Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Annual overview report on the regulation of designated centres for adults and children with disabilities — 2015

July 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.

Table of Contents

A Message from the Director of Regulation, Chief Inspector

I am pleased to introduce the Health Information and Quality Authority's (HIQA's) first overview report on the regulation of designated centres for people with disabilities in 2015.

Throughout 2015, the Regulation Directorate undertook an internal organizational review resulting in the creation of four distinct speciality functions for the regulation of Healthcare, Children's, Older Persons and Disability services. In March 2015, we created a Regulatory Practice Development Unit and a Business Team to improve our operational practices, coordinate the development and enhancement of regulatory practice and approaches, and ensure that, as a regulator, we continually learn and improve.

In May 2015, we commenced a significant project to review the current policies, procedures and regulatory practices associated with the Authority Monitoring Approach.[1]

As a public body, HIQA continually seeks ways to reduce regulatory burden so that providers and their staff can spend as much time as possible caring for and supporting residents. In 2015, we developed an online portal system to allow providers and persons in charge of residential centres to submit notifications required by the regulations online. By early 2016, this portal was extended to providers and persons in charge of centres for people with disabilities. The benefits of this online system include: a more reliable notification process; the safe storage of notifications, which facilitates the review of previously submitted notifications; and a reduction of the administrative burden on providers.

During 2015, inspectors from the Adult Social Care section in the Regulation Directorate completed a total of 741 inspections of centres for adults with disabilities and centres for mixed adult and children with disabilities. While it was necessary to take escalated action in relation to a number of centres, including court action in

[1] The 'Authority Monitoring Approach' enables HIQA to carry out its functions as required by the Health Act 2007. Application of the Authority Monitoring Approach works to ensure the consistent and timely assessment and monitoring of compliance with standards and regulations, and managing risk

relation to four centres, inspectors also visited centres where a good standard of care and support was provided; some of which were found to provide innovative and excellent standards of care and support.

Since the beginning of 2016, the new disability function has a dedicated inspectorate team led by Finbarr Colfer, Deputy Chief Inspector, and supported by four area inspector managers and a programme manager. The area inspector managers lead a team of inspectors and regulatory officers who are assigned specifically to the regulation of centres for people with disabilities.

Responsibility for the regulation of designated centres for children with disabilities transitioned from the Children's Team to the new disability section in the Regulation Directorate in April 2016. As part of this transition, inspectors from the Children's Team joined the Disability Team.

In 2016, the Disability Team will continue working with the Regulatory Practice Development Unit to produce further guidance and improved processes for the management of our regulatory work. We will engage with representatives of people who use residential services to ensure that their views inform our work. We will also review the way in which we report our findings to ensure that the voice of residents is reflected in regulatory reports. Throughout 2016 we will consult and communicate with the relevant stakeholders in relation to these practice enhancements.

This report has been designed to distil some of the overall learning from our inspections from 2015. In doing so it is hoped that service providers may use this document as a tool to further inform their improvement efforts.

Mary Dunnion

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

1. Introduction

The Health Information and Quality Authority (HIQA) is the statutory body established under the Health Act 2007 with responsibility for the registration and inspection of 'designated centres' for people with disabilities.

This report is the first annual overview of HIQA's regulatory work in relation to centres for people with disabilities. The main body of this report provides information on centres which were within the remit of HIQA's Adult Social Care section, and were centres for adults and centres with a mix of adults and children. Centres for children only were regulated by HIQA's Children's Team, and the findings from their work are contained in the Annual Overview Report on the Inspection and Regulation of Children's Services 2015. The part of this report that relates to centres for children with disabilities is included in Appendix 1 at the end of this report.

This report presents an overview of the findings from 518 announced and 223 unannounced inspections carried out by HIQA in 561 of the 937 designated centres for adults with disabilities and centres for mixed adult and children with disabilities[2] in 2015. Throughout the year, we published 577 inspection reports into these services on our website www.hiqa.ie.

Overall, while HIQA found that improvements were required in many centres, most providers were ensuring that residents had a good quality of life. In 2015, 93% of all inspected centres had either one or two inspections. From a regulatory perspective, one or two inspections indicate that the centre provides a good quality service. In 49 of the 577 inspection reports published during 2015, there were no outcomes of non-compliance found and this indicated an excellent standard in the provision of support and care to residents.

