Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

OVERVIEW REPORT

MONITORING AND REGULATION OF DESIGNATED CENTRES FOR PEOPLE WITH DISABILITIES IN 2021

July 2022

Safer Better Care

Table of contents

A message from the Chief Inspector of Social Services

Carol Grogan, Chief Inspector of Social Services

I am delighted to be presenting my first annual overview report as Chief Inspector on the inspection and regulation of centres for people with disabilities. At the outset, I would like to acknowledge that 2021 was another challenging year for residents in designated centres for people with disabilities, their loved ones, staff, managers and providers of 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.

While this is my first report as Chief Inspector, I am very aware of the work of providers in this sector and over the years have had opportunity to meet providers and their representatives through provider roadshows, attendance at the provider representative forum meetings and through various provider engagement work, such as the development of the thematic inspection programme on the management of restrictive practices.

As in previous years, our inspections in 2021 showed the link between well-governed services and a safe, good quality service where residents are able to enjoy a good overall quality of life and experiences. Again, this year's overview report finds that the majority of centres are providing good standards of care and support to people with disabilities.

However, there was a notable deterioration in the levels of compliance with governance and management over the course of 2021, partly due to remote or off-site management and oversight arrangements since the COVID-19 pandemic. This is a worrying development, as poor governance and management can lead to an overall deterioration in the quality and safety of services, if providers fail to improve or sustain their management and oversight arrangements in the short to mid-term.

As I look to the future, I am hopeful that regulatory reform will enable the development of a regulatory framework that maintains a focus on the residents' safety and ensures that they have a good quality of life, reflecting the ongoing

development and innovation in providing support services to people with disabilities. I continue to engage with the Department of Health in relation to the need for regulatory reform, as reflected in *The Need for Regulatory Reform* position paper submitted to the Department and published on the HIQA website in February 2022.

My team and I will also continue to contribute on the development of a national safeguarding policy with the Department of Health which can then be used to inform much needed safeguarding legislation. Our Regulation of Homecare: Research Report, published in 2021, also advocates that the sector needs a complete overhaul, given the uneven distribution of homecare services and the absence of a statutory footing. Regulation will strive to acknowledge the good practices of providers, while also holding providers who fail to uphold the rights of people with disabilities to account.

2022 will also see the transition of the disability function from the Department of Health to the Department of Children, Equality, Disability, Integration and Youth. HIQA have been engaging with both Government departments to plan for this transition, and I look forward to working closely with the new department to ensure that regulation continues to make an effective contribution to the ongoing quality improvement of services for people with disabilities. The Assisted Decision Making (Capacity) Act (2015), due to be enacted this year, will also ensure that a person's will and preferences guide their treatment when they no longer have the capacity to make certain decisions for themselves. This will impact on existing regulations for the registration and monitoring of services.

And finally but most importantly, I would like to thank the residents living in residential services who welcomed our inspectors into their homes and engaged with us throughout the year to tell us what it was like to live in your homes. This is a critical part of our assessment of the quality of support being provided to residents and informs our engagement with providers.

Carol Grogan

Chief Inspector of Social Service

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

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

2021 was another busy and challenging year for residents in centres for people with disabilities and also for providers. The pandemic continued to impact on the lives of residents, particularly in the first half of the year, and there were anxieties for both residents and staff in managing the transition to less restrictive conditions, particularly later in the year.

This overview report sets out the work and the findings of inspectors during 2021. Inspectors undertook 1,220 inspections and found that the majority of centres provided a good standard of care and support to people with disabilities. Overall, inspectors found that providers continued to manage the risks of infection for residents and where infection occurred, providers responded quickly. Although, compliance levels deteriorated when compared with 2020, there were significantly more on-site inspections completed in 2021, which may account for the variation.

As in previous years, inspectors found that centres in congregated setings had higher levels of non-compliance than centres based in the community. Furthermore, more congregated settings than in previous years required improvements to the overall quality and safety of the premises.

Inspectors also identified centres where providers were not ensuring that the rights of people with disabilities were being promoted and protected. In these centres, inspectors have required providers to improve the quality of support for residents and where required, have taken escalated regulatory action to ensure that residents are provided with the quality of service that they are entitled to. Unfortunately, these escalated actions included the cancellation of the registration of two centres in 2021, because the providers failed to improve the safety and quality of life for residents. Further information on escalated regulatory action is provided throughout the report.

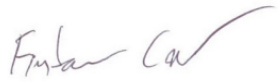
Hearing the views of residents on inspection and observing what life in their home is like for them is a critical component of our inspection process and informs the judgments of inspectors. Residents' experiences are also detailed throughout this

report. In addition, we have included a specific section on the voice of children within centres, in line with the *National Strategy on Children's and Young People's Participation in Decision Making 2015 to 2020*.

HIQA also recognise the value of hearing the views of residents outside of the inspection process and during 2021, inspectors met with 20 local resident advocacy groups across the country. In December 2021, the findings were presented in a video, published by HIQA on United Nations International Day of People with Disabilities. In 2022 HIQA will also publish a report on the views of residents provided through meeting with their advocacy groups during 2021.

As we go forward, 2022 will be another year of change. Given that society is still dealing with COVID-19 and the risk of other types of infection, infection prevention and control (IPC) remains a very pertinent issue which requires ongoing vigilance. In that context, the programme of IPC inspections will continue into 2022. As the regulator we are also mindful of the impact of the programme to transition residents from congregated settings and the focus on the provision of additional respite services for people with disabilities during 2022.

As regulators, we will continue to use the regulatory framework to ensure the rights of people with disabilities are promoted and protected during this time of change.



Finbarr Colfer

Deputy Chief Inspector of Social Services (Disability)

Chapter 1. Overview of disability services in 2021

1.1 Introduction

This report sets out the findings of our regulatory programme for designated centres for people with disabilities in 2021. This year the data is being presented in a slightly different format than in previous years, and we have included separate data on findings from our programme of regulation in designated centres for children with disabilities and mixed centres for adults and children.

In disability services, designated centres can be registered as centres for adults, children or mixed. Mixed centres may offer a service to people from both age groups and most are respite centres or centres where children are transitioning to adulthood and the provider is facilitating them to continue living together. However, in respite centres, children and adults may not be accommodated at the same time.

As in previous overview reports, this report will highlight the experience of people with disabilities who live in registered designated centres, and again this report highlights the different experiences in the overall quality and safety of services across both community-based settings and congregated settings.

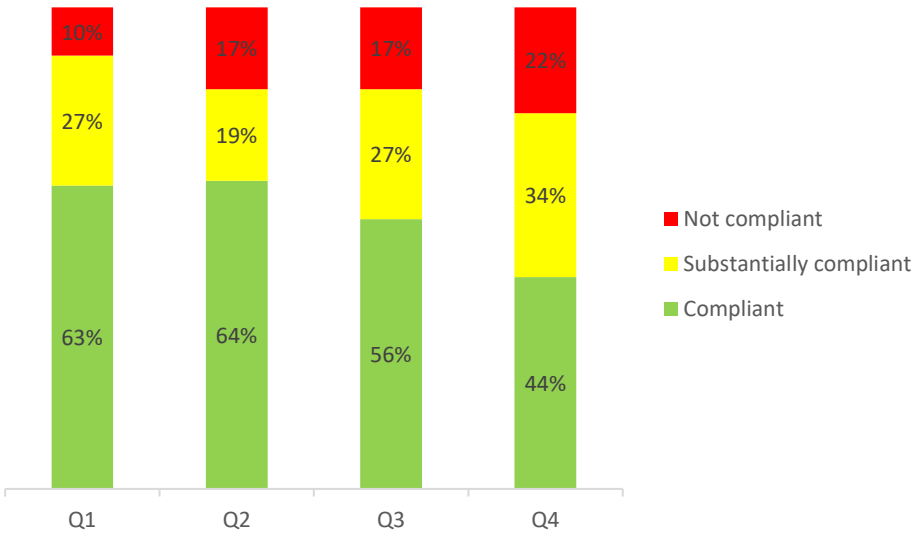
Throughout 2021, residents living in these centres have had to adapt to the ever changing landscape of the pandemic. While for many of these residents, this bought opportunities for fresh and new personal outcomes and experiences, for some, these restrictions lead to increased periods of time spent within the confines of their own homes, with limited opportunities for social, educational or work-based activities.

Fortunately in the second half of 2021, the national restrictions began to ease and this meant that many residents could again begin to enjoy freedom of access to their local communities and their activities of interest. However, for some residents the transition back to their previous levels of community involvement was slow and in some cases residents experienced periods of restrictions in excess of their peers or people living in their own homes in the wider community.

In previous reports, the link between well-governed services and a safe, good quality service where residents are able to enjoy good overall quality of life and experiences has been well established. During 2021, overall compliance with Regulation 23: Governance and management has remained largely consistent with findings from 2020. However, as can be seen in

Figure 1 below, over each quarter in 2021 there has been notable deterioration in the levels of compliance, partly due to the continued use of remote or off-site management and oversight arrangements used during the pandemic.

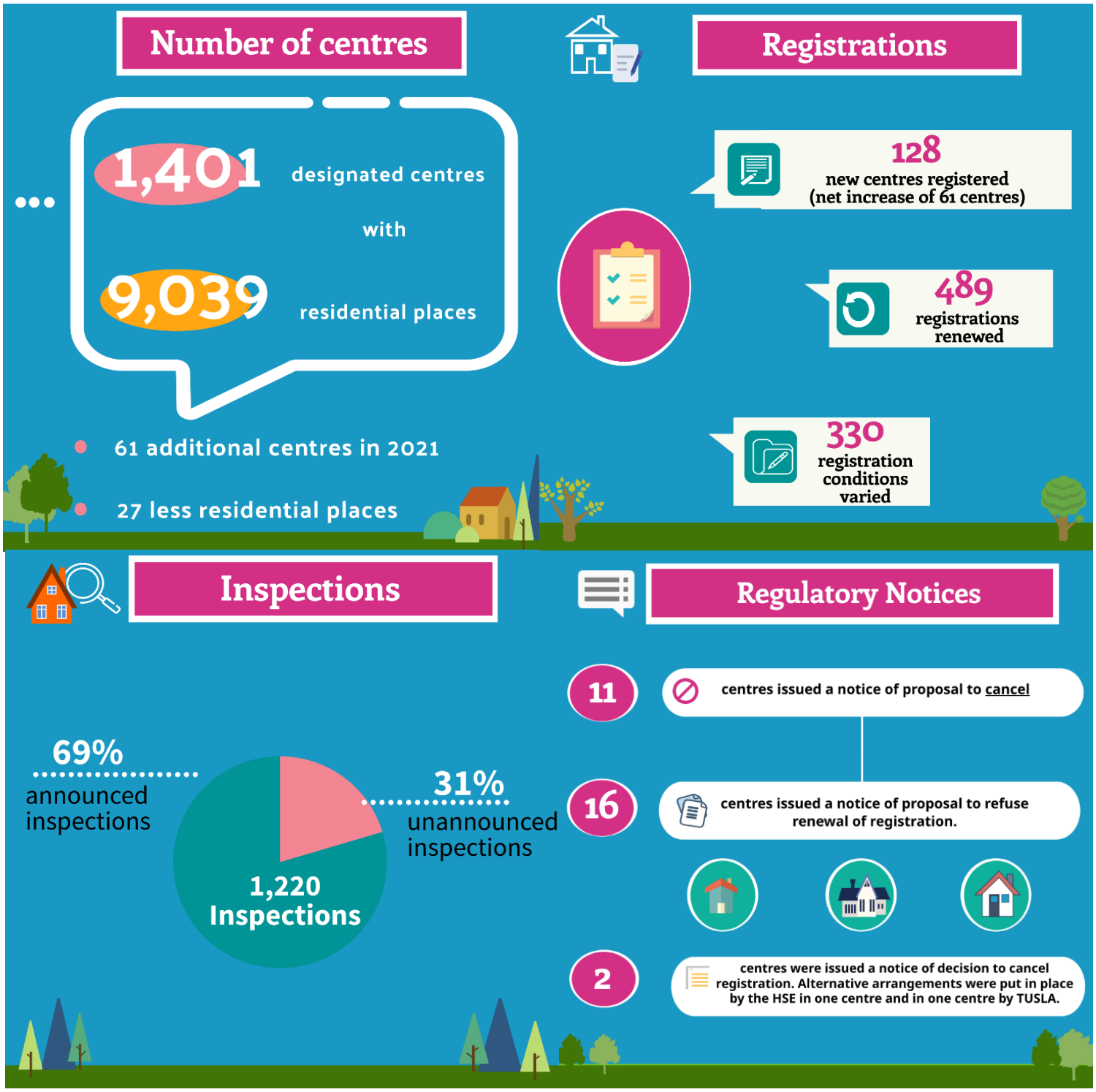
Figure 1: Overview of compliance with Regulation 23: Governance and management during 2021

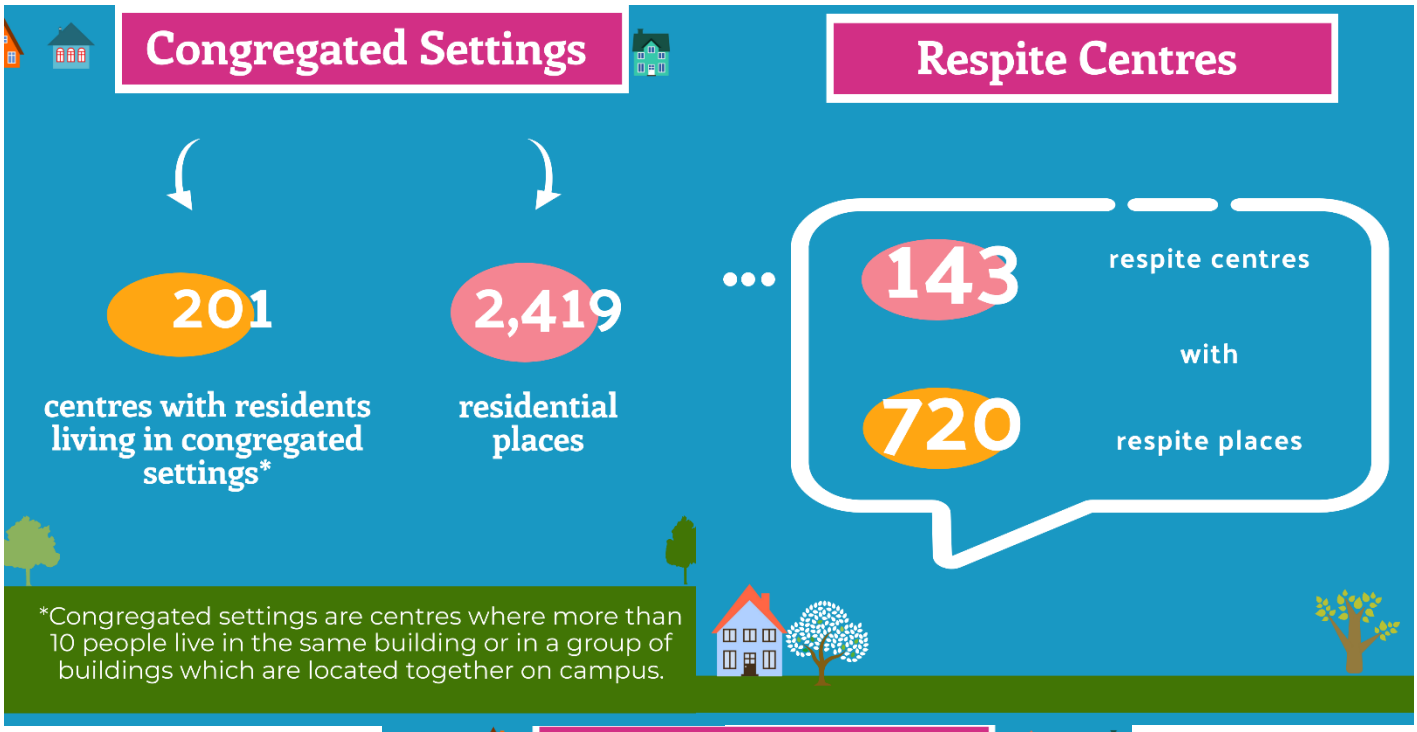


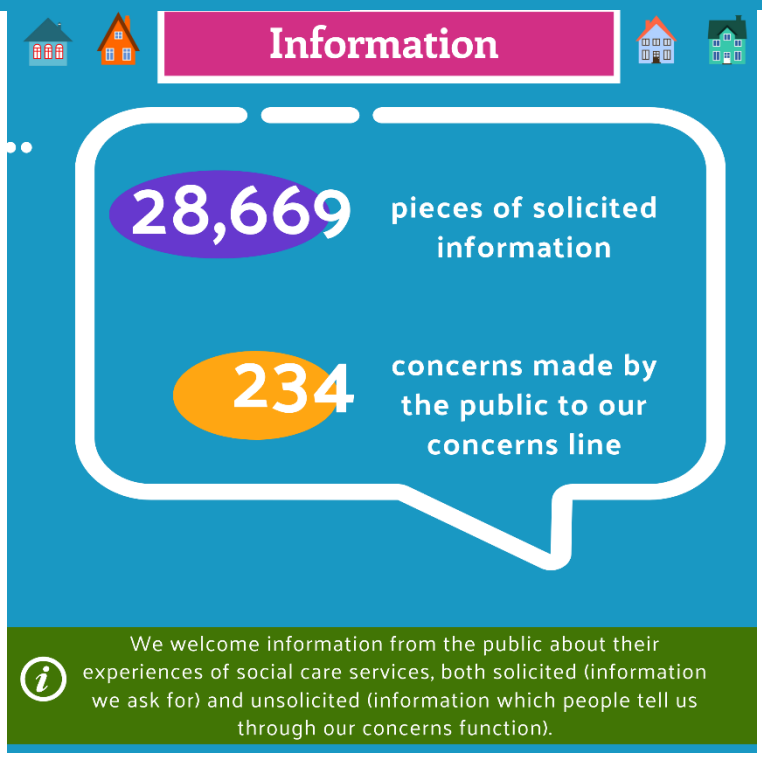
This trend is worrying as it could result in an overall deterioration in the quality and safety of services in the sector, if providers fail to improve or sustain their management and oversight arrangements in the short to mid term.

The remainder of this report will give an overview of the key findings made during our 2021 programme of regulation and highlight some of the good practice that inspectors have found and where further improvements are required to the overall delivery of residential services in designated centres for people with a disability in Ireland.

1.2 The Profile of Disability Services in Ireland in 2021




Congregated Settings
201
centres with residents living in congregated settings*
2,419
residential places
*Congregated settings are centres where more than 10 people live in the same building or in a group of buildings which are located together on campus.
Respite Centres
143
respite centres
with
720
respite places


Information
28,669
pieces of solicited information
234
concerns made by the public to our concerns line
We welcome information from the public about their experiences of social care services, both solicited (information we ask for) and unsolicited (information which people tell us through our concerns function).

1.3 Developments in the regulation of designated centres for people with a disability during 2021

Good infection prevention and control practices and policies are essential to help prevent the spread of transmisable diseases such as COVID-19. To better support providers, the Chief Inspector developed an infection prevention and control assessment judgment framework and guidance. In November 2021, the disability pillar commenced a pilot programme of infection prevention and control (IPC) inspections, using this new IPC assessment and judgment framework. A series of webinars and training events were held with providers with a total of 1,105 attendees, to prepare them for this new programme of focussed inspections.

Focusing on infection prevention and control through inspections can help drive improvements in infection prevention and control practice and improve the overall quality of a provider's approach to IPC. The early inspections have told us that there were many areas of good and improving practices in disability centres, however, key themes where improvements are required include:

1. The completion of records which provide evidence relating to cleaning in the designated centre and the completeness of these.
2. Multi-use items or items that are not used regularly, such as oximeters, hoists or nebulisers, were not itemised on cleaning records in some centres, and there were no clear guidelines in place for how these should be cleaned, decontaminated and re-commissioned once used, or how frequently these should be cleaned when not in use.
3. Departures from the provider's own policies and procedures or national guidelines for IPC.
4. Outbreak management plans were not being kept under review.
5. Lack of sufficient guidance for staff in relation to how to initiate and maintain isolation, zoning and good IPC arrangements, where needed, for donning and doffing personal protective equipment (PPE) and in the disposal of clinical waste.

Following on from the success of this pilot, this programme of IPC inspections will be continued into 2022.

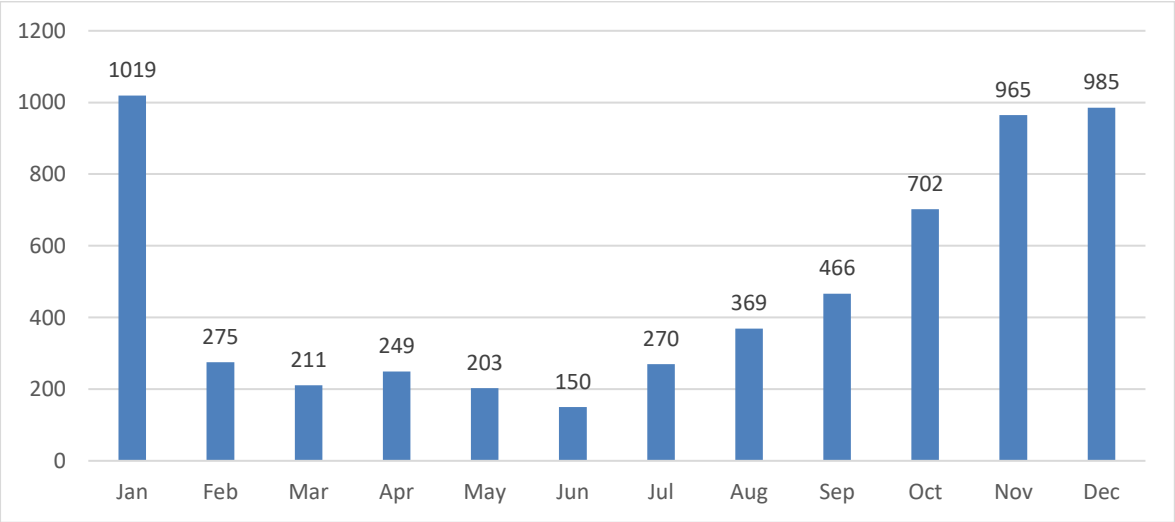
1.4 Provider representative forum and meetings with the HSE and Department of Health

In 2021, the Deputy Chief Inspector continued to engage with the four provider representative bodies of disability providers; the National Federation of Voluntary Service Providers, Disability Federation of Ireland, the National Disability Services Association and the HSE, in their role as service provider. This forum met on nine occasions during 2021, supporting effective and ongoing channels of communication between the regulator and providers. These meetings have proven to be a valuable opportunity for providers of services to update the Chief Inspector on any emerging issues and for the Chief Inspector to provide regular updates on any forthcoming regulatory matters. The Chief Inspector also met regularly with the HSE and the Department of Health to exchange information on the response of providers to the pandemic.

