilities living in Ireland, and for the people who work with them to bring their dreams and aspirations to life, the last year has been particularly challenging. In general, providers and their staff have demonstrated a capacity to respond to the global pandemic and created often innovative approaches to meeting and supporting the needs of people with disabilities living in Ireland.

It is important to recognise that the information presented in this report represents a person with a disability or a member of staff. While this information is important in highlighting the overall effect of COVID-19, it does not give the whole story. It is therefore of critical importance to acknowledge the resilience and tenacity shown and demonstrated by people with disabilities and the staff who support them every day, which has no doubt been one of the cornerstones in managing and reducing the impact of COVID-19 in their homes.

Chapter 2. Listening to the views of residents

2.1 Introduction to engaging with residents during inspections

During 2020, we had to change the way that we engaged with residents during inspections due to the prevailing public health guidance. Measures such as maintaining social distancing, limiting the time inspectors spent on inspection and the use of PPE, such as masks, meant that opportunities to meet with and speak to residents about their experiences and lives during the pandemic was constrained. However, within these constraints, inspectors continued to observe the day-to-day life of residents, and where possible, listened to and spoke with residents about their experiences in their homes.

For many residents, particularly during extended periods of national lockdown or periods when they were required to self-isolate, the inspector may have been the first person residents met for a long time outside of their staff support network.

To ensure that residents were prepared for these visits and reassured about the safety precautions that inspectors would be taking in advance of the inspections, the vast majority of these inspections were announced a minimum of 48 hours in advance of the inspection. However, a small number of these inspections, due to concerns about the welfare and safety of residents, were unannounced.

During warmer months and sunnier days some inspectors were able to speak with residents in their gardens or, when a resident preferred, through a window, while always ensuring that the conversations remained confidential. In addition to this, inspectors spoke by telephone with residents' family members who had expressed a wish to talk to inspectors.

Residents and their families/advocates can also tell us about their views of the quality of the service in their centre through a resident questionnaire which is available to download on www.hiqa.ie and can be completed by residents or their representatives outside of the inspection process and sent directly to HIQA.

2.2 Capturing residents' voices in the inspection report

All of our inspection reports include a section called 'What residents told us and what the inspectors observed'. In this section, inspectors outline what residents told them on the day of inspection or through the questionnaires about what it is like to live in their home. In some cases, residents used alternative methods of communication to interact with inspectors, such as greeting the inspector with an elbow tap, using a thumbs up, sign language and individualised communication boards to converse with the inspector about their interests. As some people are not in a position to communicate verbally with inspectors, observation is also used to get a sense of the day-to-day experiences of residents and to describe the interactions between staff and residents, the environment and the general atmosphere in the centre.

For almost all residents living in designated centres for people with disabilities, the arrival of COVID-19 in Ireland resulted in a total change to their daily lives. For example, many of the residents had previously attended day services, supported employment or educational activities. The introduction of public health restrictions throughout the early phases of the outbreak meant that many residents were required to restrict their movements and contact with others.

In many centres, inspectors found evidence that residents had been supported by staff to understand the reasons for the national restrictions and why their daily plans needed to change. Inspectors saw examples where public health posters and advice were being used as visual reminders in designated centres to support and assist residents. For example:

- Leaflets and social stories were made available to clearly explain and provide reassurances for residents
- Records of weekly house meetings showed that COVID-19 was openly discussed and residents had regular opportunities to voice their opinions, queries or concerns to peers and staff
- Many residents were observed to have a good understanding of temperature checking, social distancing and appropriate use of PPE
- Posters on hand washing, coughing and sneezing etiquette and testing for COVID-19 were clearly displayed in an accessible format in designated centres
- Staff members were observed to use verbal prompts and cues in a positive manner to ensure the residents remembered to maintain social distancing with inspectors when on site.

In several centres, inspectors were shown a number of key documents and leaflets that had been developed by providers and staff to help residents to keep each other safe and to ensure they were being kept up to date with changes in public health guidelines. For example, in one centre residents showed the inspector an easy-to-read infection control folder/guide that had been developed for them. While in

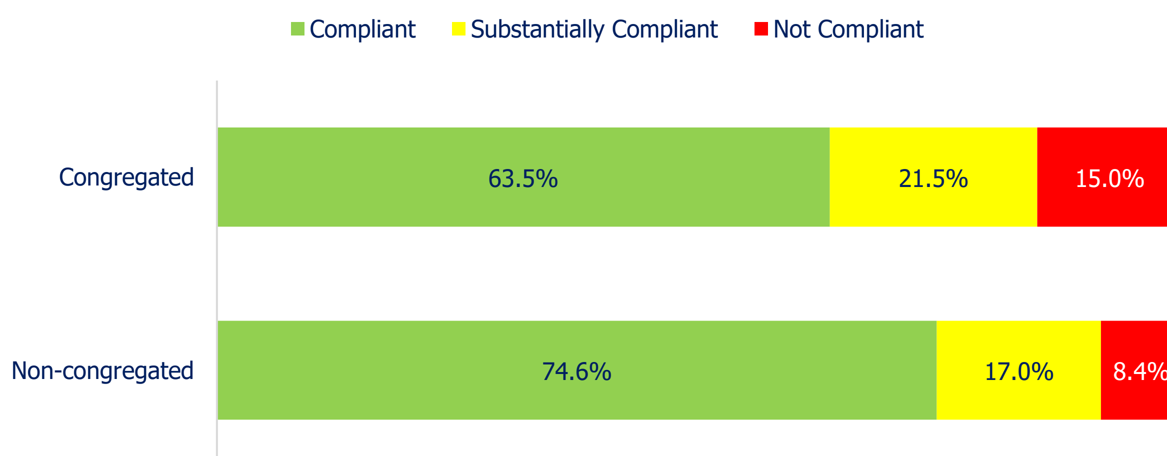
another example, residents were actively using their own smartphones and tablet devices to access this information themselves and to ensure that they kept themselves informed.

Some residents told inspectors that they found the restrictions during the COVID-19 lockdown periods difficult at times. These residents told inspectors that they understood the reasons for the restrictions and outlined some of the things their centres had implemented to reduce the impact of the restrictions on them. For example:

- contact with families and peers via technology
- where possible, residents were allowed window visits from relatives and friends
- ‘drive-by’ visits
- click and collect grocery shopping.

During periods where lockdown restrictions were eased, inspectors saw many examples of where residents were resuming safe external activities with family and home visits being reintroduced slowly with due regard to the resident’s health vulnerabilities and public health advice. However, residents also told inspectors that they wanted to get back to the way they used to live and were looking forward to getting out and about again, having visitors, meeting their families properly and returning to their part-time work.

Figure 2: Comparison of overall compliance levels in congregated and non-congregated residential disability settings in 2020



In 2020, the impact of COVID-19 on the quality of life for residents who live in smaller community-based homes when compared against those who live in larger campus or congregated settings, once again demonstrates that those who lived in smaller homes often had more control and choice over their day-to-day routines during the pandemic and were still able to maintain a degree of control and input

into how they spent their day, including being able to go for exercise in the local area and to participate more in the preparation and cooking of their meals.

However, this had not been possible for many residents who lived in congregated or campus-based settings. Figure 2 above shows that overall non-compliance levels in congregated settings were almost twice that of non-congregated centres (centres in the community) during inspections in 2020.

2.3 Residents' day-to-day experiences

As reflected in the 2020 inspection reports, it was evident to inspectors that the majority of providers were committed to promoting the rights of residents, particularly when residents were making decisions about their own lives. Inspectors found that in many centres, residents were actively involved in the running of their homes through a variety of activities including preparing their own meals, running errands in the community, household chores, laundry and weekly meetings. In many cases, the residents' contributions through house meetings or consultation in their service reviews contributed to positive changes being made to the overall running and delivery of the 18espons.

In these centres, it was clear to inspectors that the residents were comfortable asking for support from staff where they needed it. Residents enjoyed telling inspectors about how they liked to spend their time and about the activities or people that were important to them. The majority of residents told inspectors that they were supported by staff to participate in meaningful activities of their choice.

In other centres, residents were unable to communicate with the inspectors and inspectors spent time observing what life was like for those residents. In many centres, staff were observed engaging with and supporting residents in an understanding and kind way, and supporting residents to have a day that was meaningful to them. The hobbies and interests that residents had were varied, some of which included; baking, gardening, looking after farm animals, music, arts and crafts, shopping, accessing the local community, taking part in local groups and meeting with friends and family. The residents showed the inspectors some of the artwork they had completed and the crops and flowers they were growing in their polytunnels.

> ...the inspector observed that the garden at the front of the designated centre had been decorated with colourful planters and flowers. It was observed that the back garden had also been transformed into a welcoming, bright and colourful space. The person in charge told the inspector that residents had taken part in a gardening competition held by the organisation, where they had won second prize.
>
> Extract from inspection report in 2020

However, while inspectors saw examples of engaging and positive support for residents in some congregated setings, in other congregated settings residents were not always supported to access opportunities and activities in accordance with their interests and assessed needs. Inspectors found that in some cases, although there were activities available, these were often limited both in scope and frequency. In addition, there continued to be evidence in some centres of periods of time where activities were not facilitated due to the number of residents being accommodated together, inadequate staffing numbers or limited access to the local community due to the lack of access to a vehicle.

In response to COVID-19, and to the introduction of national restrictions which resulted in many residents not having access to their usual day services or employment, many providers initiated programmes of activities which supported the residents to continue to enjoy active lifestyles and interests in their own homes. For the majority of residents this meant that alternative routines were developed in consultation with them. Inspectors saw examples of providers introducing friendly competitions between different centres, including baking or flower competitions. Residents were encouraged to engage with each other during these competitions using video conferencing technology. Residents who had participated in these activities expressed joy and could be seen by inspectors to have gotten great fun from the involvement.

Inspectors saw examples of staff who had begun to engage with residents to develop time capsules or memory books about how COVID-19 had changed their lives and the things that they were most looking forward to getting back to doing. Residents used this as an opportunity to also highlight some of the things that they had previously been involved in that they no longer wanted to participate in. However, many residents missed being able to attend their usual day services. This was identified as a concern by residents, relatives and staff. Some relatives spoke to inspectors over the phone about the dedication and support the staff team had

given their relatives and they expressed concerns regarding the lack of day services and the resulting impact on their relatives lives.

> Not all residents were supported to engage in a meaningful day based on their assessed needs and [a resident] described feelings of loneliness and isolation to inspectors.
>
> Extract from inspection report in 2020

2.4 Voice of the child

During 2020, many respite services were suspended which placed significant pressure on families trying to cope with meeting the needs of children with disabilities. As the year progressed, respite breaks were recommenced in a measured way, to ensure that there was a minimal risk to children.

Inspectors completed 76 inspections, 59 of which were in centres for children, with the remaining 17 inspections occurring in centres which may accommodate both adults or children. During these inspections, inspectors met with children and spent time with them observing their day-to-day life in the centre. The inspection reports give examples of children who indicated or said that they were happy and safe, and that they loved their bedrooms and personal space. For example, in one centre the children especially wanted to say to the inspector that the staff and manager were "A1" and were a great help to them in lots of ways. Inspectors also viewed a number of compliments from children's representatives in relation to care and support for children in the centre.

In the majority of these centres, there was evidence that childrens' voices were central to the ethos of the service. Inspectors saw that children were actively involved in the running of the house, they chose what social activities to engage in and agreed menus between them. These centres often had a strong emphasis on supporting residents to develop life and self-care skills, such as preparing meals, with the support of the staff. However, in some centres there was limited evidence that residents were consulted about their choices and preferences.

Inspectors found that despite the closure of school-based activities for children, many designated centres for children were continuing to focus on meeting the assessed social and educational needs of the children, supporting their independence and assisting them to reach their maximum potential. During the COVID-19 pandemic, staff in these centres were seen to be actively supporting the

children to keep in contact with their school and, in some centres, to complete and submit any schoolwork assigned. In addition, where the goals of the children could not be achieved, inspectors found evidence of providers working with these children to look at alternative ways to meet their needs.

> The inspector observed that the centre was promoting the rights of the respite residents. Residents were consulted and made decisions regarding the services and supports they received and their views were actively and regularly sought by the residential service. This was highlighted in resident meetings where the agenda included matters relating to making suggestions about the service, making choices around meals and activities and informing residents who they could go to when the needed support.
>
> Extract from inspection report in 2020

Throughout the various stages of the pandemic, inspectors saw examples of staff ensuring that children and their families maintained close and nurturing relationships with each other. Inspectors saw where staff facilitated children to have visits from and visits to their family members, while ensuring good adherence to public health measures.

> Improvements were required to ensure that resident's rights were promoted by the care and support provided in the centre. There was limited documented evidence that residents availing of shared care were consulted with, regarding their choice and preferences during their stay.
>
> Extract from inspection report in 2020

In some situations, inspectors saw where children had temporarily moved back to the family home during the pandemic. Inspectors found that contact with the child and the family had been maintained by staff which ensured a continued relationship and good planning for when the child was due to return to their residential facility. In other examples, inspectors saw where family members were unable to visit their child or relative in person, due to prevailing public health guidance, in such instances inspectors saw examples of the provider ensuring telephone or video conferencing contact was maintained on a regular basis.

> Residents were supported to have personal goals which had been identified through ongoing discussions. Some goals, such as a trip to Mondello race track and accessing a local gym had been postponed in light of COVID-19, however, staff members had pursued other goals and assisted a resident to get three dimensional glasses which would help the resident experience Mondello race track.
>
> Extract from inspection report in 2020

2.5 The impact of compliance with regulations on residents' lived experiences and their human rights

In order to protect and promote the rights of people with disabilities, it is important that providers put in place systems to ensure residents can participate in, are consulted with and consent to making decisions about their own lives.

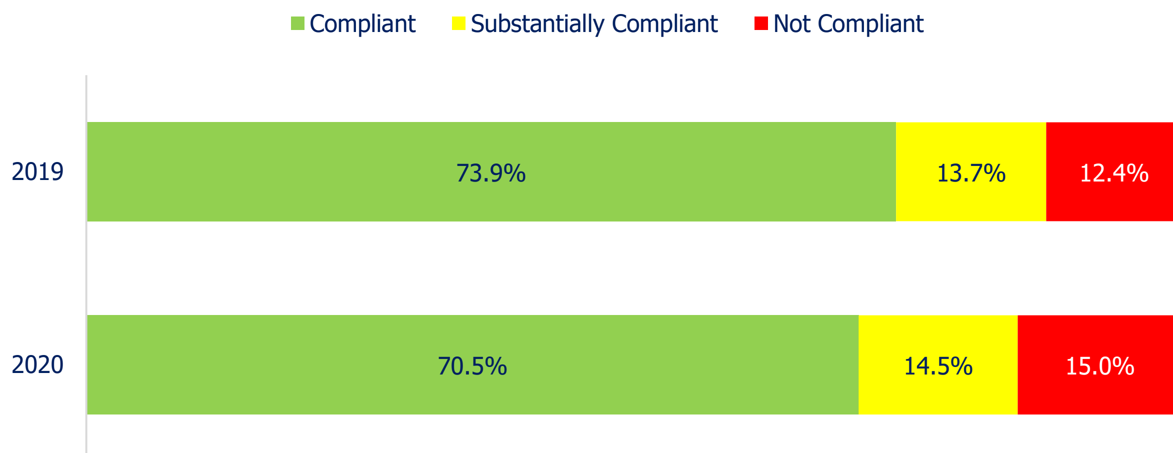
For providers to comply with Regulation 9: Residents' Rights, they should ensure positive outcomes for residents by supporting the residents in so far as possible to make their own decisions about their lives and in a way that maximises their autonomy and independence. Failure to meet the minimum requirements of this regulation increases the risk of institutional staff practices and the risk of a reduced quality of life.

The rights of people with disabilities are enshrined in the UN Convention on the Rights of Persons with Disabilities (UNCRPD). The general principles underpinning the convention include:

- respect for the dignity, autonomy and independence of people with disabilities
- full participation in society
- recognition and respect of people with disabilities as part of human diversity
- freedom to make one's own choices
- non-discrimination and equality of opportunity
- respect for the evolving capacities of children with disabilities.

During the pandemic, inspectors considered the rights of residents in the context of the public health restrictions required of all citizens. Even when allowing for these restrictions, inspectors found that there was an increased level of non-compliance with Regulation 9 when compared to 2019.

