Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Annual overview report on the inspection and regulation of children's services — 2015

June 2016

About the Health Information and Quality Authority

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

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

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

- **Setting Standards for Health and Social Services —** Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.
- **Regulation —** Registering and inspecting designated centres.
- **Monitoring Children's Services —** Monitoring and inspecting children's social services.
- **Monitoring Healthcare Safety and Quality —** Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment —** Providing advice that enables the best outcome for people who use our health service and the best use of resources by evaluating the clinical effectiveness and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion and protection activities.
- **Health Information —** Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

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A message from the Director of Regulation

I am pleased to present the Health Information and Quality Authority's (HIQA's) annual overview report detailing our regulatory activities related to children's services. The report presents findings of inspection for all services monitored and inspected by the children's team.

These services include statutory children's residential centres and special care units, statutory and privately provided foster care services, child protection and welfare services, designated centres for children with a disability and children detention schools (Oberstown Campus). HIQA will continue to monitor all these services using standards and regulations, and will work together with providers to promote improvement in the safety and quality of services to vulnerable children and young people.

In producing this annual overview report for children's services, we hope not only to provide information on the regulatory programme of activity for 2015, but also to share the outcomes of that activity in a way that assists providers to inform their own quality improvement agenda in the interests of all children and families who require their services.

Mary Dunnion,

Director of Regulation and Chief Inspector, Health Information and Quality Authority

A message from the Head of Children's Programme

In regulating services for children, the children's team works with different providers. The Child and Family Agency (Tusla) is the largest of these providers of services for children and families, reflected in the fact that, at the end of 2015, there were 6,388 children in the care of the State and 26,655 cases open to Tusla's child protection and welfare services. Other providers of services include the Health Service Executive (HSE) and providers in the private and voluntary sectors who deliver residential and respite services to children with disabilities, and the Irish Youth Justice Service in relation to children detention schools.

During 2015 the children's team completed a total of 114 inspections of different services for children. In our monitoring and inspection of children's services we have found that good quality services are ones in which there is effective integration of systems, processes and behaviours by which the service is led, managed and delivered so that services can achieve their objectives in a consistent and sustainable way.

In essence, a well-governed and monitored service provides consistently high quality services with minimal variation across the wider system. While the findings of inspections during 2015 are set out in this report, what is clear from inspection and monitoring activity is the variance of practice by different providers in relation to the quality of service delivered.

2015 saw preparation for a national review of the child protection and welfare service provided by Tusla and the governance arrangements in place to ensure an effective, timely and safe service.

This review, which will be carried out during 2016, will identify the extent to which national governance arrangements have been, and are being, put in place to address variations in practice that impact on the quality and safety of the service, and which are necessary to assure it is a safe and effective service.

In addition to our regulatory programme during 2015, HIQA undertook a review of the different functions in the Regulation Directorate. The review resulted in a decision to re-organize the directorate into four distinct operational functions: Healthcare, Children's, Older Persons and Disability, which had a target implementation date of 1 January 2016. As a result of this restructuring, responsibility for the regulation of designated centres for children with a disability was transferred from the children's team to the new disability section in April 2016.

Ann Ryan,

Head of Children's Programme, Health Information and Quality Authority

1. Introduction

The Health Information and Quality Authority (HIQA) is responsible for regulating and monitoring the quality and safety of adult and children's health and social care services across Ireland. The Regulation Directorate of HIQA encompasses the statutory functions of the Chief Inspector of Social Services and provides for:

- the monitoring, inspection and registration of adult social care services and services for children with disabilities
- the monitoring and inspection of healthcare and children's services.

This report provides an overview of the 2015 regulatory programme for services for children in need of care or protection and also children with disabilities living in designated centres. It primarily sets out how we met our business plan objectives to:

- conduct regulation programmes of health and social care services so that those services are driven to continuously improve, and in turn better safeguard people and achieve improved outcomes for service users
- regulate effectively and efficiently and ensure that outcomes and impact on policy are communicated to all relevant stakeholders.[¥]

Full reports on each service inspected in 2015 are available on the HIQA website www.hiqa.ie.

2. How we regulate services

2.1 The statutory framework — monitoring against standards and regulations

Each type of children's service has its own statutory framework that gives authority to HIQA to monitor the service, using standards and regulations which set out what is expected from the service. Table 1 shows the statutory framework for each type of service monitored by HIQA.

[¥] HIQA Business Plan 2015, page 6

Table 1. Statutory basis for inspection and monitoring of children's services by HIQA

Functions	Authority to inspect	Primary legislation	Regulations	Standards
Child Protection and Welfare Services	Inspected under Section 8(1)c of the Health Act 2007	Health Act 2007		*National Standards for the Protection and Welfare of Children* (HIQA, 2012)
Foster care services	Inspected under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011	Child Care Act, 1991, as amended	Child Care (Placement of Children in Foster Care) Regulations, 1995 Child Care (Placement of Children with Relatives) Regulations, 1995	*National Standards for Foster Care* (DOHC, 2003)
Special care units	Inspected under Section 69 of the Child Care Act, 1991	Child Care Act, 1991, as amended		*National Standards for Special Care* (HIQA November 2014)
Children Detention Units	Inspected under Section 185 and Section 186 of the Children Act 2001, as amended by Criminal Justice Act, 2006	Children Act, 2001 as amended by Criminal Justice Act, 2006		*Standards and Criteria for Children Detention Schools* (DOJELR, 2008)
Designated Centres for children with a disability	Inspected under Section 41 of the Health Act 2007	Health Act 2007	Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013	*National Standards for Residential Services for Children and Adults with a Disability* (HIQA, January 2013)
Children's Residential Centres	Inspected under Section 69 of the Child Care Act, 1991, as amended	Child Care Act, 1991, as amended	Child Care (Placement of Children in Residential Care) Regulations, 1995	*National Standards for Children's Residential Centres* (DOHC, 2001)

2.2 Monitoring

HIQA monitors services by carrying out inspections and reviewing information which it receives between these inspections, which can take the form of notifications, requested and unsolicited information.

In 2014, HIQA began to supplement these sources of information with a quarterly data collection of key performance indicators (specific and measurable elements of practice that can be used to assess quality and safety of care) from Tusla.

This information alerts HIQA to possible risks in services which may affect the health, safety and wellbeing of children. All information is risk-assessed and used to inform inspectors' judgments about what actions they should take.

Regulatory actions can range from conducting an unscheduled inspection, issuing an immediate action plan, asking for assurances or more information, or requesting the provider to undertake a provider-led investigation.

For designated centres, the Chief Inspector of Social Services has the option of taking enforcement action. This can take the form of prosecutions, changes to a centre's registration status, including the closure of a centre or the use of enforcement notices.

2.3 Inspection

Inspection is the most significant component in the ongoing monitoring of services. The type and frequency of inspection is based on the level of risk that the inspector deems to be present in the centre or service, the requirement for registration inspections, the provider's history of compliance and a minimum number of inspections over a given period.

The different types of inspection are:

- **Monitoring inspections:** these monitor ongoing compliance with the national standards and regulations.

- **Registration inspections:** these are conducted to inform a registration decision and usually assess compliance with all standards and regulations. At the time of this report, only residential services for children with disabilities are registered by HIQA, under the Health Act 2007.

- **Follow-up inspections:** these assess the extent to which the provider has implemented required actions related to the findings of a previous inspection.

- **Single or specific-issue inspections:** these concentrate on a specific issue following the receipt of information about a service.

- **Thematic or focused inspections:** these relate to a particular issue and aim to raise quality of services under a predetermined theme or themes. However, any other risk identified by inspectors during the course of inspection is brought to the attention of the provider and is included in published findings and recommendations.

2.3.1 Inspection activity in 2015 — number and types of inspections

The children's team conducted 114 inspections of different services for children over the course of 2015. There were 78 inspections of designated centres for children with a disability, 42 of which were for the purpose of registration.

Thirty-six inspections were conducted of other services such as statutory children's residential centres, foster care and child protection and welfare. Table 2 provides a complete breakdown of all inspections by service type.

Table 2. Inspection activity for 2015 by service and inspection type

Service type	Inspection type	Number of inspections
Child protection and welfare	Monitoring	3
Statutory foster care	Monitoring	2
Private foster care	Monitoring	2
Statutory residential care	Monitoring	23
Special care	Monitoring	4
Detention schools	Monitoring	2
Designated centre for children with a disability	Monitoring	36
Designated centre for children with a disability	Registration	42

2.4 Listening to children's voices

In accordance with the goal of the National Children's Strategy 'that children would have a voice in matters which affect them' and Article 12 of the UN Convention,

HIQA's children's services' inspectors engage directly with children during inspections to hear their views on the quality of the service they receive. Inspectors meet children on an individual and group basis and also obtain their views through child-friendly questionnaires.