Since we commenced the regulation of designated centres providing disability services, HIQA has identified three principle characteristics that determine a good service:

[2] The outcomes from inspection of child specific services are contained in HIQA's overview report for children's services. An extract from that report can be found in Appendix 1 at the end of this report.

1. A staff culture which promotes and protects the rights of residents through person-centred care and support.
2. A service that is led by a capable person in charge, who is knowledgeable about the support needs of residents and effectively manages staffing and other resources.
3. A provider who has arrangements in place to support the person in charge, as well as appropriate monitoring arrangements such as strong auditing processes, to assure themselves that a safe and good quality service is being provided to residents.

However, HIQA also identified centres where the provider had failed to ensure that residents were safeguarded and had failed to promote the rights and welfare of residents. In particular, HIQA found that residents living in many large congregated settings were not being adequately protected or kept safe. The institutionalized care practices in those centres further impacted adversely on the quality of life for residents. In such circumstances, HIQA takes proportionate regulatory action to ensure that the provider improves the safety and quality of life for residents. Where the provider fails to achieve adequate improvements, HIQA will consider escalated action, up to and including the cancelation of registration.

The inspection process contributed to a greater understanding of the poor standard of care and support in some large, congregated settings. This has been recognized by the Government, and in 2016 there was a commitment of resources to escalate the movement of residents from inappropriate, congregated setting to more appropriate living arrangements.

HIQA also continued with its programme of registration for designated centres for people with disabilities in 2015. Initially, progress on registration was slow because the sector was not adequately prepared for regulation. HIQA has also had to commit significant resources to risk-based inspections where and when significant risk for residents has been found. However, the registration programme accelerated during 2015 and by the end of the year 368 of the designated centres for adults and mixed adults and children with disabilities had been fully registered. When centres for children with disabilities are included, there were 402 registered centres for people

with disabilities by 31 December 2015.

During 2016, we will continue to acknowledge the good quality service provided in the majority of centres for people with disabilities. HIQA will continue to take action where standards are not being met and where providers are failing to provide residents with a good quality of life.

Finbarr Colfer

Deputy Chief Inspector of Social Services

2. Engaging with Residents

An essential part of the regulation process is listening to the views and opinions of people who use services and their representatives.

Spending time with and speaking to residents and their representatives is a critical aspect of all inspections. Inspectors want to hear from residents and listen to residents about what it is like to live in a particular centre. Residents and their representatives are also invited to submit questionnaires to HIQA about their views of their centres.

Based on feedback from residents and their representatives, HIQA is currently looking at improving how the views of residents are reflected in our inspection reports. HIQA is also reviewing its questionnaire to enhance the way in which the views of residents and their representatives can be conveyed to HIQA.

In addition, HIQA has a service user representative forum which met three times during 2015 and provided valuable feedback on the way in which HIQA carries out its work. HIQA also met with three advocacy groups during 2015 to hear directly about their experience of inspection and to answer the questions residents had about our work.

3. A profile of designated centres

Under the Health Act 2007, providers are required to ensure that designated centres are registered with HIQA. To assist providers, HIQA published a revised guidance document in 2015 on identifying which residential services constitute a designated centre. 'What constitutes a designated centre' can be found on www.hiqa.ie.