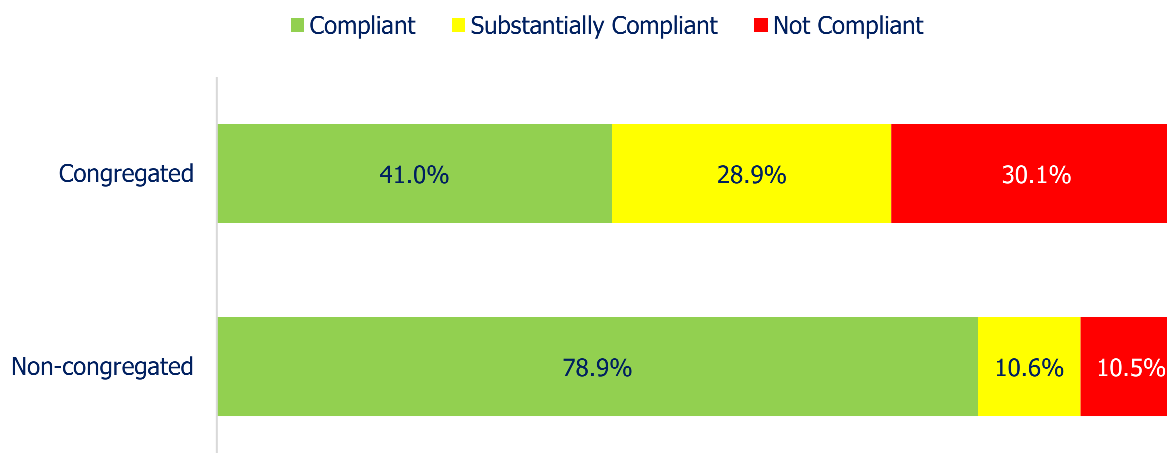
Figure 3: Comparison of overall compliance with Regulation 9 – Residents' Rights between 2019 and 2020



Residents who lived in centres where there were higher levels of compliance told inspectors about how their lives had improved. Some residents attributed these improvements to the impact of regulation by the Chief Inspector. In these centres, residents told us that they felt very much at home in the centre and that they liked planning the activities for their day rather than going to their previous day centres. Inspectors saw evidence of providers taking a positive approach and quickly adapting to the limitations, while exploring new and interesting ways for residents to maintain control over their lives and express themselves and their choices.

However, it remains of significant concern that residents who live in many larger congregated or campus-based settings continued to be more likely to experience less opportunities to exercise their rights, were more likely to be exposed to higher restrictions on their liberty and expressed higher levels of dissatisfaction with their service to the inspectors. Figure 4 below demonstrates the significant difference in compliance levels between congregated settings and smaller community-based homes in 2020 under Regulation 9: Residents' Rights.

Figure 4: Comparison of compliance with Regulation 9 in congregated and non-congregated settings



Inspectors found that most residents who lived in congregated settings did not have the same supports in place to help them exercise and enjoy their human rights.

Inspectors spoke with residents and also spent time observing residents and many of those in congregated centres were not supported to avail of opportunities to access their community or determine the way in which they spent their day. In some of these centres, the day continued to be determined by the staffing arrangements and residents did not have access to advocacy or support to assert their rights.

2.6 Engaging with residents outside of the inspection process

At all times, the Chief Inspector welcomes information or feedback from residents about their experiences of living in a designated centre or about the inspection process. Since the regulation of designated centres for people with disabilities began, the Chief Inspector has taken a number of steps to engage proactively with residents and national advocacy bodies.

Throughout 2019 and in January 2020, inspectors met with 171 residents through 18 resident forum meetings throughout the country. Feedback from residents was analysed during 2020 and the following key areas were identified as being important to residents:

- my rights
- people who are important to me
- my community
- my home.

The findings were presented in the Disability Services Resident Forum Meetings report, which was published by HIQA on Unitied Nations International Day of People with Disabilities, 3 December 2020, and is available on the HIQA website. This report represents the voices of residents whom HIQA engaged with outside of the inspection process. The report also included a number of key actions to be undertaken by the regulator during 2021 based on residents' feedback.

Plans to undertake a further round of meetings with residents during 2020 had to be postponed due the the the impact of COVID-19. However, inspectors did conduct two pilot web-based meetings with residents with a view to using that format to undertake a more limited engagement with residents during 2021.

We continue to use the information and feedback provided by residents to improve the way we do our inspections. In light of the ongoing COVID-19 restrictions, we will continue to explore alternative ways of engaging with residents outside of the inspection process in 2021.

Chapter 3: Provider engagement and feedback

3.1. Introduction

During 2020, the Chief Inspector prioritised engagement with providers, the HSE and the Department of Health, as a way to share critical information about the management of COVID-19 in centres for people with disabilities.

3.2. Provider representative forum

Since the commencement of regulation in centres for people with disabilities, representatives of the Chief Inspector have been meeting quarterly with representatives of the main provider umbrella bodies. This forum currently consists of representatives from the National Federation of Voluntary Service Providers, the Disability Federation of Ireland, the National Disability Services Association and the HSE in their role as the service provider.

During 2020, given the impact that the pandemic was having on people with disabilities living in designated centres, the frequency of meetings with this group was increased to monthly and the meetings were conducted by web-based video conferencing.

As well as sharing information, provider representatives also gave feedback to the Chief Inspector on the challenges for providers in managing the risk of COVID-19. Through this forum, the Chief Inspector's representatives answered queries and provided clarification to providers in areas such as the revised arrangements for inspection activity during the pandemic and changes to requirements for providers to submit notifications.

3.3. Infection Prevention and Control (IPC) Hub webinars

In addition to advice and support to providers by the IPC Hub, staff from the Hub hosted four webinars to inform providers about the COVID-19 assurance framework which had been developed to assist providers in managing the risk of COVID-19. The interactive nature of the webinar provided the opportunity for two-way engagement and for the sharing of information.

The webinars were attended by 1,379 staff from provider organisations, including 44% from disability services. Feedback from attendees was very positive with many saying they found it very informative.

Chapter 4. Analysis of regulatory compliance in designated centres

4.1 Introduction

In 2020, inspectors undertook 750 inspections and this chapter provides information on the findings of these inspections. 80% (597) of inspections were announced while 20% (153) were unannounced. The majority of the inspections occurred in the period between 1 January 2020 and 12 March 2020. From that date, inspections moved from a programme of routine inspections to a risk-based programme of short notice announced inspections.

In the context of the pandemic, short notice announced inspections were utilised to provide an opportunity for service providers to make suitable arrangements for the inspection to proceed safely. This meant that providers could alert residents or their families that an inspector would be on site and enabled the provider to advise the inspector in advance of the inspection about whether there was either a confirmed or suspected case of COVID-19 in the centre.

The regulations discussed in this report were chosen because they are a good measure of the overall quality and safety of care and give us a picture of what life is like for residents in centres. The data presented below also demonstrates the continuing inequalities in the quality of care and support experienced by residents living in congregated settings compared to their peers who live in smaller, community-based settings.

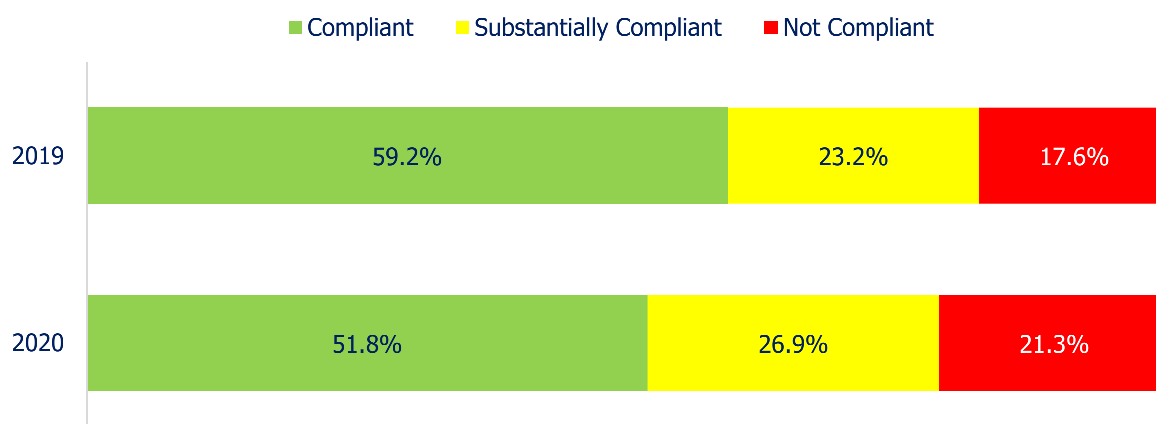
> The inspector found that governance systems in place ensured that service delivery was safe and effective through the ongoing auditing and monitoring of its performance.
> The inspector found that the person in charge had a clear understanding and vision of the service to be provided and, supported by the provider, fostered a culture that promoted the individual and collective rights of the residents living in this centre.
>
> Extract from inspection report in 2020

4.2 Governance and management

Good governance and management continues to be a fundamental cornerstone in the successful delivery of a good quality and safe service to residents living in designated centres, regardless of the setting. An effectively governed designated centre is typically one that is well managed with good internal systems and oversight which is subject to regular scrutiny and is capable of ensuring that residents' needs, wellbeing and quality of life are prioritised. This enables providers to take timely action to ensure that any deficiencies in the quality and safety of the care and support or in the day-to-day running of the centre are addressed in a timely manner.

Figure 5 below shows compliance findings against Regulation 23 on governance and management in 2019 and 2020. Concerningly there was a reduction in the overall level of compliance with this regulation in 2020 in comparison to the previous year. While this may have been impacted by the COVID-19 pandemic, it highlights the critical need for providers to continually review and assess the quality and effectiveness of their oversight and governance arrangements.

Figure 5: Comparison of 2019 and 2020 in relation to compliance with Regulation 23: Governance and Management



Examples of governance issues identified in inspection reports included providers who were undertaking a range of audits and reviews, but who were failing to take action to resolve issues identified. While most providers had good COVID-19 management plans in place, some providers did not have an effective service continuity plan, which was of particular concern during a pandemic. In addition, many inspections found that resources were not always in place to ensure that residents could be provided with a continuous programme of social engagement and

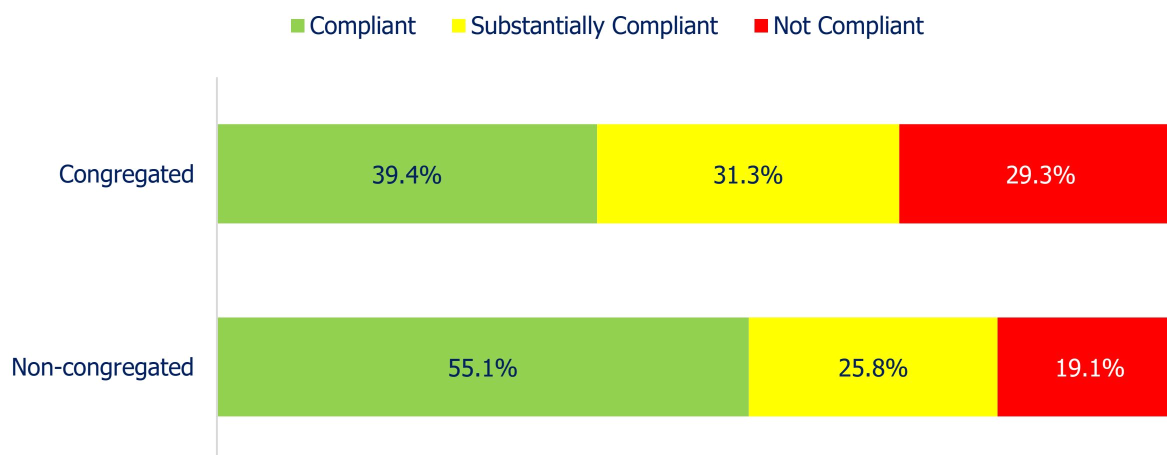
activities while not attending their regular day service or when isolating or cocooning in their home.

A comparison of the levels of compliance between community-based settings and congregated settings highlights the continued difference in levels of compliance with governance and management, and again demonstrates that residents living in congregated settings continue to be at higher risk of poor quality and safety in their services.

During 2020, inspectors found that provider governance arrangements in almost a third of congregated settings inspected were unsatisfactory

Figure 6). This was particularly evident in settings with a higher number of buildings or units or with a high number of residents. In many of these settings, inspectors found that the failure of provider governance systems were negatively impacting on both the residents' quality of life and the provider's level of compliance across other regulations.

Figure 6: Compliance with Regulation 23: Governance and Management in community settings and congregated settings



4.3 Staffing

Providers have a responsibility to ensure there are sufficient staff with the necessary experience and competencies to meet the needs of the residents living in the centre and which reflects the size, layout and purpose of the service. Each staff member has a key role to play in delivering person-centred, effective and safe care and support to residents living within centres.

Figure 7: Comparison of 2019 and 2020 in relation to compliance with Regulation 15: Staffing

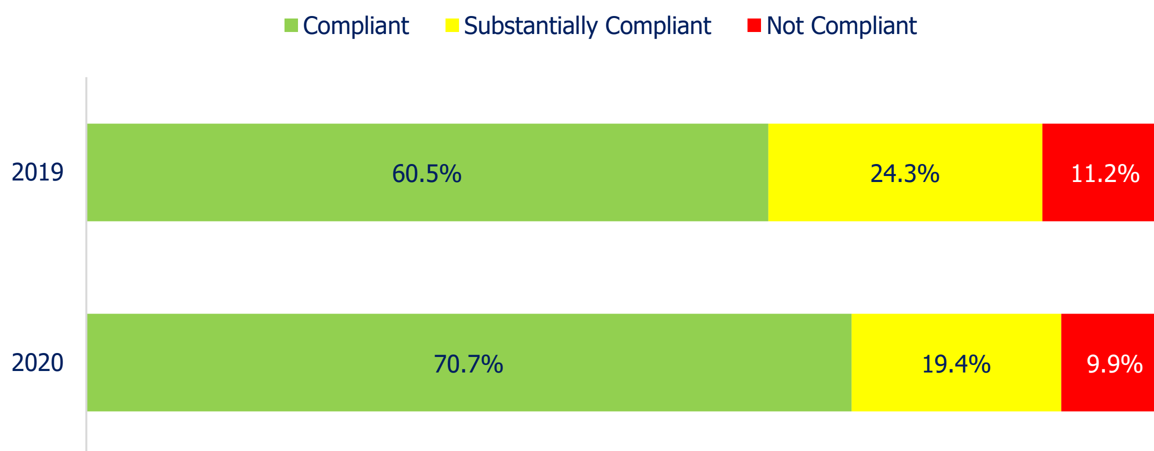


Figure 7 highlights that since 2019, providers have made improvements in the overall level of compliance against Regulation 15. Inspectors found the majority of centres were well managed with good systems and contingency plans in place during the COVID-19 pandemic, which included alternative arrangements in the event of staff shortages due to sickness. Some centres had a relief panel and some day service staff had been assigned to provide additional support in centres.

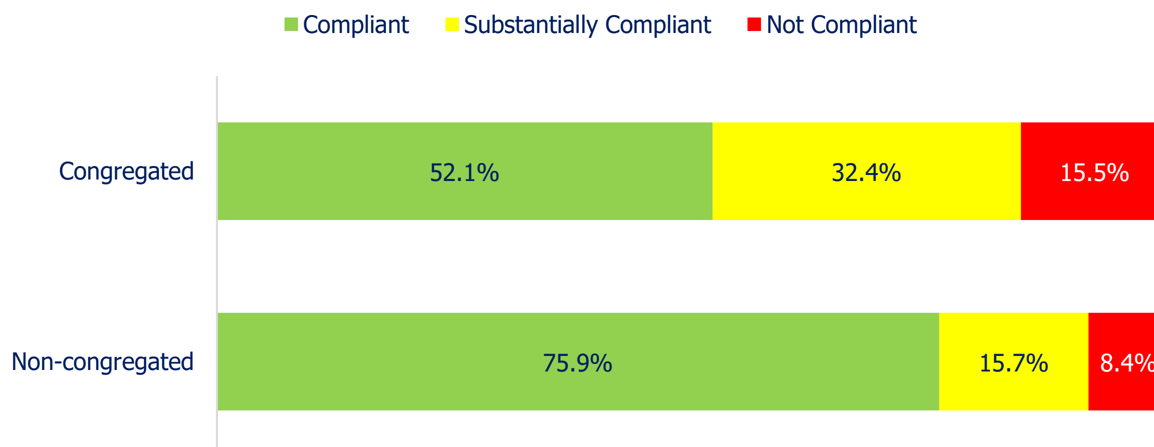
The inspectors viewed a number of compliments from residents' representatives in a number of centres and in relation to care and support for residents in the centre. They were particularly complimentary towards the dedication and support the staff team showed residents, especially during the COVID-19 pandemic.