In 2015, inspectors met with 148 children during their inspections of alternative care and child protection and welfare services. A further 42 children were met during the inspection of Oberstown Campus and 240 were met during the inspections of designated centres for children with a disability.

Table 3. Number of children met by inspection type

Number and type of inspections	Number of children met with during these inspections
3 child protection and welfare	23
4 foster care	47
2 detention schools	42
23 children's residential centres	59
4 special care units	19
78 designated centres for children with a disability	144 and observed 96 children who did not use or were limited in using language

Inspectors talked to children about how they experienced the services they received and whether or not their wishes and views were reflected in decisions made about their lives and day-to-day care.

Children described to inspectors what they knew about their rights, how well they were supported to maintain relationships with families and friends and to take part in their favourite recreational activities and hobbies.

The majority of children had positive experiences of services and they felt respected and listened to. They said that they and their families had benefitted from a social work or other type of care intervention. Many experienced life opportunities similar to their peers not in receipt of a service.

However, in some services children and young people had a lack of knowledge about their rights, particularly their right to access information held about them and how to make a complaint.

3. Monitoring and inspection findings of services provided by Tusla and two private providers of foster care services

Tusla has responsibility to protect children and promote their welfare under both the Child Care Act, 1991 and the Child and Family Act 2013. It does this by direct service provision and by funding other organizations to do so on its behalf.

Tusla provides two types of residential services for children in the care of the State: children's residential centres and special care units. It delivers foster care placements, and in addition purchases places from several private providers. All of these services are inspected by HIQA.

3.1 Monitoring and inspection of services provided by Tusla

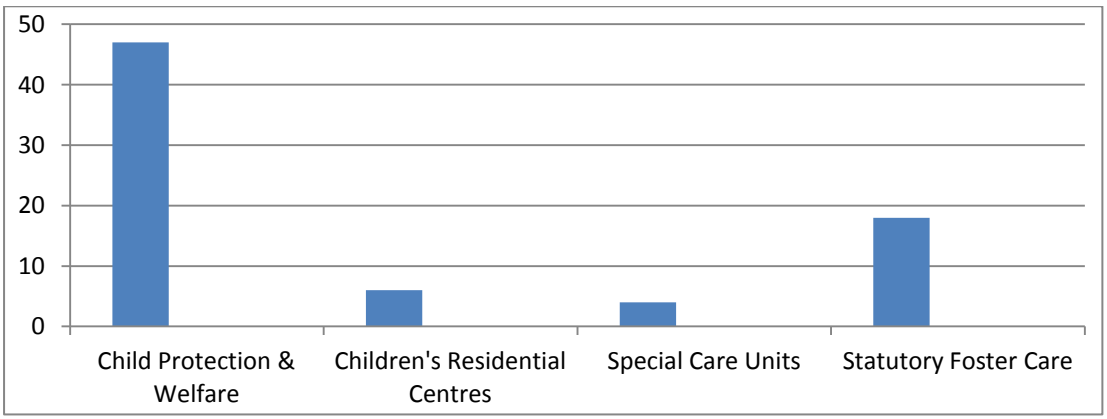
During 2015, the children's team reviewed all available information about services and used it to monitor those provided by Tusla. This included unsolicited information, Tusla monitoring reports and notifications, as well as evidence gathered on inspection.

All information was assessed, risk-rated and used to inform monitoring activity. HIQA also received metrics from Tusla on a quarterly basis in relation to child protection and welfare and foster care services and this was analyzed to identify any potential risks in these services.

3.1.1 Receipt of unsolicited information

The children's team received 75 pieces of unsolicited information relating to Tusla's services during 2015. This is broken down by the type of service this information was related to in Figure 1.

Figure 1. Unsolicited information by service type



Considering the high volume of work undertaken by Tusla across a wide range of services, the level of unsolicited information was low. Unsolicited information received by HIQA related to concerns about the quality and safety of care, lack of timely access to services and poor communication.

All of the information received was risk-rated and action taken where necessary. In some cases, the person was signposted to the relevant service that could address their concerns; in others, inspectors sought information and assurances from Tusla about the safety and quality of services. Where inspectors deemed the information was of serious concern, an inspection took place.

3.1.2 Notifications of serious incidents including deaths of children in care or of children known to the child protection and welfare service

During 2015, Tusla continued to notify HIQA of deaths and serious incidents involving children in care and children known to the child protection and welfare service, as required by the *Guidance for Tusla on the Operation of the National Review Panel,* published by the Department of Children and Youth Affairs in 2014.

In 2015, HIQA received 21 notifications of deaths of children in care or of children known to the child protection and welfare service, and seven serious incidents involving children. It should be noted that some children in care die of natural causes or in circumstances which could not be prevented. The National Review Panel carried out formal reviews of some of these deaths and serious incidents.

Tusla submitted 13 reports from the National Review Panel during the year to HIQA. Ten of these related to children who had died in previous years and two related to serious incidents. The remaining report was a composite report that related to six children.

These reports were reviewed by inspectors to inform monitoring activity and to contribute to HIQA's assessment of the safety of a particular service or specific aspects of service provision. This information was also used by inspectors whilst on inspection to determine whether learning from such events had occurred.

3.1.3 Escalations to Tusla

The first step taken by HIQA in response to non-compliance with national standards and regulations is to issue an action plan* based on inspection findings. An action

* An action plan sets out the actions required by the provider to meet the requirements of national standards and regulations.

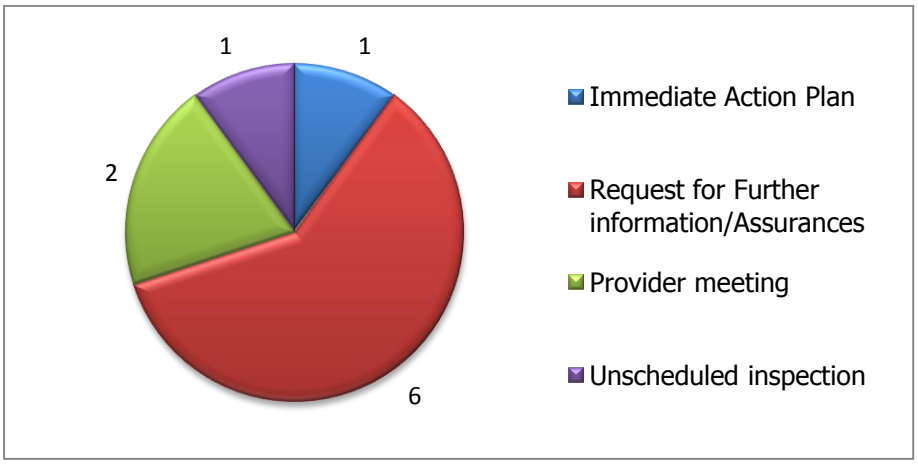
plan indicates the failings in service provision and providers must submit in writing to HIQA how they will address these failings within a reasonable timeframe. However, other or additional actions may be taken depending on the nature and level of risk involved.

These actions include issuing an immediate action plan to a service during or soon after an inspection to ensure specific risks are managed, or a request for further information or seeking assurances about the safety of a child or children. Provider meetings may also be convened with senior managers of a service when required.

Figure 2 shows the 10 actions that were taken by the children's team in 2015 in relation to services provided by Tusla. These included:

- Issue of one immediate action plan
- A request for further information/assurances in relation to six different services
- Convening of two provider meetings in relation to two different services
- One unscheduled inspection.

Figure 2. Monitoring actions taken in 2015



3.2 Child protection and welfare services

Tusla has legal responsibility to promote the welfare of children and to protect those who are deemed to be at risk of harm. These children require a proactive service which acts decisively to assess and meet their needs in order to promote their safety and welfare.

From time to time there are children who need to be protected from the immediate risk of serious harm, but the majority of children and their families who come in

contact with Tusla require a targeted preventative service and interventions aimed at supporting families to adequately care for their children.

The *National Standards for the Protection and Welfare of Children* (2012) provide a framework for the development of child-centred services in Ireland that protect children and promote their welfare.

HIQA monitors against the standards to ensure children are supported through the provision of accessible information, access to services, screening of referrals, assessments to ensure that appropriate services are made available, and the taking of timely action to protect children at risk of harm underpinned by child-centred planning, review and monitoring processes by Tusla.

An effective child protection system requires a systematic approach involving good leadership, interagency cooperation, skilled and experienced staff and the effective management and deployment of resources - with the child always at the centre of everything that is done.