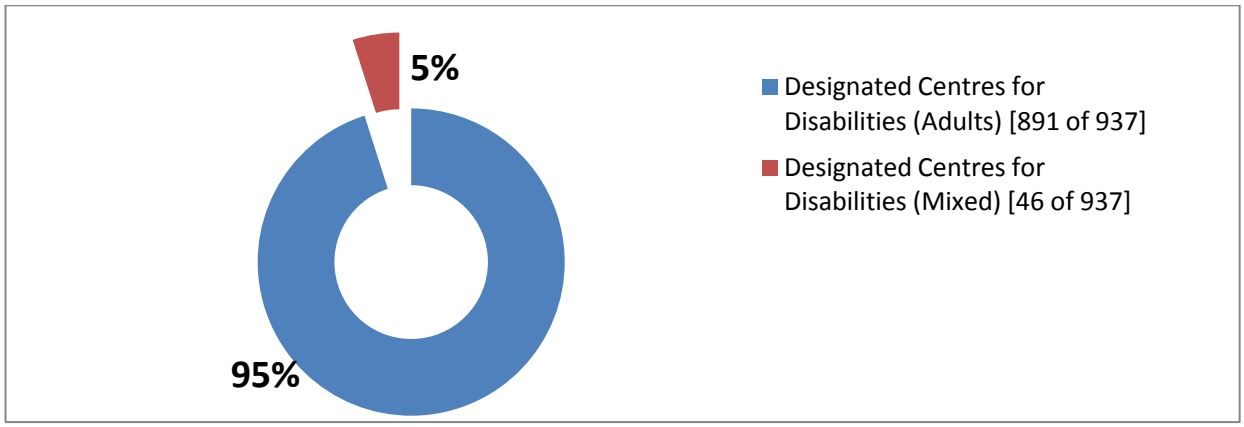
Throughout 2015, due to the reconfiguration of centres by providers, there was a fluctuation in the total number of designated centres for people with disabilities. Providers informed HIQA that they were dividing large, institutional, campus-based services into a number of smaller designated centres as part of their preparation for moving residents to more appropriate living arrangements in the community. Also, some providers grouped a number of small, dispersed community based houses into a single centre for the purposes of registration.

As of the 31 December 2015, there were 937 centres for adults with disabilities and for a mix of adults and children. It is expected that the number of designated centres will continue to fluctuate as the first cycle of registration for centres progresses.

3.1 Types of designated centre

Of the 937[3] designated centres regulated by the Adult Social Care section in HIQA, 891 were exclusively for adult residents while the remaining 46 accommodated both adult and child residents[4].

Figure 1. Percentage of centres for adults and mixed adults and children with disabilities.



3.2 Funding of Services

Designated centres are primarily funded by public money allocated to providers by the Health Service Executive (HSE) or operated by the HSE. Providers are responsible for ensuring that this public money is used to afford residents with a good standard of service that promotes and protects the rights of residents, and provides them with a good quality of life.

Of the 937 designated centres, 97 were operated by the HSE, 517 were funded by the HSE under Section 38 of the Health Act 2004 and 322 under Section 39 of the Health

[3] 937 designated centres for adults or for a mix of adults and children. During 2015, centres for children with disabilities were regulated by the Children's Team in HIQA and information on those centres can be found in Appendix 1.

[4] The outcomes from inspections of child specific services are contained in HIQA's Overview report for children's services, and in an extract from that report at the end of this report.

Act 2004. One centre was in receipt of funding assistance under Section 10 of the Child Care Act 1991.

4. Key Regulatory Findings

A key finding from 2015 is that a significant number of centres inspected provided a good standard of care and support to residents, with some services providing an excellent standard of care and support.

4.1 Findings on inspection

Inspectors found that many service providers showed increasing regulatory maturity, with a number of centres moving from a compliance-only based agenda to a quality improvement agenda. This resulted in an improved service for residents. In those centres inspectors found:

- Staff were focused on meeting the assessed support needs of residents.
- The rights of residents were protected and promoted, and residents tended to have a good quality of life.
- Residents contributed to the running of the centre and decision making about their homes.
- Residents had interesting things to do during the day, based on their preferences and goals.
- Residents in these centres were also supported to engage with their local communities and were considered part of the local community.
- Where residents had concerns or complaints, they were listened to and there was an appropriate response.