Each of the residents spoke fondly of the staff team and the support they offered them. They were particularly complimentary towards how supportive staff were during some difficult times which they had encountered over the last number of months...They described how important it was to them to have someone to talk to, and to have staff who they could trust working with them. They described how staff in the centre listened to them and helped them when they had a complaint.

Extract from inspection report in 2020

During 2020, inspectors consistently found a higher level of non-compliance with staffing arrangements in a range of congregated settings (Figure 8).

Figure 8: Level of compliance with Regulation 15: Staffing in community settings and congregated settings



This was particularly evident in settings with a higher number of residents on large campuses.

> While the provider of a congregated setting had appointed a number of staff since the last inspection, there was evidence that there was still some reliance on volunteers to participate in the staff rota. This meant that the provider had not ensured that there were sufficient numbers of staff on duty at all times required.
>
> Extract from inspection report in 2020

In other examples of non-compliance, inspectors found that the changing needs of residents indicated more staff were required and staffing arrangements at night in some centres required review. Inspectors found that these providers were not reviewing staffing levels and, in some centres, there were insufficient staff numbers to meet residents' assessed needs, which prevented them from participating in regular and meaningful activities.

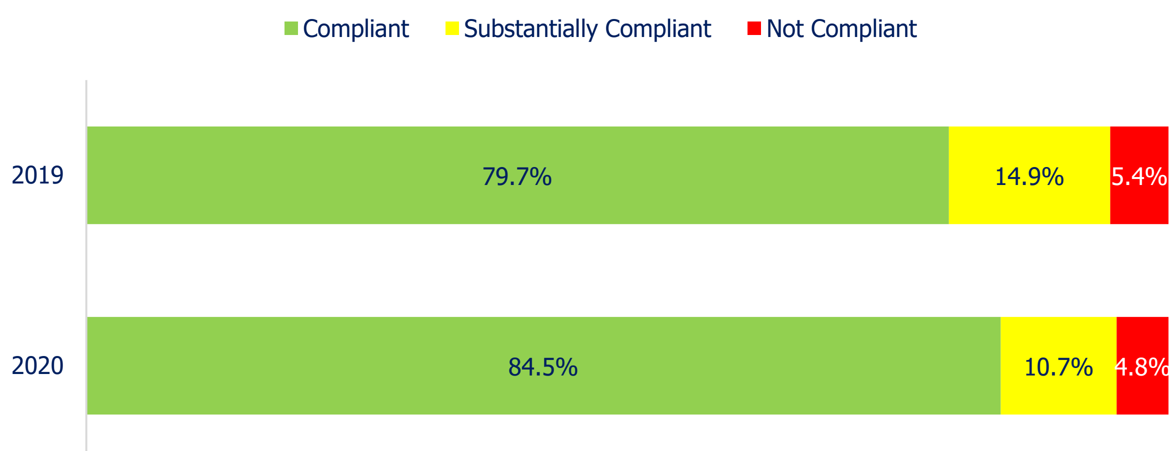
4.4 Infection Prevention and Control

This year, the quality and reesponsibility of providers' infection prevention and control measures have been continually tested as a result of the ongoing pandemic

and are a significant factor in preventing or controlling the risk of COVID-19. For the most part, inspectors found that providers were implementing the necessary protocols and guidelines in relation to good infection prevention and control to ensure the safety of residents during the COVID-19 pandemic and this was evident from the significantly lower rates of infection in designated centres for people with disabilities.

During 2020, despite the pandemic, there was a slight improvement in compliance against Regulation 27: Infection Prevention and Control (see Figure 14). For the most part inspectors found that designated centres had contingency plans in place that were effective, subject to regular review by senior management and able to provide appropriate guidance on the actions that staff should take in the event of an outbreak of infection within the centre.

Figure 9: Comparison of 2019 and 2020 in relation to compliance with Regulation 27: Infection Prevention and Control



For the most part, inspectors found that providers had ensured that residents who were at risk of healthcare-associated infections were protected by adopting procedures consistent with HIQA's *National Standards for infection prevention and control in community services* [3].

[3] https://www.hiqa.ie/sites/default/files/2018-09/National-Standards-for-IPC-in-Community-services.pdf

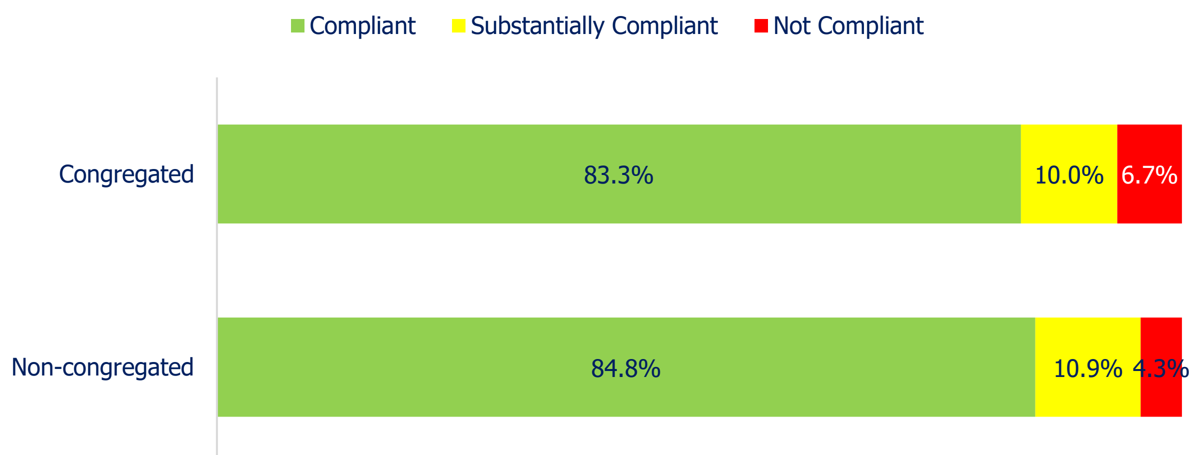
> There had been two separate infectious disease outbreaks in the designated centre within a short period of each other. On the day of the inspection, the inspectors found that the provider had oversight of the outbreaks and had corresponded with the appropriate services and carried out measures required to ensure the safety of residents. However, improvements were warranted with regards to the overall systems in place to ensure that residents were protected against infection at all times.
>
> Extract from inspection report in 2020

Providers who had good oversight and infection control measures in place were ensuring that there was timely access to personal protective equipment (PPE), good hand washing and sanitising arrangements, training in infection control measures, such as breaking the chain of infection, increased cleaning arrangments in designated centres and regular temperature checking of staff and residents.

Inspectors found that staff in most centres provided residents with easy-to-read information to support their understanding of COVID-19 and the restrictions in place.

However, in a small number of centres inspectors found that there were inadequate sanitising arrangements and staff were not adhering to best practice in the use of PPE while supporting residents.

Figure 10: Level of compliance with Regulation 27: Infection control and prevention, in congregated settings and community-based settings



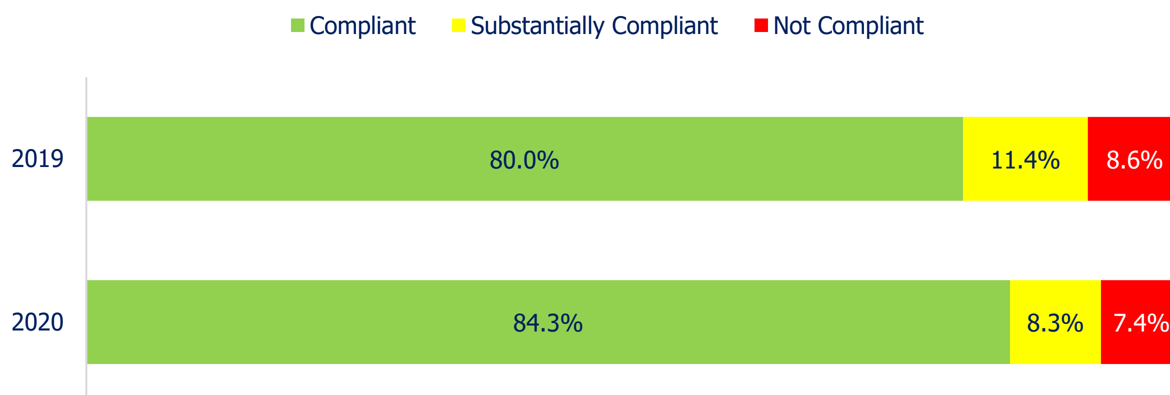
The overall level of compliance in infection prevention and control between congregated and community settings was very similar, with similar issues arising in non-compliant centres whether they were a congregated setting or not.

4.5 Safeguarding

The continued absence of specific safeguarding legislation remains a concern in relation to consistency and effectiveness of safeguarding arrangements. While the current regulations[4] place 35esponsibilities on providers to have arrangements in place to safeguard people with disabilities living in designated centres, further work is required to ensure that residents are being kept safe at all times. Overall, inspectors found that there was a small improvement in compliance with safeguarding during 2020 as can be seen in Figure 11 below.

[4] Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations, 2013.

Figure 11: Comparison of overall compliance against Regulation 8: Protection in 2019 and 2020

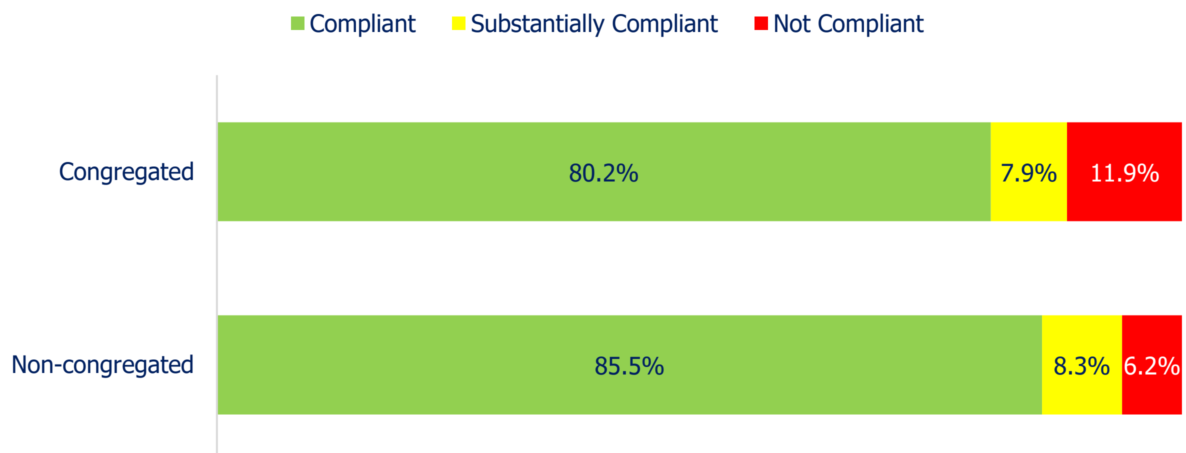


The safeguarding measures that a provider puts in place to prevent and protect residents from abuse remains a core requirement of a safe service. In the event that a resident experiences harm or abuse, how a provider responds is a key consideration in determining the level of compliance against the safeguarding regulations. Inspectors found that providers with good safeguarding arrangements, were responsive to emerging issues and continuously demonstrated the capacity and competence within their workforce and leadership arrangements to put suitable safeguarding plans in place.

> The provider made arrangements for each resident and/or their representative to be assisted and supported to develop the knowledge, awareness, understanding and skills needed for care and protection. Staff worked closely with residents around protection and safeguarding issues. Staff had received the appropriate training in this area and records were maintained of such training.
>
> Extract from inspection report in 2020

In 2019, inspectors found 20% non-compliance with Regulation 8: Safeguarding in congregated settings. This clearly demonstrated the increased risk to residents who live in congregated settings. While there has been significant improvement in the level of compliance in 2020 as can be seen in Figure 12 below, the figure for non-compliance remains significantly higher at nearly double the level of non-compliance found in community-based settings.

Figure 12: Level of compliance with Regulation 8: Protection in congregated settings and community-based settings



The main safeguarding concerns arising in community settings during 2020 were in relation to residents' compatibility. While compatibility issues were also prevalent in congregated settings, risk of institutional abuse was an additional safeguarding risk in some larger campus settings.

For example, on one inspection the provider had not ensured that the premises was being well maintained which resulted in residents living in very poor conditions. As a result of this ongoing failure by the provider, the inspector made a referral to the National Safeguarding Office due to concerns that this failure was an indication of potential neglect and a form of institutional abuse.

> There were safeguarding plans in place for residents following identification of risks, however at the time of inspection there was evidence that the risk of potential institutional abuse had not been adequately addressed. It was found that residents were experiencing reduced quality of care with insufficient staffing, rigid routines, and limited choice.
>
> Extract from inspection report in 2020

It remains clear from the inspections conducted during 2020 that residents who live in congregated settings are at increased risk of being exposed to safeguarding issues. In addition, where these issues occurred, some providers failed to demonstrate an ability to take appropriate and effective action to identify the safeguarding concerns and take action to protect these residents from harm.

4.6 Positive Behavioural Support

In 2019, HIQA launched guidance on a 'Human Rights-based Approach in Health and Social Care Services' [5]. This guidance, developed in partnership with Safeguarding Ireland, and part funded by the Irish Human Rights and Equality Commission (IHREC), supports providers to develop a human rights-based approach within their services. Such an approach seeks to ensure that the human rights of people using health and social care services are protected, promoted and supported in practice, and embedded in the culture of the service.

One indicator of how a provider works with residents to ensure their rights are protected is compliance against Regulation 7: Positive Behavioural Support. This regulation requires providers to work with residents in order to understand and alleviate factors which may result in behaviour that may challenge. Providers are required to ensure that staff are suitably trained and skilled in understanding, responding to and managing any behaviours that are challenging and are capable of intervening and using de-escalation techniques.

On occasion, a provider may determine there is a need to introduce restrictive practices for the safety of the resident. In such circumstances, providers must demonstrate that all other opportunities to explore and alleviate the underlying causes of the behaviour have been exhausted and all other alternative measures have been considered. In addition, the restriction on the resident's liberty should only be used for the shortest duration necessary and in accordance with prevailing national policy and evidence-based practice.

> Residents had behaviour support plans in place to provide guidance on promoting positive behaviour. These had been developed with input from relevant allied health professionals. Efforts had been made since the previous inspection to reduce the amount of restrictive practices in use in the centre.
>
> Extract from inspection report in 2020

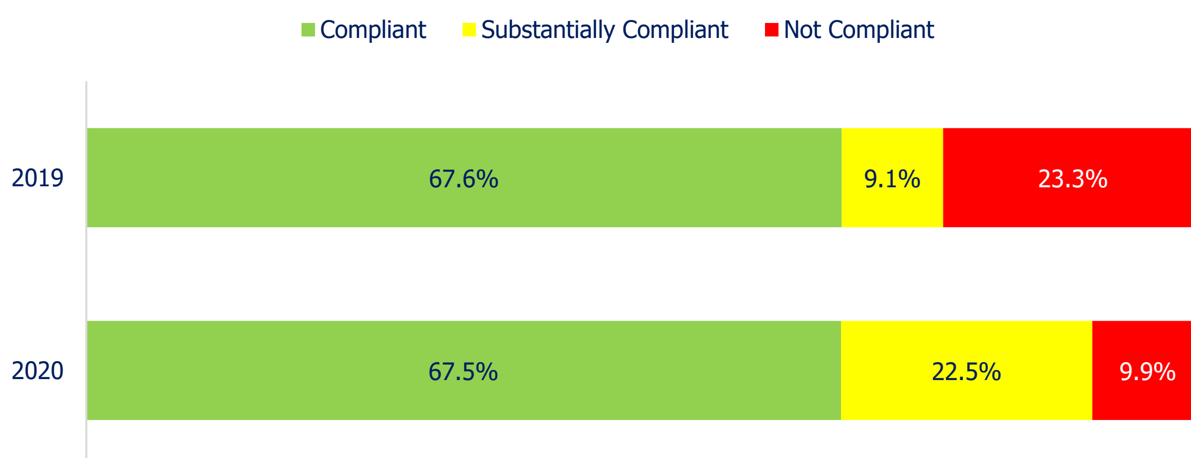
A provider's governance arrangements should therefore be capable of constantly monitoring the use of restrictive practices to ensure residents' rights are protected and promoted. Monitoring allows for identifying trends in the use of restrictive practices and also ensures that regular reviews of restrictive practice are conducted

[5] Guidance on a Human Rights-based Approach in Health and Social Care Services is available online at https://www.hiqa.ie/reports-and-publications/guide/guidance-human-rights-based-approach-health-and-social-care-services

with a view to promoting a restraint-free environment.