Child protection and welfare services are provided by Tusla in each of its 17 service areas that are located within four national regions. Between 2012 and 2015, HIQA carried out inspections of the child protection and welfare services delivered through 14 of the 17 service areas. Three of these inspections were carried out in 2015 in Louth Meath, Dublin North and Dublin South East/Wicklow.

An inspection of the Midlands service area was scheduled for April 2015. However, in April 2015 Tusla reported to HIQA on a high number of unallocated child protection cases and notifications of alleged abuse received from An Garda Síochána (Ireland's National Police Service) to which no response had been made by the Midlands service area.

As Tusla had reported the risk, they were given an opportunity to put corrective actions in place and provided regular progress reports to HIQA. The Midlands service area was subsequently inspected in January 2016 and findings will be considered as part of the national governance review.

There are 27 standards against which child protection and welfare services are inspected. The findings of the three inspections carried out in 2015 against these standards reflected a variance in practice and capacity to meet these standards across the three service areas as outlined in Table 4.

This meant that children experienced a different quality of service from a national service provider that was dependent on the service area they were engaged with.

Table 4. Compliance with standards by service area

Service Area	Standards met	Standards requiring improvement	Standards against which significant risk was identified
Louth Meath	1	18	8
Dublin North	8	17	2
Dublin South East/ Wicklow	8	18	1

3.2.1 Standards met

Inspectors found that, where children received a social work service, day-to-day social work practice was generally good and many children and their families benefitted from social work interventions.

Inspectors observed staff of all grades carrying out their duties in a professional way and drawing on their knowledge, experience and strengths when working cases, in particular, when responding to risk. Children and families were found to be treated with respect and supported to understand and participate in decisions being made about them.

However, Tusla has been challenged in recent years in recruiting sufficient numbers of social workers to fill vacancies within child protection and welfare services and this continued in 2015.

One standard met by all three service areas was in relation to interagency and inter-professional cooperation. This meant that agencies and professionals shared information and worked together for the protection of the children they were involved with.

Other standards that were met by two of the service areas related to performance of functions within relevant legislation and national policies; the consistent implementation of key principles of Children First (2011); review and learning from serious incidents; having adequate systems in place to monitor performance; the effective use of available resources.

3.2.2 Standards requiring improvement

Performance against the majority of the standards required improvement and this was reflected in some of the data provided by Tusla during 2015, particularly in relation to delays in the allocation of social workers and timely interventions.

Overall, findings from data and inspections showed that the key areas of practice which required improvement were related to providing a consistently safe service in a timely way. When this was not achieved, some children experienced delays having their needs assessed and met, placing them at unidentified risk.

3.2.3 Significant risk identified

Table 4 shows that there were judgments of significant risk to children across the three service areas indicating that some elements of service provision across the country were not safe.

For example, there was a need to ensure risks associated with adults of concern in the community were known and managed, that information systems were safe and dependable and supported Tusla to protect children, and that services were well monitored and managed to ensure good quality service provision.

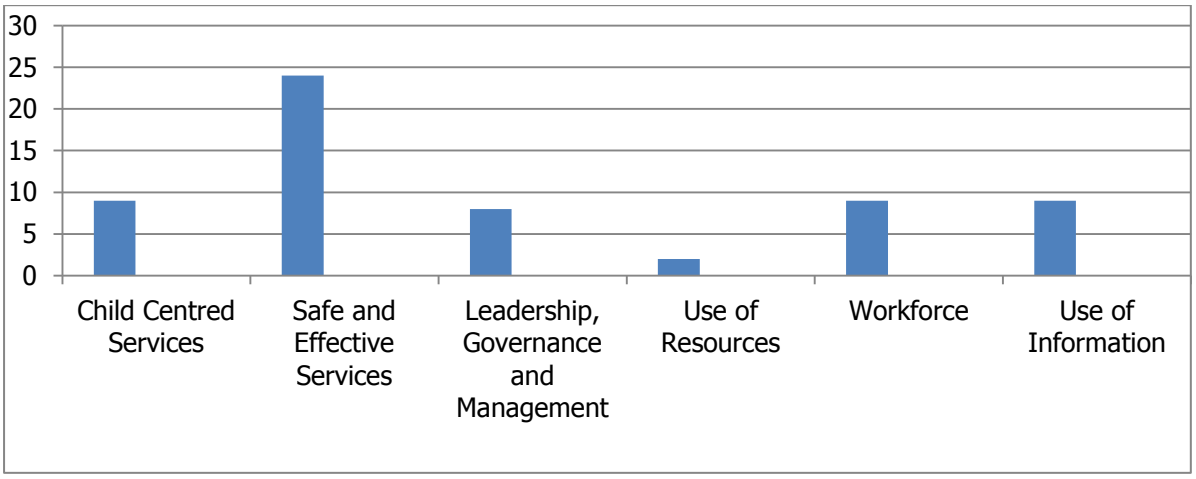
Inspections found that the nature of serious risks in each service differed significantly and one service area was less safe due to the nature of the risks identified.

Levels of significant risk in this service area were found to be closely related to findings of inadequate management and monitoring systems, requiring immediate actions to be taken to respond to the risk involved.

3.2.4 Action plans

There were 62 required actions resulting from the findings of the inspection of child protection and welfare services in the three areas inspected. Figure 3 shows a breakdown of all actions required under the relevant themes.

Figure 3. Actions required per 'theme'



The majority of actions (24) concerned the theme of safe and effective services. These related to waitlists for assessment and allocation to a social worker, delayed notifications to An Garda Síochána in relation to alleged abuse, children on the Child Protection Notification System (CPNS) not being allocated a social worker, quality and timeliness of initial assessments, the CPNS not being available on a 24 hour basis, management of complex cases, implementation of recommendations of serious incident reviews and systems to identify and assess risks to children from adults of concern in the community.

Other actions required were in relation to providing adequate information to children and their families regarding their rights, improvements in the management of risk and monitoring of services, gaps in staff files and the use of information in planning and developing service provision and delivery.

3.2.5 Child Protection Notification System (CPNS)

At the end of 2015, 1,349 children were listed on the Child Protection Notification System (CPNS). The CPNS is a secure database and contains a national record of all children who have reached the threshold of being at on-going risk of significant harm.

A welcome improvement for Tusla in 2015 was that access to the CPNS national database was made available to all hospitals and out-of-hours General Practitioner (GP) services (funded by HSE) in December 2015. Up until this time, there was no access to the CPNS on a 24-hour basis and this had been a recurring recommendation in previous inspection reports.

3.2.6 Metrics received from Tusla

The analysis of data supplied by Tusla has a dual purpose. It facilitates inspectors to identify service areas that are performing well on a consistent basis and it can also assist in the identification of periodic or sustained underperformance.

For example, data for 2015 indicated improvements in some service areas' capacity to allocate high priority cases to a social worker and this reduced the number of cases awaiting allocation nationally.

However, fluctuations in the figures provided indicated that some service areas did not have the capacity to consistently allocate a social worker to all children listed on the CPNS or to those placed in foster care. Where the analysis of data indicated potential risk to children, inspectors sought further information from Tusla and, in some incidences, assurances that risk to children was being managed.

Data provided by Tusla showed that at the end of 2015, there were 26,655 cases open to Tusla child protection and welfare services nationally. When compared with figures for 2014, this showed a reduction by almost 1,000 cases open to the service year on year (Figures 4 and 5).

Inspections found that this reduction was due in some part to improved systems of screening cases referred to the service. There were national thresholds in place to support decisions about referrals. Although these thresholds were not always consistently applied, they contributed to an improved system of determining whether a referral met the threshold of requiring a social work service, or would be better dealt with within a community based, non-social work service.

Another factor found to contribute to the reduction in cases open to the service was a higher rate of case closure within service areas, so that cases open to the service that no longer met the threshold for a social work service were more likely to be closed.

The data provided indicated improvements in Tusla's capacity to allocate a social worker to cases identified, using Tusla's own definition, as high priority. While this data refers to all 17 service areas, the figures provided correspond with findings of some service area inspections in 2015.

However, similar to inspection findings, waitlists continue to exist in relation to allocating children a social worker in a timely way, including those assessed as high priority.