1.5 Ongoing COVID-19 response and actions

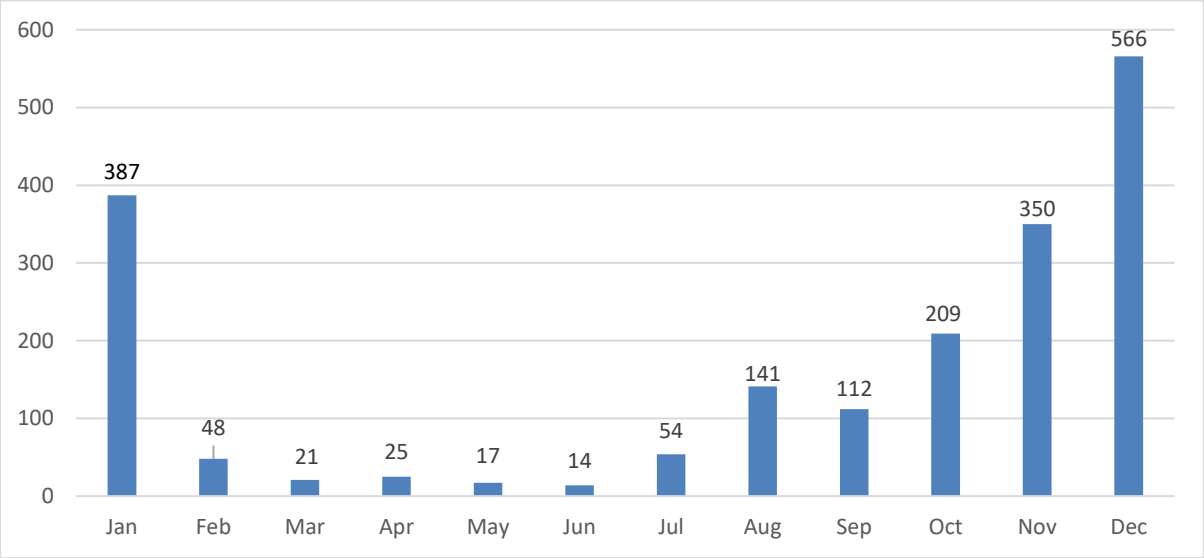
In 2021, 5,864 notifications were received where centres had suspected or confirmed cases of COVID-19, with the highest number of notifications received in January 2021, coinciding with the third wave of the public health emergency. When a notification of COVID-19 is received by the Chief Inspector, it is reviewed, risk rated and closed where no outbreak is detected or when the outbreak at the centre is over, in line with public health advice. Of the 5,864 notifications received, 33% of these notifications had reported at least one or more residents or staff members with a confirmed case of COVID-19.

Figure 2: Number of notifications received in 2021 reporting a resident or staff member with suspected or confirmed COVID-19



Of the 1,401 registered designated centres for people with a disability, 1,305 centres submitted a COVID-19-related notification in 2021 and of these centres 87% had at least one confirmed resident or staff case. 271 centres reported no outbreak of COVID-19 in 2021.

Figure 3: Number of notifications received in 2021 reporting a resident or staff member with a confirmed case of COVID-19



Chapter 2. The voice of residents and Residents' rights

2.1 Engaging with residents during inspections

In 2021, HIQA continued to engage with residents during inspections within the constraints of prevailing public health guidance. Inspectors were able to meet and speak with residents in their homes and listen to their lived experiences. These discussions provided invaluable insights about the overall quality and safety of the service from the residents' perspectives. These discussions and observations are included in our inspection reports and bring these reports to life, highlight both good practices and expose areas for renewed focus or improvement within the sector.

Where inspections are announced (aside from short-notice announced inspections which were introduced as a COVID-19 risk management measure), the Chief Inspector sends information posters to designated centres, 20 days in advance of a planned inspection, with details of the upcoming inspection so that residents and their families are able to be available to meet the inspectors, if they so wish. A resident questionnaire is also available to all residents or their advocates to fill out. These are usually sent out to designated centres in advance of the inspection. In addition, the questionnaire is also 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 Reflecting residents' voices in inspection reports

Our inspection reports include a section on 'What residents told us and what the inspectors observed'. Here, inspectors outline what residents told them on the day of inspection or their responses to the questionnaire 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 or an individualised communication board to converse with the inspector. As some people are not in a position to communicate verbally with inspectors, observation is also used to gain an understanding of the interactions between staff and residents, the environment and the general atmosphere in the centre.

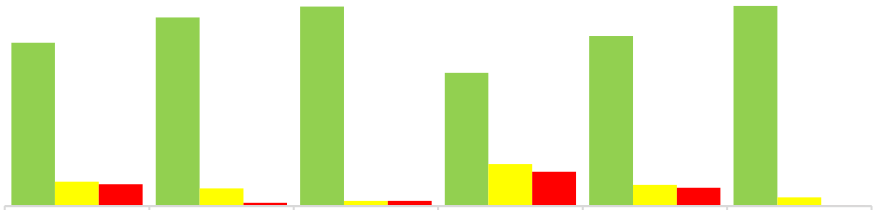
2.3 Residents' rights in 2021

While all regulations contribute to a resident's overall quality and experience of a service, some regulations relate to residents' rights and their lived experiences in the centre. These provide valuable insights into residents' lives and how they are

supported to exercise their rights and choices and maintain influence and control over their daily lives. These regulations focus on residents' rights, their possessions, their communications, their general welfare and development, arrangements for visitors and the information that is provided to them about their centre. The regulations also focus on how they are supported to participate in their communities.

As can be seen in the following graphs, of all of these regulations, the overall experience of residents in terms of their rights, their posessions and general welfare have the highest level of non-compliance and require improvements.

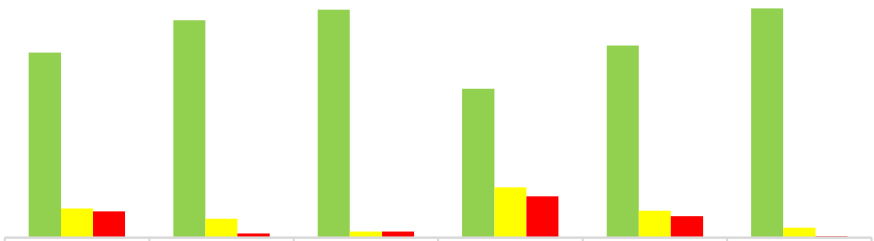
Figure 4: Overview of key rights-based regulations



	Residents' rights	Communication	Visits	Personal possessions	General welfare and development	Information for residents
Compliant	77.9%	90%	95.1%	63.6%	81.1%	95.4%
Substantially compliant	11.7%	8.5%	2.4%	20%	10.2%	4.2%
Not compliant	10.4%	1.5%	2.4%	16.4%	8.7%	0.5%

However, when we break this data down into the three service groups it is clear that this finding is primarily based on the experiences of people who live in adult-only centres.

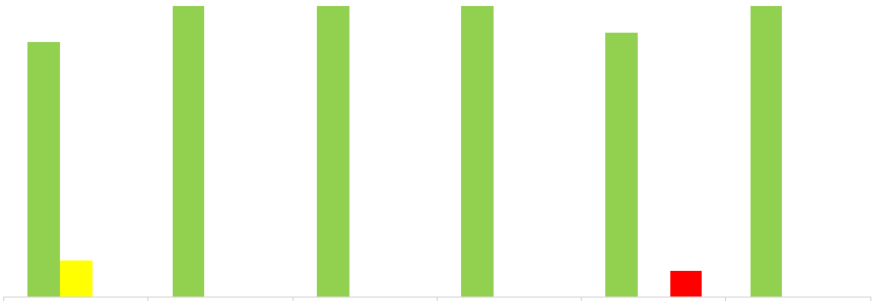
Figure 5: Overview of key rights-based regulations in designated centres for adults



	Residents' rights	Communication	Visits	Personal possessions	General welfare and development	Information for residents
Compliant	77%	90.4%	94.9%	61.9%	79.9%	95.3%
Substantially compliant	12.1%	7.9%	2.6%	20.9%	11.1%	4.1%
Not compliant	10.9%	1.7%	2.6%	17.2%	8.9%	0.5%

While issues relating to residents' rights can occur in any centre, this higher level of non-compliance in adult services is most likely due to the high number of residents who continue to live in congregated settings or campus-based settings, who often experience a poorer quality of service, as discussed later in this report.

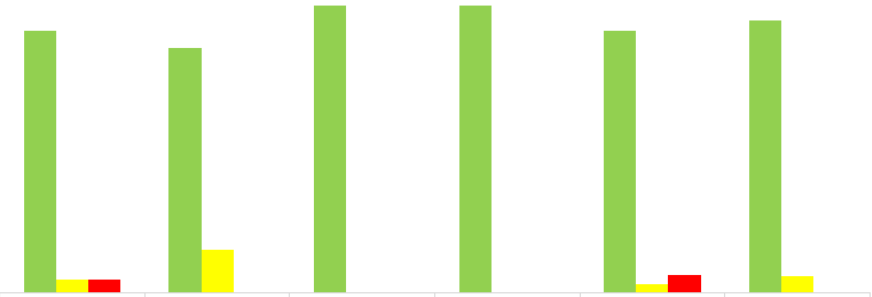
Figure 6: Overview of key rights-based regulations in designated centres for adults and children



	Residents' rights	Communication	Visits	Personal possessions	General welfare and development	Information for residents
Compliant	87.5%	100%	100%	100%	90.9%	100%
Substantially compliant	12.5%	0%	0%	0%	0%	0%
Not compliant	0%	0%	0%	0%	9.1%	0%

In mixed centres, while there was a high level of compliance overall, there was a small percentage of centres where further work was required in the delivery of good outcomes for residents in relation to their general welfare and development. This included opportunities for residents to access activities, education, occupation and play.

Figure 7: Overview of key rights-based regulations in designated centres for children



	Residents' rights	Communication	Visits	Personal possessions	General welfare and development	Information for residents
Compliant	90.9%	85.2%	100%	100%	90.9%	94.4%
Substantially compliant	4.5%	14.8%	0%	0%	3.0%	5.6%
Not compliant	4.5%	0%	0%	0%	6.1%	0%

For children, the overall focus on the delivery of a rights-based approach in designated centres provided better outcomes. As a result, children were more likely to be able to participate in activities they enjoy, while their rights, dignity, privacy and choices were supported and promoted.

Throughout this report, we have included excerpts from inspection reports, many of which are examples of where residents have spoken with our inspectors about their own services. Using the findings from our inspection reports, inspectors are able to describe the experiences, contributions and observations of residents' lives in order to give a good overview of their lived experience and to highlight how good or poor levels of compliance can directly impact a person's life, freedoms and choices.

☺ Some residents were representatives on the organisation's advocacy board and had participated in different advocacy projects throughout the year. Staff had supported residents' ongoing participation in their advocacy roles throughout the pandemic, both through the use of video conferencing and other technology.

2.4 The lived experience of adults with disabilities

Being able to participate in and direct choices and decisions about our lives are basic human rights. Being listened to and, if needed, being supported to be heard means that we are able to ensure people understand and value our contribution. During 2021, inspectors heard from and saw many of the ways that providers have

supported and encouraged residents to participate in and direct their own care and support.

Some residents had become involved in their organisation's advocacy groups and were actively helping the organisation understand and learn from the lived experiences of residents. Inspectors found, in organisations where such groups existed and were conducted collaboratively, that residents expressed feeling more empowered and supported by the staff working in the centre. In these centres, residents said that they could speak up when things were not right, were confident that they would be listened to and that their views would be respected.

In organisations where there was limited provision for independent choice or self-advocacy, residents were more likely to express dissatisfaction. There were occasions where residents told inspectors that they did not always feel that they were being listened to or that their rights, privacy and dignity were being respected.

Some residents were unhappy living in the centres they currently lived in. For example, in one centre a resident felt that the arrangement had become very difficult and that they could not spend time in the communal areas of the centre and did not feel able to do their own cooking or cleaning. They wanted a better quality of life in their own home, but no progress was being made towards achieving this.

 [For] one resident, who was dissatisfied with their placement in the centre, there had been no referral to advocacy services and in another case, a family member told the inspectors that there had been no follow up to request for the transfer of a resident to a more suitable location.

 56 different staff had worked in this centre since June 2021, but from records reviewed by the inspector, only five staff members had completed training in LAMH with all of these five [being] relief staff, rather than staff who were [employed] to work permanently in the centre.

Residents living in designated centres may have many different approaches to communicating how they feel, what they would like to do, where they would like to go or when they do not want to participate. Many residents, when expressing their own will and preferences, rely on staff understanding their communication needs and staff members competence and ability to communicate and respond to their verbal and non-verbal communications. Providers who have developed good systems, which promote and respect each resident's individual communication needs

and preferences, ensure that residents can be actively involved in their own homes and participate in choices about their lives.

However, while the majority of providers did ensure that staff were equipped with the necessary skills, knowledge and training to communicate effectively with residents, some residents were not being actively supported by consistent and meaningful approaches to communication. For example, while some providers had developed communication passports for each resident, these did not outline how best to communicate with residents.

Some providers used the support of speech and language therapists to work with the residents and staff to develop communication plans and strategies. Providers in good centres were found to have supported residents to continue to communicate using their preferred communication method and, where needed, had made changes or additions to the centre to help residents do this independently.

Throughout 2021, there was a gradual easing of restrictions on being able to meet up with family and friends, including indoor dining and visits to residential centres. During the restricitions, residents in many centres were supported through a variety of means to maintain regular and meaningful contact with people who were important to them, outside of their health and social care staff. For some residents, this meant many visits with their families were conducted as window or garden visits.

When residents were once again able to invite their friends and family back into their home, they identified that it was important for them to have somewhere they could meet their family that was quiet and private. Again, in the majority of centres, providers had made such an arrangement. However, there continued to be examples where residents and their families did not have access to such facilities. In these centres, residents told inspectors that they often had to meet with their families in communal areas, these could be noisy and distracting and meant that sometimes residents had to meet with their family in their bedrooms.

 They had communication passports, plans and personal communication dictionaries in place. The personal communication dictionaries gave staff details on how the person communicated and how best to interpret and respond to that communication. In addition, residents meetings took place using a Total Communication Approach to best support residents to understand the information that was being discussed in the meeting.

While the registered provider facilitated visitors in accordance with the resident's wishes, there was no suitable private area, which was not the resident's room, in order for these visitors to be received. Family members expressed to inspectors that this was an area that they would like to see improved.

Being able to direct how you live your own life and have access to and control over your own private space, possessions and money are very important to residents' independence. Providers of good services have continually strived to ensure that residents are supported to be as independent as they wish. During 2021, some residents spoke to inspectors with pride about their rooms, their belongings and what brings most meaning for them in their lives. Other residents spoke about being able to manage and maintain control over their own bank account, keeping their money and personal banking card in a secure location in their own room. These residents often spoke about some of the fun and enjoyable activities they had been able to do in the past, such as going out for coffee to the local centre with their friends and being able to buy new clothes or personal care items independently. They spoke about how much they were looking forward to being able to do this again, when restrictions on meeting up with people, and on inside dining, were eased.

Residents living in one of the houses were training to participate in a walking trail, which would be completed in stages. For example, one resident was supported by staff members to go cycling on a local track and sea-swimming at local beaches.

However, some providers were not ensuring that residents could directly access their own money. It was also evident in some centres, that the residents' belongings and possessions were not always treated with respect. Some providers failed to make suitable arrangements for the storage of these personal items so that they could be easily accessed by the residents. For example, during one inspection, inspectors saw that a framed collage of a resident's photos was on the ground behind a wardrobe, and in another, many of the residents' personal possessions had been sealed in plastic bags and stored on the top of wardrobes.

Throughout the last two years, residents living in designated centres have experienced significant challenges and this has impacted on how they lead their lives during periods of restrictions. Inspectors found that in well-run centres, staff and residents used this as an opportunity to explore different ways of filling their day. For many residents, this meant they were able or supported to develop new and interesting activities, which has allowed them to continue to live active lives and develop new interests and skills.

Outdoor visits with family were facilitated and visits to home with controls recommenced as soon as was feasible and reasonably safe to do so. Staff encouraged the use of technology so that residents remained connected to family, friends and life in general. The inspector noted a bracket on the wall near a window and the person in charge described how the resident had placed their personal tablet here during window visits with family so that photos could be shared and enjoyed.

Some staff members had completed training on human rights to further strengthen the human rights-based approach implemented in the centre. There was guidance and information for students on accessing advocacy services, and their rights. Students had attended advocacy classes and some had completed learning programmes on advocacy. The students attended monthly house meetings and discussed topics such as complaints, infection prevention and control, household chores, and leisure activities. Inspectors observed the students to be independent and to have full access to the environment of the centre.

Unfortunately, this experience has not been the same for other residents, particularly those living in some of the larger congregated settings. As a result, some residents spent the majority of their time doing very little, without meaningful contact or engagement during the day.

2.5 The lived experience of children

Children living in designated centres are supported to develop and flourish when providers ensure that there are suitably trained and knowledgeable staff who are supported by child-centred service arrangements. This ensures children can be kept safe from harm and have access to education, play and facilities in their centres, which are appropriate to their age and developmental stage. In centres where suitable systems were put in place by providers, inspectors found children were supported to understand and exercise their rights, and were encouraged and able to express their views and choices.

In a number of centres, inspectors were informed that children had chosen to be referred to as students, which they felt better reflected their status. In these centres, students reported feeling valued and supported to contribute and take control of their lives.

While in the majority of centres, the lived experience of children was positive, in some cases there continued to be some difficulties with the compatibility of some children living together, and the use of shared bedroom spaces. Some children preferred their own private spaces and were not happy with other children going in to their rooms. While staff were aware of these issues, inspectors found that there was not always a planned response to support children to maintain control over their private spaces.

In other examples where adverse incidents occurred in the centre, there were occasions where the right of the child for privacy and dignity was not always maintained during the ensuing review and documentation of the events. However, these situations were very rare and in the majority of cases, childrens rights were respected and supported by good and effective governance systems.

Over the course of the 2021 programme of inspections of centres for children with disabilities, inspectors noted good compliance with how children were supported to communicate and develop their communication skills. While there were some centres that were found to be in substantial compliance with the regulations, no centres were found to be in non-compliance. Areas that inspectors noted for minor improvement to achieve full compliance with this regulation included; ensuring adherence to communication plans and supporting staff training in communication skills.

This means that overall, children in the centres that were inspected were being actively supported by providers to ensure that they were able to communicate and express their views, while in the designated centre.

☺ Staff members had supported the resident to become friends with two other children who were supported by the organisation. It was clear that they enjoyed playing outside, and staff facilitated times where they could play video games online together. Staff members were aware of the importance of building and maintaining the children's relationship with friends.

In all centres for children with disabilities that were inspected during 2021, inspectors found that providers were in full compliance with the regulations relating

to residents' visits. Inspectors found that the children were supported to receive visitors and maintain contact with their family and friends, throughout the various stages of restrictions. For example, when the restrictions had eased and visits inside the designated centre were once again permitted, there was evidence that regular visits had recommenced, one young person had celebrated their birthday and had invited all there family members to attend a party in their home.

Most children were also being supported to have access to private space and were able to have their personal possessions with them when they were staying in a designated centre for periods of respite or longer stays. For one resident, this meant that they were able to have their pet with them in their room. While for other children it meant that they could bring possessions with them to make their room feel more like home.

Children should be supported to access and participate in educational programmes while living in designated centres and attending respite services. In addition, children should have access to and be supported to play in suitable play areas, both inside and outside.

☺ Children had communication plans which guided staff on the most effective verbal, pictorial and gestural means of communicating in line with children's assessed needs. In addition to this, visual supports were used within the house to help guide children through everyday routines. Communication supports were also in place during children's advocacy meetings to ensure each child had the opportunity to appropriately express their individual preferences.

Inspectors observed that many providers had made such arrangements for residents, including the development of sensory rooms and gardens, which supported children with different sensory needs to have active sensory experiences or interaction within their environments.

☺ Children had access to and retained control of their personal property and possessions while staying in the centre. There was adequate space and storage in each bedroom to store their belongings. Children could bring their own linen if they wished, otherwise freshly laundered items were available in the centre.

☺ In the context of national restrictions and the impact this had on visits in designated centres, the provider and person in charge had ensured to the best of their ability that residents were facilitated to receive visitors in accordance with their wishes. For example, through window and garden visits.

Unfortunately, some residents were not actively supported to access a programme of education in some centres. Inspectors also found occasions where residents were not being actively supported to be involved in meaningful play or social activities. However, overall throughout 2021, inspectors found that children were provided with good support in well-led centres.

😐 The inspector found residents' rights had not been consistently upheld and the privacy and dignity of residents had been compromised in the follow-up procedures to adverse incidents.

😐 Children did not have a school placement or an individual education plan. There was evidence that efforts were being made by staff in the centre and external professionals, who were responsible for this child's care, to secure a school placement. However, the child had not attended school or attained formal home school tutoring for an extended period.