Figure 13 below demonstrates the significant improvements that have been made by providers during 2020 in relation to compliance with Regulation 7: Positive Behavioural Support. Inspectors found that providers who had good compliance in the management of behaviour that challenges, had structured routines and clear activities timetables based on the individual support needs of the resident. They also had behavioural support plans in place in the event of unfamiliar staff having to work in the centre because of staff shortages.

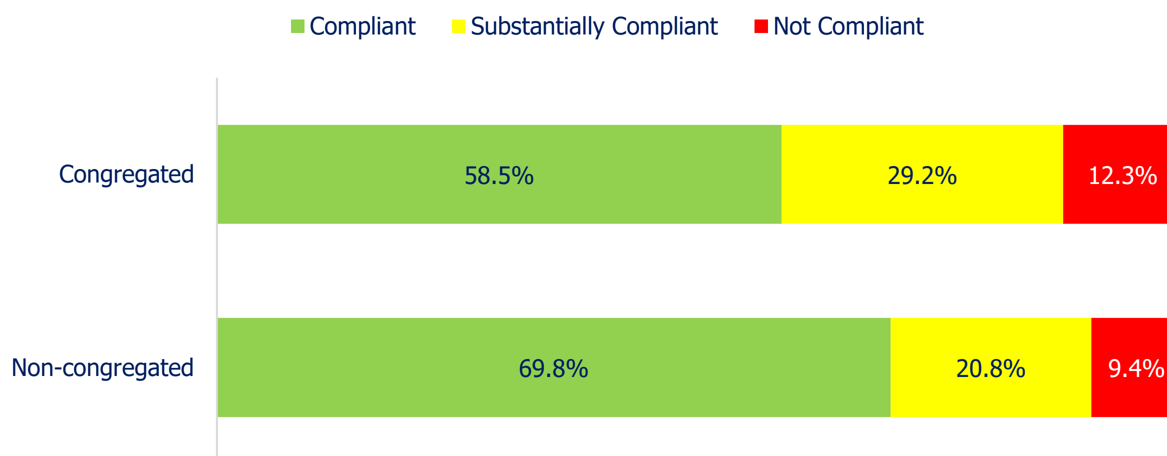
Figure 13: Comparison of 2019 and 2020 in relation to compliance with Regulation 7: Positive behavioural support



Inspectors found that the improvements in positive behaviour supports were across both congregated settings and community-based housing. Inspectors found that generally there was evidence of positive behaviour support plans for residents, where required. These plans guided staff in supporting residents to manage their behaviour.

However, in some cases improvements were required in the review and updating of safeguarding plans to ensure their ongoing relevance. Another area for improvement identified on a number of inspections was the management of the use of PRN (as required) medications. In some campus-based settings inspectors found behavioural support plans had not been reviewed by behavioural support specialists and there was an over reliance on restrictive practices.

Figure 14: Level of compliance with Regulation 7: Positive behavioural support in congregated settings and community-based settings

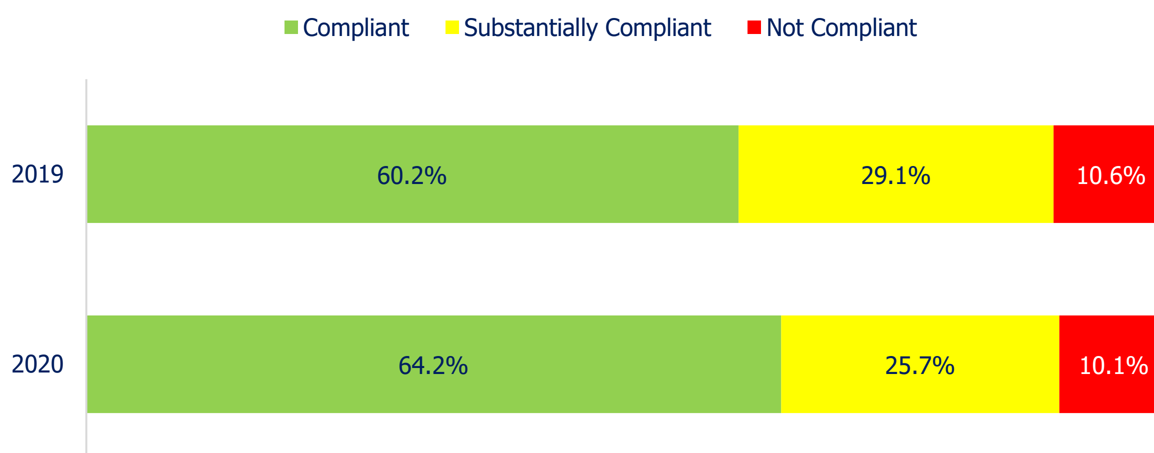


Providers in both community and congregated settings reported an unexpected positive outcome for a cohort of residents as a result of public health measures. Providers reported that some of these residents felt less rushed in the mornings as they did not need to get ready to leave their homes to attend their day programmes. Some residents also reported that they were enjoying a more relaxed, less active life, which they preferred. During this time, a number of providers in some centres reported a reduction in behaviour incidences and, in some cases, they were able to remove a number of restrictive practices. For example, one provider told inspectors that they were able to remove a plastic guard from the front of a communal television due to the reduction in the number of incidents in the centre.

4.7 Social care

Overall, inspectors found that the improvement in compliance against this regulation compared to previous years was small.

Figure 15:Comparison of 2019 and 2020 compliance with Regulation 5: Individual Assessment and Personal Plan

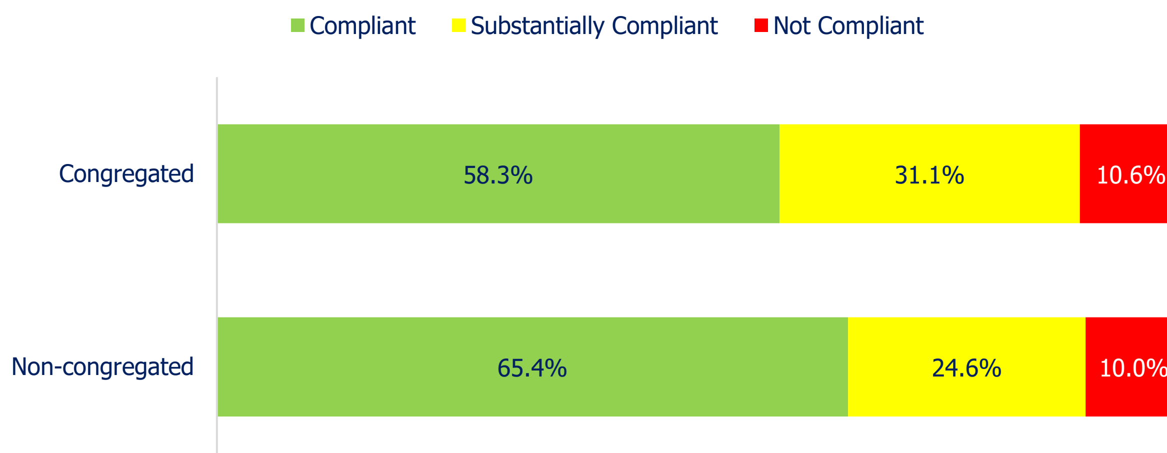


During 2020, inspectors reported that in centres that had good levels of compliance, residents' personal plans were detailed, reflected staff knowledge of the residents and were presented in an individualised manner. The plans were easy-to-read and accessible to the residents. Where they could, residents were encouraged to sign their plans to indicate their participation in their care. The residents' plans were updated to reflect the impact of COVID-19 restrictions on their normal routines and quality of life. For example, restricted access to their homes, peers and local communities.

Although improvements are still required in community and congregated settings, there was a marked improvement in the overall level of compliance in the management and delivery of social care in congregated settings. In 2019 for example, 26% of centres were non-complaint and found to have poor arrangements in place to assess and meet the social care needs of residents. As can be seen in Figure 16 below, this figure had reduced to 10.6%, which was more in line with the figure found in community-based settings. This meant that during 2020, residents in congregated settings were experiencing better personal planning, with more choice, independence and control in their daily lives than in previous years.

> This risk [of COVID-19 infection] in conjunction with the closure of favoured amenities resulted in staff coming up with alternative solutions that ensured that residents had the opportunity for meaningful and safe community access. Staff planned for trips and outdoor activities and had also created a step challenge between houses. The person in charge reported that in many ways this had resulted in healthier choices and activities with benefits for residents, for example in relation to better weight management.
>
> Extract from inspection report in 2020

Figure 16: Level of compliance with Regulation 5: Individualised assessment and personal plan in congregated settings and community-based settings



In relation to centres with non-compliance with this regulation, inspectors found examples of some residents who had been assessed as requiring specific supports with their health or social care, but this was not being provided and was not included in their support plans. In other examples, inspectors found that social care plans were not being reviewed to reflect the changing needs or interests of residents.

4.8 Visits

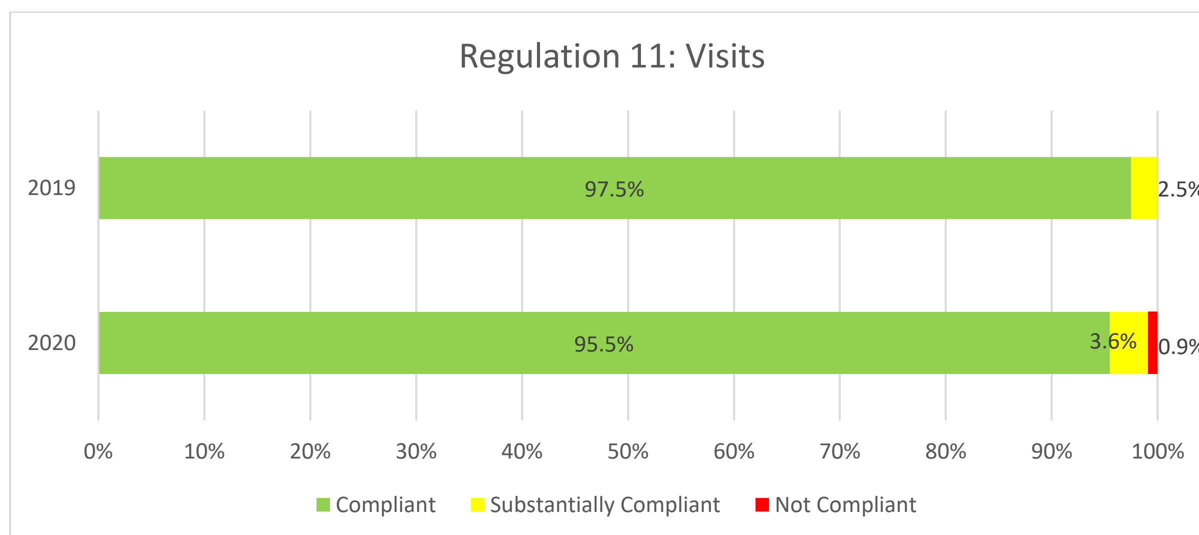
At the beginning of the first wave of COVID-19, the most vulnerable people in society, including those living in designated centres for people with disabilities were asked to cocoon in their homes and to limit the risk of contracting COVID-19 by reducing their potential exposure to the virus in the community. This meant residents living in designated centres could only leave their homes for essential reasons, including hospital or medical appointments. Many residents who had previously been involved in day-to-day activities that were very important to them, such as shopping for their own groceries, could no longer do so.

In addition to being asked to restrict their movements and to remain at home, in the early stages of lockdown all visits to designated centres, except visits on the grounds of compassionate reasons or emergencies, were stopped. For many residents, this meant for the first time in their lives they would not be able to see, hold or meet with their closest family or friends.

> There was no designated area in the centre that could facilitate private visits for residents and their family and friends that was not their own bedroom. This was also secondary to the premises being too small for the number of residents living there.
>
> Extract from inspection report in 2020

Throughout this time, in the majority of centres, inspectors found evidence that residents and their representatives were kept informed of updates or changes in the public health guidance on visitors. However, the overall level of compliance in 2020 with this regulation was only slightly impacted by the national restrictions. Inspectors found that most providers proactively found alternative ways to ensure that residents were able to maintain meaningful relationships with people important to them, as can be seen in Figure 17 below.

Figure 17: Comparison of 2019 and 2020 overall compliance with Regulation 11: Visits

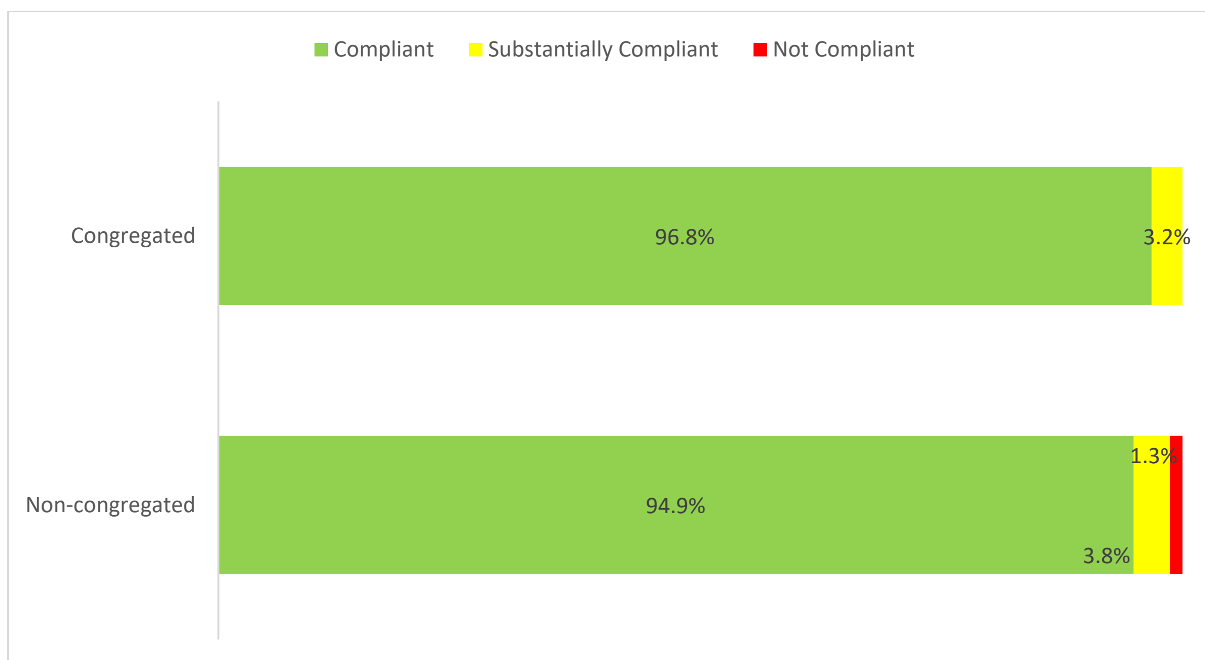


Inspectors found that during the early phases of public health restrictions, providers actively explored and introduced many different ways for residents and their families to maintain meaningful contact using telephones, their own handheld devices or video calls. When restrictions began to ease, and when additional guidance was issued by Public health on visiting arrangements to residential care facilities, inspectors saw that overall, providers ensured that residents were able to recommence window visits, 'drive-by' visits and eventually face-to-face vists once again.

> Residents had been supported to maintain contact with family members during the pandemic restrictions. Staff had facilitated some residents to maintain home visits following risk assessments while ensuring adherence to public health guidelines. In addition, guidelines for visits to the designated centre were clearly outlined for residents and reflected individual requirements.
>
> Extract from inspection report in 2020

Figure 18 below demonstrates that there was a very slight level of non-compliance in community-based settings in relation to Regulation 11.

Figure 18: Level of compliance with Regulation 11: Visits in congregated settings and community-based settings

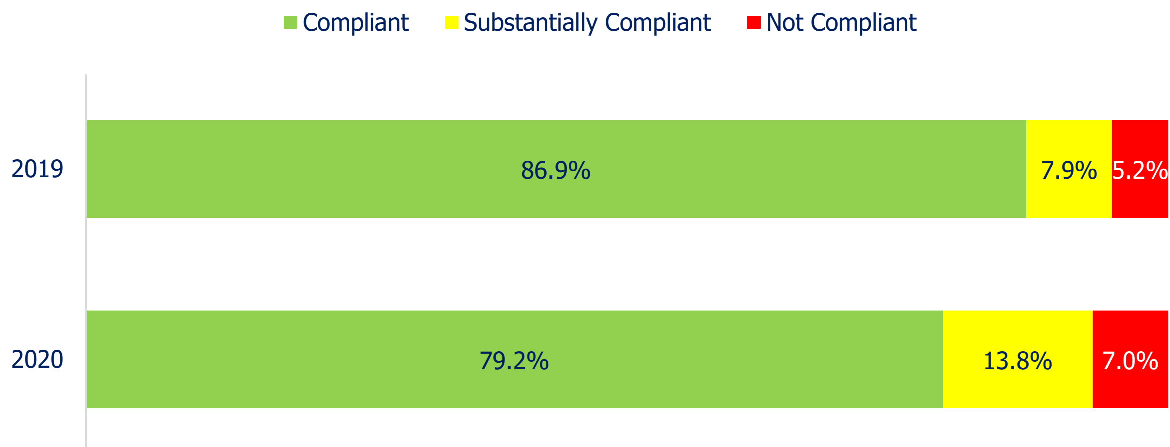


4.9 General Welfare and Development

In 2020, there was a further deterioration in the overall level of compliance with Regulation 13: General Welfare and Development. While the level of non-compliance is low, this is the second year in a row that there has been a recorded deterioration in the overall level of compliance in this area and indicates that some providers are failing

to ensure that they are actively monitoring and adapting resources in centres to respond to changing care and support needs of residents.