Figure 4. Open and unallocated cases end of 2014

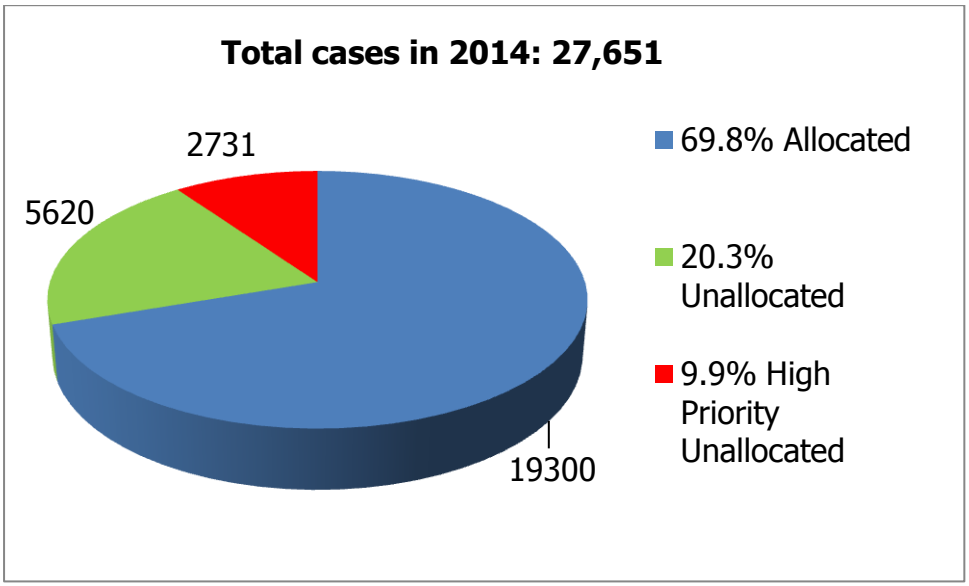
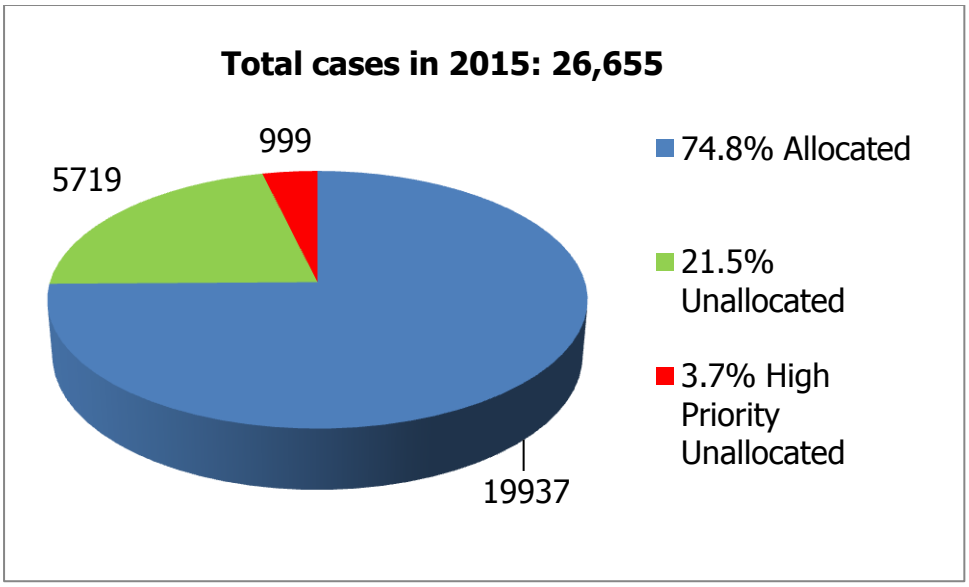


Figure 5. Open and unallocated cases end of 2015



The majority of all cases awaiting allocation were of a lower priority level, reflecting Tusla's continuing efforts to deploy its resources to children most in need of a service.

Inspections found that lower priority level cases awaiting allocation were typically cases where there were welfare rather than child protection concerns, indicating that children about whom there is a welfare concern are less likely to receive a timely social work service.

Inspectors found that the services or interventions for which waitlists existed varied, as did each service area's approach to managing them. As stated, the majority were cases where there were welfare concerns about children and, due to their priority level, they were placed on a waitlist for allocation to a social worker.

However, there were a number of children identified to be at ongoing risk of significant harm and placed on the CPNS, who were not allocated a social worker. Data received over the course of 2015 showed that the number of such cases fluctuated and varied significantly across service areas nationally.

There were also waitlists in relation to holding some child protection conferences and waitlists for the assessment of potential risk posed by adults of concern in the community. Although the cumulative numbers of these wait-listed cases were low in comparison to welfare cases awaiting allocation and assessment, they were significant in nature and in the potential risk they posed to children through limited or non-action.

Inspectors found that there was a lack of a common approach to the management of waitlists, with some service areas lacking an effective strategy to reduce them over time while also responding to incoming demands on the service.

While a National Child Care Information System (NCCIS) is in development and was being piloted in one service area, Tusla continued to provide a child protection and welfare service in the absence of an appropriate integrated information system.

Some service areas have a computerized system, but these systems are limited in their functions and are not always integrated with another social work office in the same service area. Other offices have a paper based system and basic information technology packages, for example a spreadsheet or individual databases.

3.2.7 Going forward: child protection and welfare services

Inspections of child protection services delivered in 14 out of 17 (80%) Tusla service areas were completed by the end of 2015. They found that the safety and quality of services varied across service areas and reinforced the pivotal role of local managers in meeting service objectives and goals within a national model of service delivery.

In 2016 HIQA will carry out a national review of the child protection and welfare service provided by Tusla and the governance arrangements in place to ensure an effective, timely and safe service. The review will complete the first round of inspections of child protection services provided by the 17 service areas within Tusla and its findings will inform the inspection and monitoring approach that we apply to this service going forward.

3.3 Statutory foster care services

The majority of children in the care of the State live with foster carers and a significant number of these children are cared for by members of their extended family in relative foster care.

Children are placed in foster care either at the request of a parent(s) who believe they are not in a position, at that time, to adequately care for their child or by order of the Court. The responsibility is then placed on Tusla to provide adequate care and appropriate parental guidance.

Foster care services are provided by Tusla in each of its 17 service areas. In 2015, HIQA inspected statutory foster care services delivered in two Tusla service areas — Cavan Monaghan and Galway Roscommon. Inspections were also conducted of two private providers who deliver foster care services on behalf of Tusla. Findings of these inspections along with data provided by Tusla on a quarterly basis were analyzed to inform overall findings for 2015.

Data provided by Tusla showed that at the end of 2015, 5,932 children were in foster care in Ireland. The majority, 4,100 (69%) were placed with general (non-relative) foster carers and 1,832 (31%) children were placed with relatives. Figures showed that although most children in foster care had an allocated social worker, 440 (7%) did not and 588 (10%) did not have a written care plan.

There are 26 standards against which foster care services are inspected. Although there were some common findings in statutory services inspected in 2015, services differed in their respective capacity to meet or exceed these standards.

Table 5 provides an overview of how well statutory foster care services inspected in 2015 met national standards and full reports on these services can be found on the HIQA website www.hiqa.ie.

Table 5. Compliance with standards by service area

Service area	Exceeds the standard	Number of standards met	Number of standards requiring improvement	Number of standards against which significant risk was identified
Galway Roscommon	2	4	20	0
Cavan Monaghan	0	6	18	2

3.3.1 Standards met or exceeded

Both service areas inspected in 2015 met the standard related to promoting children's education and one exceeded this standard. There was a high value placed on children's education and they were supported to achieve their educational potential. Many went on to further education with full support from the service area. Timely action was taken when children experienced difficulties in school and this was effective in maintaining them in mainstream education.

On an individual basis, service areas met standards related to meeting children's diverse needs, placing children in safe and nurturing homes and generally, providing children with good quality, safe placements.

Overall, social work practice was good and children were supported to maintain their sense of identity and keep in touch with important people in their lives. As a result, long-term outcomes for many children were positive and they experienced stability in their lives, which continued with support from services once they left care.

3.3.2 Standards requiring improvement

The areas of practice where improvements were required included providing a well resourced service that had the capacity to meet the needs of all children, including those with a disability and those who displayed certain types of behaviours.

Limited numbers and types of foster care placements meant that matching children with carers who could meet their needs was not always possible. This resulted in some placements breaking down and also in placing several unrelated children in the same foster care placement.

It also meant that some foster carers were acting outside of their approval status. This undermined the approvals system in that carers approved to provide placements of a particular type or duration were acting outside of their assessed capacity and some children's needs were not fully met.

There was also a challenge to services to provide culturally sensitive placements, although each service area was endeavouring to address this deficit.

The level of support to foster carers varied across these services and although many received high quality support, others did not have an allocated social worker, and the quality of support to them was not sufficient.

There were some delays in the assessment and approval of some foster carers who had children placed with them, and this meant that potential risks to some children may not have been identified. This delay was reflected in data provided by Tusla.

There was also a need to ensure complaints, concerns and allegations related to foster care placements were well managed and reported to ensure all children remained consistently safe and content in their placements. Managerial oversight of foster care services needed to improve to ensure services were developed and delivered based on need, as opposed to availability.