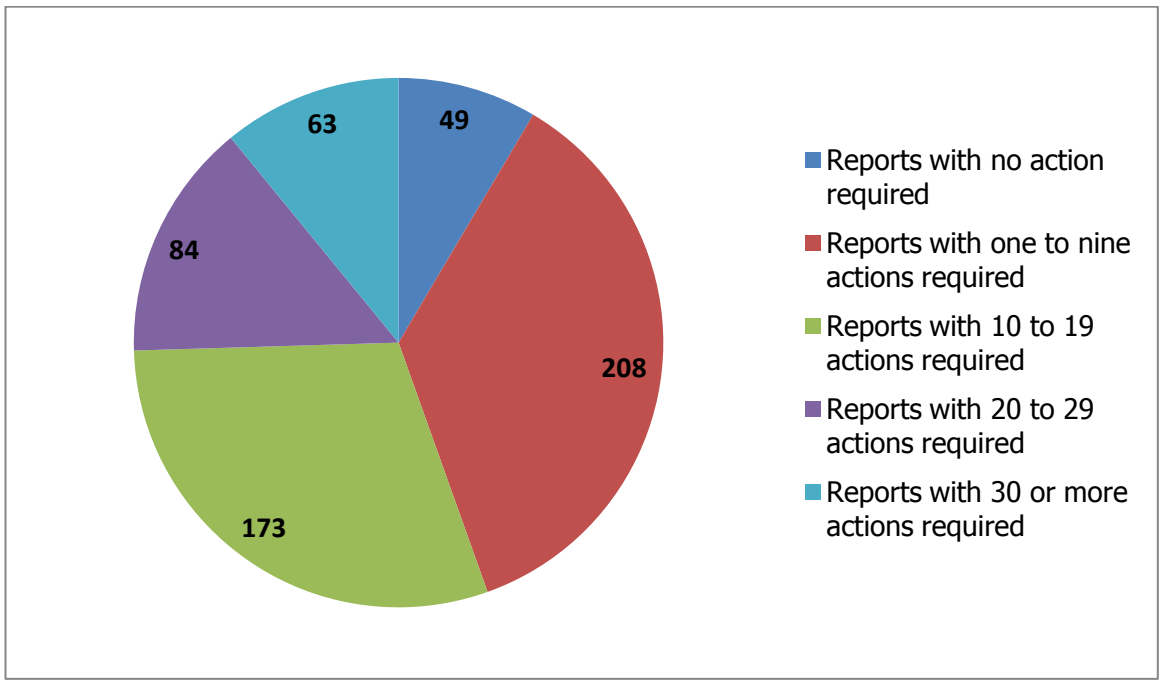
Effective governance arrangements were a key factor in achieving these good outcomes for residents. These arrangements included:

- The appointment of a competent person in charge who had the knowledge and management skills to ensure that residents were provided with a good quality service based on the individual care and support needs of residents.

- Providers had arrangements to assure themselves that the service was being delivered as described in the statement of purpose, residents had a good quality of life and residents had a safe place to live.

Good practice is reflected in the number of actions which providers were required to respond to in inspection reports. Of the 577 inspection reports published during 2015, 49 reports did not identify any actions required while a further 208 had less than 10 actions required.

Figure 2. Number of actions required in reports published during 2015



Where providers were failing to implement adequate governance arrangements, there tended to be poor outcomes for residents. The highest level of non-compliances related to centres where:

- The person in charge had not ensured effective, individualized assessment arrangements for residents.
- There had been a failure to develop adequate personal plans with residents or their representatives.
- This impacted adversely across a range of aspects of residents' lives and lead to inconsistencies in the quality of support for residents.

There were also high levels of non-compliance relating to providers' failure to have appropriate oversight and auditing arrangements. These providers were not assuring themselves that staff were providing a safe service to residents. Risk management and safeguarding arrangements featured significantly as areas of non-compliance.

Figure 3 sets out the main areas of non-compliance found in inspection reports that were published during 2015.

Figure 3. Regulatory actions in 2015 reports

Inspection reports published in 2015 – actions required by regulation	Number of regulatory breaches	As a percentage of total regulatory breaches
Regulation 05: Individualized assessment and personal plan	800	10%
Regulation 23: Governance and management	748	9%
Regulation 28: Fire precautions	582	7%
Regulation 17: Premises	566	7%
Regulation 26: Risk management procedures	561	7%
Regulation 07: Positive behavioural support	389	5%
Regulation 29: Medicines and pharmaceutical services	364	5%
Regulation 15: Staffing	363	5%
Regulation 34: Complaints procedure	357	5%
Regulation 09: Residents' rights	336	4%
Regulation 16: Training and staff development	323	4%

Regulation 04: Written policies and procedures	315	4%
Regulation 06: Healthcare	277	4%
Regulation 24: Admissions and contract for the provision of services	264	3%
Regulation 08: Protection	250	3%
Other regulations	1,386	18%
Total	**7,881**	**100%**

4.2 Receipt of information

In addition to inspections, the receipt and assessment of information from providers through regulatory notifications or information required from others as a concern about the centre are key monitoring activities. This information keeps HIQA informed of adverse or potentially harmful events in designated centres. It also gives providers an opportunity to demonstrate whether their governance arrangements are effective in responding to such incidents.