Figure 19: Comparison of 2019 and 2020 overall compliance with Regulation 13: General welfare and development

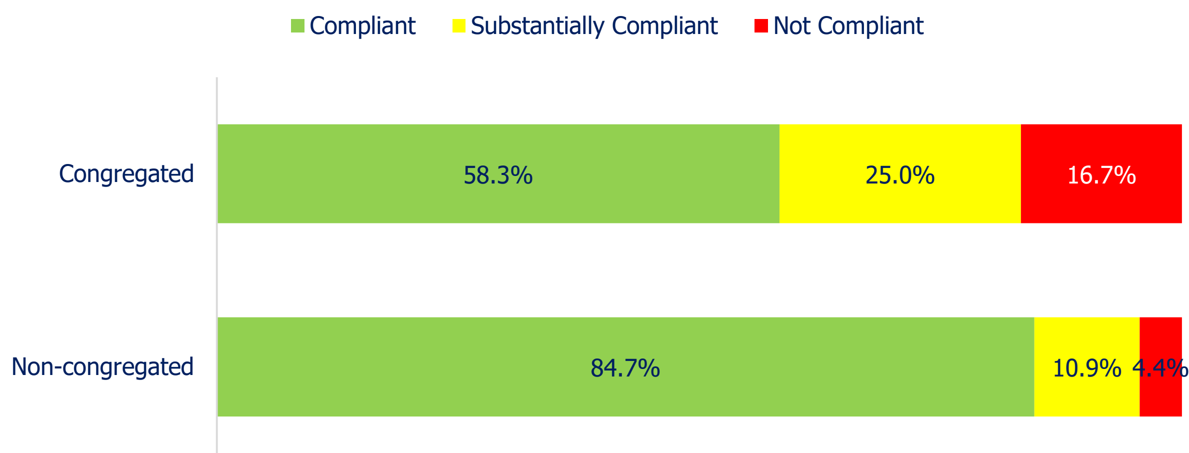


During COVID-19, some providers redeployed their day centre staff to work in their residential services in order to provide additional support for residents. In many instances, this meant that residents had a variety of things to do during the day which were outside of the structure of their usual day services. It is important to note that most providers ensured residents were provided with opportunities to participate in activities in accordance with their choice, albeit in a different way than they had previously experienced.

Although, as noted in Figure 20 below, there continues to be a variation in the overall level of compliance between congregated and community settings, the level of non-compliance noted in congregated settings has significantly reduced from the 29.7% non-complaince rate found during 2019. This indicates that providers have started to work on addressing the inequalities experienced by residents living in congregated settings.

> Residents access to facilities for occupation and recreation, had been curtailed due to COVID-19. Nonetheless, residents went for walks, enjoyed baking, and took part in table top activities. In particular, residents enjoyed the one-to-one time with staff. This was helped by the redeployment of day centre staff to the residents home. This resulted in a higher resident to staff ratio than there would be ordinarily.
>
> Extract from inspection report in 2020

Figure 20: Level of compliance with Regulation 13: General welfare and development in congregated settings and community-based settings



In general, inspectors found that in community settings residents were more likely to have increased choice of activities and access to their local communities, while in a number of congregated settings residents had limited options to participate in activities of their choosing and reduced opportunities to build relationships in the wider community. For example, on one inspection in a congregated setting, inspectors found that there were extended periods durng the week when residents had no access to activities either inside or outside their home. Some residents told inspectors that they had planned to go to certain activities that they enjoyed, but that staff were not available and their plans had to be cancelled.

4.10 Healthcare

Maintaining good health and wellbeing, with timely access to healthcare professionals and services are key elements of being able to live active lives for people with disabilities. Principles of good healthcare include health promotion, prevention, independence and meaningful activity. Services such as primary health care including GP visits, dental care or chiropody and factors including maintaining a healthy well-balanced diet, all contribute to the overall day-to-day health of a resident.

Timely access to secondary care services and specialist services, which include consultants and hospital inpatient treatment are also critical factors for many residents who may have complex and ongoing medical conditions. Providers are required to ensure that residents are supported to access and receive treatment, and to ensure that residents are supported to attend any regular or ongoing appointments.

Throughout the inspections completed during 2020, inspectors consistently found that providers were ensuring that residents received appropriate healthcare in accordance with their assessed needs. Inspectors found good improvements had been made in the levels of compliance against this regulation compared to previous years (Figure 21).

Inspectors saw examples of staff ensuring that residents could attend healthcare appointments while also making sure that measures were taken to implement the recommendations from those appointments. As shown in Figure 22 below, the levels of compliance across congregated and community settings were broadly comparable. This meant that residents in both types of settings were receiving similar levels of health and wellbeing support, and that for the vast majority of these residents, this was of a good quality.

Figure 21: Comparison of overall compliance against Regulation 6: Healthcare in 2019 and 2020

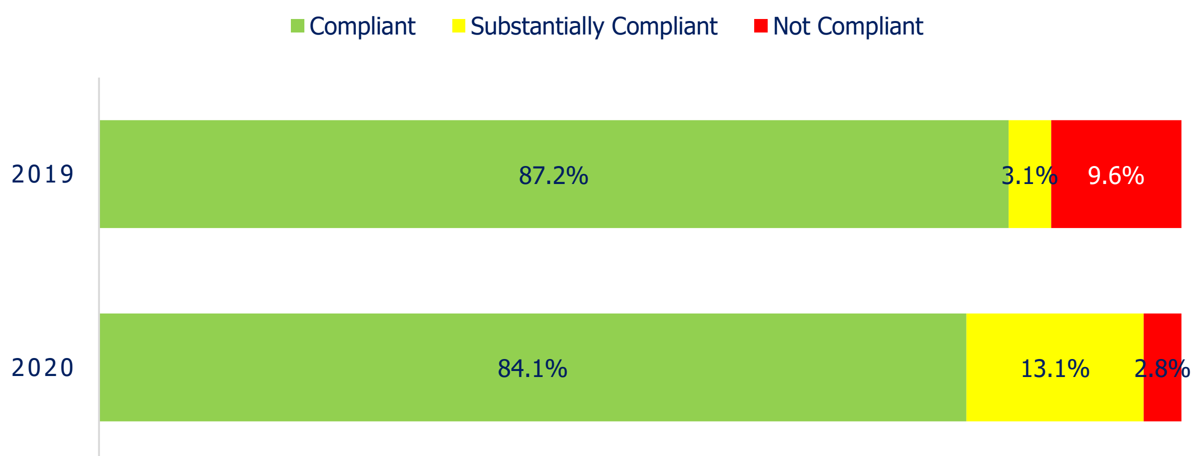
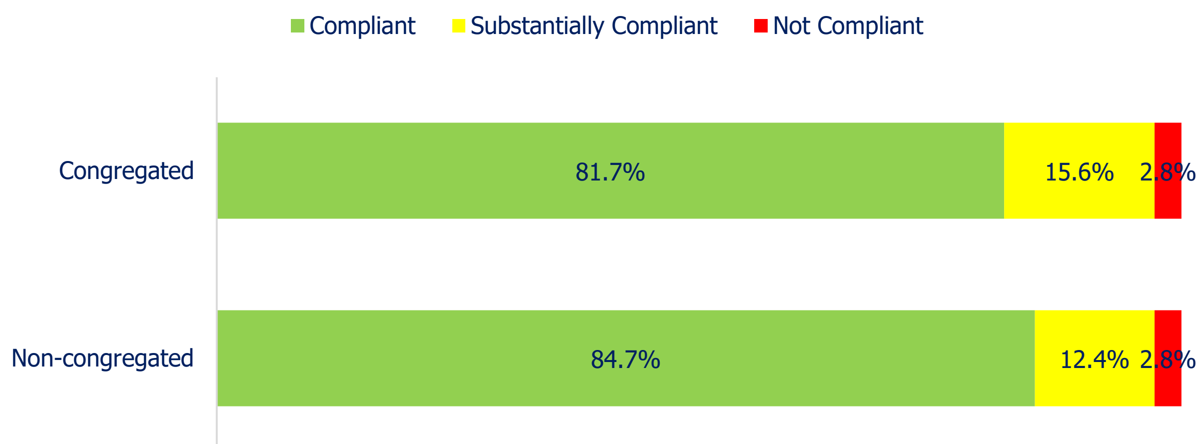


Figure 22: Level of compliance with Regulation 6: Healthcare in congregated settings and community-based settings



From a sample of residents' personal plans the inspectors found that each resident had access to allied health professionals including access to their general practitioner (GP). Where appropriate residents were supported to attend appointments with their psychologist, occupational therapist, chiropodist, social worker and speech and language therapist. Residents were provided with a hospital passport to support them if they needed to receive care or undergo treatment in the hospital.
Extract from inspection report in 2020

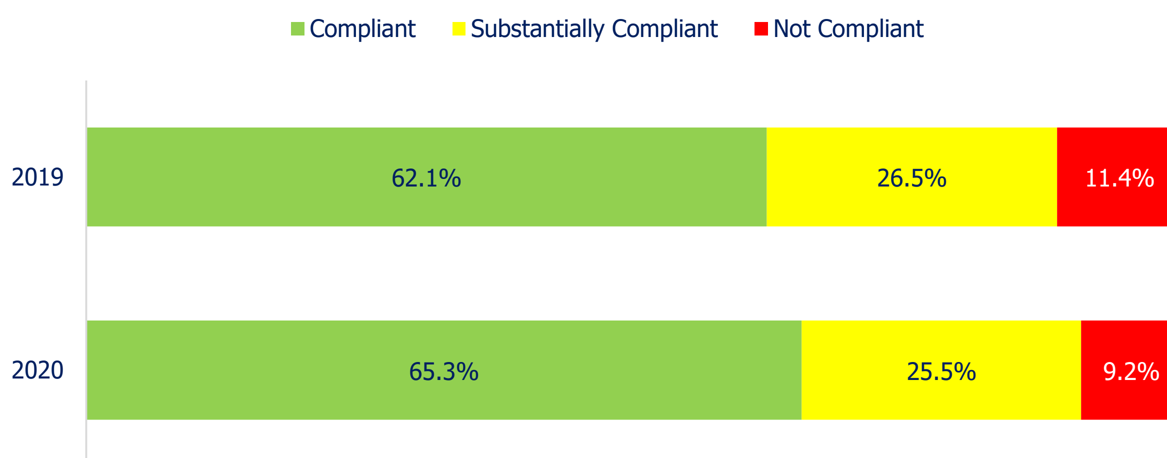
While the progress towards and impact of good health provision was very positive for the vast majority, in some instances, inspectors found improvements could be made by providers in relation to ensuring appropriate guidance was in place to guide staff should the residents require an emergency response or life-saving treatment, such as the emergency administration of anti-epliepsy medication.

4.11 Risk management

Operational risks, their detection, management and control are all critical features of a provider's overarching governance arrangements and if done well, ensure that the overall day-to-day operation of a centre is safe and consistent. When issues arise, the provider has ensured that they have the capacity to respond. Providers who fail to ensure the effective detection and control of hazards, increase the risk of harm to both the operation of the service, to their staff and most importantly to residents.

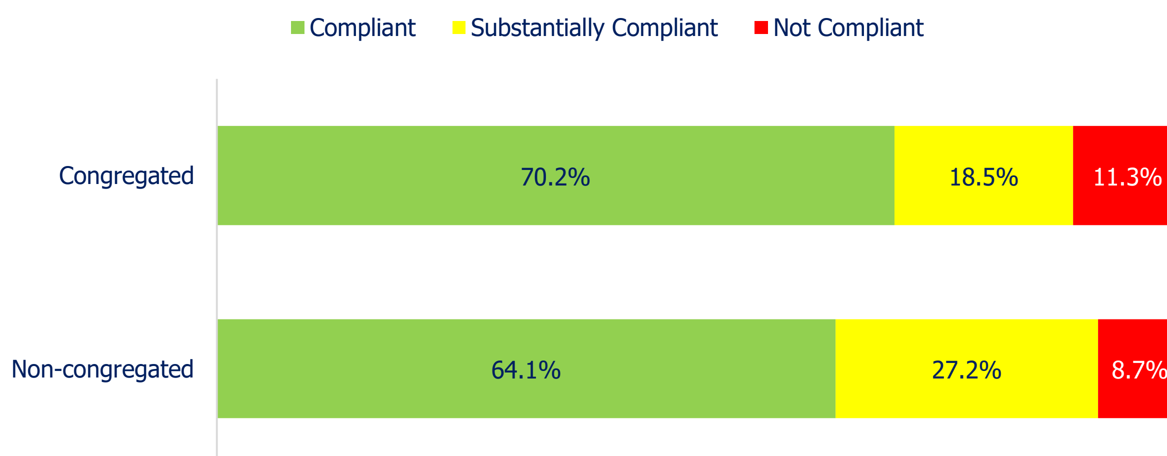
Effective management of risks in centres ensures that there is a good balance between safeguarding residents from harm and positive risk taking. In positive risk taking, a risk-averse culture is avoided and residents' abilities are recognised and they are supported and encouraged to be independent. In 2020, as demonstrated in Figure 23 below, the overall compliance level with Regulation 26: Risk Management procedures improved.

Figure 23: Comparison of 2019 and 2020 overall compliance with Regulation 26: Risk Management



In addition, inspectors found that this improvement occurred in both congregated settings and community-based centres .

Figure 24: Level of compliance with Regulation 26: Risk management procedures in congregated settings and community-based settings



In 2020, providers were faced with perhaps their biggest challenges to date in terms of risk management, mitigation and control. In the context of preventing the risk of

an outbreak of COVID-19, ensuring operational resilience and continuity of staffing and providing a safe and effective service to the residents. The majority of providers were able to demonstrate good and effective control measures and timely actions to mitigate or eliminate the risk of infection.

> The provider had reviewed the risk management register when the COVID-19 pandemic began and a risk assessment regarding COVID-19 had been carried out... This risk assessment was updated regularly in line with public health guidelines and included infection prevention control training for staff and cleaning regimes.
>
> Extract from inspection report in 2020

Compliant providers kept their risk assessments and the associated control measures under regular review and could demonstrate how risks could be escalated from their front-line services and resolved either locally or through senior management input.

This ensured that there was a good flow of information from 'floor to the board' and that risk management plans remained active and up to date.

However, in some centres, providers had failed to ensure that there was an adequate risk management policy and inspectors found a poor risk management culture and ultimately a failure to adequately address and mitigate risk. For example, the findings in one centre lead to an increased programme of risk-based inspections across a number of one provider's designated centres. Worryingly a number of consistently poor findings were made in each of these centres. Inspectors took immediate action to require the provider to improve their arrangements to keep residents safe and the Chief Inspector took escalated regulatory action, which resulted in the provider being issued with warning letters for a number of their centres.

> Risk management procedures required improvement to ensure that all risks were identified and more importantly a clear control measure was implemented to manage each risk. For example, COVID-19 related risks, residents with behaviours of concern, compatibility of residents, fire/evacuation, food safety all required further review. Some of these areas had not been assessed as risks and others were found to have absent or inadequate assessments and/or control measures.
>
> Extract from inspection report in 2020

Further information on escalation and enforcement is provided in Chapter 6.