3.3.3 Significant risk identified

Significant risk was identified in elements of service provision in the service area of Cavan Monaghan. Risks identified were related to children who had experienced a significant delay in accessing psychological services and there was a concern about their wellbeing.

There were also risks related to a lack of appropriate supervision of foster carers by a qualified social worker. HIQA was satisfied with the assurances provided by the service area in response to these risks.

3.4 Privately provided foster care services

Tusla purchases placements from several private providers of foster care services. However, all foster care placements are approved by Tusla. Privately provided foster care services are inspected by HIQA against the same national standards as statutory services, where applicable.

HIQA commenced its inspection of privately provided foster care services in 2014. During 2015, HIQA carried out inspections of two private providers against 18 and 19 of the national standards that applied to their services, respectively, at the time of inspection. As shown in Table 6, these inspections found that both services varied in how they were managed and delivered.

Overall, children were found to be safe in their placements, with carers who provided a good level of care in nurturing environments. However, there was a need to ensure services were managed in a way that met the needs of all children and their carers.

For example, training, supervision and support to some carers required improvement and there was a need to ensure services had the capacity to meet the complex needs of some children it provided placements for.

Table 6. Compliance with standards by service provider

Service provider	Exceeds standard	Standards met	Standards requiring improvement	Standards against which significant risk was identified
Fresh Start	0	4	14	0
Oaklodge	1	10	8	0

3.5 Statutory residential care centres: thematic inspection on 'behaviour that challenges'

During 2015, inspectors carried out 23 inspections of children's residential centres run by Tusla. Ten of these were conducted between May and August 2015 as part of a thematic programme which focused on the quality of work undertaken with children whose behaviour was challenging. This work built on similar inspections undertaken in 2014.

The 10 centres inspected as part of the thematic programme were located amongst the four regions: three in Dublin North East, two in Dublin Mid-Leinster, two in the West and three in the South.

In general these were chosen on the basis of risk ratings, geography, and the length of time since the last inspection. Inspectors met with or had telephone contact with 33 children and 11 parents during these inspections.

The findings across the 10 inspections provided evidence of good child-centred practice across many centres while all centres required improvements under the headings of safeguarding and child protection, planning for children and governance, management and leadership.

3.5.1 Child-centred services

Seven of the 10 centres met the standard relating to the care of young people. Many of the inspections found that the overall quality of the care provided was good and that interactions between children and staff were positive. Staff were familiar with the needs of the children.

There was evidence of opportunities being created in centres for children to reflect on their behaviours. This enabled them to participate in how behaviour was managed and to make changes to how this happened.

Staff were proactive in responding to the needs of children. Children participated in care planning meetings and they were consulted about the running of centres. Care planning and review processes were in place and care plans were kept up to date in most of the centres inspected.

3.5.2 Safe and effective services

Two of the 10 centres inspected as part of this project were found to have met the standard on safeguarding and child protection. Practice in seven centres required improvement as described below. Significant risk was identified in one centre.

There was evidence across centres of good working relationships between staff and social workers with systems in place to report child protection and welfare concerns to social work departments. Staff in all centres had received training in Children First (2011), but some staff were not aware of who the designated liaison person was or of Tusla's protected disclosure policy.

Staff were vigilant in efforts to protect children against bullying and they were familiar with protocols related to children going missing in care. Some centres promoted an open culture encouraging staff to express concerns if necessary and to challenge each other's practice within a supportive environment. However, some centres did not have a system in place to audit or review significant incidents involving children.

Inspectors found that child protection reports concerning behaviour and peer relationships were not always acknowledged by child protection and welfare services and some centre managers did not know if these reports resulted in any changes in assessment of the overall care plan for children.

Staff were trained in the management of behaviour and young people were able to tell inspectors about the model of behaviour management in use and how it worked in practice.

Absence management plans and individual crisis management plans were in place for children and many of these were of good quality.

3.5.3 Governance, leadership and management

None of the centres inspected met the standard related to management. One centre was found to be operating with significant risk and nine were found to require improvement.

Admission processes were not always child-centred in terms of managing behaviour that challenges, because they did not always take into account the dynamics between the children and the possible impact a new resident could have on those

already living in the centre, or the impact the behaviour of existing residents might have on new admissions.

Strong leadership is required in residential centres in order to prevent placements of children being disrupted by peers whose needs are complex and may not be able to be met in that particular centre.

A number of centres had a model of care or an approach that guided staff in their work with children. These included 'trauma' and 'strengths' models. One centre was engaged in a pilot programme responding to behaviour that challenges. In some centres, clinical specialists were available to support staff teams where there was identified need in relation to behaviour that challenged.

Some centres did not have a model of care and staff were not familiar with any particular approach being followed to guide their work with children. This absence of clarity on the therapeutic model or focused approach was a factor that limited the extent to which teams were able to manage behaviour that challenges in a respectful, confident and creative way.

Where a model was not identified, there was a less coherent approach to how staff worked with children and the likelihood of a more reactive culture being employed in managing behaviour that challenged.

Centres with a dedicated model of care which acknowledged the context of children's early experiences and that built on the strengths of the child, allowed for a foundation to be laid for developing good relationships between staff and children.

The purpose and function of some centres required review. Some centres had not reviewed their purpose for several years and this allowed for drift in focus and was more likely to result in the admission of children whose needs could not be met.

There was evidence of close working relationships between centre staff, An Garda Síochána and social workers and the use of joint protocols when required.

3.5.4 Action plans

Table 7 sets out the 48 actions that Tusla was required to address under the three themes of Child-centred Services; Safe and Effective Services; and Leadership, Governance and Management.

The 14 actions under the theme of child-centred services related to poor complaint management systems, the absence of placement plans and the need to better promote children's right to privacy.

The 17 actions required under the theme of Safe and Effective Services related to admission policies, statutory care planning, staff training, child protection and the absence of specialist services for children.

The 17 actions required under the theme of Leadership, Governance and Management related to the morale of staff teams, managing and reporting risk, inappropriate admissions, absence of learning from significant events and centres being unable to manage children's behaviours.

Table 7. Number of actions required per 'theme'

Theme	Child-centred services	Safe and effective care	Leadership, governance and management
Number of actions	14	17	17

3.6 Special care

Special care units (SCUs) are inspected annually by HIQA against the National Standards for Special Care Units (2014).

Children are detained in these units under a High Court order on the basis that they pose a serious risk to themselves or others. Under High Court order, children's liberty is restricted in order to secure their safety and welfare needs.

The children's team carried out four inspections of special care units in 2015.

Three of these were annual full inspections against 30 national standards and one was a triggered inspection[¥] of one unit that assessed the use of single separation[≠] under specific standards.

[¥] Unannounced inspections as a result of receiving information relating to concerns or notifications
[≠] Single separation is defined as the isolation of a seriously disruptive young person, for as short a period as possible, to give them an opportunity to regain self-control. Department of Health and Children's National guidelines on the use of single separation in special care units (2003).

Table 8. Compliance with standards in special care units

	Exceeds standard	Standards met	Standards requiring improvement	Significant risk identified
Coovagh House	1	18	8	3
Ballydowd	0	13	17	0
Gleann Alainn	0	13	15	2

3.6.1 Standards met and exceeded

Annual inspections found that in general, practice across the three special care units was similar, although they varied to some degree in relation to levels of risk at the time of their respective inspections.

Table 8 shows that the three units met 18, 13 and 13 of the national standards respectively and one centre exceeded one of the national standards. The majority of these were related to promoting children's rights.

Children were encouraged to take part in decisions about their care, they had access to independent advocates and their right to have their diverse needs respected was promoted. Children were supported to maintain links and positive attachments with their families. These were very positive findings for children whose liberty is restricted.

Records for each child were well maintained and their educational needs were met. Resources were well managed in these units. Other identified areas of good practice across units included safeguarding and child protection practices and management of complaints.

There were notable improvements to practice in relation to the use of single separation following the findings of the earlier triggered inspection, which had identified key areas for improvement required to address specific deficits such as:

- Single separation was not always used as a last resort
- Policies and procedures in relation to the use of single separation were not always followed and they required review and change
- A lack of managerial oversight of day-to-day practice
- Some children's rights were not always promoted when they were singly separated.

Inspectors found that policies and procedures had been revised and were in the process of being implemented in all units.

There was a re-focus on the promotion of children's rights when singly separated. Cultural changes had taken place that meant exploring effective alternatives to this practice were the main objective. Incidences of single separation had decreased nationally, but some children remained separated from their peers for protracted periods of time.

3.6.2 Standards requiring improvement

Common areas of practice that required improvement were related to promoting children's right to dignity and privacy, the development of an individual programme of special care for each child, the premises and the need to improve elements of their leadership, governance and management.