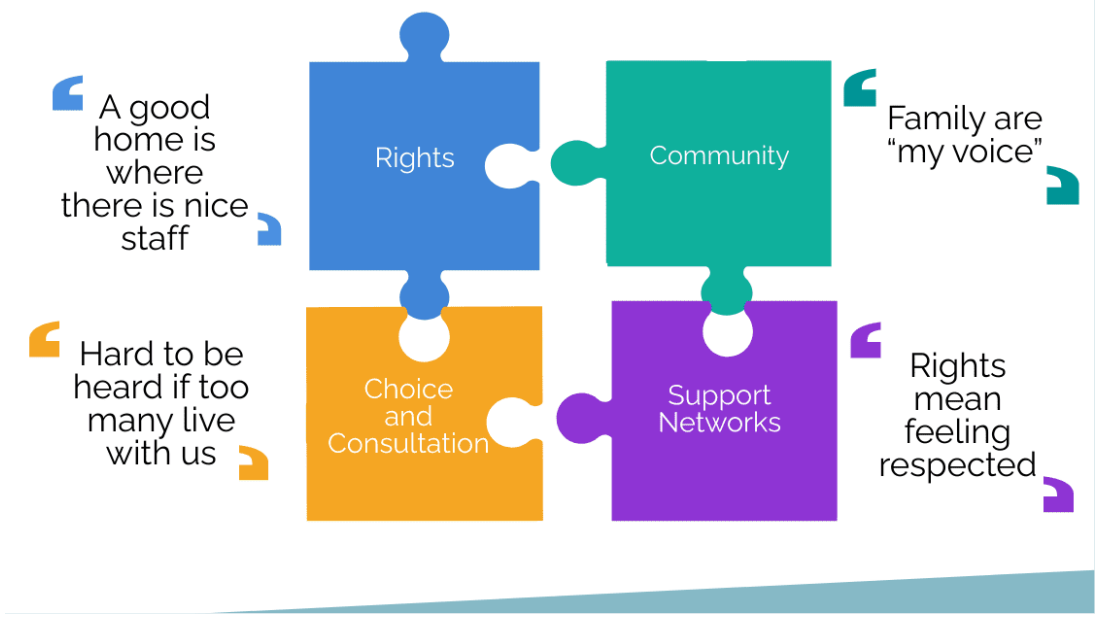
😐 While residents told the inspector that they were happy living in the centre, it was found that there was minimal off-campus opportunities for them to engage in activities. The activities available were primarily centre and campus based. When a sample of activity records were reviewed by the inspector, there were entries such as 'leisure at home', 'home activities', 'listening to music' and 'watching television', recorded as the main activities for the majority of the resident group rather than the pursuit of residents' interests in the community.

2.6 Engaging with residents outside of the inspection process

In 2021, inspectors continued to meet with residents outside of the inspection process, to listen to their experiences living in registered designated centres. Inspectors also met with 20 different resident groups across the country, virtually via video conference calls. Topics discussed included residents' rights, their choices, their home, their experience of the inspection process and the impact of COVID-19 on their lives.

Residents told us about their experiences living in a congregated or campus-based setting with many other people and what it was like moving into housing in the community.

On 3 December 2021, to mark International Day of Persons with Disabilities, HIQA shared a video outlining these experiences in residents' own words. When asked what a home meant to them, residents told us they were happy when they had their own space and did not share homes with a lot of people. Some residents said they had lived in congregated settings for a long time and told us of their delight at being able to decorate their own bedroom in their new home. The Chief Inspector will use the feedback from our meetings with residents to enhance the inspection process for residents, as well as informing the agenda for any planned resident roadshows organised in the future. You can watch the video and read more about what residents told us here[1]



[1] Available online from: https://www.hiqanews.com/residents-in-campus-based-or-congregated-settings-experience-poorer-quality-of-life/

Chapter 3. Inspection activity in 2021

3.1 How inspectors judge compliance

Inspection is a fundamental component of the assessment of compliance with regulations and national standards. Inspectors 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. Inspectors want to know that people who are receiving residential care and support:

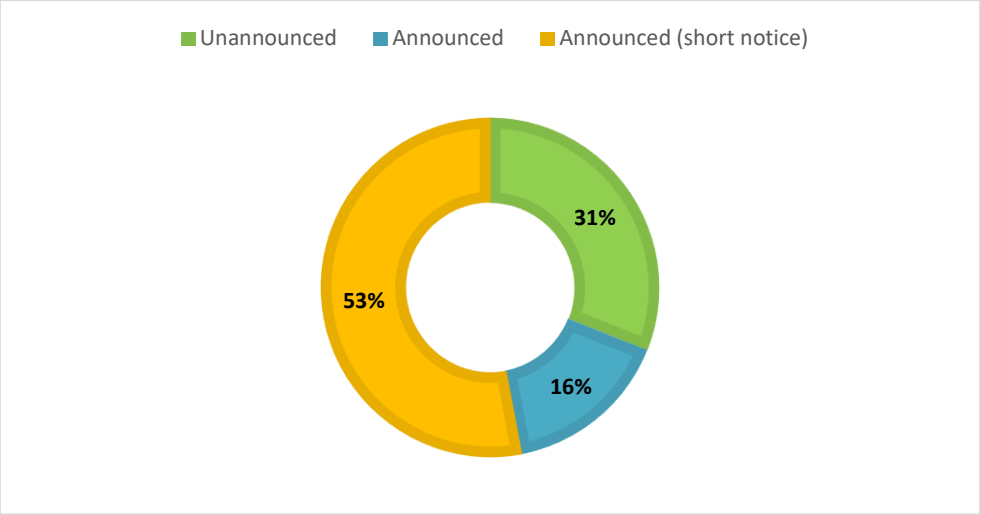
- are safe
- have their human rights respected
- are included in decisions about their care and support
- are provided with care and support that matches their individual health and social needs
- are living in suitable, fit-for-purpose environments and
- have a good quality of life.

3.2 Inspection activity in 2021

On-site inspections allow inspectors to observe the daily routine of residents, to hear from them about what it is like to live in a centre or 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. For this reason, inspections can be announced or unannounced.

In 2021, inspectors carried out 1,220 inspections in 1,121 designated centres for people with disabilities; 384 (31%) were unannounced, while 193 (16%) were announced. Due to ongoing national restrictions in relation to COVID-19, there were 643 (53%) short-notice announced inspections, in order to ensure that the inspector was able to plan and complete an inspection, with minimal risk of exposure or transmission of COVID-19. The short-notice announcement also enabled residents and relatives to communicate their views to the inspector, as they knew in advance when inspectors would be present in the centre.

Figure 8: Percentage of unannounced and announced or short-notice announced inspections of designated centres for people with a disability carried out in 2021



3.3 Centres requiring repeat visits in 2021

The Chief Inspector ensures that providers who are failing to comply with the regulations are given clear information and feedback about what is required to improve the safety and quality of the service for residents, and the time frame in which these improvements must be made. More frequent inspections may take place in these centres in order to gather evidence and to monitor the provider's progress and the impact of the provider's actions on the safety and quality of residents' lives.

Of the 1,121 centres inspected in 2021, 1,025 of these centres received one inspection. This was because they had a good level of compliance and where there were non-compliances the provider had responded appropriately. A total of 94 centres required two inspections, while two centres required three inspections.

Figure 9: Percentage of inspection visits per centre inspected in 2021

3.4 Publication of inspection reports

The Chief Inspector believes that the publication of inspection reports has increased transparency in how services are being run by providers and how centres are regulated. 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 provides further information to the public.

By the end of 2021, 938 inspection reports had been published. Some reports of inspections carried out in late 2021 were published in early 2022. In addition, a small number of 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.

3.5 Feedback on inspection reports and submissions

Before an inspection report is published, providers are given the opportunity to comment 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 1,220 inspections completed in 2021, providers gave feedback on 195 reports. Of those, amendments were made to 164 of those inspection reports.

After the feedback process, providers can make a submission on an inspector's judgments to the Chief Inspector, when they believe that the inspector's judgements are either incorrect or disproportionate.

In 2021, the Chief Inspector received three submissions from three providers in response to inspections completed in centres for people with disabilities. These submissions related to 12 regulatory judgments, 10 of which were judgments of non-compliant, with two relating to judgments of substantial compliance. Of these,

eight judgments were upheld, while four were not upheld following submission panel review and were changed. Three were changed from non-complaint to substantially compliant, with one changed from substantially complaint to compliant.

Chapter 4. Overview of regulatory compliance in disability settings

4.1 Introduction

By the end of 2021, there were 1,401 designated centres with 9,039 residential places for people with disabilities. This was a net increase of 61 centres since the end of 2020. Of these, 27% or 2,419 residential places continued to be located in congregated settings. Of these, 1,893 residents were living in campus-based settings and 526 residents were living in stand-alone congregated settings for 10 or more people.

At the end of 2021, there were 1,270 centres for adults with a disability, with 8,424 residential places, 37 mixed centres, for both adults and children with 233 residential places and 94 children's centres with 382 residential places. The below figures give a visual picture of how these centres break down as an overall representation of the total number of centres and bed numbers per service type.

Figure 10: Breakdown of registered designated centres by service type and bed numbers

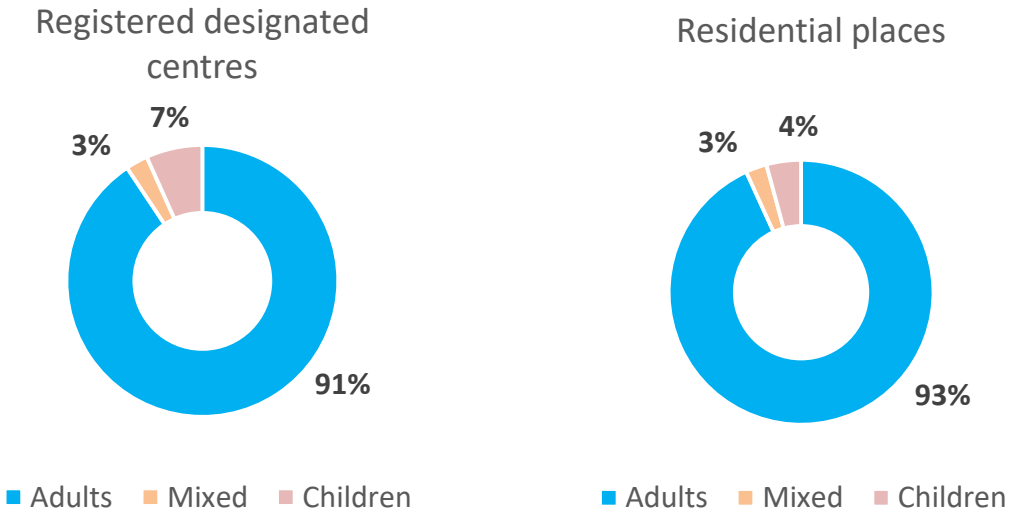
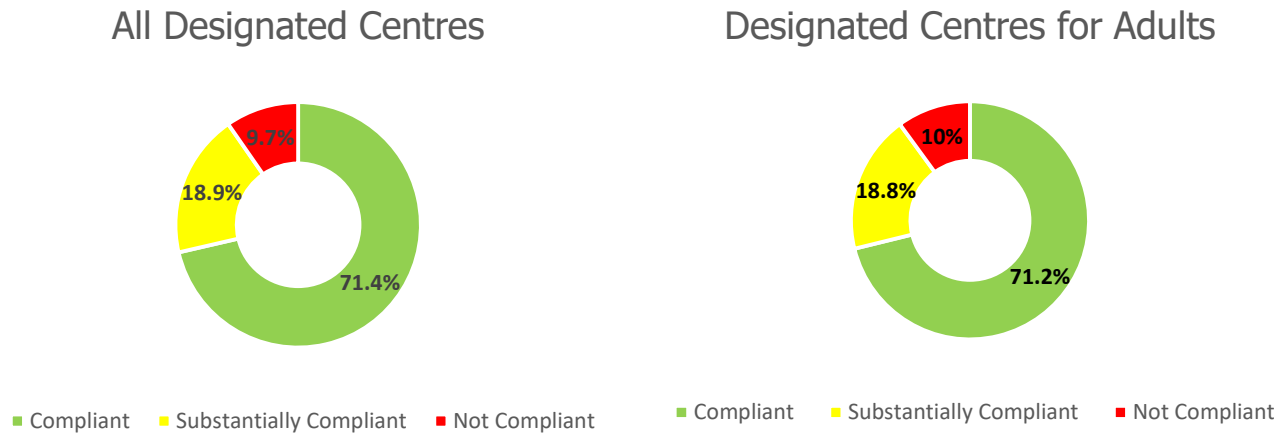
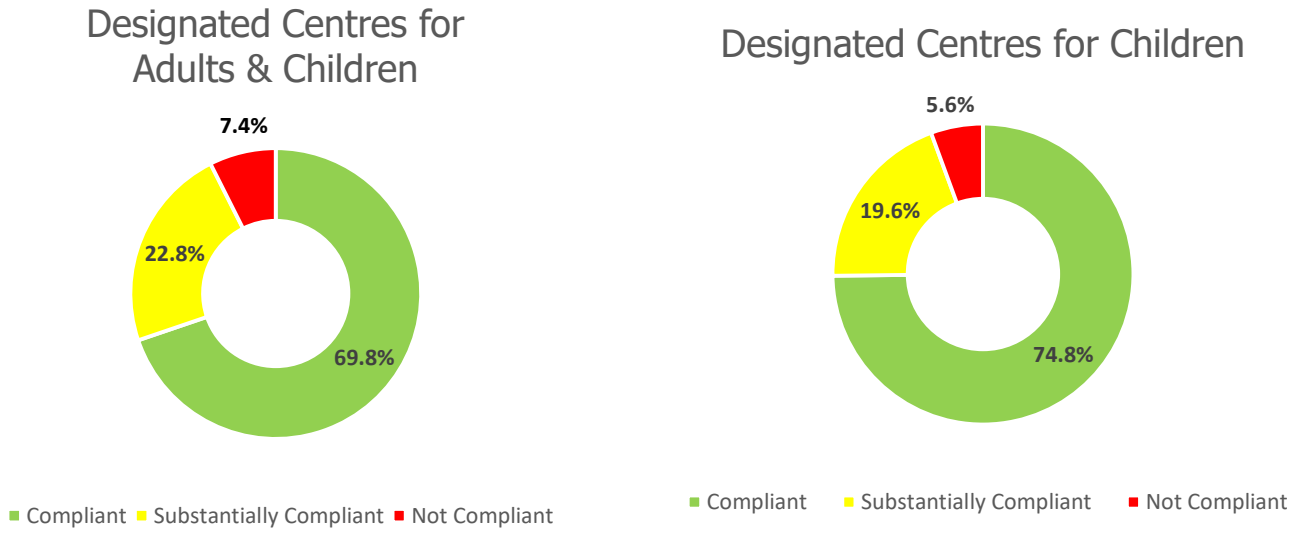


Figure 11: Breakdown of compliance by service type in 2021



During 2021, there were a total of 1,220 inspections completed across all three service types. This can be broken down into 1,106 inspections in centres for adults, 27 in mixed centres for both adults and children and 87 in centres for children

☺Residents had access to a range of social, recreational and educational opportunities in line with their preferences and goals. Residents were provided with the support to maintain their personal relationships and links to the community.



While compliance findings in centres for adults were slightly poorer than the overall findings, compliance findings for people accessing mixed or standalone children's centres indicated better overall compliance levels, which meant that people living in these centres experienced safer and better quality services. This variation may be

due to the continued high number of congregated settings providing residential care to adults.

4.2 Level of compliance in congregated and small community-based settings

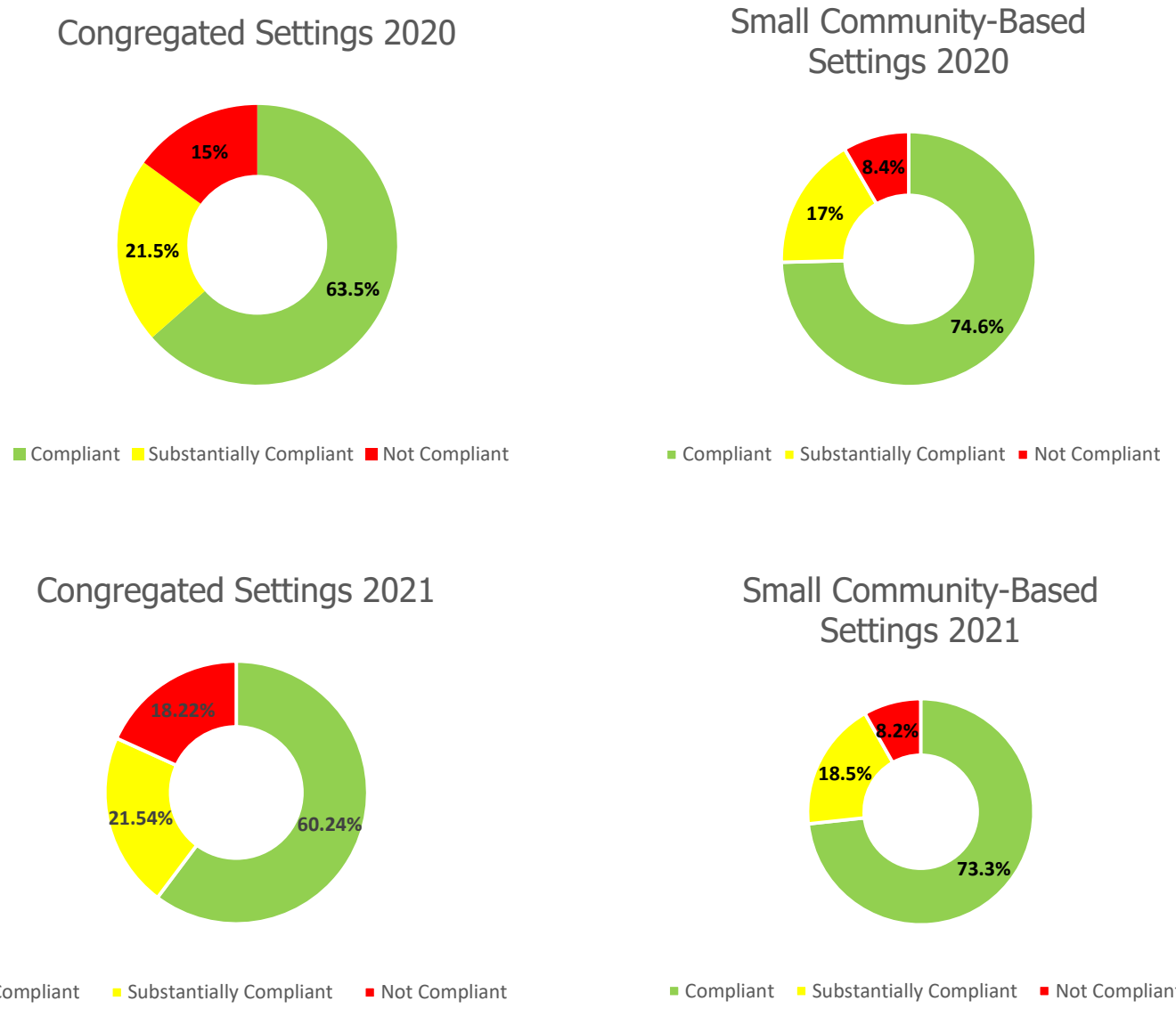
As detailed in Chapter 1, as of 31 December 2021, there were 201 centres based in congregated settings offering a total of 2,419 residential places in Ireland. A congregated setting is:

> 'Where 10 or more people with a disability live together in a single living unit or are placed in accommodation that is campus 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[2]'

When the data is broken down further to show the overall levels of compliance in centres where residents live in either community-based settings or congregated settings, we can see that during 2021 there has been significant deterioration in compliance levels for congregated settings when compared to similar data for 2020.

[2] Health Service Executive. *Time to move on from congregated settings: A strategy for community inclusion,* Dublin, Health Services 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

Figure 12: Overall compliance findings between congregated and small community-based settings between 2020 and 2021



As a consequence of this, residents living in congregated settings were more likely to experience a poorer quality of life with notable inequalities in the overall quality and safety of the services being provided to residents, when compared to their peers living in small community based settings. For many residents living in congregated settings, during periods of national restrictions and lockdown, inspectors found that there was a significant reduction in the provision of activities of interest during the day. Many residents living in congregated settings spent a significant proportion of their time in their centres with limited visits from either their families or to the community. The majority of people in the general community and many residents living in community-based settings were able to enjoy more freedom to access the community during 2021.

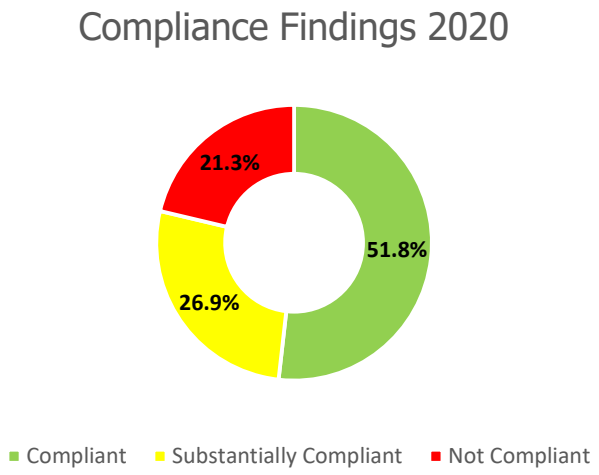
The remainder of this section of the report presents information about compliance levels in 2021 against a number of key regulations. These regulations were chosen because they are a good measure of the overall quality and safety of care and give us a picture of what it is like for residents who live in centres. The data presented below, demonstrates the overall quality of care and support that is experienced by residents living in congregated settings compared to their peers who live in smaller, community-based settings. In addition, we have included a breakdown of the data for 2021 by service type to highlight any differences in the overall quality of service being provided to children and adults in the service.

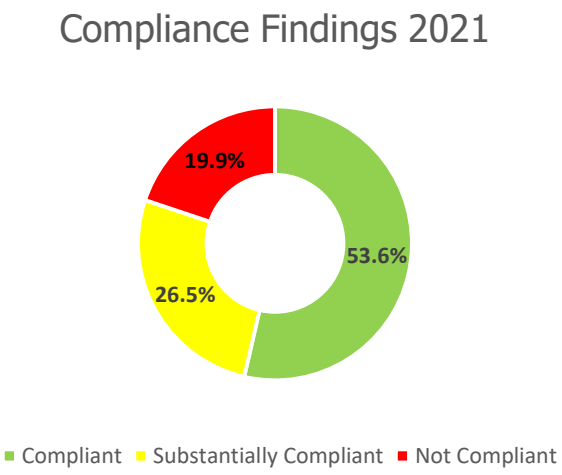
4.3 Governance and management

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 the 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.