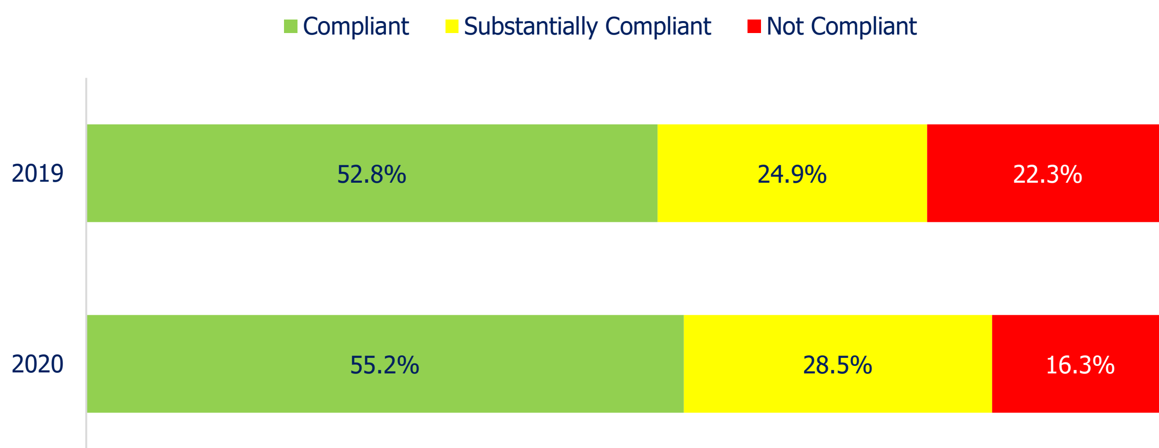
4.12 Fire safety

Providers must have suitable arrangements in place to manage the risk of fire and ensure residents are safe in their homes at all times. Providers are required to ensure that their staff are adequately trained so that they are able take necessary actions to raise an alarm and respond to a fire, competently use any emergency equipment and are able to effectively support residents to evacuate the centre in the event of a fire emergency.

> There were established fire safety arrangements in place, including appropriate measures to detect fire, fire fighting equipment and containment measures. Residents took part in planned emergency evacuations drills, and there were individual evacuation plans in place for each resident. There was adequate means of escape including emergency lighting. Staff received appropriate fire prevention and emergency evacuation training.
>
> Extract from inspection report in 2020

In 2020, providers continued to address areas for improvement noted in 2019. As can be seen in Figure 25, the continued focus by providers has led to an overall improvement in the quality of fire safety measures in designated centres.

Figure 25: Comparison of 2019 and 2020 compliance with Regulation 28: Fire precautions



In 2020, there were 31 centres which had restrictive conditions of registration requiring providers to improve fire safety measures in their centres. These conditions

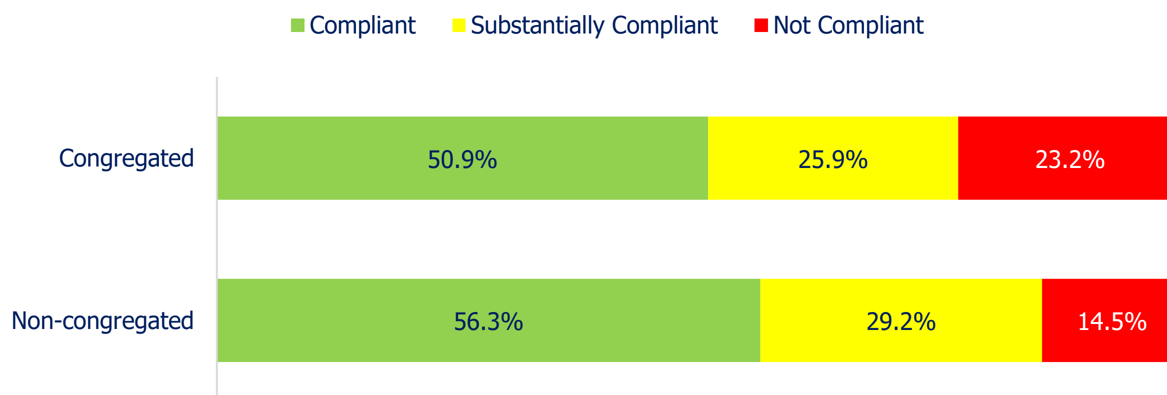
included a requirement for the provider to ensure that there were sufficient arrangements in place for detecting and containing a fire or for safely evacuating the centre in the event of a fire.

It is concerning to note that areas of common non-compliance continue to be identified by inspectors during inspections. Although not an exhaustive list, examples of these included:

- fire alarm and detection systems in place which did not comply with the required standard
- appropriate emergency lighting not fitted both inside and outside of the centre, which would illuminate all emergency exit routes
- fire doors not installed in critical risk areas such as kitchens
- self-closing mechanisms had not been fitted to all fire doors.

While there was an improvement noted in the overall level of fire safety measures within congregated settings in 2020, just under one quarter of congregated settings that were inspected continued to be assessed as non-compliant.

Figure 26: Level of compliance with Regulation 28: Fire precautions in congregated settings and community-based settings



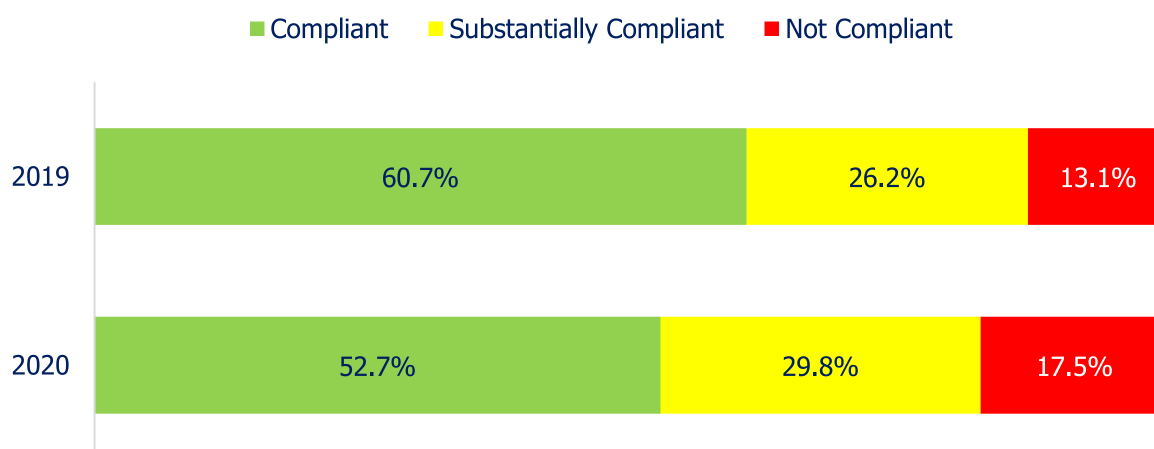
This meant that although some providers had taken steps to ensure fire safety management systems were in place, residents living in these centres continued to be exposed to an increased risk of experiencing a negative consequence, in the event of a fire.

4.13 Premises

During 2020, inspectors found that there had been a deterioration in compliance with Regulation 17: Premises, as illustrated in

Figure 27. Inspectors found that the general maintenance and overall upkeep of the premises had been impacted by COVID-19, which meant that many planned and scheduled works had to be cancelled due to public health restrictions.

Figure 27: Comparison of 2019 and 2020 overall compliance with Regulation 17: Premises

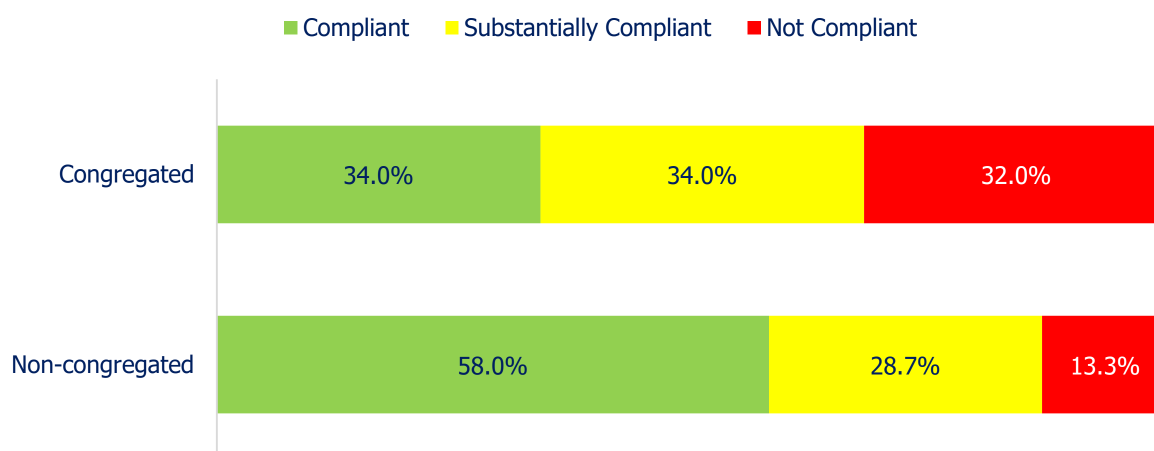


Residents in congregated settings experienced the impact of a higher level of non-compliance in relation to the standard and upkeep of their homes, as can be seen in Figure 28 below. The higher level of non-compliance in congregated settings continues to be of significant concern, despite some improvements. Providers in a cohort of these settings are failing to ensure that the living environment is homely,

> The centre was homely, clean and maintained to a good standard. However, the number of showers to meet the needs of residents was insufficient and some areas of the centre required upkeep.
>
> Extract from inspection report in 2020

clean, suitably decorated and meets the needs of the residents who live there.

Figure 28: Level of compliance with Regulation 17: Premises in congregated settings and community-based settings



Some of the main issues identified in congregated settings were the institutional nature of the buildings and their lack of suitability to meet the needs of residents. For example, in some centres, the buildings are very large and old, are difficult to maintain and are unhomely. Residents in congregated settings sometimes do not have access to facilities within their home, such as a kitchen or washing machine and are dependent on centralised facilities.

Despite the global pandemic, many residents were able to continue with their plans to move out of congregated settings and into smaller homes in the community. Inspectors visit these new homes within a few months or when residents move in, to verify that the new arrangements are meeting the needs of residents. Some residents said that they liked their new homes and enjoyed choosing furnishings and decorations. Inspectors spent time observing other residents who were unable to communicate with the inspectors and found that they were settling into their new homes and they appeared very happy.

However, for a number of residents, COVID-19 and the national restrictions meant that their plan to move into their new homes was delayed, and while they understood and were kept informed about this, they expressed dissatisfaction to inspectors.

> Some residents were unhappy with the delays to their move into different accommodation, which was due to happen by the end of 2019. However, they felt informed about the delay and had regular meetings with the management team who were assisting them.
>
> Extract from inspection report in 2020

Chapter 5. Registration and inspection activity in 2020

5.1. Introduction to registration and inspection

The regulations are put in place by the Government and set out the minimum standard of safety, care and support that a provider must achieve for residents. Providers are responsible for complying with these minimum requirements and the Chief Inspector monitors compliance with the regulations. The national standards are developed by HIQA and mandated by the Minister for Health. They challenge providers to continually review and improve the quality of their services, and to go beyond compliance with the minimum requirements of the regulations.

In 2020, to support providers and staff of designated centres, we published a *Regulation Handbook* which can be found on the HIQA website, www.hiqa.ie. This handbook covers all aspects of registration and regulation by the Chief Inspector.

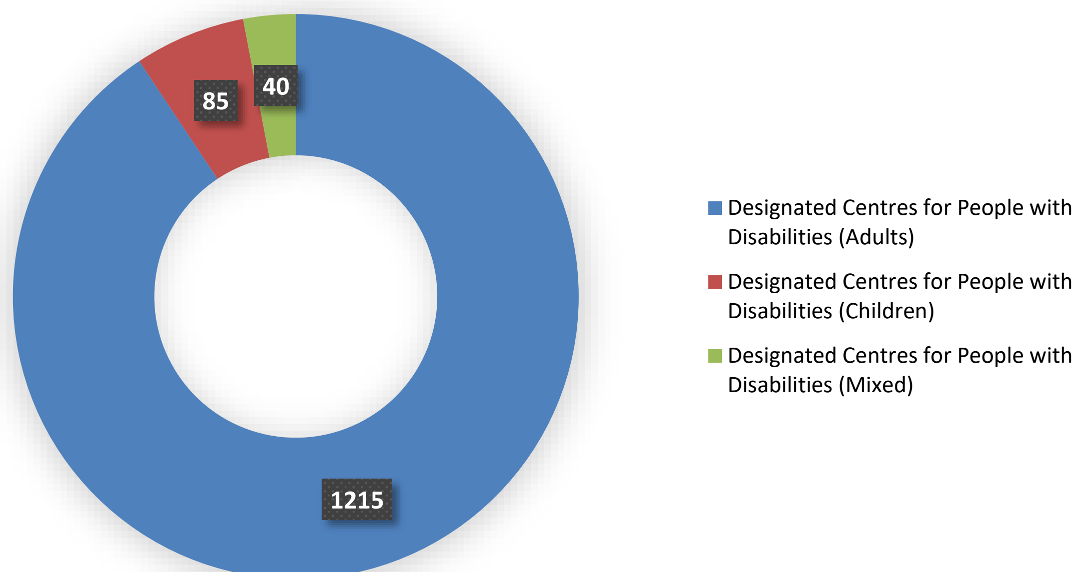
Designated residential centres for children and adults with disabilities must be registered by the Chief Inspector, and registration is granted for three years. The lived experiences of people with disabilities (such as maximising opportunities for greater independence and autonomy over their own lives in accordance with the preferences and wishes of residents and the nature of their disability) and how providers focus on improving the safety and quality of life for residents, are fundamental components of how the sector is regulated by the Chief Inspector.

5.2. The number and type of designated centres

By the end of 2020 there were 1,340 registered designated centres for people with disabilities in the Republic of Ireland, which represents an increase of 72 registered centres during the year. These centres provided residential accommodation for 9,166 people with disabilities compared with 9,064 residential places at the end of 2019, a growth of 1% in the sector.

Figure 29 provides a breakdown of the type of designated centres registered. Of these, 8,558 residential places were in centres for adults with disabilities, 351 were in children's centres and 257 were in mixed centres where both children and adults lived. Most of these mixed centres were respite services which provided breaks to adults and children separately.

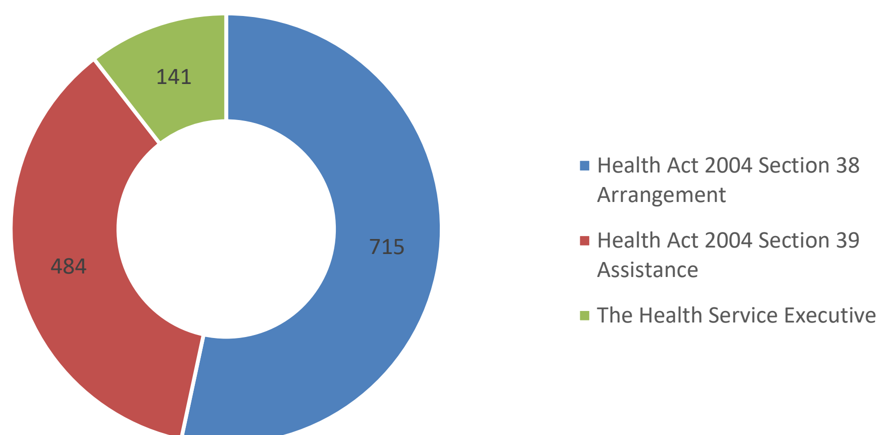
Figure 29: Number and type of designated centres for people with disabilities at the end of 2020



The increase in the number of designated centres can be partially attributed to the number of centres which were created to support residents to move out of larger congregated settings into more appropriate community settings. Other centres were opened to provide increased respite facilities, while others were opened to respond to the urgent requirement for residential care for people with disabilities. However, in response to the global pandemic, providers also opened six standalone centres. These centres were developed to provide isolation facilities for residents with COVID-19 as an alternative to isolating in their own home, or to enable an early discharge from hospital, should the need arise.

The funding arrangements for designated centres changed little in 2020, with most centres either being directly provided by the State through the Health Service Executive (HSE) or provided by organisations funded by the HSE. Figure 30 provides the breakdown of designated centres for people with disabilities by the type of provider funding model at the end of the year.