3.6.3 Significant risk identified

Two and three significant risks were identified in Gleann Alainn and Coovagh House respectively which were related to the use of restrictive practices and managing behaviour that challenged.

3.7 Child protection and welfare services provided to children living in direct provision accommodation

Direct provision is the name given to accommodation provided by the Department of Justice and Equality, through the Reception and Integration Agency (RIA), to asylum seekers in Ireland.

Tusla has statutory responsibilities under the Child Care Act 1991 to identify children at risk, provide care and family support services and promote the safety and welfare of children not receiving adequate care and protection. This includes children accommodated in direct provision.

In 2014, HIQA elected to monitor the quality of service provided by Tusla to children and families living in direct provision accommodation against specific *National Standards for the Protection and Welfare of Children*.

This inspection was carried out by the children's team over seven days during November and December 2014 and the findings were published by HIQA in May 2015.

The inspection process included an analysis of data and information provided by Tusla on the number and nature of child protection and welfare concerns reported to their service over a specified 12 month period and a review of national and local operational policies that guided social work practice in this area.

Fieldwork visits were made to four service areas: Louth Meath, Midlands, Sligo/Leitrim/West Cavan and Dublin North City. These service areas were selected mainly on the basis of the number of children living in direct provision in that area and the type of referrals they received. Inspectors also consulted with managers of RIA on their interaction with Tusla in relation to child protection and welfare referrals.

There were 209 referrals to Tusla in relation to 229 children living in direct accommodation during the period August 2013 to August 2014, 51% of which were child protection concerns and 49% were in relation to children's welfare.

In response to the child protection concerns received, Tusla sought and received care orders for 13 children, made 18 notifications to An Garda Síochána about alleged abuse, identified 11 children as being at risk of ongoing harm and placed five children on the CPNS.

The inspection found that child protection concerns were characterized by children's exposure to domestic violence, physical abuse due to excessive physical chastisement and poor parental supervision of children.

Child welfare concerns were closely related to parental physical or mental health issues that impacted on their capacity to care for their children, children's mental health issues and gaps in provision of practical supports. There were environmental factors that prompted referrals to Tusla that included inappropriate contact between some adults and children, accidental injuries due to cramped living space and children's exposure to violence between other residents.

However, the standard of accommodation for children in direct provision was outside the remit of Tusla, as it is provided by the Department of Justice and Equality, through RIA.

There were positive findings of this inspection that included the provision of family support services and ensuring children were safe through home visits and listening to what children had to say.

However, through a review of records and data, the inspection found that some children did not receive the services they required and risks were not always addressed.

There was also a need to improve communication between Tusla and RIA when children were moved for safety reasons, as this impacted on the timeliness and effectiveness of some social work interventions and potentially placed some children at risk.

Overall, the quality of the child protection and welfare service provided to children and families in direct provision accommodation was inconsistent and it varied across the service areas visited by inspectors.

Service provision was not supported by effective information and data systems and this meant that services could not be designed to meet the needs of this group of children that had a higher than average national rate of referral to Tusla.

Tusla took a proactive approach to the inspection findings and committed to several actions that included an increased emphasis on collaborative and interagency working, staff training on cultural diversity, improved systems of collecting and analyzing information and data, and to carry out an audit of all referrals about children living in direct provision, to ensure risks to them were identified and addressed.

4. Inspection findings of children detention schools

Oberstown Campus is inspected against Standards & Criteria for Children Detention Schools issued by the Department of Justice and Equality in 2008.

Oberstown Campus is funded by the Department of Children and Youth Affairs, through the Irish Youth Justice Service, and managed by a Board of Management. It offers care and education to boys who have been committed to custody after conviction for criminal offences, up to the age of 17 years and to girls up to the age of 18 years. They also provide places for boys and girls remanded in custody while awaiting trial or sentence, for boys up to 17 years and girls up to 18 years.

Two inspections were carried out of Oberstown Campus during 2015. The first was an unannounced inspection in June 2015 which focused on the implementation of actions from the previous inspection in 2014. The second was an announced annual inspection in November 2015.

As the inspection report related to the annual inspection in November was at due process stage, findings of that inspection are not included in this report.

At the time of the follow-up inspection in June 2015, which was carried out against nine standards, the management and staff team of Oberstown Campus were undergoing a process of significant change. Since the previous inspection there were newly constructed units and construction work was ongoing.

New staff members had been recruited as part of a significant recruitment programme, and new policies and procedures had been introduced. The inspection found that some progress had been made in addressing deficits found on the previous inspection, but further improvements were required.

Progress found during this inspection related to more robust systems of reviewing significant events and consistent reporting of child protection and welfare concerns. There were improved systems in place in relation to care planning, and, although there was a variation in the quality of assessments, the comprehensive assessment of some of the children's needs was evident.

There were positive findings in relation to supporting children on discharge from the service and a review was carried out of the offender programme. Work was ongoing in relation to the review and development of policies and procedures to support and inform practice.

Continued improvements were required in relation to the significant use of single separation and the need to ensure consistent implementation of the campus policy in this regard.

Improvements were required in relation to the quality of staff supervision and adherence to the timeframes required by the campus policy. While the new units had sophisticated fire prevention systems in place, the children had not received information on evacuation procedures in the event of a fire. Following inspection an immediate action was taken by the campus to address this.

5. Monitoring and inspection findings of designated centres for children with a disability

5.1 Introduction

The National Standards for Residential Services for Children and Adults with Disabilities in Ireland were published in January 2013. These Standards apply to residential and residential respite services across disability sectors in Ireland, whether they are run by public, private or voluntary bodies.

Based on key principles, they provide a framework for providers to develop high quality, safe and effective services to adults and children who live there.

Regulation of this sector began on 1 November 2013 when the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 came into effect. Essentially this means that only providers that are fit to provide a residential service for children with disabilities are registered to do so.

All designated centres for people with disabilities are required to register with HIQA. Under the Health Act 2007, as amended, designated centres for people with disabilities were deemed registered for a period of three years from 1 November 2013, or until registered by HIQA.

Since commencement, centres for children with disabilities were regulated by the Children's Team, and those for adults were regulated by the Adult Social Care Team, with support provided by the Children's Team for centres that accommodated both children and adults.

5.2 Profile of designated centres for children with disabilities

5.2.1 Location of centres by county

By the end of 2015, there were 62 centres for children with disabilities, which includes those centres that have completed the registration process and those that have yet to do so by October 2016. This was an increase of seven centres from 2014.

Until all of the centres have completed the registration process, it is not possible to give an accurate figure on the number of residential places that each centre has been registered by HIQA to provide.

Table 9. Number of designated centres end 2015

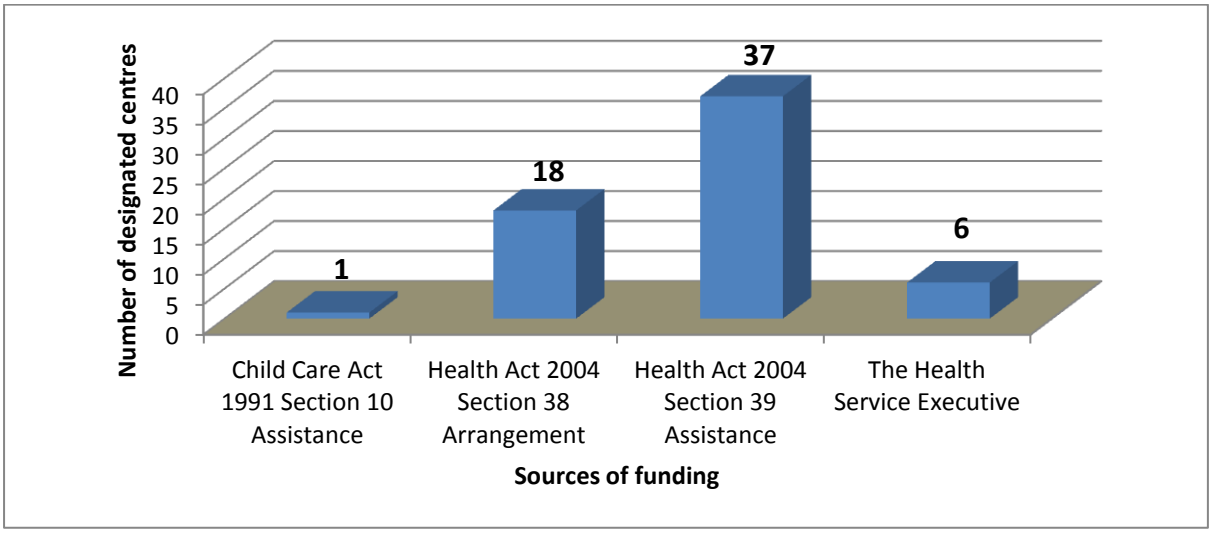
County	Number of centres for children with disabilities on 31 December 2014	Number of centres for children with disabilities on 31 December 2015	Variation in number of designated centres between 2014 and 2015
Carlow	1	1	0
Cavan	0	0	0
Clare	3	3	0
Cork	7	6	-1
Donegal	0	0	0
Dublin	13	18	+5
Galway	3	4	+1
Kerry	2	2	0
Kildare	0	0	0
Kilkenny	1	1	0
Laois	1	1	0
Leitrim	1	1	0
Limerick	3	3	0
Longford	1	1	0
Louth	1	1	0
Mayo	1	1	0
Meath	3	3	0
Monaghan	0	0	0
Offaly	1	1	0
Roscommon	0	0	0
Sligo	0	2	+2