The figure below shows compliance findings against Regulation 23: Governance and management in 2020 and 2021. Overall, while there was a slight increase in the overall level of compliance with this regulation in 2021 in comparison to the previous year, in one fifth of all inspections, inspectors found that improvements were required to the provider's governance and management arrangements. In addition, as stated earlier in the report, there was a marked decrease in compliance levels during the course of 2021.

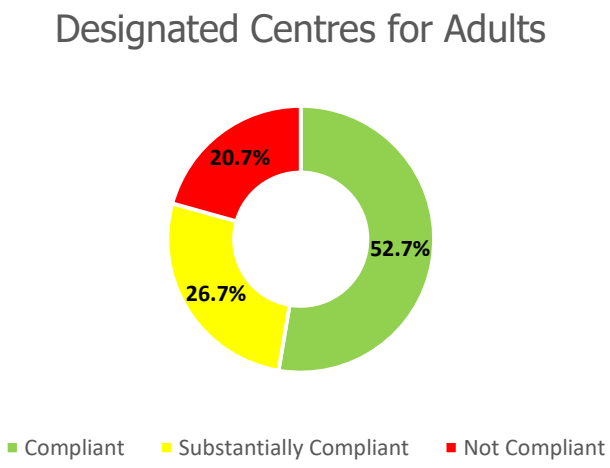
Figure 13: Comparison of compliance for Regulation 23: Governance and management between 2020 and 2021

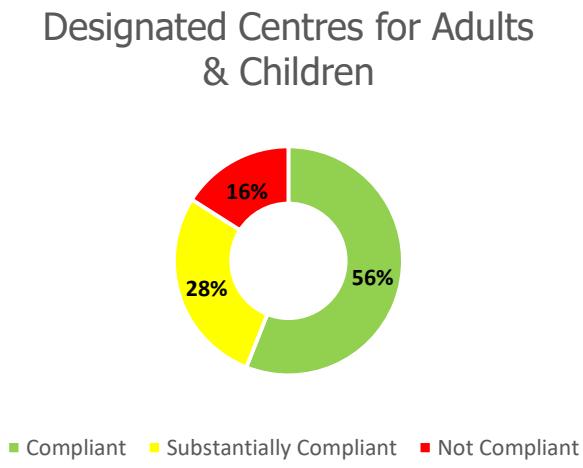


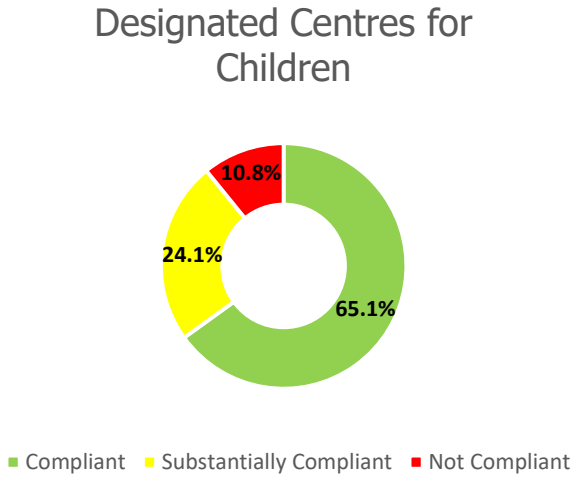


Findings from our 2021 inspection programme highlight that many providers had started to re-introduce on-site governance and oversight arrangements that had previously been reduced during 2020, and in some cases stopped. This meant that during 2021, there were noted improvement in the quality and effectiveness of some provider's surveillance systems. These help providers identify and address any emerging or ongoing deficits in their services and are an essential component of a provider's governance toolkit.

Figure 14: Compliance level for Regulation 23: Governance and management 2021 across service type







Providers with good governance and management systems were consistently keeping their policies and procedures up to date (in light of any ongoing changes to public health advice). They were supporting staff through training and education to keep their knowledge and skills current and were ensuring that their centres were well resourced throughout different phases of the ongoing restrictions and periods of increased staff absence.

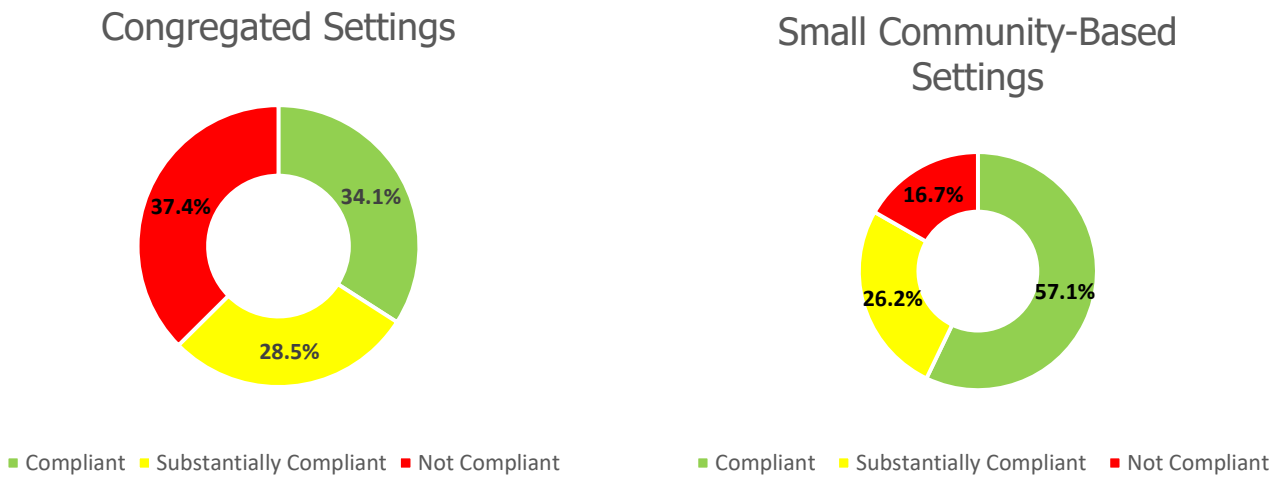
Compliance levels in centres for children with disabilities were significantly better than those of adult centres or mixed centres. This may be attributable to the smaller number of residents that children's centres tend to accommodate and also the higher number of congregated settings that accommodate adults.

Unfortunately, a comparison of the levels of compliance between community-based settings and congregated settings continues to highlight a significant difference in the levels of non-compliance in congregated settings. However, the 2021 compliance findings in congregated settings had a concerning deterioration in the level of non-compliance (29.3%) compared to 2020.

There was a lack of leadership in the centre which resulted in the absence of clear direction for the staff team. There was an overarching absence of developed management systems to allow the centre to operate to a high standard or to achieve its objectives.

The provider has systems in place to monitor and review the quality of services provided within the centre, such as bi-annual unannounced visits and an annual review of the quality and safety of care. The annual review clearly sets out how the views of residents, family members and staff were captured in order to inform the review.

Figure 15: Comparison of Regulation 23: Governance and management between congregated and community-based settings in 2021



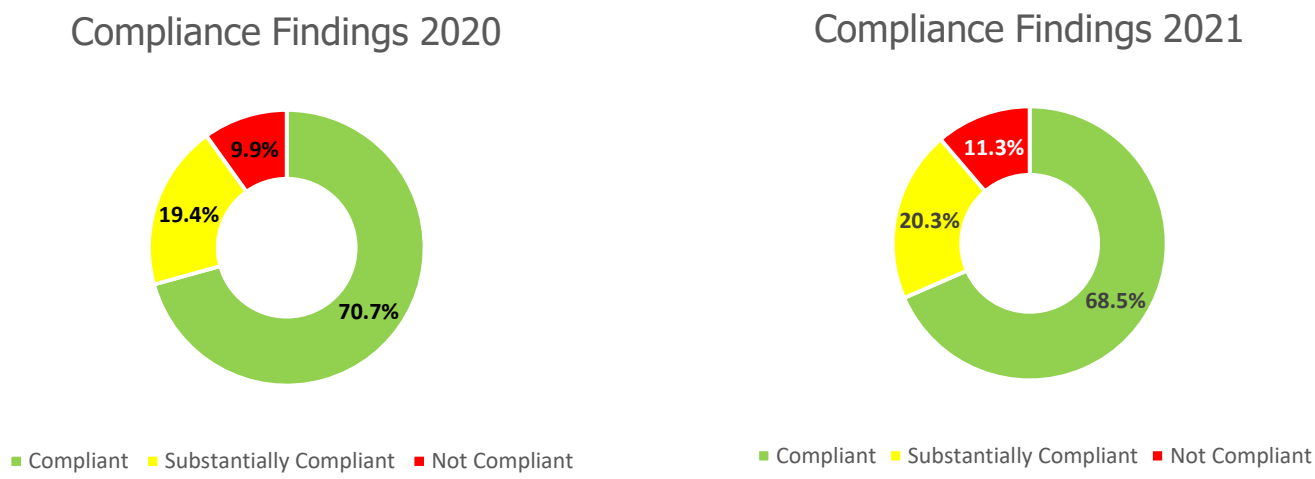
While issues and actions were being identified by the provider, actions, which would ultimately resolve and improve the overall safety of the service were either not being taken in accordance with the provider's own time frames or had not been adequately developed and monitored for completion.

The centre had a clearly defined management structure in place which consisted of an experienced person in charge who worked on a full-time basis. They ensured that resources were managed and channelled appropriately, which meant that the individual and assessed needs of the residents were being provided for. The person in charge ensured staff were appropriately qualified, trained and supervised so that they had the required skills to meet the needs of the residents.

4.4 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.

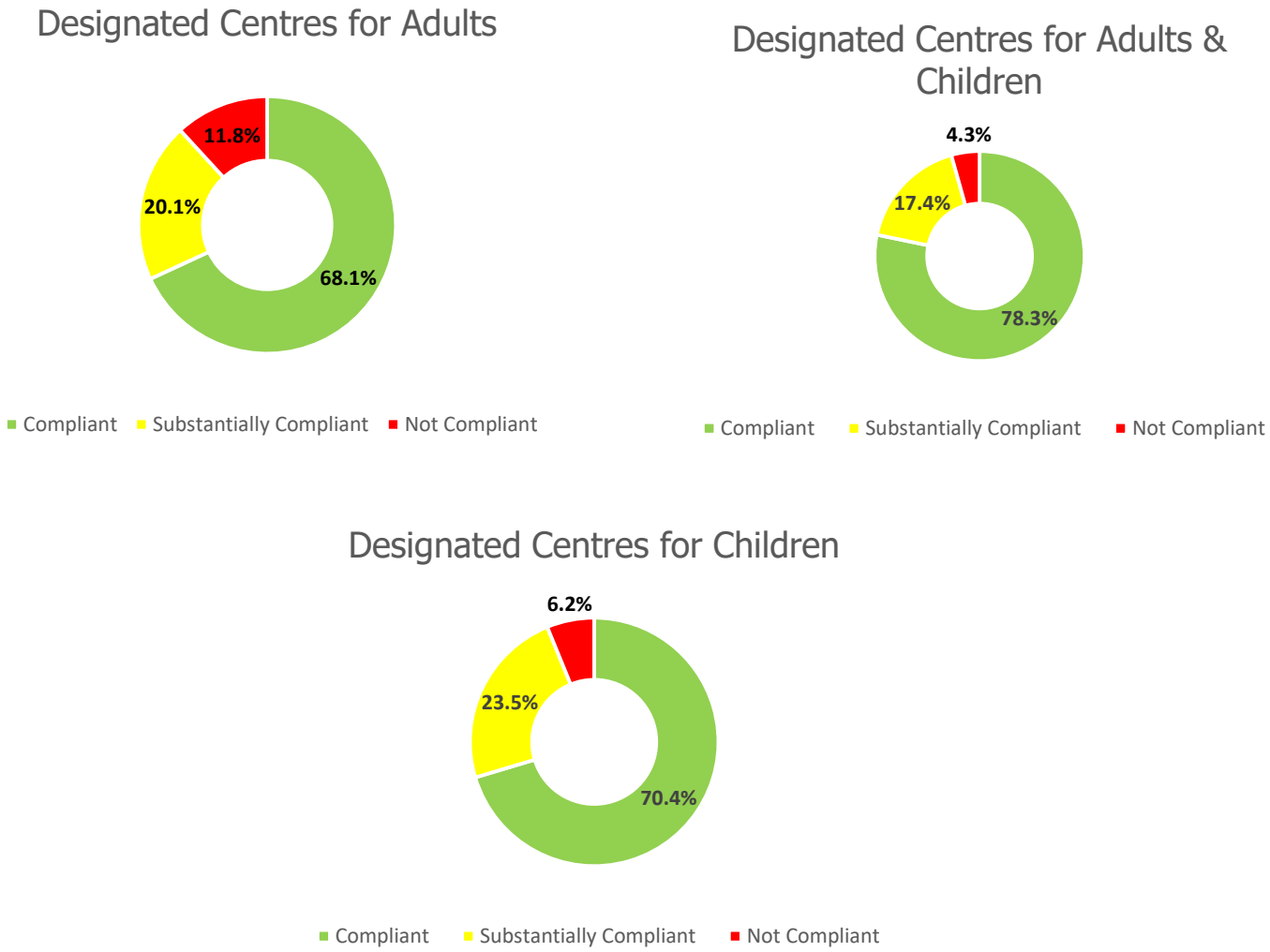
Figure 16: Comparison of compliance for Regulation 15: Staffing in 2020 and 2021



As can be seen in Figure 16, during 2021 there was a small decrease in the overall level of compliance with this regulation when compared to the previous year. While many providers were found to have suitable contingency arrangements in place and could deploy staff who were suitably skilled and trained from other parts of their organisation, some providers had struggled to recruit staff or to put in place suitable contingency plans to maintain a safe and minimum staffing complement.

In some instances, inspectors found providers had significantly reduced the level of minimum staffing available in their centres at times of high levels of COVID-19 infection, sickness or absence. While many providers had undertaken risk assessments and controls to manage these situations, worryingly some providers had failed to undertake an adequate risk assessment of minimum staffing levels. This meant that there were observable gaps found by inspectors in the overall quality of service provision in these services and occasions where residents were not engaged on an ongoing basis in any meaningful activity or able to leave the centre due to staff constraints.

Figure 17: Compliance level for Regulation 15: Staffing in 2021



Where compliance with this regulation was found to be good, providers were keeping their staffing needs under regular review, and were safely managing their staffing levels during periods of restriction, periods of increased staff absence or during the easing of restrictions. This meant that in these centres, residents were being supported by sufficient numbers of skilled staff who had been suitably trained and had knowledge about how to support the residents in meeting their individual needs and preferences.

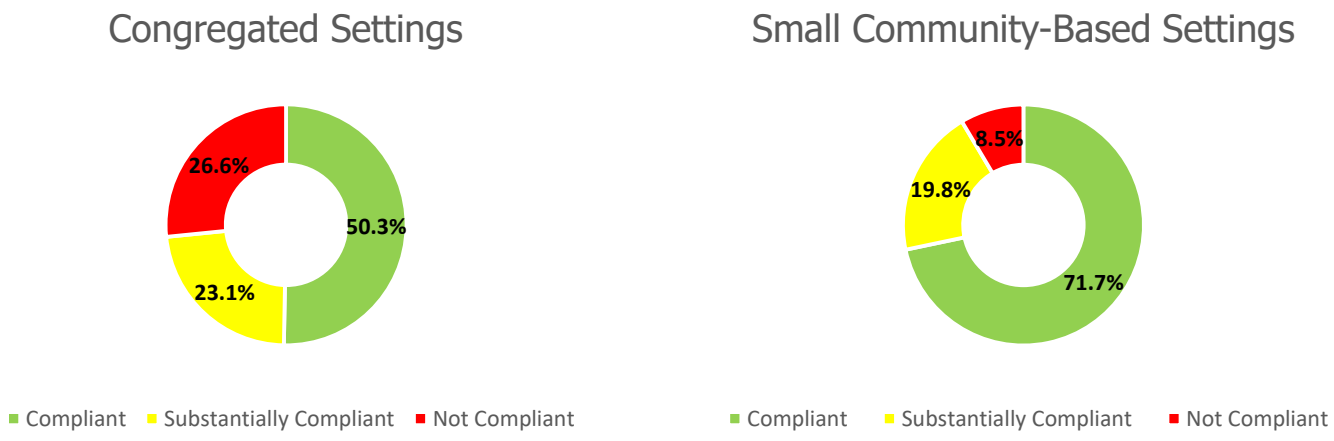
Comparing compliance across each of the service types highlights that compliance in adult centres is broadly consistent with the overall findings for 2021. However, it is evident that a provider's staffing arrangements in centres for children and in mixed centres are significantly better than those centres for adults with disabilities.

☺ At the time of the inspection, there was a full complement of staff with no vacancies. Rosters reviewed indicated that where annual leave or unexpected absence required cover, this was done through staff working shifts that were additional to their contract, and where that was not sufficient, using a consistent relief staff arrangement.

😐 Staffing resources remained an issue on the day of inspection, and the recruitment of appropriately skilled staffing in line with the identified needs of residents, had yet to be completed.

As demonstrated below, there is again a substantial difference in the overall level of compliance with staffing, when compared across congregated and community settings. Data from our 2020 overview report demonstrated that for community-based settings compliance levels remain similar in 2021. However, in congregated settings there has again been a significant and negative shift in the previous level of non-compliance from 15.5% in 2020 to 26.6% in 2021.

Figure 18: Comparison of Regulation 15: Staffing - between congregated and community-based settings in 2021



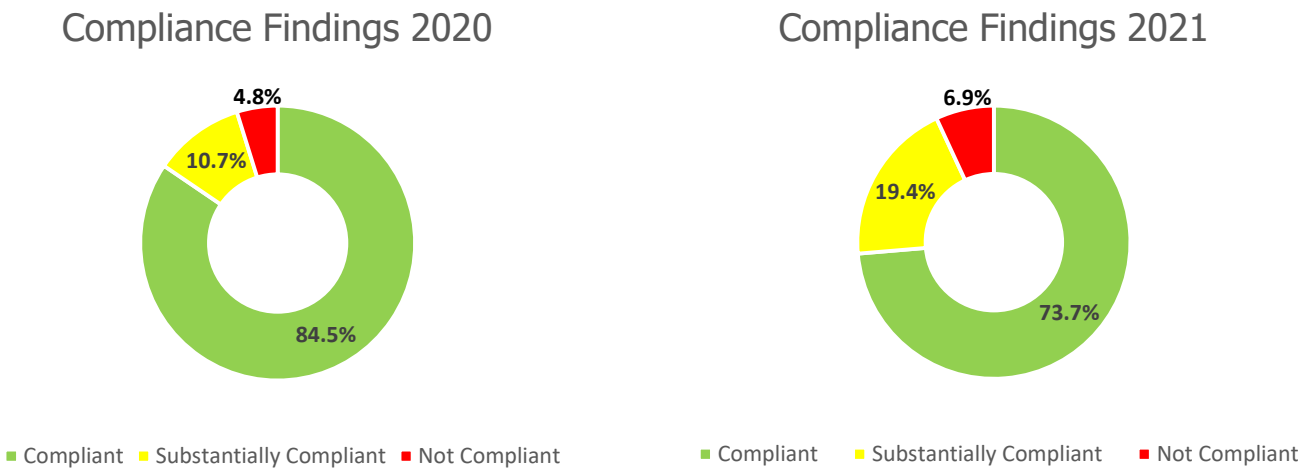
☺ The number and skill-mix of the staff team deployed in the centre was appropriate to meet the number and needs of the residents who were availing of its services. There were significant improvements in the continuity of care being provided to residents, which had a positive impact on the wellbeing of the group who had developed meaningful relationships with the staff team.

☹ The inspector found that repeated non-compliance with Regulation 15: Staffing, had not been adequately addressed since it was identified as an area for improvement in 2016. This resourcing issue had a negative impact on the provision of care and support to residents living in the centre.

4.5 Infection control and prevention

Ensuring good infection control practice in centres for people with disabilities across the sector is a cornerstone of a provider's strategy to keep residents safe from the risk of infection. In order to meet the requirements of Regulation 27: Protection against infection, the provider must ensure that residents who are at risk of healthcare-associated infections are protected by adopting procedures consistent with the *National standards for infection prevention and control (IPC) in community services*[3].

Figure 19: Comparison of Compliance for Regulation 27: Protection against infection 2020 and 2021

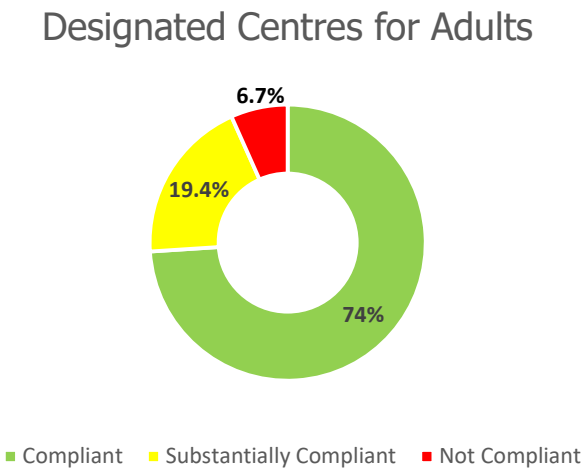


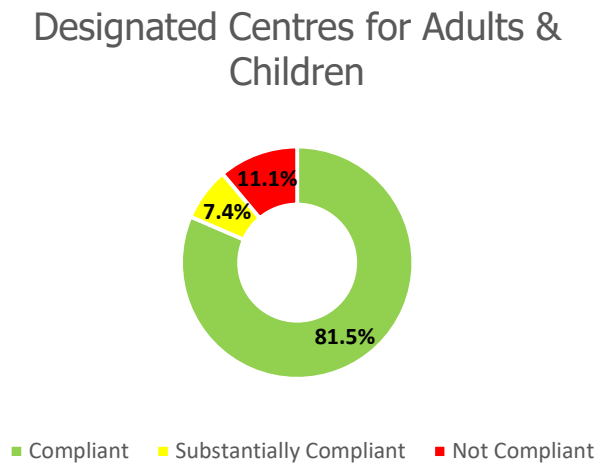
During 2021, inspectors found that overall compliance levels across the sector deteriorated when compared with 2020. However, it is important to note that there were also significantly more on-site inspections completed in 2021. In 2020, Regulation 27 was reviewed in 72% percent of inspections compared to 95% in 2021, which also contribute to understanding the variation. Providers with good IPC precautions were consistently able to demonstrate good governance arrangements in their centres, including clear lines of accountability and responsibility for IPC, clear IPC policies, procedures and outbreak management arrangements which were consistent with national guidance. Those providers also had clear contingency planning arrangements for managing an outbreak that were kept under regular review, were effective and were regularly audited.