During 2015, providers submitted 10,422 notifications and 174 pieces of unsolicited information were submitted from the public relating to incidents and concerns about centres for adults and mixed adults and children with disabilities. When notifications from centres for children with disabilities are included, HIQA received 11,088 regulatory notifications in 2015. Each individual piece of information is risk assessed by an inspector and the provider may be required to submit further information.

Providers who have effective governance arrangements generally respond to HIQA with evidence that the issue of concern has been responded to appropriately. Where providers are unable to provide appropriate assurances, the inspector will consider a range of actions which might include consideration of the issue at the next inspection or, if the issue relates to the safety of residents, the inspector may conduct an unannounced, specific issue inspection to confirm whether the provider has responded

appropriately.

The most common notification submitted by providers during 2015 related to the safety of residents. This is also reflected in the information received from those contacting HIQA with concerns they have in relation to centres.

Figure 4 provides information on the notifications that were submitted by providers.

Figure 4. Breakdown of number and types of notifications in 2015

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.	102
NF02D	An outbreak of any notifiable disease as identified and published by the Health Protection Surveillance Centre.	63
NF03D	Any serious injury to a resident which requires immediate medical or hospital treatment.	1,310
NF05D	Any unexplained absence of a resident from the designated centre.	183
NF06D	Any allegation, suspected or confirmed, of abuse of any resident.	1,799
NF07D	Any allegation of misconduct by the registered provider or by staff.	159
NF08D	Any occasion where the registered provider becomes aware that a member of staff is the subject of review by a professional body.	1
NF09D	Any fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place.	835
NF20D	Where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more, the registered provider shall give notice in writing to the chief inspector of the proposed absence.	154
NF21D	Return of the person in charge after being absent for a continuous period of 28 days or more.	69
Other types	Including changes to directors, changes to persons involved in management, quarterly reports, closures of centres.	5,747
Total		**10,422**

HIQA received 174 pieces of information from the public in 2015. While some people who reported their concerns chose to remain anonymous, others included residents

and their advocates (12); relatives (82); healthcare professionals (4) and employees of the service provider (30).

The highest frequency of concern was in relation to the safety and safeguarding of residents (55), followed by residents' rights, dignity and consultation (22) and staffing arrangements (14).

Figure 5. Classifications of concerns received in 2015

Type of concern	Number received
Admissions and Contract for the Provision of Services	9
Communications	3
Family and personal relationships and links with the community	2
General Welfare and Development	4
Governance and Management	11
Health and Safety and Risk Management	10
Healthcare Needs	11
Medicines Management	7
Residents' Rights, Dignity and Consultation	22
Safe and suitable premises	3
Safeguarding and Safety	55
Social Care Needs	5
Statement of Purpose	1
Workforce	15
	174

5. Regulatory Activity

The regulations and National Quality Standards for Residential Services for Children and Adults with Disabilities give providers a framework which can be used to assure themselves about the safety and the quality of the services that they provide.

Under the Health Act 2007 providers are responsible for ensuring that designated centres are in compliance with the regulations and that there is ongoing quality improvement through implementation of the National Standards. HIQA inspectors monitor centres to assess the level of compliance with the requirements of the regulations, and to acknowledge ongoing quality improvement in designated centres through implementation of the National Standards.

5.1 Inspection activity

During 2015, inspectors conducted 741 inspections of 561 centres for adults and mixed adults and children with disabilities.

Figure 6. Types of inspection in 2014 and 2015 for adult and mixed designated centres

	Designated centres for adults and mixed (adults and children) 2014	Designated centres for adults and mixed (adults and children) 2015	Change
Full 18 outcome inspections	210	438	**+228**
Monitoring inspections	338	157	***-181***
Follow-up inspections	10	91	***+81***
Single Issue inspections	42	55	***+13***
Total	**600**	**741**	***+141***

HIQA focuses its inspection resources on centres that are of concern. Providers can expect more inspection and monitoring activity in centres where they are failing to ensure safe, good quality services or where there are inadequate governance arrangements to ensure the delivery of a consistent, effective service.