Figure 30: Number of registered designated centres for people with disabilities by provider funding type at 31 December 2020



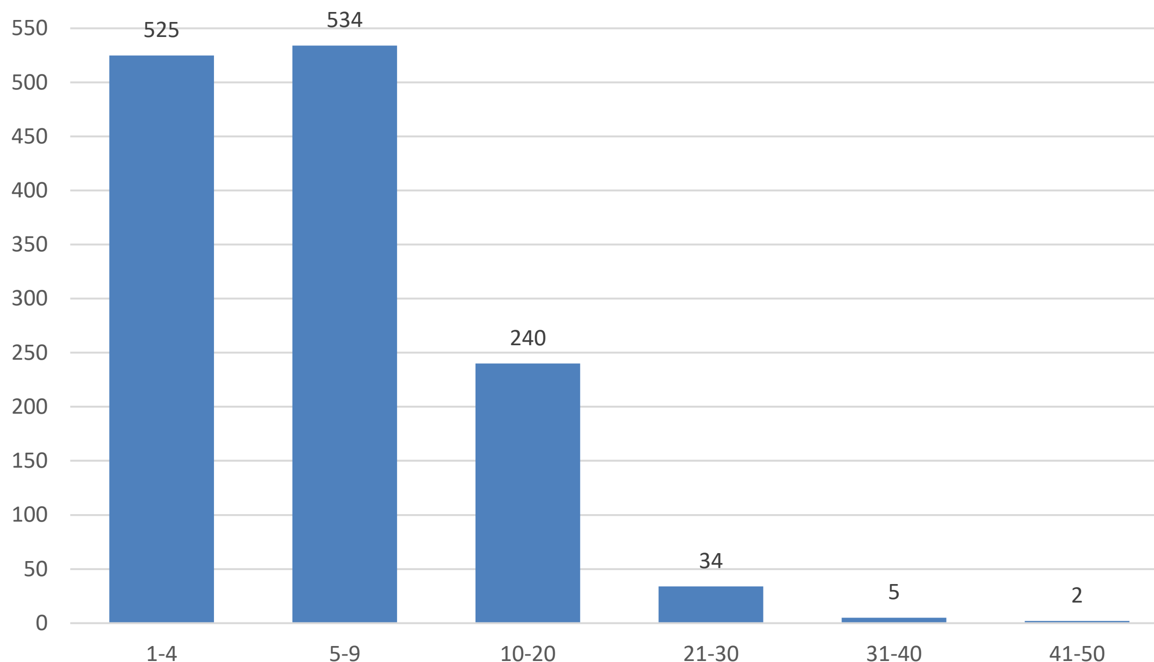
The HSE directly provided 1,151 residential places (12.6%) in a total of 141 centres. A total of 5,083 places (55.5%) were provided by organisations funded through HSE-funded section 38[6] arrangements in a total of 715 centres, and 2,932 residential places (32%) were provided through HSE-funded section 39[7] assistance in 484 centres.

5.3. The size of disability centres

Residential centres for people with disabilities range in size from single occupancy centres up to large congregated institutional settings (see Figure 31 for details). In addition, some community-based houses are grouped into a single designated centre and some designated centres are accommodated on the same campus. The Chief Inspector maintains an online register of all disability centres, which is available at www.hiqa.ie.

[6] Section 38 of the Health Act 2004 states that the HSE can have an arrangement with a person to provide a health or personal social service on behalf of the HSE.
[7] Section 39 of the Health Act 2004 states that the HSE can provide assistance to any person or body providing a similar service to the HSE.

Figure 31: The number of residential places in designated centres



Note: the figures on the top of each bar represents the number of designated centres. So, for example, there are 525 centres with between one and four places in each centre.

There has been little change in 2020 in the number of residential places located in congregated settings – a 2.5% decrease (2,914 in 2019 vs 2,841 in 2020). Of these 2,841 places, 2,196 residential places were in campus-based settings. Usually, these large campuses are divided into a number of centres and while the number of residents in each centre may vary, all of them are based on the same site. 645 places were in standalone congregated settings for 10 or more people.

5.4. Congregated settings

While there has been a continued effort, despite COVID-19, within the disability sector to reduce the number of large congregated settings, in line with national policy, many residents continue to be accommodated in congregated settings, as the above figures show. The national policy on congregated settings[8] defines a congregated setting as follows:

> Congregated settings are where 10 or more people with a disability live together in a single living unit or are placed in accommodation that is campus

[8] Health Service Executive. *Time to move on from congregated settings - A strategy for community inclusion*. Dublin, Health Service Executive; 2011. Available online from: https://www.hse.ie/eng/services/list/4/disability/congregatedsettings/time-to-move-on-from-congregated-settings-%E2%80%93-a-strategy-for-community-inclusion.pdf.

based. In most cases, people are grouped together and often live isolated lives away from the community, family and friends. Many experience institutional living conditions where they lack basic privacy and dignity.

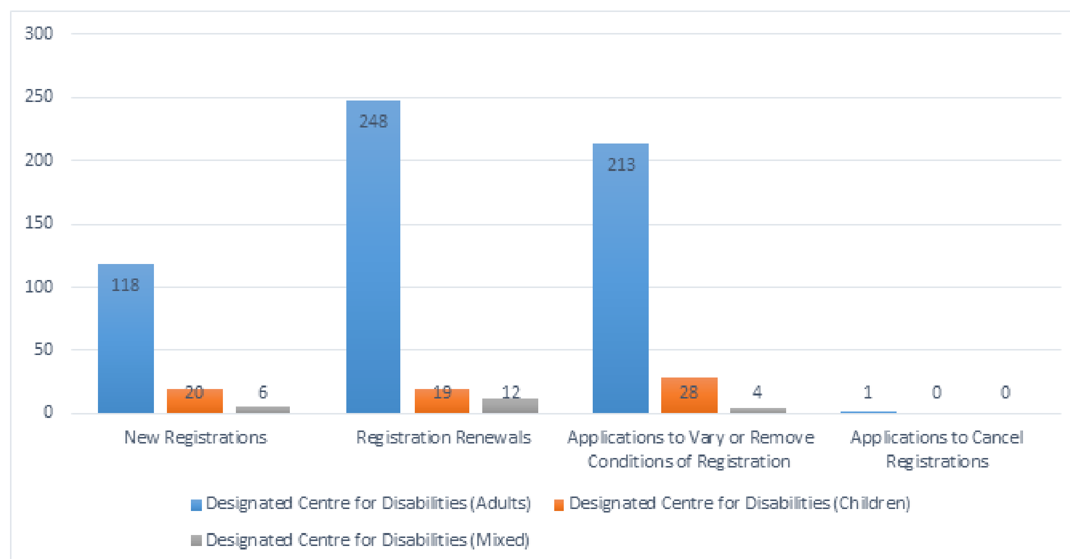
Our analysis for this overview report demonstrates that while providers have improved compliance with some regulations, overall residents who live in congregated or campus-based settings often experience inequalities in terms of the quality and safety of their services, control over their own lives and their ability to independently exercise their rights and choices.

5.5. Registration activity in 2020

Each designated centre is granted registration for three years and must then apply in advance to renew their registration. In 2020, there were 144 applications to register new centres, while 279 centres had their registration renewed.

Figure 37 shows the breakdown of the applications received across adult services, children's services and mixed services for people with disabilities, which indicates the level of registration related activity undertaken during the year.

Figure 37: Number of notices of proposed decision issued in 2020 by application type



A further 76 applications were made to vary the registration of existing centres in order to increase or change a centre's footprint and create additional capacity for the isolation and treatment of residents with COVID-19.

5.6. How we judge compliance

Inspection is a fundamental component of the assessment of compliance with regulations and national standards. We take a risk-based approach to regulation. Therefore, more frequent inspections are carried out in those centres which have higher levels of repeated non-compliance with the regulations and standards. We want to know that people who are receiving residential care and support:

- are safe
- have their human rights respected
- are included in decisions about their care and support
- are provided with care and support that matches their individual health and social needs
- are living in suitable, fit-for-purpose environments and
- have a good quality of life.

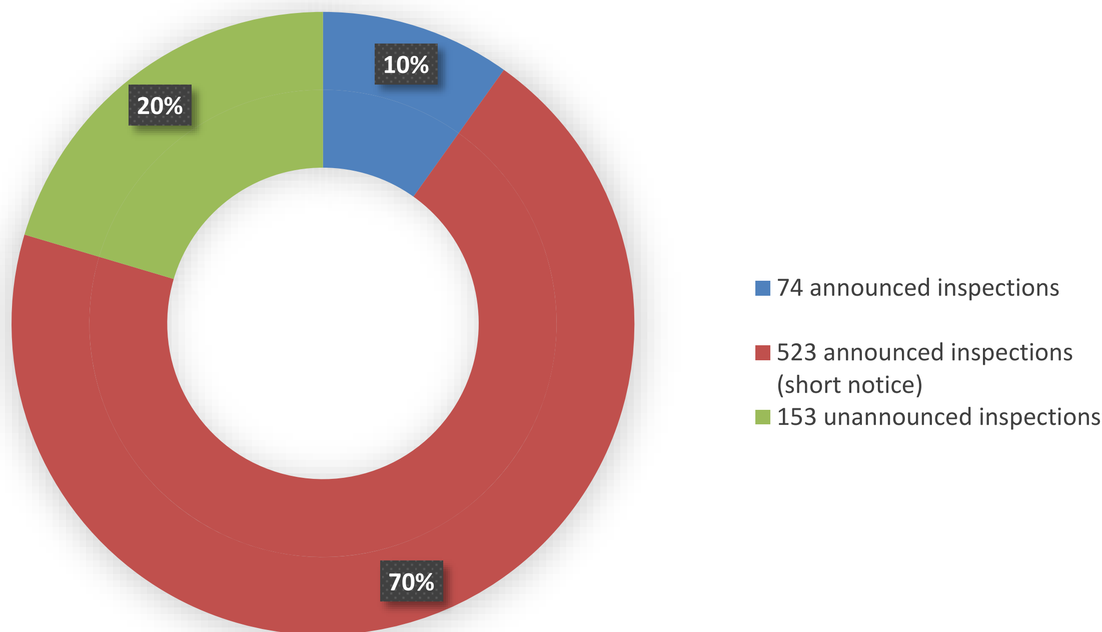
5.7. Inspection activity in 2020

On-site inspections allow inspectors to observe the daily routine of residents, to hear from them about what it is like to live there and to observe interactions between staff and residents. It also helps inspectors to judge the provider's compliance with the regulations and how their level of compliance affects the lived experience of residents. Inspections can be announced or unannounced.

From May 2020, inspections were primarily short notice announced inspections to ensure that arrangements were in place to minimise the risk of exposure or transmission of COVID-19. This also enabled residents and relatives to communicate their views of the centre to the inspector by letting them know in advance, or telling them while they were in the centre.

In 2020, inspectors carried out 750 inspections in 702 designated centres for people with disabilities. While not all centres were inspected during 2020, all centres are inspected during their registration cycle.

Figure 32: Breakdown of announced and unannounced inspections in 2020

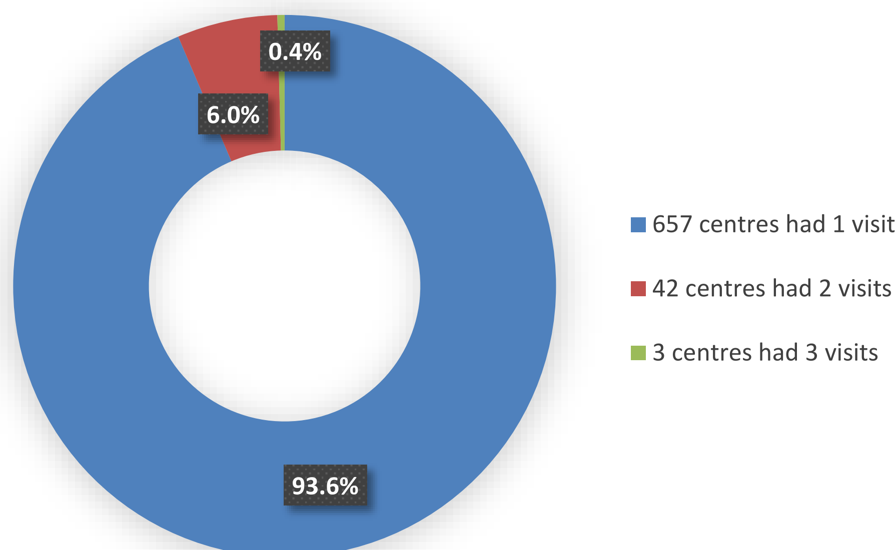


5.8. Centres requiring repeat visits in 2020

The Chief Inspector ensures that providers who are failing to comply with the regulations are given clear information and feedback about what those non-compliances. More frequent inspections may take place in some centres to monitor the provider's progress and the impact of the provider's actions on improving the safety and quality of life of residents.

Of the 702 centres inspected in 2020, 657 of these received one inspection. This was because they had a good level of compliance and where there were non-compliances, the provider responded appropriately. A total of 42 centres required two inspections, while three centres required three inspections (Figure 33).

Figure 33: Level of inspection activity for centres inspected in 2020



5.9. Publication of inspection reports

We believe the publication of inspection reports has increased the transparency about the quality of life for residents and about how we regulate centres. Further information on the publication process is contained in our *Regulation Handbook*, available on www.hiqa.ie. In addition to individual inspection reports, HIQA's annual corporate report also contains data on our inspections, while this annual overview report is also published.

By the end of 2020, 651 inspection reports had been published. Some reports of inspections carried out in late 2020 were published in early 2021. In addition, some reports were not published in order to protect the privacy of residents where the contents of a report could result in residents being identifiable. In such cases, the provider must make a copy of the report available to residents.

5.10. Feedback on inspection reports and submissions

Before an inspection report is published, providers are given the opportunity to comment on and provide feedback on the factual accuracy of reports and on inspectors' regulatory judgments. This ensures that the provider has a fair and reasonable opportunity to consider the evidence in the report. Of the 750 inspections completed in 2020, providers gave feedback on 102 reports. Of those, amendments were made to 84 inspection reports, which were subsequently re-issued to the providers of those services.

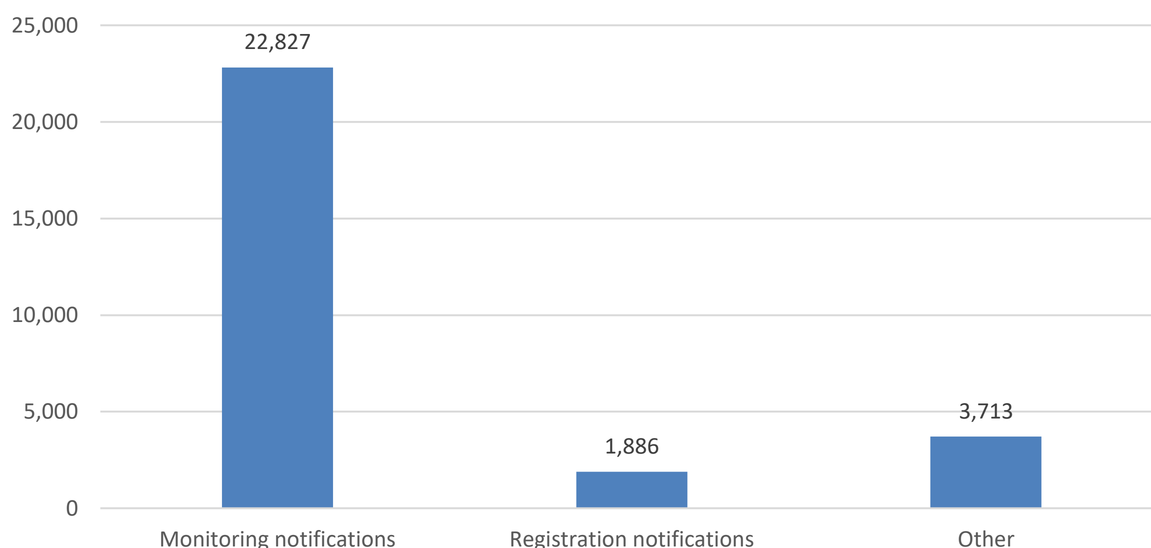
If the provider is not satisfied with the outcome of the feedback process, they can make a submission on inspector's judgments to the Chief Inspector. In 2020, the Chief Inspector received no submissions from providers in response to inspections completed in centres for people with disabilities.

5.11. Notifications of incidents and other reportable matters

In addition to inspection activity, inspectors continually monitor all centres based on information which we receive through a number of channels, including mandatory notifications from providers of incidents, events or changes that happen in the centre. Inspectors assess this information to identify any changes or trends in the life of the centre which might alert inspectors to the need to take further regulatory actions.

In 2020, inspectors processed 28,426 such notifications from designated centres for people with disabilities (Figure 34: Number of notifications received in 2020). This is an increase of 6,811 compared to 2019.

Figure 34: Number of notifications received in 2020



The 22,827 monitoring notifications relate to specific instances that may occur in the centre in relation to the safety and wellbeing of residents and the operation of the centre. Most of these must be submitted within three working days of the event (Figure 35) with others required to be submitted on a quarterly basis. A large number of notifications does not necessarily imply there is a risk of non-compliance with the regulations or poor outcomes for residents. Further information on the notifications process can be found in our *Regulation Handbook*.