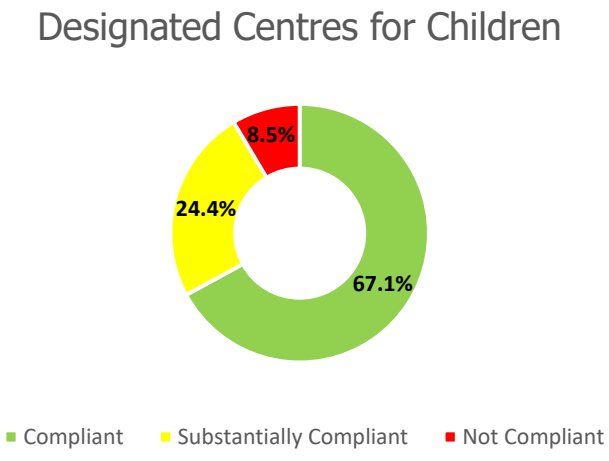
[3] *National standards for infection prevention and control (IPC) in community services*. Available from: https://www.hiqa.ie/sites/default/files/2018-09/National-Standards-for-IPC-in-Community-services.pdf

While the vast majority of providers were found to have good IPC practices, where issues did arise they included the quality of the centre's premises which impacted on the effectiveness of cleaning and disinfection. Other issues included inadequate stock control procedures for medical products and single use equipment, insufficient arrangements for the review and update of IPC policies and procedures in light of changes to national guidance and failing to ensure the proper use of PPE in residential settings.

Figure 20: Compliance level for Regulation 27: Protection against infection 2021







Across the different types of services within the disability sector, inspectors noted that while compliance in centres for adults with disabilities was broadly in line with the overall national findings, there were a number of children's centres that some improvements were required to deliver better IPC arrangements.

☺ The provider ensured that there were systems in place for the prevention and control of infection. This included staff training, infection prevention and control audits and the availability of personal protective equipment (PPE).

☺ Staff were observed to follow good hand hygiene practices, wear PPE and adhere to social distancing where possible. Staff spoken with were knowledgeable in relation to cleaning schedules and practices for the designated centre.

😐 A number of staff required refresher hand hygiene training, and some were due to complete a number of other infection prevention and control trainings.

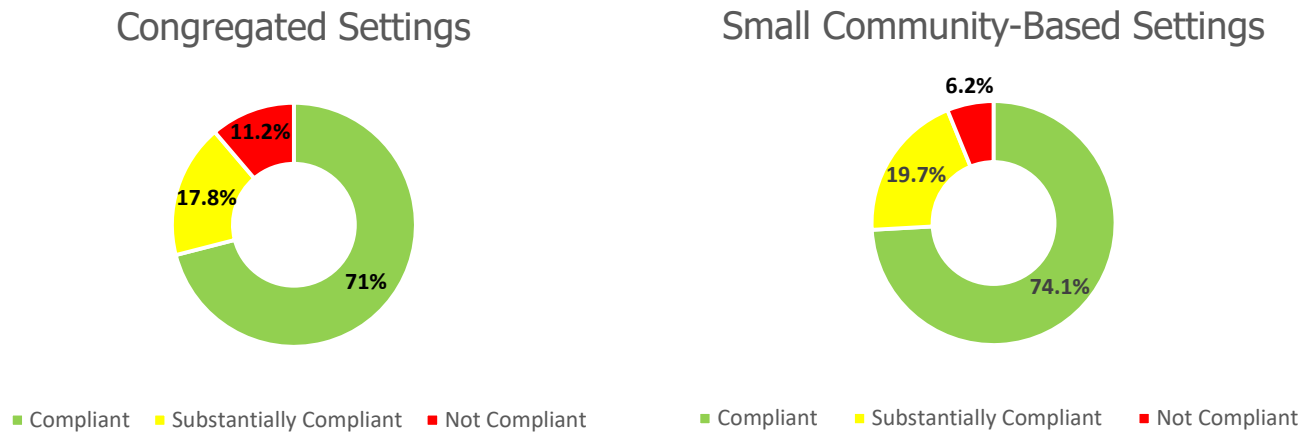
😐 Urgent maintenance to the resident's bedroom and en suite was required to mitigate a strong unhygienic odour that was present in both rooms. Furthermore, the inspector observed mould on either side of the window walls in the en-suite bathroom.

However, inspectors noted that there was a higher compliance with good IPC practices in mixed centres for both adults and children. These mostly offer respite to adults and children which meant that there were frequent changes in residents using these facilities and associated cleaning arrangements between respite breaks.

Inspectors found that the overall IPC arrangements in community-based settings, although requiring some improvements, were better that those found in congregated settings. Inspectors consistently found that the maintenance and repair of dilapidations (items of disrepair or defects), and overall quality of the environments in larger, institutional buildings meant that providers could not ensure effective arrangements for the cleaning, disinfecting and decontamination of those centres. In a number of larger centres, inspectors found equipment such as wheelchairs, shower trolleys and hoists were shared by a number of residents, and were often stored in

communal areas, some were damaged and visibly unclean and on many occasions were not included in the provider's regular cleaning programme.

Figure 21: Comparison of Regulation 27: Protection against infection between congregated and community-based settings for 2021



☺ The staff team were observed to be wearing personal protective equipment (PPE) in line with public health guidelines. There were good stock levels of PPE available in the centre at the time of the inspection.

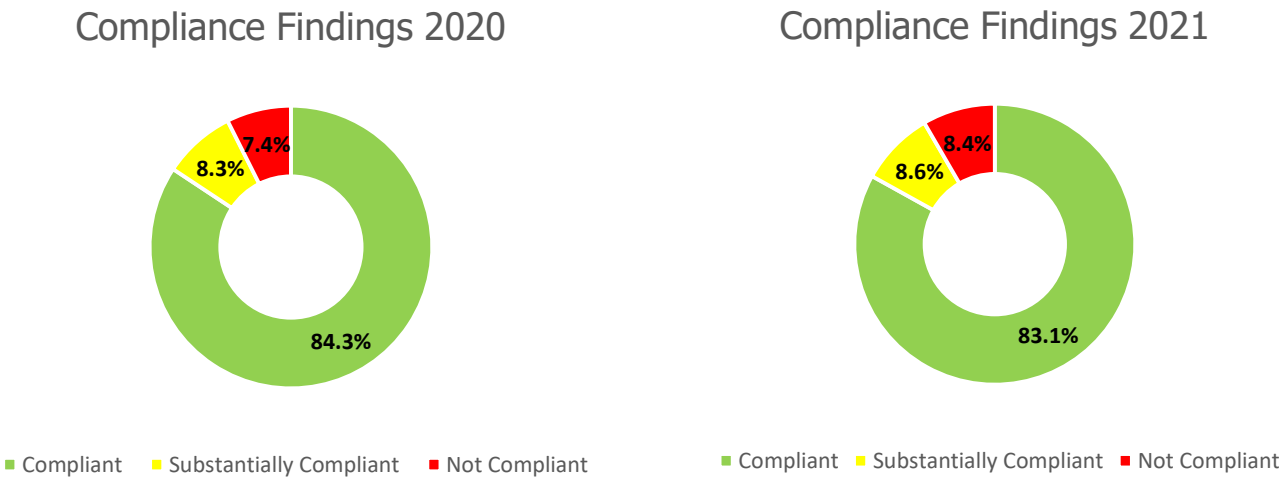
In September 2021, the Chief Inspector issued a guide and assessment and judgment framework to providers for IPC inspections. Following a series of webinars with providers, a pilot programme of infection prevention and control inspections commenced. This programme of inspections will continue throughout 2022 and will aim to drive improvements in the overall quality of IPC arrangements in the sector.

4.6 Protection

In the absence of specific safeguarding legislation for adults to prevent and protect adults from the risk of abuse, the Health Act 2007 (as amended) places limited obligations on providers and persons in charge to put in place arrangements to protect residents from abuse, to investigate and to take action where allegations of abuse have arisen. As can be seen from the data below, there has been a slight deterioration in the overall effectiveness of safeguarding in the sector, clearly

highlighting that more work needs to be done to ensure that residents are protected from abuse through statutory legislation.

Figure 22: Comparison of Compliance for Regulation 8: Protection between 2020 and 2021



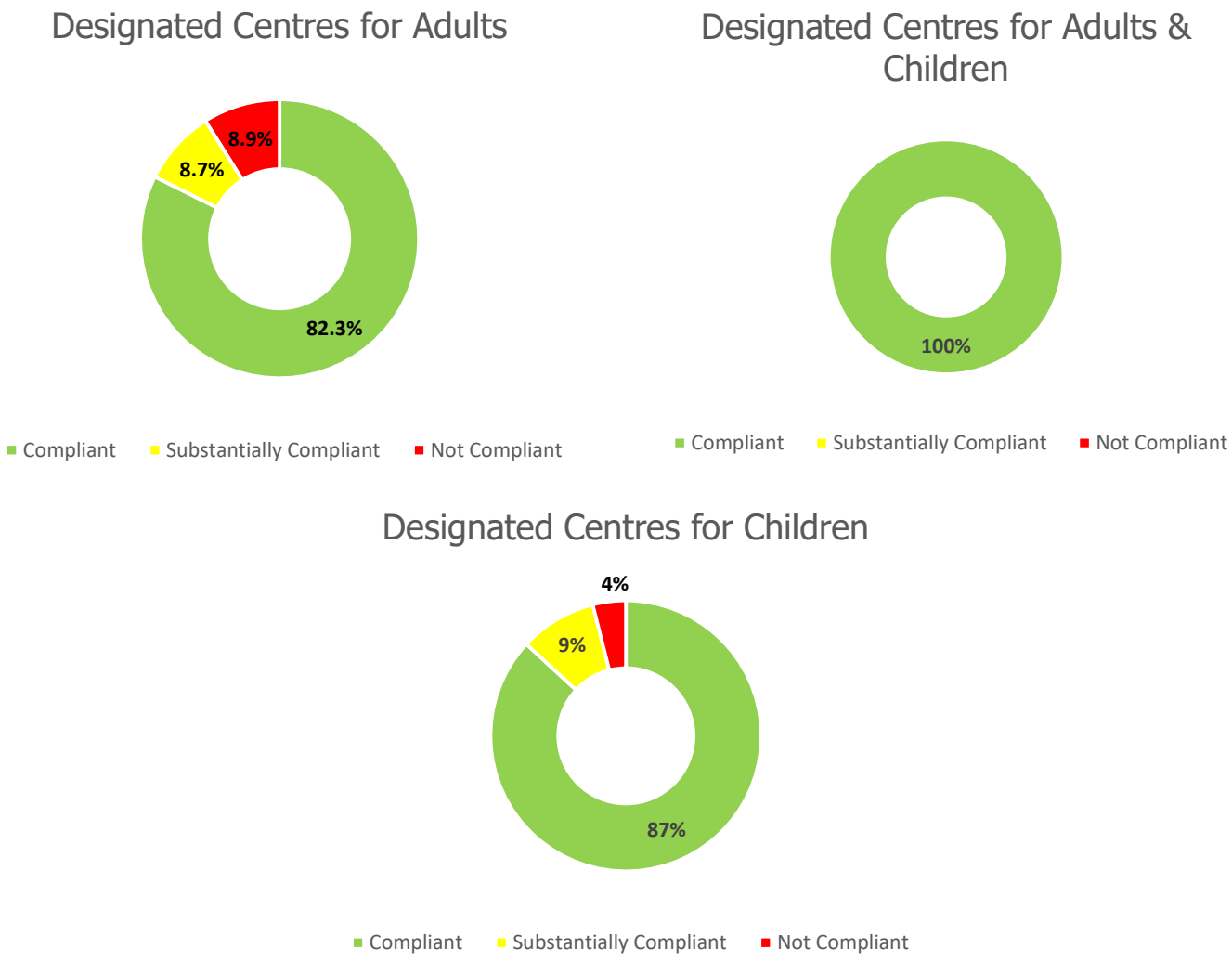
How a provider puts in place, monitors and oversees their safeguarding arrangements, and ultimately ensures that residents are kept safe from all forms of abuse, are key components in the delivery of a safe, effective and quality service. In addition, ensuring staff are trained, competent and confident in the detection, reporting and ultimately responding to safeguarding concerns provides a good framework for a positive safeguarding culture within a service.

In the event that a resident experiences harm or abuse, the provider's response 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.

In addition, in centres with good compliance levels, inspectors identified that staff were being supported to keep their safeguarding training up to date and knew and understood how to identify and report safeguarding concerns. In these centres, residents who spoke to inspectors about safeguarding reported that they felt safe and knew who they could speak to if they did not feel safe or had been hurt.

😐 A review of the centre's safeguarding folder detailed that there had been a substantial number of peer-to-peer related safeguarding incidents during the last 12 months. Many of the incidents were attributed to the lack of personal space for residents who required calm, low arousal environments.

Figure 23: Compliance level for Regulation 8: Protection



As can be seen in the breakdown across all service types, safeguarding practice was found to be mostly in compliance with the regulations, with mixed centres for adult and children being found to have full compliance in relation to safeguarding regulations.

Where non-compliance was identified in relation to safeguarding, providers had either failed to appropriately identify safeguarding concerns and take action to ensure the safety of the residents. Providers were required by inspectors to take action to ensure each of these cases were appropriately followed up and that they were reported to the relevant agencies.

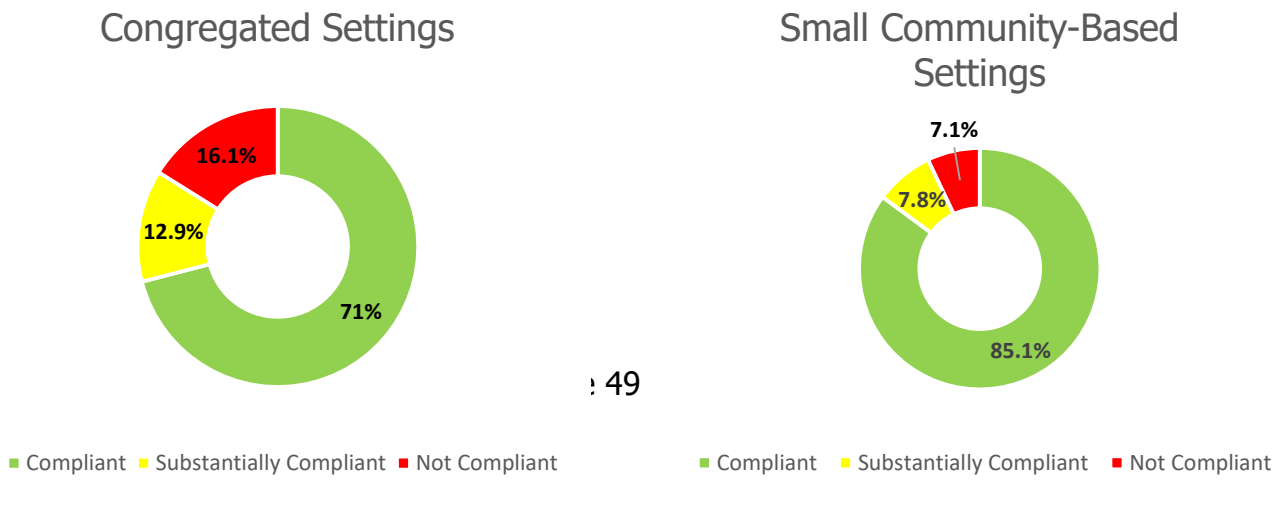
☺ Staff had received training in safeguarding adults and were knowledgeable of their role in relation to protection. Any potential safeguarding incident was screened appropriately and, where necessary, a safeguarding plan was developed.

During 2021, the Chief Inspector referred three safeguarding concerns to the HSE's National Safeguarding Office. Of these, one case was also referred to both An Garda Síochána and TUSLA, due to the nature of the concerns identified.

😐 There was a consistent pattern of serious incidents of self-harm, aggression and violence towards staff and safeguarding incidents towards peers occurring in the centre. These incidents had significantly impacted on the residents' safety and quality of life, despite additional supervision being put in place to protect residents. The provider was aware of these ongoing risks in the centre, but had not addressed these issues to ensure resident safety.

In 2020, inspectors found 11.9% non-compliance in congregated settings with Regulation 8: Protection. In 2021, non-compliance was found in 16.1% of inspections. However, there was a smaller level of increase in the comparative data in community-based settings from 6.2% to 7.1% non compliant.

Figure 24: Comparison of Regulation 8: Protection between congregated and community-based settings in 2021



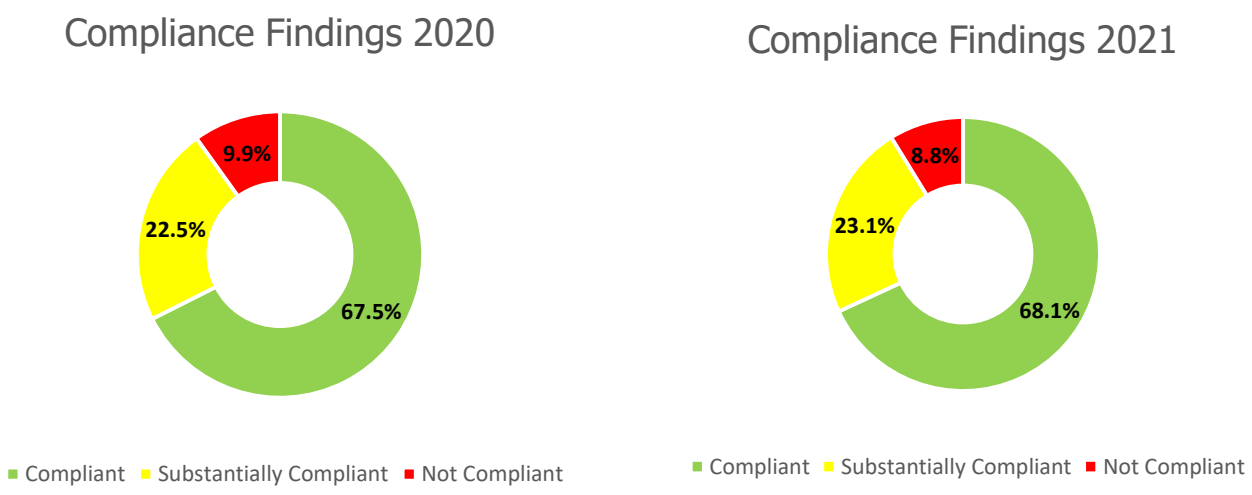
☺ There were clear lines of reporting and any potential safeguarding risk was escalated and investigated in accordance with the provider's safeguarding policy.

The data for 2021, once again clearly demonstrates the significant difference in the quality and effectiveness of safeguarding arrangements in congregated settings when compared to community-based settings, and highlights the continued and urgent need for the introduction of safeguarding legislation.

4.7 Positive behavioural support

One indicator of how a provider ensures the rights of residents are protected is compliance against Regulation 7: Positive behavioural support. This regulation requires that providers work with residents in order to understand and alleviate factors which may result in behaviour that may challenge. Providers need 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. As can be seen below, there has been a modest improvement in compliance during 2021, when compared with the findings from 2020.

Figure 25: Comparison of Compliance for Regulation 7: Positive behavioural support 2020 and 2021



On occasion, a provider may identify a need to introduce a restrictive practice to ensure the safety of residents. However, these should only be introduced where all other opportunities to explore and alleviate the underlying causes of the behaviour have been exhausted and where all other alternative measures have been considered. In addition, the restriction on a resident's liberty should only be used for the shortest duration necessary and in accordance with prevailing national policy and evidence-based practice.

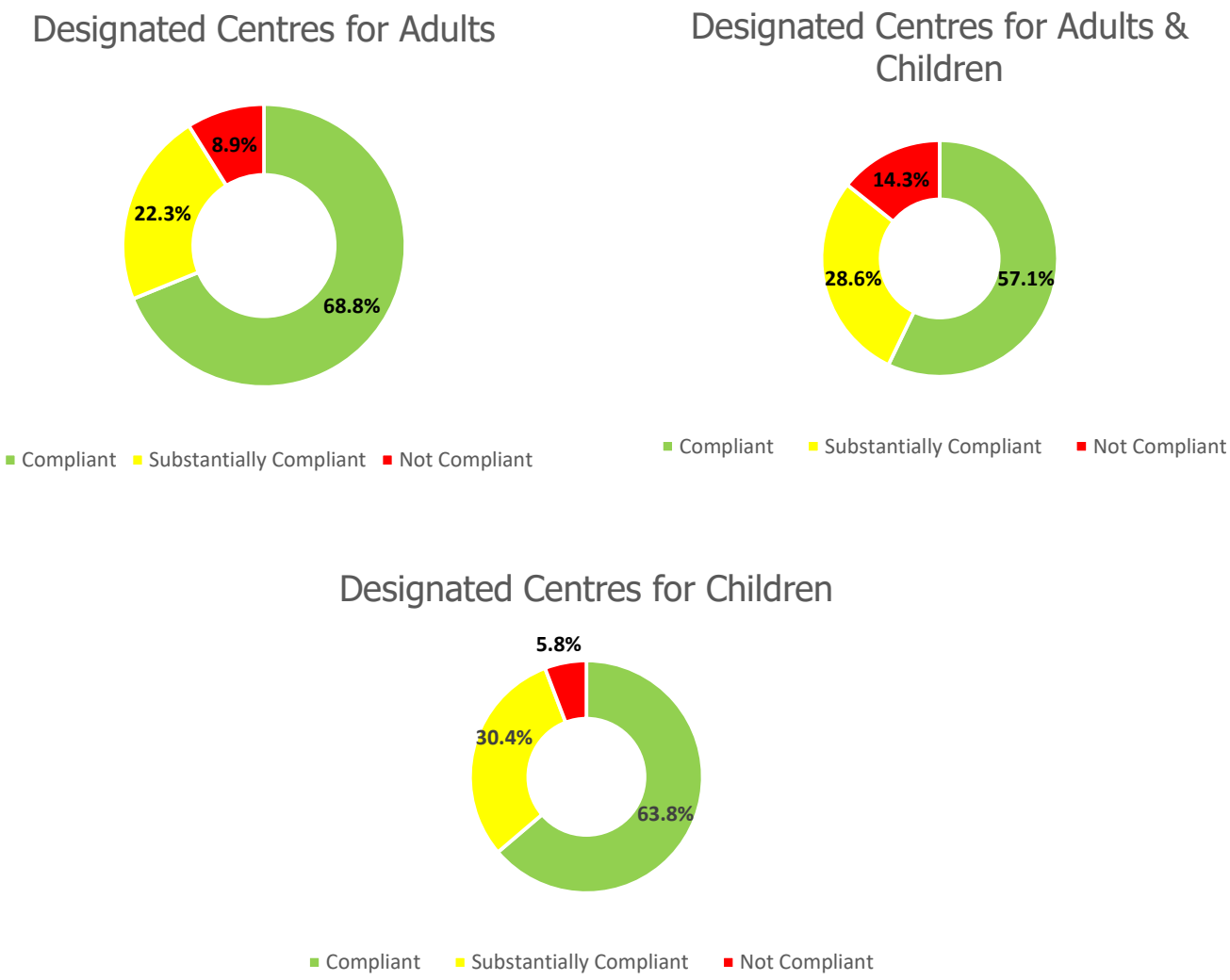
Given how fundamental this is in relation to the rights of residents, inspectors expect a high bar of evidence to demonstrate that any such measures are the least restrictive and are for the shortest duration possible.