In many instances, a second inspection is carried out to verify that the provider's action plan from a previous inspection has been implemented and is achieving the required improvements. From HIQA's perspective, a centre that receives only one or two inspections indicates that a good quality of service is provided in that centre. During 2015, 93% of inspections were in centres which received one or two inspections. This indicates that the majority of centres provide a good service.

However, HIQA also had to assign significant resources to the monitoring and inspection of centres of concern. For example, 36 centres inspected during 2015 required a total of 135 inspections.

Figure 7. Inspection figures for adult and mixed designated centres for people with a disability in 2015

Number of inspections of adult and mixed centres for people with disabilities in 2015.	Number of centres	As a % of number of centres inspected	Total inspections	As a % of inspections
1 inspection	444	79.14%	444	59.92%
2 inspections	81	14.44%	162	21.86%
3 inspections	22	3.92%	66	8.91%
4 inspections	10	1.78%	40	5.40%
5 or more inspections	4	0.72%	29	3.91%
TOTAL	**561**	**100%**	**741**	**100%**

5.2 Monitoring information received

In addition to inspections, the receipt and assessment of information is a key monitoring activity for inspectors. Providers are required to inform HIQA of certain events which occur in the designated centre. This not only allows HIQA to be informed of critical events, but also allows the provider to tell HIQA about how they have responded to the events. During 2015, providers submitted 10,422 notifications to HIQA in relation to centres for adults and mixed adults and children with disabilities.

Additional unsolicited information is also received by HIQA from people who have a concern about the care provided to residents. This information is submitted by post, through HIQA's helpline, 021 240 9646 or by email to concerns@hiqa.ie.

Each piece of information received by HIQA is referred for consideration to an inspector. The inspector risk assesses the information in light of any other information that HIQA has about the centre. The inspector will then decide the most appropriate action to take. This action ranges from seeking further information from providers to triggering an inspection of the centre.

5.3 Escalated and enforcement activity

While the majority of centres provide a good standard of care and support to residents, HIQA has also identified centres where providers are failing to do this. In most cases, providers submit an action plan which tells HIQA how they will improve the service they provide to residents, and how they will bring the centre into compliance with the regulations and National Standards. However, in some instances the provider fails to address the areas of concern. HIQA must then consider escalated regulatory action.

To assist with this, HIQA has developed a dynamic approach to monitoring centres using a centre risk profile for each designated centre. This centre risk profile is continuously updated and is informed by the analysis of all solicited and unsolicited information received in relation to the designated centre and by findings from inspections. Where the assessment indicates that there may be a serious risk to the health, safety or welfare of a resident, HIQA will review the information and may

undertake an escalated approach which can include formal provider meetings, the issuing of improvement notices, and enhanced monitoring and inspection activity. This approach ensures that any provider who is persistently non-compliant with the standards and regulations, or who places residents at risk of harm, is identified quickly and faces proportionate and meaningful regulatory action.

HIQA will consider taking enforcement action where there are reasonable grounds to believe that there is a risk to the life, or serious risk to the health or welfare of residents, or if there is a substantial and significant breach of the regulations as a result of a provider failing in its duty to safeguard a resident or residents.

Formal enforcement procedures under Section 59 and Section 60 of the Health Act 2007 as amended were used in respect of four centres during 2015. In one of the centres, HIQA applied to the court to cancel the registration of the centre and this was granted. In accordance with the Health Act 2007, the Health Service Executive then became responsible for the operation of the centre. HIQA applied to the court to have additional restrictive conditions on the registration of three other centres. The court granted these conditions which required the provider to put specific arrangements in place to improve the safety and welfare of residents in those centres. HIQA continues to monitor the implementation of those court orders to ensure the quality and safety of care for residents.

5.4 Voluntary closures

During 2015, HIQA received 74 notifications of voluntary closure from providers resulting in these centres being removed from the register of centres. Two of these centres were subsequently registered under the management of a new provider. A further three services were registered, but at new locations. Some of the notifications of voluntary closures related to the reconfiguration of designated centres. Some also related to a decision by providers to cease the operation of the centre and to facilitate residents being transferred to a more appropriate residential service.