Figure 35: List of significant events which require notification to the Chief Inspector within three working days

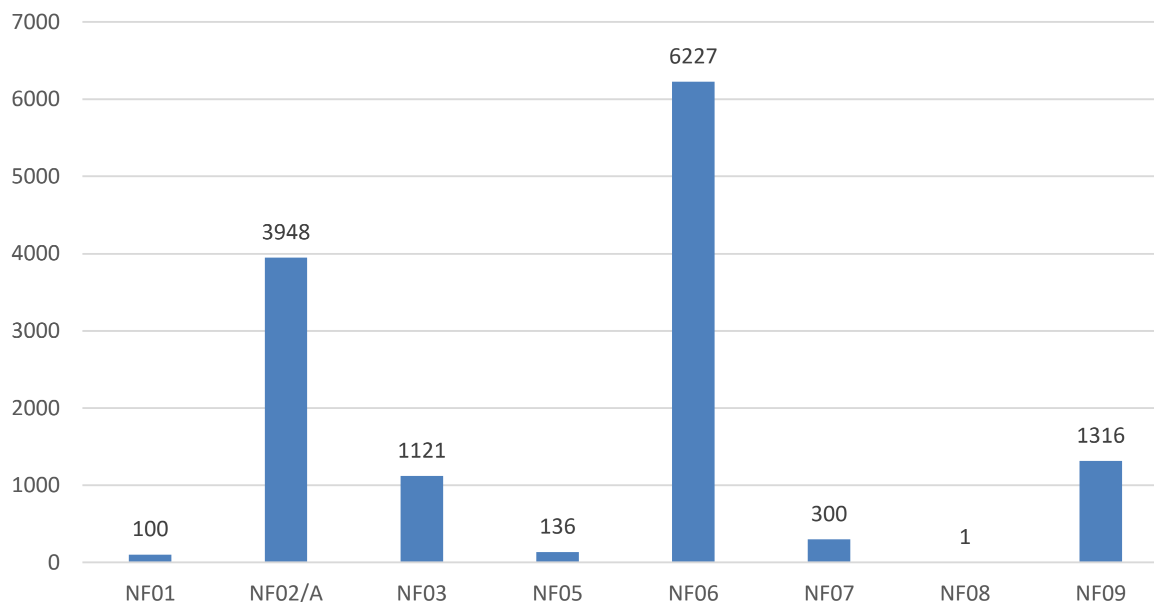
Form number	Title of monitoring notification required
NF01	The unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre
NF02/A	An outbreak of any notifiable disease as identified and published by the Health Protection Surveillance Centre including a suspected or confirmed incidence of COVID-19 in the designated centre
NF03	Any serious injury to a resident that requires immediate medical or hospital treatment
NF05	Any unexplained absence of a resident from the designated centre
NF06	Any allegation, suspected or confirmed, of abuse of any resident
NF07	Any allegation of misconduct by the registered provider or by staff
NF08	Any occasion where the registered provider becomes aware that a member of staff is the subject of review by a professional body
NF09	Any fire, loss of power, heating or water, or any incident where an unplanned evacuation of the centre took place.

As can be seen in Figure 36 below, the highest number of notifications received related to NF06 (safeguarding concerns) — allegations, suspected or confirmed, of abuse of any resident. Many of these notifications continued to relate to altercations between residents in centres and do not necessarily mean that there is an immediate risk of abuse to residents in the centre. The second highest number of notifications related to providers reporting incidences of COVID-19 infection and the subsequent daily updates. In 2020, of the 3948 NF02 notifications submitted, 3,924 were COVID-19 related.

Each notification is assessed by an inspector who considers how the provider has responded to the situation, while the inspector also checks previous trends and overall information about the centre. Where ongoing risk is identified or where there has been a failure to respond effectively, the inspector will take further regulatory action.

Each of these notifications was risk assessed within three days of receipt, and where required, we sought additional assurances to confirm that the provider had taken the necessary action to safeguard each resident. Notifications are routinely followed up during our inspection activity and are used to inform our regulatory decisions.

Figure 36: Number and type of notification received in 2020

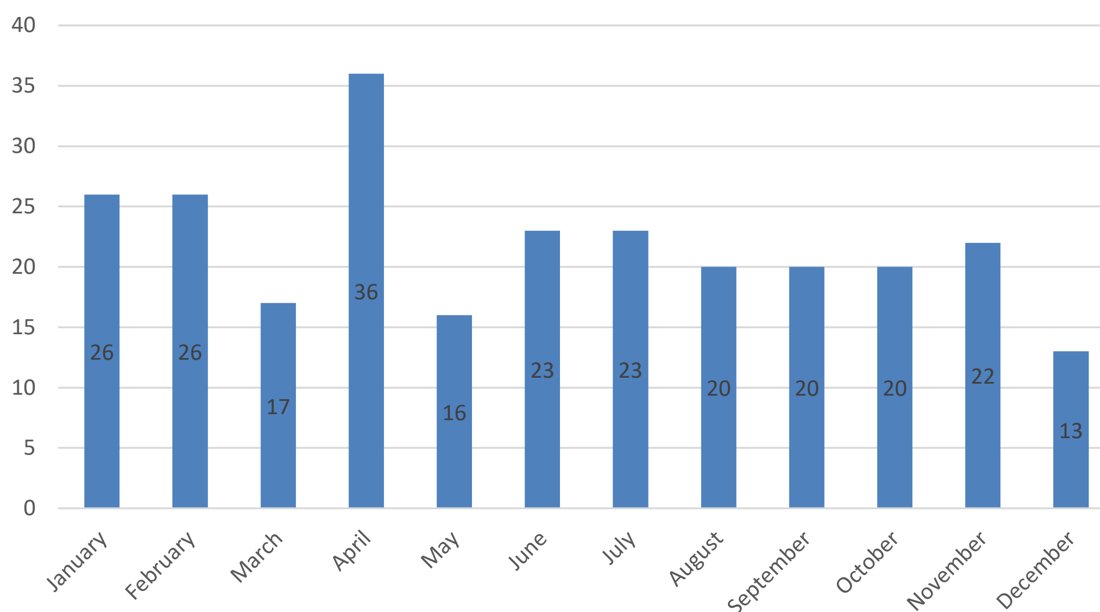


Where necessary, HIQA will notify other relevant agencies about concerns which have not been notified to them already by a provider. These agencies include An Garda Síochána, the Child and Family Agency (Tusla) or the HSE National Safeguarding Office. In 2020, inspectors in the disability sector made three referrals to the HSE National Safeguarding Office and one referral to the Fire Authority.

5.12. Information of concern

We also receive information of concern about services from residents, their families and from members of the public and other sources, which we term 'unsolicited receipt of information' or 'UROI'. This information is used to support our inspection programme. During 2020, we received 262 pieces of unsolicited information relating to designated centres for people with disabilities (Figure 37).

Figure 37: Monthly breakdown for receipt of unsolicited information in relation to designated centres for people with disabilities



The types of concern we receive can vary and include concerns relating to:

- admissions and contracts for residential placements
- responses to complaints made within the centre
- residents' access to their local community
- the general welfare and development needs of residents
- governance and management of a centre
- health and safety matters
- risk management
- healthcare
- medicines management
- residents' rights
- premises
- safeguarding and safety
- social care needs and workforce.

All items of unsolicited information are individually risk assessed and appropriate action is taken by the inspector in relation to each concern. This may mean that the provider is required to undertake a review of its service or that an unannounced inspection is completed. In addition, with the consent of the person raising the concern, this information may be referred to another agency for further follow up, if that is appropriate.

Conclusion

The regulation of centres for people with disabilities ensures that there is regular, independent monitoring of the safety and quality of care and support being provided to residents. The registration process means that providers have to demonstrate that they are meeting the minimum basic requirements set out by the State in the regulations, and that they are also striving to achieve ongoing quality improvement in their centres through the national standards.

Inspectors monitor providers through inspection and through review of information received from providers and from the public. Where providers are found to be failing to provide residents with the quality of service that they are entitled to, the Chief Inspector can undertake a range of enforcement measures to ensure that action is taken to prioritise the rights and the welfare of residents. This is discussed in Chapter 6 of this report.

Chapter 6. Escalation and enforcement

6.1. Introduction to actions to protect residents

Where inspectors find poor compliance levels that result in a poor quality of life for residents or which leads to a high risk of harm, the Chief Inspector can take a number of regulatory actions which we term 'escalation and enforcement', up to and including the cancellation of the registration of a centre. Whenever such actions are necessary, the Chief Inspector will always try to minimise disruption and anxiety for people living in designated centres.

During 2020, most providers operated good quality services. These providers focused on building high levels of compliance which improved the quality and safety of care. However, during the year, the Chief Inspector took action against a number of providers when the rights of residents were not being promoted and protected. In 2020, 106 centres (7.9% of the 1,340 registered designated centres) were the subject of increased regulatory actions and additional targeted monitoring and scrutiny of the provider's plans to improve the services.

These actions can include closer scrutiny of a provider at organisational level as well as centre level. Following consistently poor findings over a series of inspections during 2020, Camphill Communities of Ireland were required to submit a six month governance improvement plan in November 2020. Inspectors then monitored the delivery of this plan and its effectiveness in achieving improvements in support and care for residents. This escalated regulatory programme continued into 2021 when further regulatory action was required, including the cancellation of the registration of one centre in July 2021.

In another situation, inspectors found very poor living conditions for residents in a centre operated by St John of God Community Services in 2020. The provider stated that it would take a minimum of two years to rectify and inspectors rejected this response. The provider was informed of the intention of the Chief Inspector to seek a District Court Order under Section 59 of the Health Act 2007 for the immediate cancellation of the registration of the centre. The provider undertook an escalated programme of works in the centre and these were completed within six weeks. Inspectors visited the centre to verify that the works had been completed and it was not necessary to proceed to seek a court order.

In addition to the above regulatory actions during 2020, the Chief Inspector also used other regulatory actions in response to findings of poor compliance levels that impacted on the safety and quality of life for residents.

6.2. Provider warning letters

Where there are concerns about the safety or quality of life for residents in a centre, the Chief Inspector may issue a warning letter to identify the issues and to warn providers that if they do not improve their services, the Chief Inspector may take action to cancel their registration, attach additional restrictrive conditions to their registration or prosecute the provider.

In 2020, the Chief Inspector issued 26 warning letters to 11 providers. In most cases, providers took appropriate actions to improve the quality of the service and bring the centres into compliance with the Health Act 2007 (as amended) and the regulations. However, in a number of cases, further escalated regulatory decisions were required, which are set out below.

6.3. Attaching conditions of registration

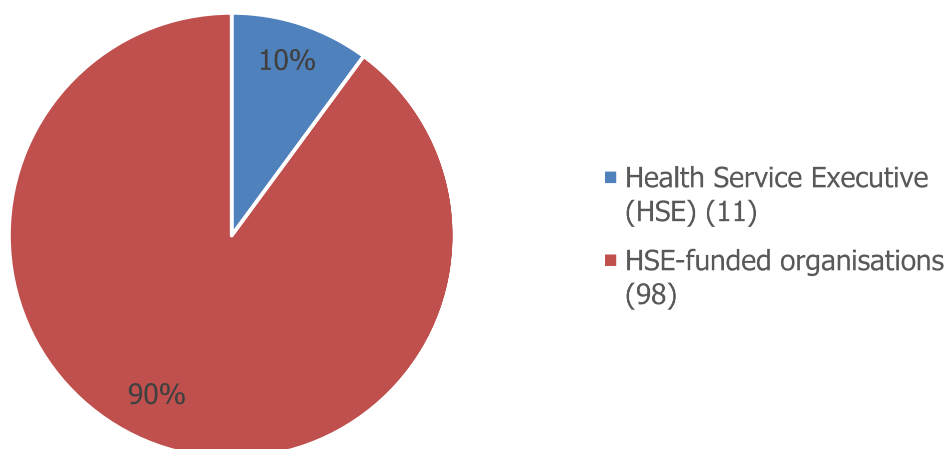
The Chief Inspector attaches three standard conditions to the registration of all centres. However, where the provider is required to undertake improvements to bring a centre into compliance, the Chief Inspector may decide to attach additional, restrictive conditions to a centre's registration. Those might include a requirement to improve the management of the centre, reduce or limit the number of residents living there, improve fire precautions or improve the fabric of the premises.

Overall, in 2020, the vast majority (92%) of designated residential centres for people with disabilities operated their services without the requirement for restrictive conditions (Figure 38). This indicates that they either had good levels of compliance with regulatory requirements or demonstrated an ability to rectify any areas of non-compliance that impacted on the quality of life and consistency of service being provided to residents.

Figure 38: Breakdown of centres requiring additional operating conditions to be applied at the end of 2020

However, at the end of 2020, 109 centres had a restrictive condition attached to their registration. Six of these had more than one restrictive condition. The HSE was the provider of 11 of these centres; the remaining 98 centres were HSE-funded organisations (Figure 39). In total, 49 of these centres were congregated or campus-based settings.

Figure 39: Breakdown of type of provider which had restrictive operating conditions attached to the registration of their centres at the end of 2020



Each restrictive condition required the provider to improve aspects of the service within a time frame set out by the Chief Inspector. Providers who have restrictive conditions are required to submit regular updates on progress towards achieving the

required actions. Where providers satisfactorily show that they have taken the necessary steps to resolve the issues which gave rise to the restrictive condition, they may apply to the Chief Inspector to have it removed from their registration.

6.4. Notices of proposed decision to cancel, refuse or attach

The decision to issue notices of proposed decision to cancel or refuse applications to register is not taken lightly, given that such actions can cause distress and anxiety for residents and for their families. In most cases, such notices are only issued after the provider has failed to improve the quality of its service following a number of other actions taken by the Chief Inspector.

In line with the powers in the Health Act 2007 (as amended), the Chief Inspector issued notices of proposed decision to cancel the registration of two centres during 2020. This was due to repeated findings of regulatory non-compliance and concern about the care and welfare of residents.

Providers have a legal right to make representation to the Chief Inspector within 28 days setting out why the registration should not be cancelled. Inspectors will verify whether the actions to improve the quality of service for residents has been effective. Where providers have improved their services, the Chief Inspector may withdraw the notice of proposed decision and inspectors will then continue to monitor progress towards improvement.

In relation to one centre during 2020, St Mary's Telford House and Apartments, the Chief Inspector proceeded with a notice to cancel the registration of the centre, because of concerns for the quality, consistency and continuity of support and care for residents. The provider had sought and been granted an order in the High Court to liquidate the company and the Chief Inspector was not satisfied with the quality of care and support for residents during this time. The registration of the centre was cancelled in November 2020 and the HSE took over the operation of the centre under Section 64 of the Health Act 2007, as amended.

Chapter 7. Concluding statement

The global pandemic has had a significant and no doubt long lasting effect on society as a whole. For people with a disability who live in designated centres, life has had to adapt at a significant rate. The majority of people with disabilities who lived in residential care throughout periods of lockdown have often spent extended periods of time in their homes, due to the closure of their day supports and often with little or no human contact with people outside of their homes.

During 2020, providers were significantly challenged in responding to the pandemic. These challenges included accessing PPE, staffing levels impacted by COVID-19, and identifying appropriate accommodation for residents who needed to isolate or receive treatment. A focus of regulation was on verifying that providers had developed contingency plans to manage these challenges during any infection outbreaks in each centre.

It is of critical importance for the future that providers continue to have effective contingency plans to manage the risk of an outbreak of infection in a way that ensures the safety and wellbeing of all residents in a centre. This includes a requirement to keep those plans under review and to test them regularly to ensure that they continue to be effective in the event of an emergency.

It is also of critical importance that providers continue to uphold the rights of residents as citizens, that within the requirement for public health measures, residents are supported to live in a home where they feel supported and safe, and can maximise their own decision making about their lives and the running of the centre. Where public health measures are required, it is important that residents are not subjected to increased restrictions unless that is evidenced by an appropriate assessment of need or by underlying health conditions.

In 2021, the Chief Inspector will be commencing a programme of inspections on the *National Standards for Infection Prevention and Control in Community Services,* which will aim to further increase the overall quality and sustainability of appropriate infection control practices within designated centres for people with disabilities.

It is clear from this report that many people who live in congregated settings continued to experience poorer overall quality of life outcomes. It is encouraging to note that some people with disabilities who lived in such settings were able to move into new community homes during 2020. However, further work is required to ensure that the use and reliance on congregated or campus-based settings continues to be reduced.

In 2021, we are also going to continue to build on our stakeholder engagement

strategy, with our commitment to meet with more resident forums this year. In addition, we will continue to meet provider representatives regularly and we will be recommencing our provider roadshows, which provide an invaluable opportunity to share information and drive a regulatory programme of quality improvement nationally.

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