A provider's governance arrangements should therefore be capable of constantly monitoring the use of restrictive practices and ensuring residents' rights are protected and promoted. Monitoring allows providers to track the use of restrictive practices and also ensures that reviews of practice are conducted with a view to promoting a restraint-free environment.

 Where physical holds were being used, the inspector found that these were not clearly described in the children's' behaviour support plans and the risks associated with their use had not been previously identified or considered by the registered provider

Data compiled from our inspection activity in 2021 highlights that similar levels of compliance were found in centres for adults, with slightly better levels of compliance found in centres for children when compared to the overall findings for all service types. However, in mixed centres for children and adults, there were significantly higher levels of non-compliance found, when compared with the overall findings for the year and in terms of the breakdown per service type.

Figure 26: Compliance level for Regulation 7: Positive behavioural support in 2021

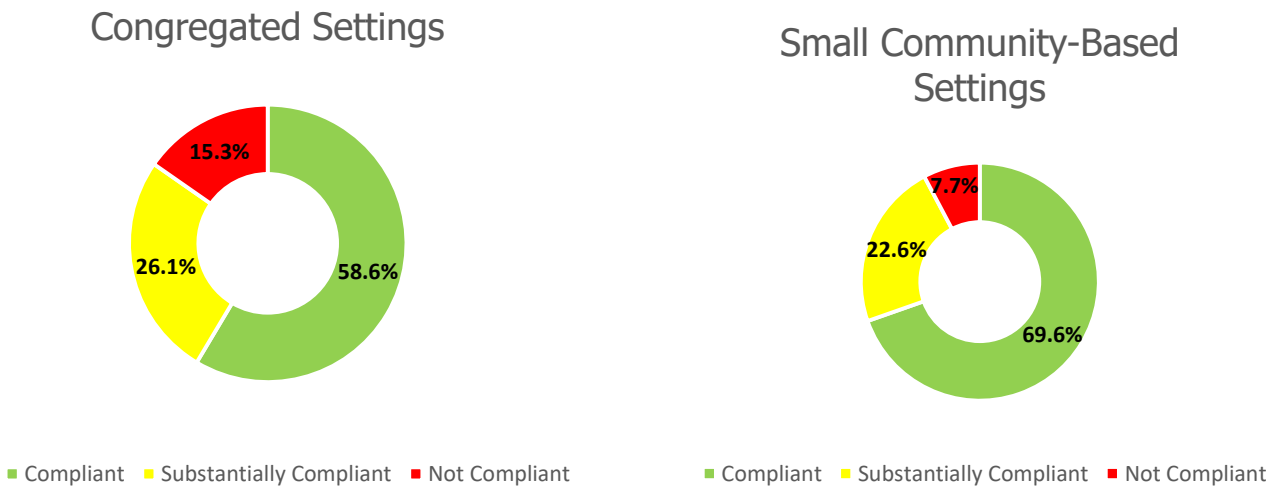


During 2021, compliance levels continued to improve for people living in community-based settings when compared to data from 2020 (9.4% non-compliance). This meant they continued to live in centres where there was less likelihood of restrictions on their liberty. However, 2021 saw a comparative deterioration in the overall level of compliance for those living in congregated settings from 12.3% in 2020, to 15.3% in 2021.

☺ A behaviour specialist was available to support residents and staff, and staff had access to training to support residents in line with their assessed needs.

😐 It was noted that not all of these restrictive practices had been identified and assessed by the provider. For example, the store cupboard upstairs and cupboards in the sitting rooms were always locked.

Figure 27: Comparison of Regulation 7: Positive behavioural support between congregated and community-based settings 2021



Inspectors found that in some congregated settings where an individual restriction was introduced, this tended to adversely impact on the remaining residents who were often then subject to restrictions even though they were not assessed as requiring them. Examples of this included the routine locking of kitchen cupboards or the fridge, restricted access to the televsion remote control and the removal of ceramic plates or kettles from kitchen areas, with all residents having to use plastic plates in response to the needs of an individual. In other examples, environmental factors continued to contribute to residents' movement being restricted, such as designated centres which were located on the first or second floor of a large

institutional building with poor arrangements for independently entering and leaving the building.

In another example, residents who used wheelchairs or other equipment to support their mobility had their movement restricted where there were limited or no arrangements for button-operated or automatic doors at key entry and exit points in the centre.

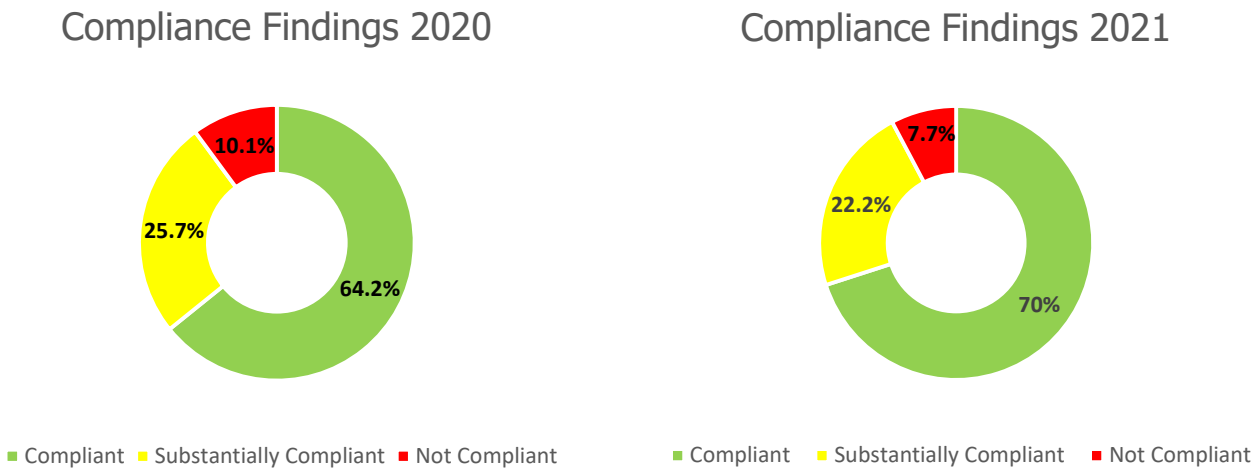
☺ While there were a number of restrictive practices in place, such as door locks, these were used as a measure of last resort and for the shortest duration of time.

4.8 Individual assessment and personal plan

During 2021, there continued to be improvements in the overall compliance levels for individual assessments and personal plans. Inspectors found that good providers have kept residents' assessments and care plans under regular review and updated these to ensure they reflected the residents' needs and personal outcomes goals, while ensuring consistency with public health guidelines. In centres with good practices, residents were supported and encouraged to participate in the development of their own personal plans.

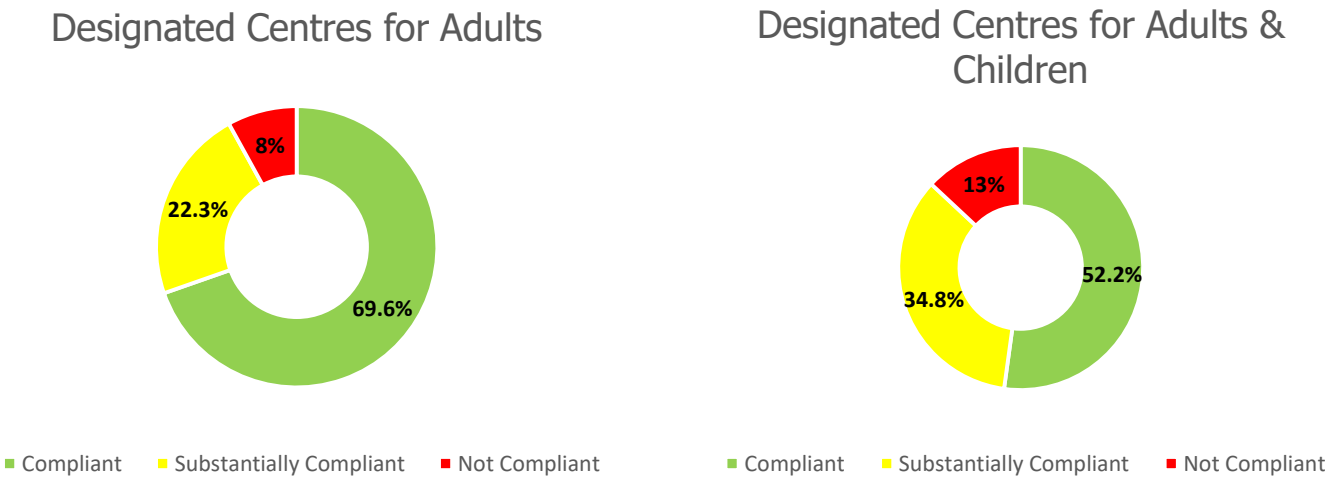
In many examples, providers had ensured residents were supported to enjoy many of their usual pastimes, even when their ability to access community-based activities was limited due to COVID-19 or the temporary closure of certain establishments for entertainment and hospitality. For example, in one centre the provider had worked with a resident to explore how they could improve their overall health and wellbeing and continue to socialise with their friends and family. This lead to the resident being supported to train and work towards completing their first ever 5km walk. They eventually achieved their goal to see a friend they had missed during previous periods of lockdown and to have a socially distanced meet up in a public space. In doing so their overall health, mobility and confidence also improved.

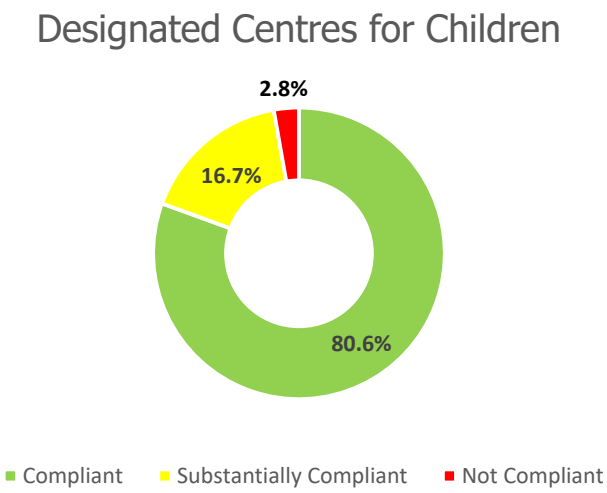
Figure 28: Comparison of compliance for Regulation 5: Individual assessment and pesonal plans for 2020 and 2021



However, for some residents there continued to be limited access to regular reviews and as a result their personal plans had not been updated to reflect changes in the public health guidelines. This meant these plans continued to focus on centre-based activities and goals, despite the easing of restrictions and uptake of the COVID-19 vaccine.

Figure 29: Compliance level for Regulation 5: Individual assessment and personal plans 2021





The overall quality of a provider's arrangements for assessment and care planning is a core component in supporting residents to have and maintain a good overall quality of life, that is person centred and meaningful to each individual resident.

The inspector found that not all of the residents had their full care and support needs adequately assessed. This resulted in a somewhat limited and curtailed daily life, notwithstanding the complexity of needs, with no meaningful goals or social experiences based on the own interests or preferences.

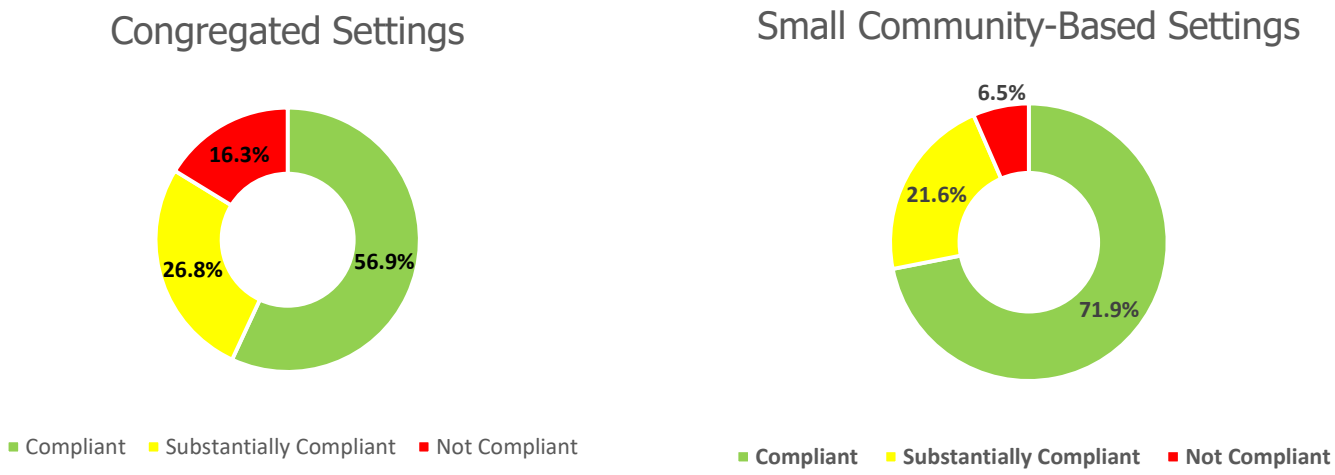
In centres for children, inspectors found evidence that residents were being supported by good assessment and personal planning processes. For centres for adults, the findings were broadly similar to the overall findings made during 2020. However, in mixed centres for adults and children there was a much higher level of non-compliance noted.

The personal plans reviewed detailed the needs and supports required by each resident to maximise their personal development. The plans set out the services and supports provided for residents to achieve a good quality of life and realise their goals. Personal plans had been developed in consultation with residents, family members and staff.

In community-based settings there was a very positive improvement from the previous year's finding of 10% of centres found as non-compliant. However, 2021 saw a significant fall in the overall level of compliance in congregated settings from 10.1% in 2020.

😐 Residents' personal goals had not been reviewed, progressed or re-adjusted to reflect the pandemic restrictions. For example, one resident's goals included re-commencing swimming and having music incorporated into their daily activities. Neither of these goals were documented as being reviewed or progressed. This resident was also still waiting for a referral for music therapy since April 2021… opportunities for residents to partake in activities of their choice were limited and had been impacted by challenges with staffing resources.

Figure 30: Comparison of Regulation 5: Individual assessment and personal plans between congregated and community-based settings 2021



This is concerning given the improvements made in 2020 from the 26% non-compliance noted in 2019. This indicates that a significant proportion of people living in congregated centres were not receiving or participating in assessments, review or personal planning activities on an equal basis to their peers living in community homes. It also indicates that many personal plans for residents during 2021 were based on the public health measures implemented during 2020, which were significantly more restrictive than the required public health measures in 2021.

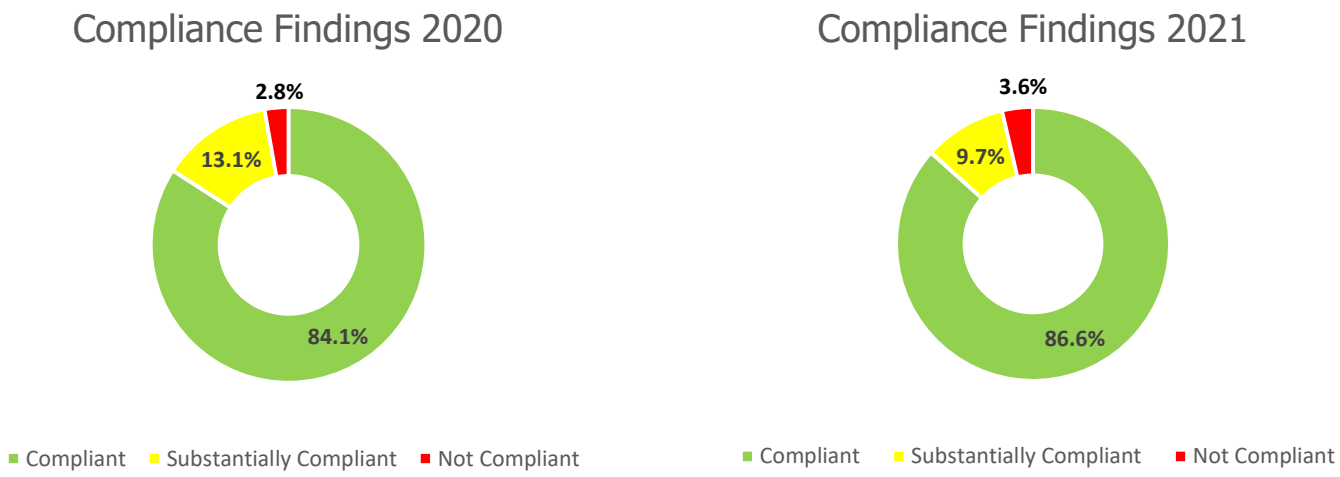
☺ The inspector reviewed a sample of residents' personal plans and saw that they included an assessment of each resident's health, personal and social care needs and that overall, arrangements were in place to meet those needs. This ensured that the supports put in place maximised each resident's personal development in accordance to their wishes, individual needs and choices.

4.9 Healthcare

Timely access to good quality and evidence-based healthcare is a critical element of keeping residents safe and well, enabling them to achieve optimum levels of physical, mental and emotional health and supporting them to lead full and active lives. These supports range from responding to underlying health concerns and pre-existing conditions, national screening programmes, annual and, more recently, specific vaccination programmes to target population health and wellbeing and health promotion services. These services are sometimes provided directly through staff employed and working within the services, through primary healthcare services, such as GP practices or community healthcare services or in secondary care services, such as hospitals or in tertiary care, such as specialist clinics for coronary care.

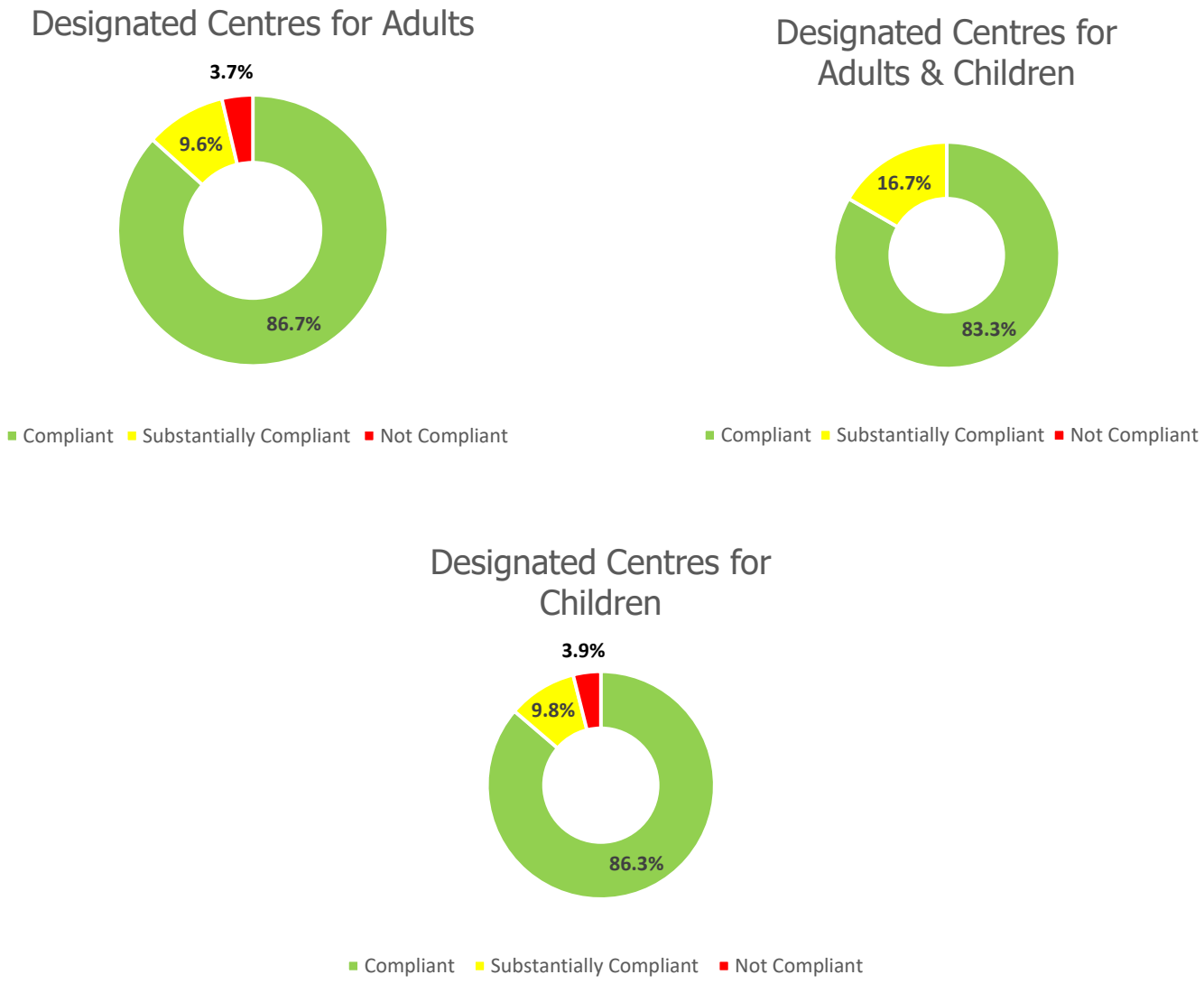
Providers are required to ensure that residents are supported to access and receive treatment, where they choose to do so, and to ensure that residents are supported to attend any regular or ongoing appointments.