County	Number of centres for children with disabilities on 31 December 2014	Number of centres for children with disabilities on 31 December 2015	Variation in number of designated centres between 2014 and 2015
Tipperary	4	4	0
Waterford	0	0	0
Westmeath	0	0	0
Wexford	1	1	0
Wicklow	8	8	0
Total	**55**	**62**	**+7**

5.2.2 Funding of services

Of the 62 designated centres, six were operated by the Health Service Executive (HSE), 18 were funded by the HSE under Section 38 of the Health Act 2004, and 37 received assistance under Section 39 of the Health Act 2004. One centre was in receipt of assistance under Section 10 of the Child Care Act 1991.

Figure 6. Sources of State funding for designated centres for children with a disability

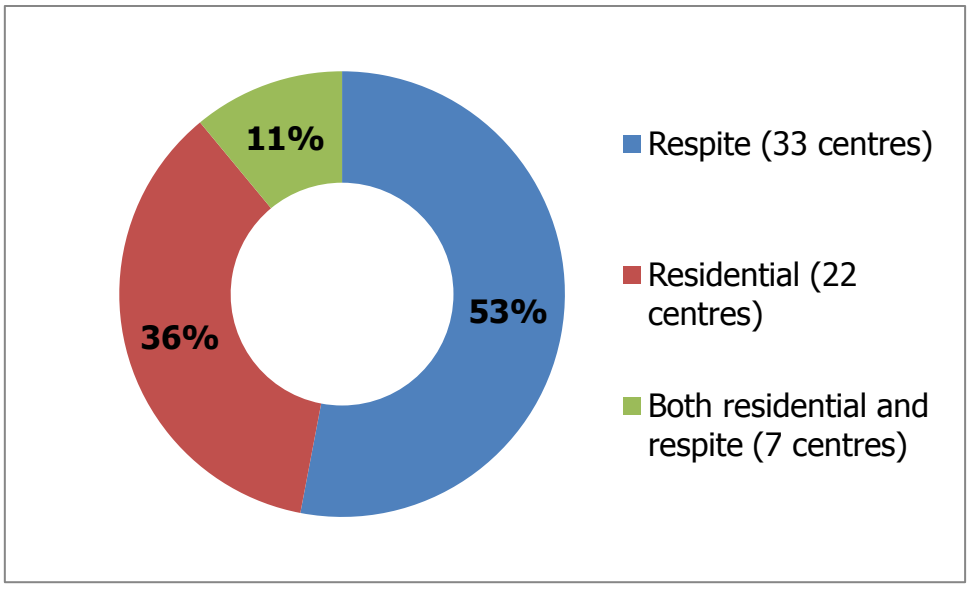


5.2.3 Types of residential services

Figure 7 sets out the three types of services provided. Thirty-six percent of services provided full-time residential care for children and 53% provided respite care only. The remaining 11% of centres provided both residential and respite care.

When monitoring these centres we focus on the extent to which providers have the capacity to care for children on both a full-time and respite basis in the best interests of all the children.

Figure 7. Types of services offered at designated centres for children with disabilities



5.2.4 Size of registered centres

By the end of 2015, HIQA had fully registered 32 of the 62 designated centres. Many of these were centres for small numbers of residents. For example, 20 of the registered centres have five or less residents, 11 had between 6 and 10 residents and the remaining centre had one resident.

5.3 Regulatory activity

5.3.1 Registration

As part of the registration and registration-renewal process, the provider must satisfy HIQA that he or she is fit to provide the service and that the service is in compliance with the Act and the relevant standards and regulations that apply to the service.

By the end of December 2015, 32 centres for children with disabilities were registered. As registration only commenced in November 2013 and each registration cycle lasts for three years, there were no registration renewal requirements during 2015.

All applications for registration which are granted have general conditions attached. These conditions require that centres operate at all times in accordance with the Act, the relevant regulations and National Standards, all other relevant legislation, and in accordance with the statement of purpose and function that applies to the centre.

Two further conditions that are attached to the registration of childrens' centres require that:

- Only children under the age of 18 years are accommodated at the centre, except where a young person is still attending 2nd level education
- Each centre is registered for the accommodation of a specific number of children

For some applications there may be particular circumstances where additional and centre-specific conditions are imposed in order to restrict or limit activity in the best interests of the children resident in the centre.

During 2015 specific conditions were attached in respect of three centres. These conditions generally related to accommodating particular children who had specific needs and had lived in the centre for a long period of time.

5.3.2 Monitoring

Registration relates to a judgement of fitness at a specific moment in time. However, it is the monitoring process that underpins continuing fitness and ongoing compliance with the standards and regulations and ultimately promotes continuous improvement.

It is through the monitoring process that we, as regulators, continue to be satisfied, or not, that the provider and those involved in the management of the centre are fit and that the centre is operating within the conditions that were attached at registration.

Monitoring contains a number of activities that inform an inspector's judgement about whether an appropriate standard of service is being delivered to the children resident in the centre.

These activities include inspections and the review of action plans, unsolicited information, and notifications, all of which inform our on-going decision-making based on assessment of risk and reflect the regulatory actions we take including, where necessary, escalation and enforcement activity.

5.3.3 Announced and unannounced inspections

While HIQA appreciates that unannounced inspections provide a perception of greater assurance to the public, announced inspections are used to enable review of information prior to inspection and greater participation of residents and relatives by letting them know when inspectors will be present in the service over a specific period of time.

Full 18-Outcome inspections for the purpose of registration are always announced and reflect the higher number of registrations achieved in 2015. On the other hand, inspections that are 'triggered' by receipt of information related to concerns or notifications, are unannounced.

Of the 78 inspections of designated centres for children with disabilities during 2015, 49 inspections were announced. This represented 63% of inspections in 2015.

5.3.4 Types and number of inspections

There were four types of inspection carried out of centres for children with disabilities during 2015 as set out in Table 10:

- Full 18-Outcome Inspections, which are required for registration
- Monitoring Inspections – where core areas of care and support are assessed
- Follow-up Inspections – where areas of improvement are reviewed following a previous inspection
- Single Issue Inspections – where an inspection focuses on a particular issue, often resulting from a particular notification or unsolicited piece of information.

Table 10. Inspections by type and number

Type of inspection	Number of inspections of designated centres for children carried out in 2014	Number of inspections of designated centres for children carried out in 2015
Full 18-Outcome inspections	19	42
Monitoring inspections	44	18
Follow-up inspections	11	17
Single Issue inspections	1	1
Total	**75**	**78**

In total there were 78 inspections during 2015. Of these inspections, 48% accounted for between two or three return inspections.

The reasons for more than one inspection in the same year varied. In some instances this included centres where a new applicant for registration was found not to be ready to progress to a registration inspection, or there was a need to assess the implementation of actions arising from an earlier inspection before proceeding to a registration decision.

In addition and in line with our risk-based regulatory approach, HIQA focuses its resources on those centres where the provider is failing to ensure that a good quality service is available to residents and where there are deficits in the governance arrangements in place to ensure a safe and effective service.

In essence, return inspections reflect a targeting of inspection resources so that centres assessed as being at greater risk are subject to greater scrutiny and enforcement activity where necessary.

5.3.5 Receipt of information

The receipt and assessment of information is a key monitoring activity. This information keeps HIQA informed of adverse or potentially harmful events that have or may impact on the health, safety and wellbeing of residents in designated centres. It also keeps HIQA informed as to how service providers respond to the needs of residents when such events arise.

Information can be requested or required by HIQA (solicited) in the form of notifications or it may be provided to HIQA by members of the public who have a concern or an issue with the care provided to residents (unsolicited).

All information received by HIQA is risk-assessed whereby the inspector considers the impact and likelihood of any risk arising from the incident, together with the centre's regulatory history. The assessment is used to inform further monitoring activity, including a request for the provider to carry out an investigation; seeking further information or documentation from the provider; or carrying out an inspection, as required.