Figure 31: Comparison of compliance for Regulation 6: Healthcare for 2020 and 2021



Overall, there continued to be a very good level of access for residents to good healthcare supports. Although there is a slight overall increase in the overall level of non-compliance with this regulation, the overall level of full compliance with this regulation has improved. This means that in the main, residents' healthcare needs were subject to ongoing assessment and review and they continued to be supported to access healthcare in a timely manner during 2021.

Figure 32: Compliance level for Regulation 6: Healthcare 2021



Generally, compliance with Regulation 6: Healthcare was good across all service types. However, while non-compliance was noted in some of the adult or children-only centres, inspectors found no areas of non-compliance in mixed centres for both

adults and children. In these centres, inspectors found that providers had a good understanding of individual healthcare needs and supports.

☺ Residents had access to health and social care professionals in line with their assessed needs and were supported to access specialist health appointments and screening appointments as required.

In respite centres inspectors found that providers and staff were routinely conducting pre-admission reviews in order to understand any new or changed healthcare support needs the residents may have. This meant staff were being kept up to date with any changes to residents' needs between each period of respite.

While the overall compliance levels for healthcare were high, there was a higher increase in non-compliance compared to 2020 in congregated settings, which had a non-compliance level of 2.8% in 2020.

😐 [Not] all residents had been offered or had [accessed] national health screening services. In addition, there was no healthcare plan in place for one identified healthcare need for a resident.

Figure 33: Comparison of Regulation 6: Healthcare between congregated and community-based settings in 2021

This means that during 2021, people living in these centres were more likely to receive poorer quality healthcare support than that of their peers living in community

settings and may not have had timely access or support to benefit from national health screening programmes or to benefit from a positive health promotion culture within their centre.

☺ The inspector observed that residents had access to appropriate healthcare professionals. There were health action plans and risk assessments focused on promoting the health of residents, and these were under regular review.

4.10 Risk management procedures

Providers are required to ensure that they have systems in place for the ongoing assessment and management of risks. Effective management and oversight of risk in designated centres for people with disabilities ensures that there is a good balance between safeguarding residents from potential harm and promoting and supporting a culture of positive risk taking. In positive risk taking, a risk-averse culture is avoided, the will and preference of residents is recognised in a considered way and residents' abilities are recognised and they are encouraged to be independent, despite a degree of risk arising with such independence.

Figure 34: Comparison of compliance for Regulation 26: Risk management procedures in 2020 and 2021

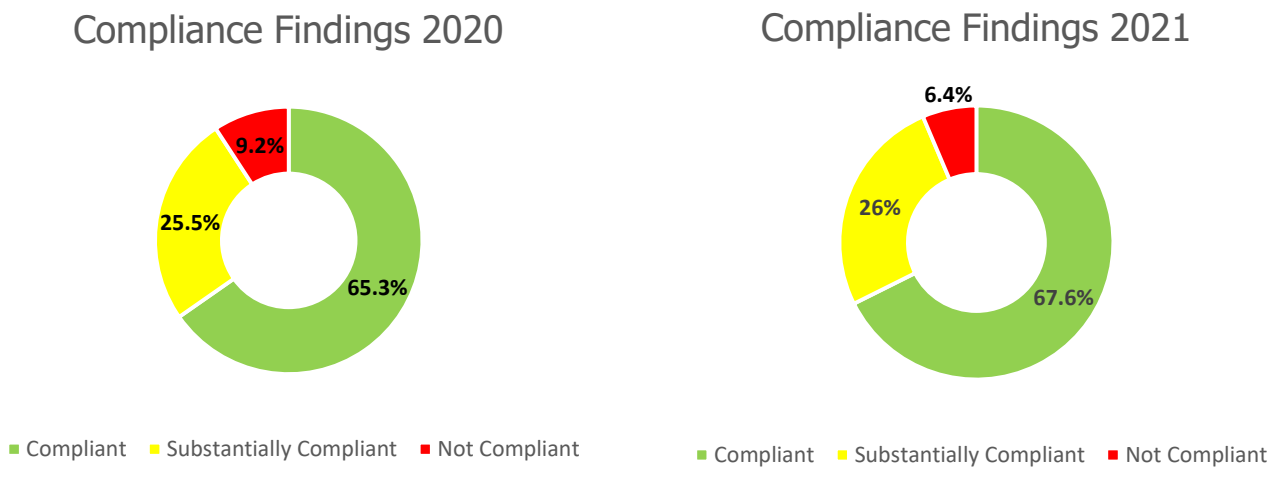
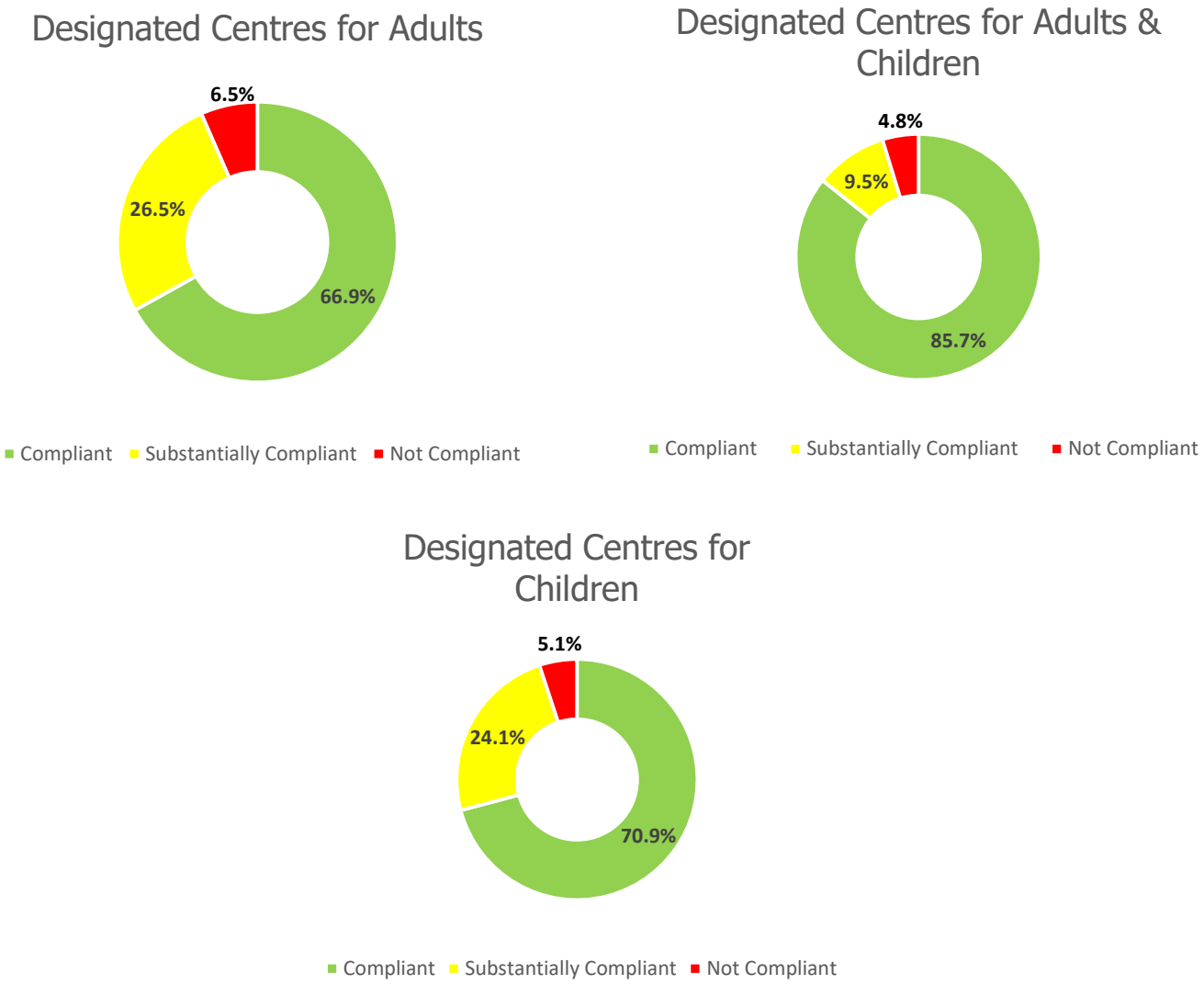


Figure 35: Compliance level for Regulation 26: Risk management procedures in 2021



In 2021, there has been a modest improvement in the levels of compliance against this regulation. The most significant risks of note during 2021 were maintaining a skilled workforce, infection prevention and control arrangements and the risks associated with the safe management of an outbreak of infection within a centre.

While inspectors found that compliance levels in mixed centres for both adults and children were more likely to be fully compliant with the regulation, compliance levels for risk management procedures in both centres for adults and centres for children were broadly similar to the overall compliance findings made in 2020.

Some incidents which occurred in the designated centre and potentially posed a risk to residents, staff and members of the community, had not been risk assessed and the inspector was informed that there was no guidance available for staff in how to respond should a similar incident occur again in the future.

Where improvements were required, inspectors found that generally these related to gaps in the continuous review of risks and to ensure that control measures and actions required to reduce the risks remained relevant and on target. This was particularly prevalent in the risk assessment and control of the risk of outbreak of COVID-19. For example, inspectors noted during some inspections that a provider's risk assessments and subsequent contingency plans did not consider surges in either infection outbreaks or staff absenteeism. As a result, these management plans did not sufficiently describe how a provider would respond or ensure continuity of the service in the event of such an occurrence.

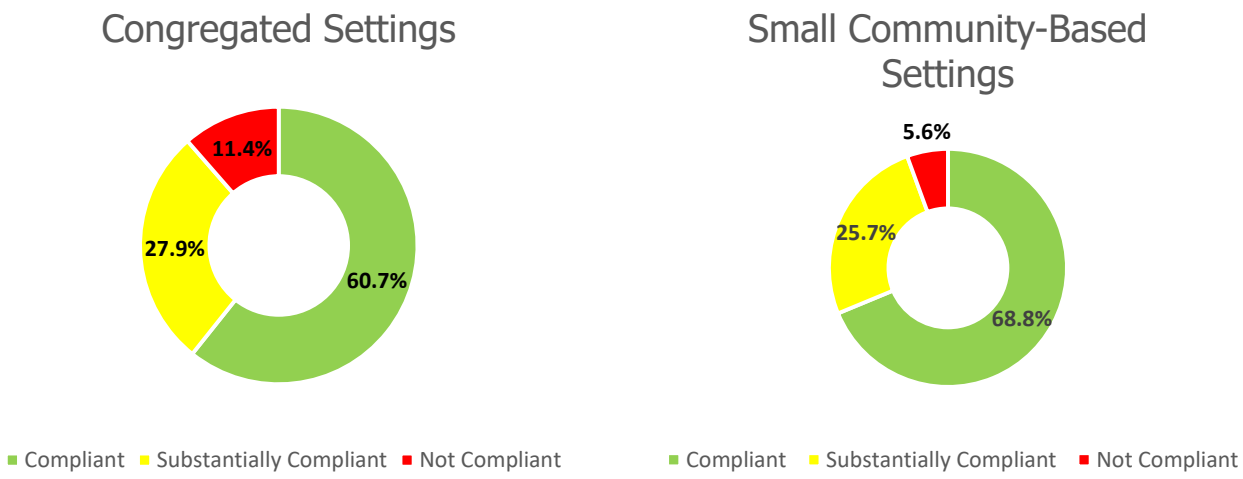
Each resident had a general health and safety risk assessment in place which outlined the assessment and mitigation of risks associated with issues, including epilepsy, absconding, challenging behaviours, safeguarding, fire and reduced mobility.

The centre's risk register was found to clearly identify the relevant risks in the house, in line with the assessed needs of the residents, including risks related to COVID-19.

In 2021, while there has been an overall improvement in the level of non-compliance in community-based settings from 8.7% in 2020, there has been no improvement in the level of non-compliance in congregated settings. In congregated settings, it was more likely that improvements were required in the ongoing review of risks and in the implementation of the provider's risk management policy.

There were several risk management systems employed in the centre and the inspector found that appropriate guidance was not available to staff members on how to use these systems.

Figure 36: Comparison of Regulation 26: Risk management procedures between congregated and community-based settings 2021



In addition, in some centres inspectors identified risks that had not been identified or risk assessed by the provider. Inspectors also found that where actions to reduce risk were taking significant time to complete, this was negatively impacting previously positive cultures towards risk management and the low risk tolerance in the centres.

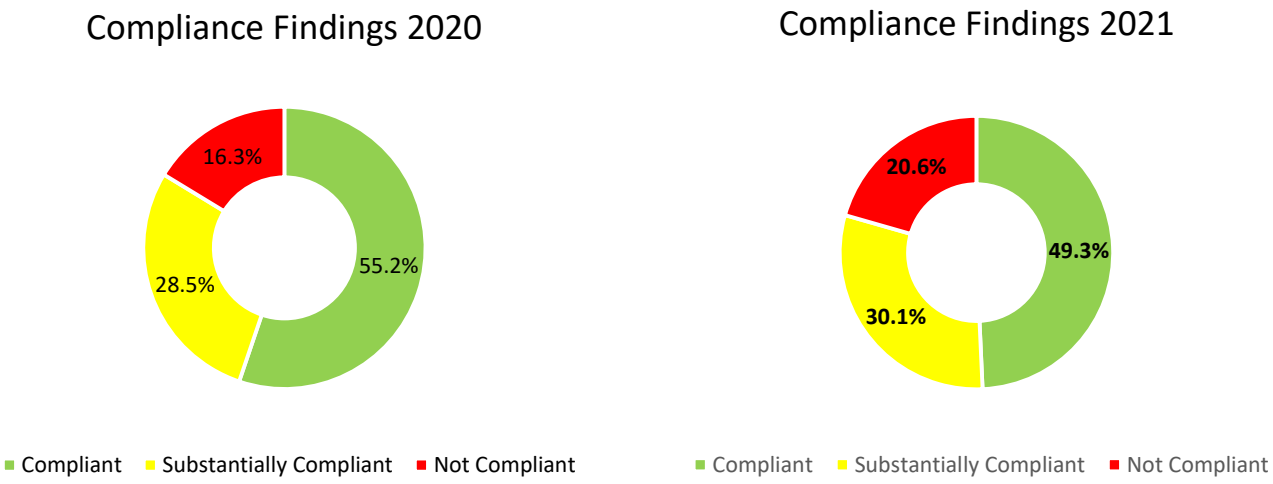
4.11 Fire precautions

Providers must have suitable arrangements to manage the risk of fire and ensure residents are safe in their homes at all times. Failure could result in harm to residents from a poorly managed response to a fire, a failure to contain a fire or a poorly managed evacuation from the designated centre in the event of an emergency.

Providers are required to ensure that their staff are adequately trained so that they are able to 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.

As demonstrated in the figure below, overall compliance with Regulation 28: Fire precautions deteriorated across all levels of compliance findings. This is concerning to note, given the year on year improvements that had been made up to and including 2020. However, in a number of instances this level of compliance relates to delays in the completion of fire improvement works due to Covid-19 related lockdowns.

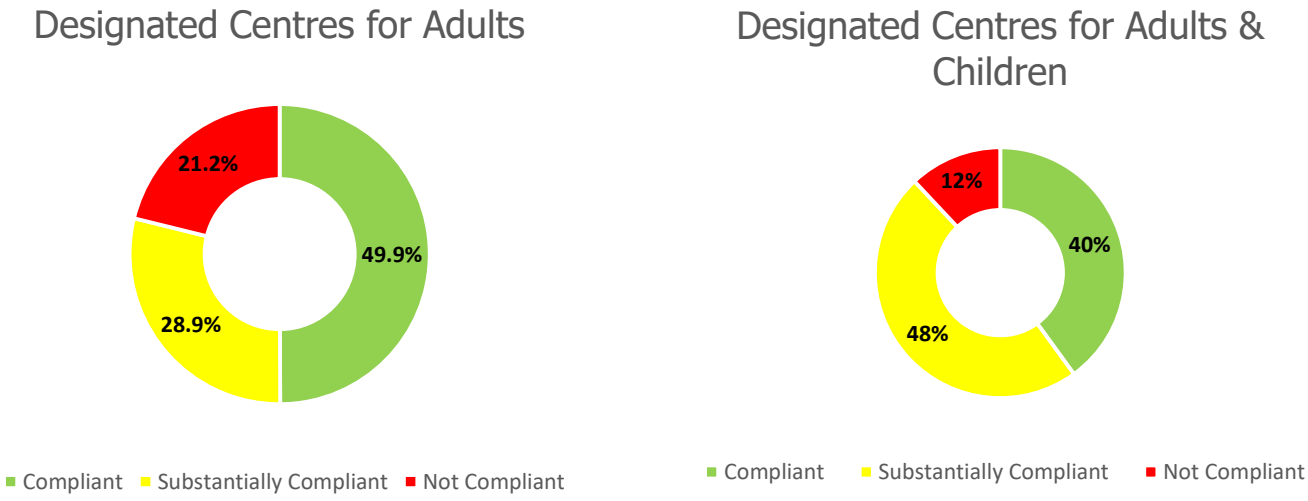
Figure 37: Comparison of compliance for Regulation 28: Fire precautions in 2020 and 2021

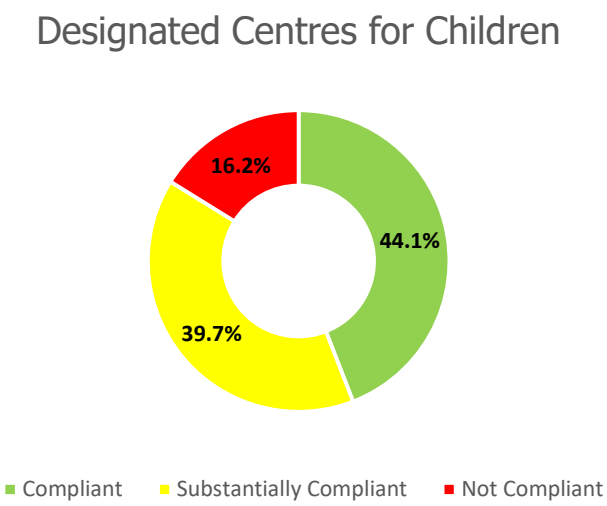


In addition, during 2021 some providers continued to operate COVID-19 related isolation facilities, either as a stand-alone unit or part of another registered designated centre. This meant residents could receive care and support in safe and appropriately resourced facilities and the risk of COVID-19 transmission to another resident could be minimised as a result.

This year, inspectors were able to undertake inspections of these additional premises and found that despite written assurances made at the point of registration, many of these did not have appropriate fire precautions in place. These included insufficient systems for detecting and alerting to potential fire or an absence of suitable evacuation plans.

Figure 38: Compliance level for Regulation 28: Fire precautions in 2021





Although mixed centres for children and adults were found to have fewer instances of non-compliance, improvements in provider's fire precautions were required across all service types. While some providers experienced delays in resolving fire safety issues, due to the availability of suitably qualified staff to complete the installation of new precautions or delays in the delivery of materials required to complete tasks, providers with good levels of compliance kept the risks associated with these delays under regular review. They also continually updated the Chief Inspector in relation to the completion of these works.

☺ One of the residents did a walk around the centre with the inspector. The resident was asked to show the inspector the fire signs and how the fire doors worked. The resident was delighted to be part of and contribute to the inspection and was able to show the inspector many of the fire precautions.

Where inspectors found improvements were required to a provider's overall fire safety measures, they were required to set out in a clear time-bound compliance plan on how these improvements would be achieved. During 2021, some providers were required to take immediate actions to ensure the immediate risks posed by the lack of suitable fire precautions were resolved and managed until these could be fully resolved.

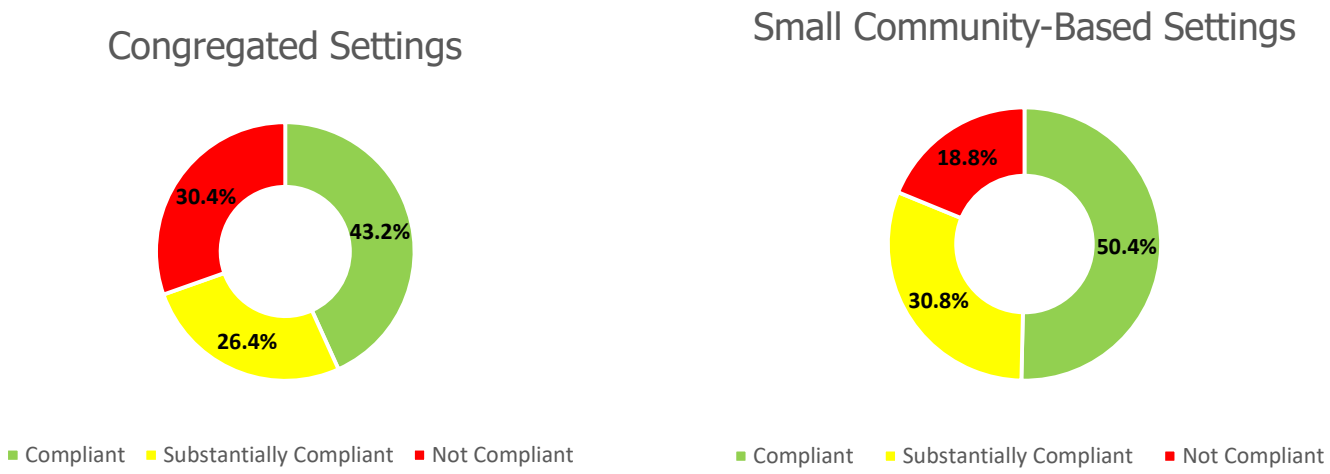
The level of non-compliance found in congregated settings was significantly higher than community-based settings and had deteriorated from the 23.2% found in 2020.

😐 The provider had not ensured that appropriate evacuation procedures were in place to safely evacuate all residents in the house in the event of a fire. Staff had identified during a fire drill last July that they could not evacuate the residents with minimum staffing levels. No action was taken to rectify this risk. In addition, a staff member was not familiar with the current evacuation procedures, and when told by the inspector what they were, they said they were not aware there were changes to the evacuation procedure. They also said they had not participated in a minimum staffing drill for over five years. Consequently, inspectors issued an urgent action to the provider to address these fire containment and evacuation risks.

😐 A number of emergency lights were not working on the day of the inspection, and three external side gates which were on the escape route were found to be locked. Inspectors were informed that each staff member had a key to these gates, however, there was no system in place to ensure they could be opened in the event of an emergency should staff not have this key on their person.

☺ There were suitable fire safety management systems in place, including detection and alert systems, emergency lighting and fire-fighting equipment, each of which was regularly serviced. There were suitable fire containment measures in place. Staff had received training in fire safety and there were detailed fire evacuation plans in place for residents that reflected learning from fire drills.

Figure 39: Comparison of Regulation 28: Fire precautions between congregated and community-based settings in 2021



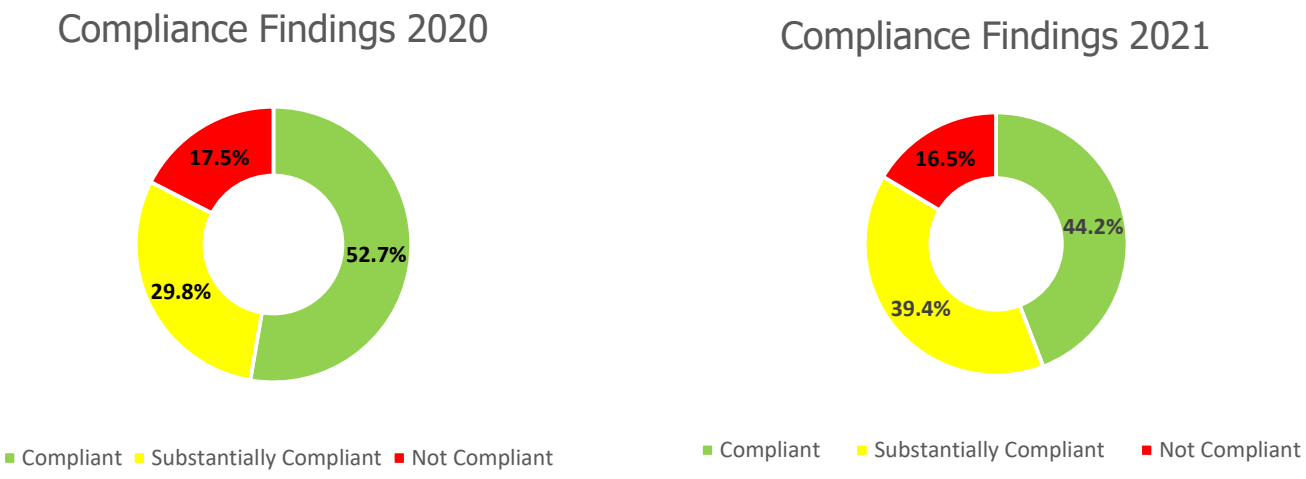
The Chief Inspector may attach additional conditions to the registration of a designated centre where there are concerns in relation to addressing fire precautions and in 2021, there were 19 centres operating with an additional condition requiring them to improve their fire safety measures.

4.12 Premises

Where we live, the community and the quality of our environment are all important factors that contribute to our overall sense of wellbeing and safety.

Throughout 2021, inspectors continued to find that residents living in smaller, purpose-built or community houses had much better living conditions. Most residents had their own bedrooms which were decorated in accordance with their personal taste. The communal and garden areas provided residents with comfortable and spacious places to enjoy. Similiarly, centres which had good governance and oversight systems were more likely to be subject to better and more regular maintenance and repairs completed in a timelier manner. However, although the overall level of non-compliance remained relatively similar to those found in 2020, the level of compliance shown in green below, highlights a deterioration in the overall quality of the premises for people with a disability.

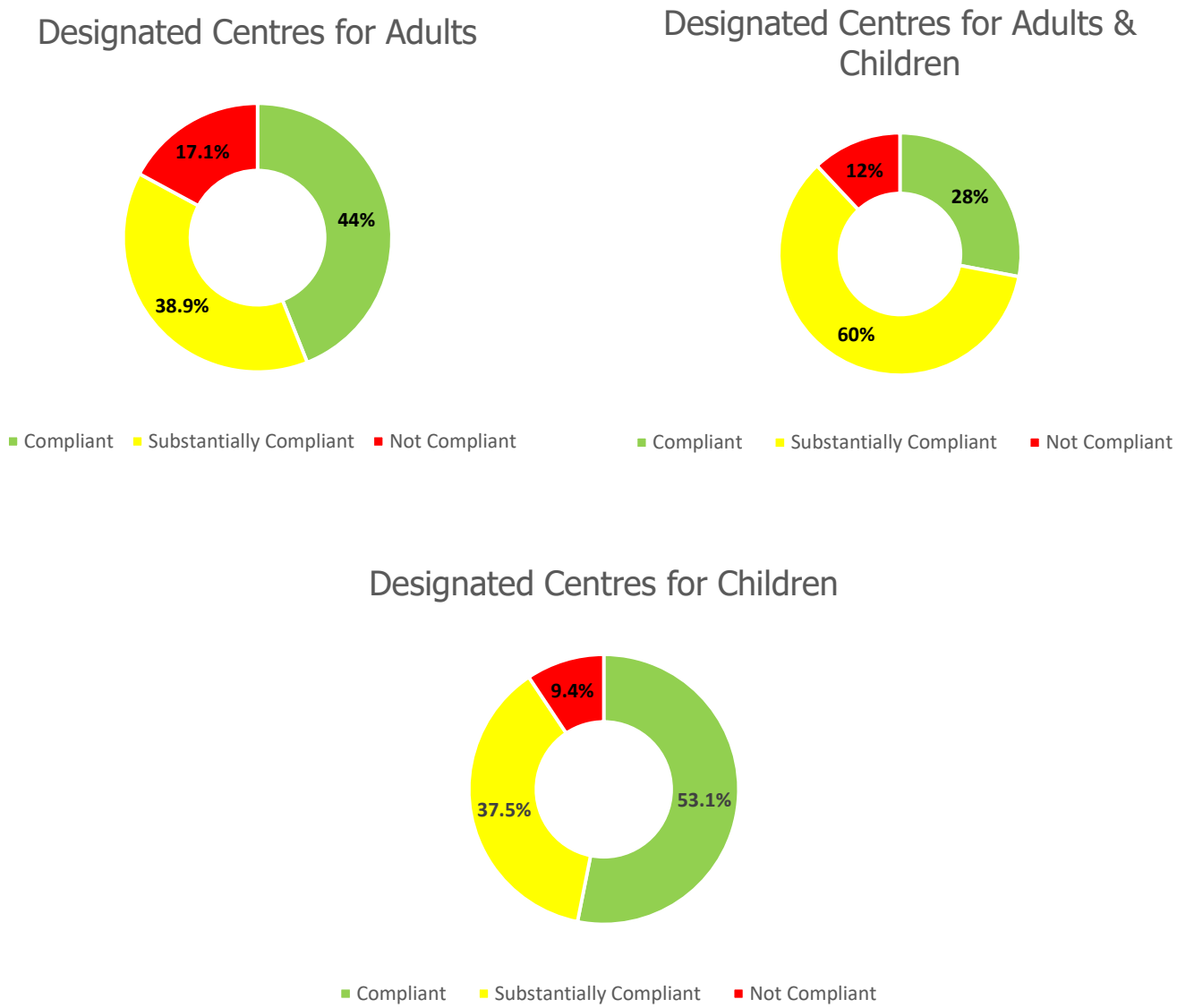
Figure 40: Comparison of compliance for Regulation 17: Premises in 2020 and 2021



Inspectors found that there continued to be evidence of delays in the repair and maintenance of centres. While some of this was due to unanticipated delays caused by the ongoing impact of COVID-19, there was also evidence that dilapidations in the quality of some centres' environments were not being reported in a timely

manner and prioritised for repair. As a consequence, the overall condition in some previously good centres was beginning to deteriorate. Well-maintained centres are more comfortable and homely. They can be more easily cleaned and directly impact on a provider's ability to ensure good infection control procedures. In addition, well-maintained centres keep residents and staff free from harm and injury and reduce the risks associated with mobilising, slips, trips and falls.

Figure 41: Compliance level for Regulation 17: Premises for 2021



The overall compliance findings in centres for adults, is broadly in line with the overall findings made for all centres for people with a disability.

☺ Throughout both premises new furniture and soft furnishings had been purchased and overall the centre was more homely, bright and welcoming. Residents' bedrooms were personalised. Another resident who liked to do some of the administration work in the centre showed the inspector their newly decorated office.

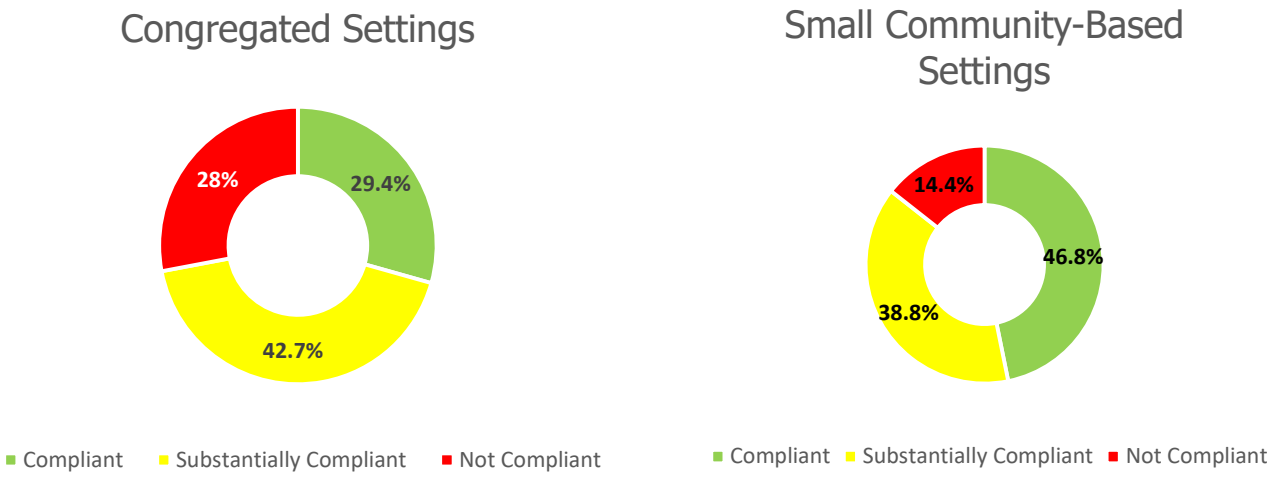
Centres for children, were found to offer better environments, and were more likely to be in compliance with the regulation. This meant children and young people could be expected to enjoy a better overall standard of maintenance and upkeep in their homes.

In mixed centres for both adults and children, while the level of non-compliance was better than that found in centres for adults, there was a higher prevalence of substantial compliance, meaning that in the majority of centres assessed (72%) some level of improvement was required to bring the premises up to the minimum standard required by the regulations. However, the most significant area for improvement continued to be found in congregated settings.

😐 As identified in previous inspections, the design and layout of the centre did not meet the collective and individual needs of the residents. In addition, improvement was required in the maintenance of areas of the designated centre, including painting and general upkeep.

Although the figures for 2021 represent an overall decrease in the level of non-compliance found in congregated settings from 32% in 2020, the level of full compliance has also slipped from 34%. This means more congregated settings than in previous years required improvements to the overall quality and safety of the premises.

Figure 42: Comparison of Regulation 17: Premises between congregated and community-based settings for 2021



These tend to be in large, older, institutional buildings or campus buildings that are difficult to maintain and repair. In some centres, inspectors found that residents' equipment was poorly maintained, often damaged and unclean. The centres lacked a homely feel, were poorly decorated, damaged or had dirty fixtures and fittings. As a consequence, the majority of residents who were yet to transition to community-based centres, continued to live in less than adequate environments.

😐There were a number of residents who were required to share bedrooms and the inspector found that this continued to impact on their privacy and dignity. While there was a risk assessment in place regarding this practice, the inspector found that personal and intimate care was carried out for some residents while others were within close proximity. In addition, the inspector found that both units of the centre required painting and decorating.

☺ The premises was maintained to a very good standard. The house was observed to be clean, tidy and fresh. Rooms were all maintained to a good decorative standard. Each resident had personalised their own bedroom with posters and photographs of interest to them. Garden areas were well kept and inviting. Some planters were raised to encourage residents to cultivate and maintain the herbs grown.

Chapter 5. Escalation and enforcement

5.1 Introduction to actions to protect residents

Where inspectors find that poor compliance results in a poor quality of life for residents or impacts on the safety of residents, the Chief Inspector can take a number of steps — which we term 'escalation and enforcement' — to bring providers into regulatory compliance and protect residents and improve their lives.

In such cases, the Chief Inspector can increase regulatory activity up to and including the decision to take enforcement action and up to and including the cancellation of a centre's registration. Whenever such activity happens, the Chief Inspector will always try to minimise disruption and anxiety for people living in designated centres.

During 2021, most providers of designated centres operated good quality services. These providers focused on building high levels of compliance focused on ongoing improvements in the quality and safety of care and support. 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 2021, 77 centres (5.5% of the 1,401 registered designated centres) were the subject of increased regulatory actions and additional targeted monitoring and scrutiny of the provider's improvement plans.

5.2 Provider warning letters and meetings

Warning letters set out the areas of significant concern which may, if unresolved, result in the Chief Inspector deciding to cancel the registration of a centre or attach a restrictive condition to the registration of a centre (such as placing a limit on the number of people who can live in a centre). The Chief Inspector may also warn providers that they may be prosecuted if they do not improve the safety of residents and their quality of life.

In 2021, the Chief Inspector issued 31 warning letters to 11 providers. In most cases, the warning letter resulted in improvements in the quality of the service for residents and the provider was effective in bringing the centre into compliance with the regulations. However, in a number of cases, further escalated regulatory decisions were required, which are set out below.

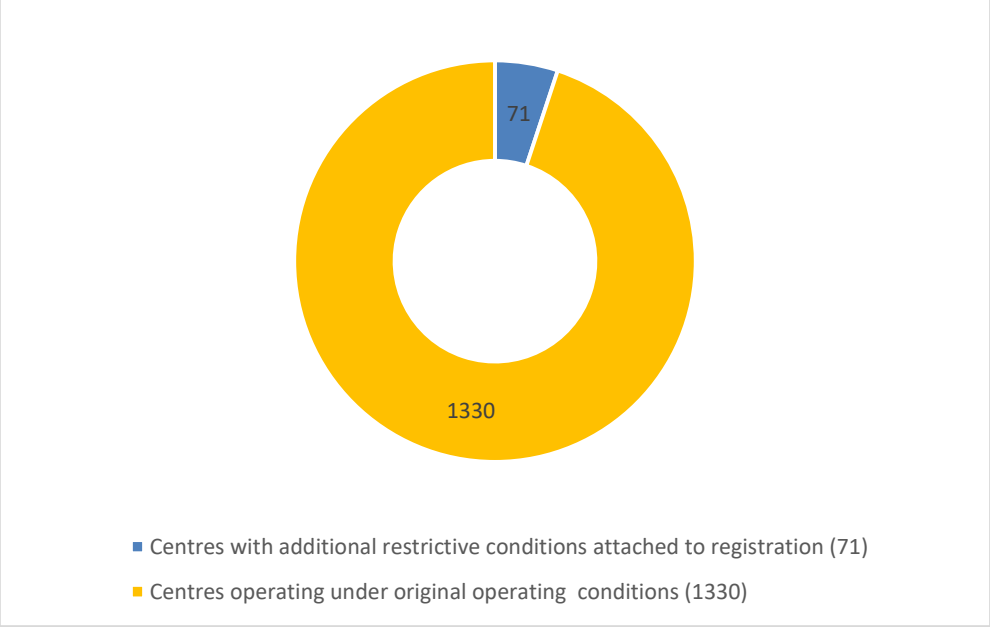
5.3 Attaching conditions of registration

The Chief Inspector attaches specific conditions to the registration of all centres and which relate to compliance with the statement of purpose (the scope of the service), the age range of residents and the number of residents that can live in a centre. These types of conditions are called 'permissive' conditions.

However, on occasion, the Chief Inspector may decide to attach additional conditions to a centre's registration. These conditions might include requiring the provider to improve the management of the centre, reduce or limit the number of residents living there or enhance the premises. These types of conditions are referred to as 'restrictive' conditions, and they make it clear to providers that they must meet these conditions in order to continue to be registered.

Overall, in 2021, the majority (95%) of designated residential centres for people with disabilities operated their services without the requirement for additional, restrictive conditions. This indicates that they either have good levels of compliance with regulatory requirements or have demonstrated an ability to rectify any areas of non-compliance that are impacting on the quality of life and consistency of service being provided to residents.

Figure 43: Number of centres with permissive or restrictive conditions



However, at the end of 2021, 71 registered centres had a restrictive condition attached to their registrations. In 6 of these 71 centres, more than one restrictive condition was attached to the centre's registration. This is a total of 77 restrictive conditions in 71 centres. The HSE was the provider of eight of these centres; the remaining 63 centres were HSE-funded. In total, 31 of these centres were congregated or campus-based settings.

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 on their centres are required to submit regular updates on the progress being made 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.

5.4 Centres operating unregistered

Providers are required to register a designated centre under the Health Act 2007 (as amended). Section 46 of the Act prohibits a person from carrying on the business of a designated centre unless it is registered. A contravention of Section 46 is an offence under the Act.

During 2021, the Chief Inspector was notified of seven centres which were operating potentially as unregistered designated centres. The Chief Inspector investigated

each of these concerns and found that one of these centres did not meet the definition of a designated centre and did not require any further action.

However following assessment, six of these centres did meet the definition and were found to be operating unregistered. In each of these situations, the provider had responded to an emergency situation where the resident or residents needed to be accommodated quickly to ensure their safety and the safety of others. The Health Act 2007 does not have provisions for temporary registration of designated centres in an emergency, and while the providers were responding to protect residents from harm, they were in breach of the Health Act 2007, as amended.

The Chief Inspector continues to engage with the Department of Health to resolve this significant gap in the legislation.

5.3 Notices of proposed decision to cancel, refuse or attach conditions

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 much distress and anxiety for residents and for their families. Providers are usually given ample opportunity to address the failings in the service before the Chief Inspector considers issuing such notices. 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 11 centres during 2021. This was due to repeated findings of regulatory non-compliance and concern about the care and welfare of residents. The Chief Inspector also issued 16 notices of proposed decision to refuse the application to renew the registration of designated centres, because of significant failings by the provider in ensuring that residents were receiving the service that they were entitled to.

When such notices are issued, the Health Act 2007, as amended allows the provider to make representation within 28 days setting out why the registration should not be cancelled. With the exception of two centres, providers submitted plans to the Chief Inspector setting out how they would improve the safety and quality of life for residents in their centres and the effectiveness of those plans continues to be monitored by inspectors.

However, in two centres the providers did not demonstrate capacity to address significant safeguarding and quality of life concerns and had their registration cancelled. One of these centres was operated by Camphill Communities of Ireland and the HSE took over the operation of the centre under Section 64 of the Health

Act 2007, as amended. The other centre was operated by Stepping Stones Residential Care Ltd and, following cancellation, the centre ceased to operate as a designated centre under the Health Act 2007, as amended.

When the registration of a designated centre is cancelled, the HSE is required to take over the operation of the centre under Section 64 of the Health Act 2007, as amended. At the end of 2021, three centres were being operated under Section 64. In addition to the centre mentioned above, a further two designated centres, which had their registration cancelled by the Chief Inspector in previous years were being operated by the HSE under this arrangement.

Three other centres, which had previously been operated by the HSE under Section 64 following the cancellation of registration, were registered by new providers during 2021.

Chapter 6. Concluding statement

During 2021, services for people with disabilities continued to adapt and evolve as a result of changes to the level and impact of the ongoing restrictions caused by the global COVID-19 pandemic. This report has highlighted the many ways that providers have been able to positively respond to ensure that residents' rights and choices have remained central to changes and decisions about their care and support arrangements. This report has also identified occasions where providers have not responded and how this has negatively impacted on residents' lives.

In previous years, inspection findings have shown that there is a strong correlation between good governance and positive outcomes for residents and again this report clearly demonstrates that a provider's governance, oversight and leadership arrangements directly impact and influence the overall quality and safety of a service. It is therefore concerning that there has been a gradual deterioration in the overall quality of these arrangements throughout 2021. Providers must act quickly in order to review these arrangements and ensure that they remain suitable and effective in overseeing their services and are capable of helping them to determine the quality and safety of services for residents.

This report has provided comparisons between the lives of residents living in community-based homes and the lives of residents who continue to live in campus-based or congregated settings. Again, the findings from the 2021 programme of regulation have consistently found that people living in smaller, community-based homes experience a better quality of life, live in safer services and are more likely to experience better personal outcomes. It remains imperative that Ireland continues its drive to fully decongregate large institutional buildings and campuses, so that all people with disabilities are provided with equal opportunities to live ordinary lives, in ordinary places.

For the first time, this report, has compared the level of compliance and experiences of children and younger people living in designated centres. As can be seen in the data and voice of the residents, while there are improvements required in some areas of services for young people, these services were more likely to be in compliance with the regulations. This means that as children become older and transition into adult services, they may experience a poorer level of service.

Finally, there continues to be a need for regulatory reform within the sector to ensure that the regulations continue to be the optimum measure for determining the overall quality and safety of services. New commencements, such as the Assisted Decision Making (Capacity) Act (2015) and future safeguarding legislation, will impact on existing regulations for the registration and monitoring of designated centres.

The last two years again highlighted the need for new legislation to support the registration of designated centres in an emergency, to ensure that no resident who requires a residential placement is at risk of being placed in accommodation that is outside the current protection of the Health Act 2007, as amended. The Chief Inspector continues to engage with the Department of Health in addressing this significant gap in the legislation and will welcome any future reform to the Act and the regulations which will afford residents this protection.

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