5.3.6 Notifications

Regulation 31 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 requires providers and persons in charge of designated centres for people with disabilities to notify HIQA of specified events.

Notifications are a constructive and necessary response from providers requiring them to provide HIQA with assurance that issues, when they arise, are being appropriately managed. The number and type of notifications received in relation to children's designated centres in 2015 are outlined in Table 11.

In the course of 2015, the Children's team received 175 notifications that alerted HIQA to potential risks to the health, safety or wellbeing of residents. The highest number of these notifications related to allegations of abuse (72). Of these, 29 were allegations of abuse by relatives, 19 were allegations of abuse by care staff and other professionals, 17 were allegations of peer-to-peer abuse as a result of behaviour that challenges between children and in seven cases the alleged abuser was unknown.

While the number of these notifications had increased since 2014, inspectors were of the view that there was a greater awareness by providers of their obligation to notify HIQA of prescribed incidents and therefore resulting in more pro-active reporting. All relevant allegations were referred to Tusla by providers of services as required.

HIQA was concerned about the unauthorized absences of what are extremely vulnerable children, of which there were nine notifications. Providers submitted their investigations of these incidents, five of which were for very short durations of time. Where HIQA was not satisfied about the safety of the service, further regulatory action was taken.

The number of notifications referring to loss of power or water in a centre increased from 2014, as even short utility outages were reported.

A further 556 notifications related to the occurrence of certain events in a centre, of which providers are required to notify HIQA on a quarterly basis. These included notifications of periods of absence of the person in charge and the arrangements in place during the absence, and changes to directors, persons involved in management and closure of centres.

Table 11. Notification by type and number

Form	Type	Number received
NF01D	The unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre.	1
NF02D	An outbreak of any notifiable disease as identified and published by the Health Protection Surveillance Centre.	2
NF03D	Any serious injury to a resident which requires immediate medical or hospital treatment.	38
NF05D	Any unexplained absence of a resident from the designated centre.	9
NF06D	Any allegation, suspected or confirmed, of abuse of any resident.	72
NF07D	Any allegation of misconduct by the registered provider or by staff.	11
NF08D	Any occasion where the registered provider becomes aware that a member of staff is the subject of review by a professional body.	0

Form	Type	Number received
NF09D	Any fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place.	42
Other types	Including changes to directors, changes to persons involved in management, quarterly reports, closures of centres.	556
Total		731

5.3.7 Unsolicited information

HIQA receives a number of unsolicited concerns from people who may be residents, relatives, staff, advocates or third parties who have direct contact with a resident or residents.

While HIQA has no legal remit to investigate specific complaints all information is used to inform if residents are being cared for appropriately. Consequently, all unsolicited information is used to further inform our monitoring and inspection programme.

In a similar fashion to notifications, HIQA responds to these by risk-rating each concern received and where necessary a range of follow-up regulatory actions are available, such as requesting information from a provider, requesting that the provider undertake an investigation or for an inspection to be undertaken to ensure the safety or welfare of residents.

HIQA received 21 concerns relating to designated centres for children with disabilities during 2015. While some people reporting concerns chose to remain anonymous, other reporters included residents and their advocates (2); relatives (12); employees of the service provider (5).

Concerns received by HIQA were in relation to governance and management of services (5), safeguarding and safety of children (4), social care needs of children not being met (4) promoting the rights of children (3), the management of medication (2), admissions (1) workforce (1) and premises (1).

5.3.8 Enforcement activity

Our risk-based regulatory approach ensures that those providers who are persistently non-compliant with the standards and regulations, and who place people using services at risk of harm, are identified quickly and face proportionate and meaningful escalation and enforcement action.

Where there is a serious risk to the health and welfare of residents, HIQA will escalate regulatory intervention which can involve formal provider meetings, the issuing of warning letters and improvement notices, increased monitoring and inspection activity, and enforcement action where necessary.

Where areas of non-compliance were judged to pose a significant risk at the time of inspection, providers were issued with an 'immediate action plan' and were required to take immediate action to mitigate the risk identified within a time frame stated by the inspector. If this is not deemed necessary, the action plan which accompanies the inspection report will set out required actions.

In the absence of an appropriate response to the action plan, HIQA will escalate its regulatory intervention. In 2015, there were 36 regulatory actions taken by the children's team with providers of designated centres for children with disabilities as shown in Table 12.

Table 12. Regulatory actions by type and number

Escalation activity in designated centres for children with disabilities in 2015	Number
Immediate action plan	12
Provider meetings	19
Warning letter	4
Carrying out unscheduled inspection	1
Total	**36**

5.4 Findings

Inspection findings are described in detail in inspection reports. Where non-compliance has been identified on inspection, it is set out in an action plan accompanying the report. The provider is required to return a detailed response, within two weeks, which identifies the measures they have taken, or will be taken, to address areas of non-compliance.

On receipt of the completed action plan, the inspector assesses whether the actions taken by the provider, or proposed to be taken, sufficiently addresses the deficits within an acceptable time frame.

In total, there were 1,728 required actions in relation to the 78 inspections. Figure 8 shows that the highest 10 areas where actions were required to address non-compliance were in relation to risk management, governance and management, assessment and personal planning, fire precautions, positive behavioural support, training and staff development, staffing, statement of purpose and function, protection, and medication management.

Figure 8. Most frequent inspection actions in 2015

Inspectors found many examples of high quality safe practice, where children's rights were respected, where they enjoyed a good quality of life, one that upheld their personal dignity, respected their autonomy and had systems in place to ensure their safety and protection.

Children were cared for and supported by staff who were sensitive to and knowledgeable about the children's needs, wishes and aspirations as they grew from childhood into adulthood. None of this comes about without good leadership and governance.

The standards with the highest number of non-compliances, as shown in Figure 8, indicate an overall deficit in relation to the governance arrangements in place to support a safe and effective service in centres.

Reflecting on the graph, key deficits found by inspectors related to poor risk management practices:

- where risks were unidentified or there was an absence of sufficient controls to mitigate those risks
- where systems and practices were not adequately monitored in a systematic way to ensure learning and continuous improvement
- where personal planning was inadequate in that it did not sufficiently capture or detail the individual child's current needs, wishes, preferences and support needs
- where some staff were not aware of the action to take in event of a fire or where evacuation procedures were not safe for some children due to the nature of their disability
- where staff struggled to provide positive behavioural support or there was an absence of specialist advice when some children experienced repeated difficulty in managing their behaviour
- where not all staff were trained in Children First: National Guidance for the Protection and Welfare of Children (2011)
- where the statement of purpose did not clearly set out the nature and objectives of the service provided
- where practice was not informed by policies and procedures to ensure safe practice or procedures were not consistently adhered to.

Good governance ensures that the designated centre is directed, managed and resourced to meet its stated objectives and to meet the necessary standards of accountability.

By comparison, those centres that provided a high quality of care were ones:

- that had a clear statement of purpose that set out the nature and objectives of the service
- where there were clear lines of accountability which were supported by systems to monitor and review practice for learning and development
- where there was an awareness of risk and a capacity to respond to risk
- where staff were supported by relevant training and development and policies and procedures to inform and direct their practice.

As regulation is relatively new to this sector, the findings of inspection presents an opportunity for many providers to review their governance structures and care practices.

As the regulator, HIQA requires that providers who are non-compliant can demonstrate a capacity and capability to learn from inspection findings and put in place the necessary improvements within a safe and appropriate timescale.

It is the absence of a safe and adequate response, and the capacity and capability to bring about improvement that places people using services at risk of harm, and requires HIQA to escalate its monitoring activity and take enforcement action as required.

5.5 Designated centres for children with a disability: next steps

Responsibility for the regulation of designated centres for children with disabilities was transferred from the children's regulatory team to a new disability section within the regulation directorate in April 2016.

The disability section will continue with the programme of registration for both children and adults during 2016, including the first centres that will be due for a renewal of their registration. It will also continue its programme of monitoring using a risk-based model where resources are targeted on centres of concern.

In 2015 HIQA developed an on-line portal system to enable providers and persons in charge to submit notifications online, which was made available to centres for people with disabilities earlier in 2016.

This will result in a reduction of the administrative burden on providers and also enhance the safe storage and review capacity of previously submitted notifications.

A number of guidance documents were produced by HIQA in 2015, which included:

- Statutory Notifications – guidance for registered providers and persons in charge of designated centres (June 2015)
- An update on: What constitutes a designated centre for people with disabilities (June 2015)
- Medicines Management Guidance (October 2015)

During 2016, the Disability Section will continue to produce guidance to enhance practice and reflect the feedback received from the provider and stakeholder engagement that took place during 2015.

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