6. Registration and conditions attached to registration

The introduction of regulation in the disability sector in November 2013 began the initial cycle of registration of centres for people with disabilities. HIQA has had to balance the requirements of this registration process with the need to respond to risk. This section of the overview report will focus on the progress of registration.

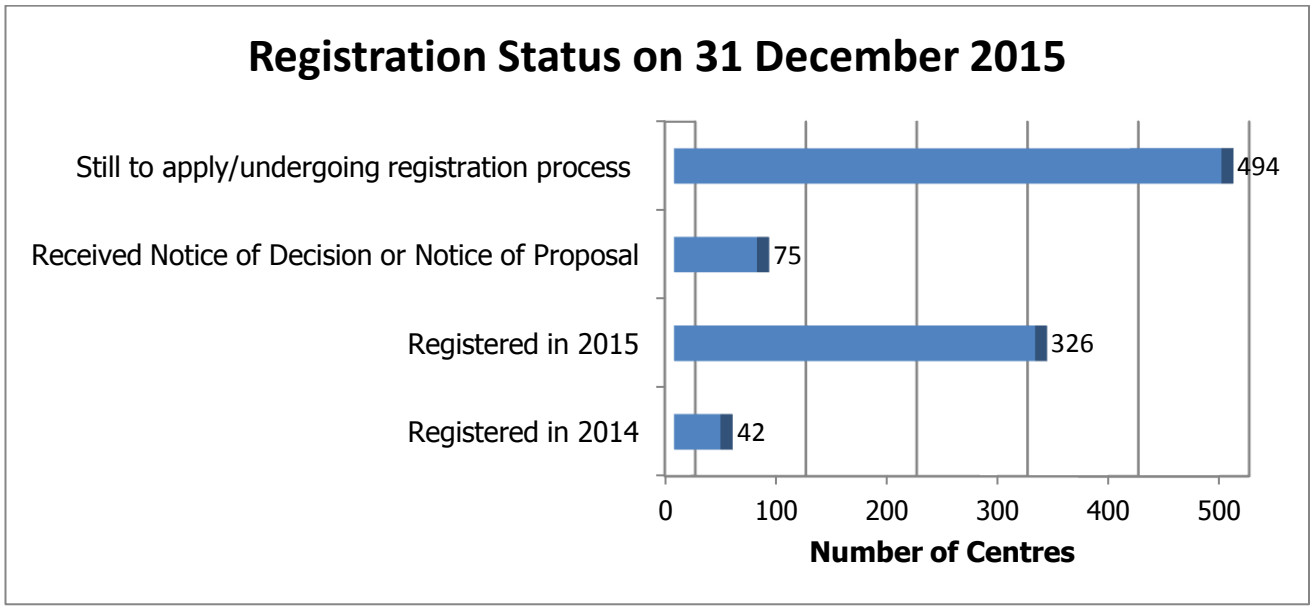
In order for a designated centre to be registered, a provider must satisfy HIQA that they are fit to provide the service and that the service complies with the Health Act 2007 as amended, as well as the relevant National Standards and regulations that apply to the service. Registration is for a three year period and the provider and persons involved in management must demonstrate ongoing fitness to provide the service during the registration period.

6.1 The number of centres that have been registered

Initially, the progress on registering centres was slow. The sector had not been regulated before and many centres were not adequately prepared for registration. As a result, only 42 centres were registered by the end of 2014. However, as providers became familiar with the requirements of the regulatory framework, and as they implemented changes to bring their centres into compliance with these requirements, there was an escalation of registrations during 2015. As of 31 December 2015, 368 of the 937 adult and mixed centres were registered with HIQA; these 368 registered centres provide a total of 3,121 registered residential places.

At the time of publication, 494 centres had begun the application to register process.

Figure 8. Number of centres registered on 31 December 2015



When registered, centres are granted their registration under certain conditions. These include conditions that:

- The centre is operated in accordance with regulations and standards while registered.
- The centre is operated within the parameters of their own Statement of Purpose.
- The centre does not exceed the maximum number of registered beds.

There may also be particular circumstances which require additional and specific conditions to be imposed, such as to restrict or limit activity in the best interests of residents. These are decided on a case-by-case basis. These conditions generally require restrictions on the number of residents accommodated in a particular room of a centre and or reconfiguration of the design and layout of a centre in line with plans submitted by providers.

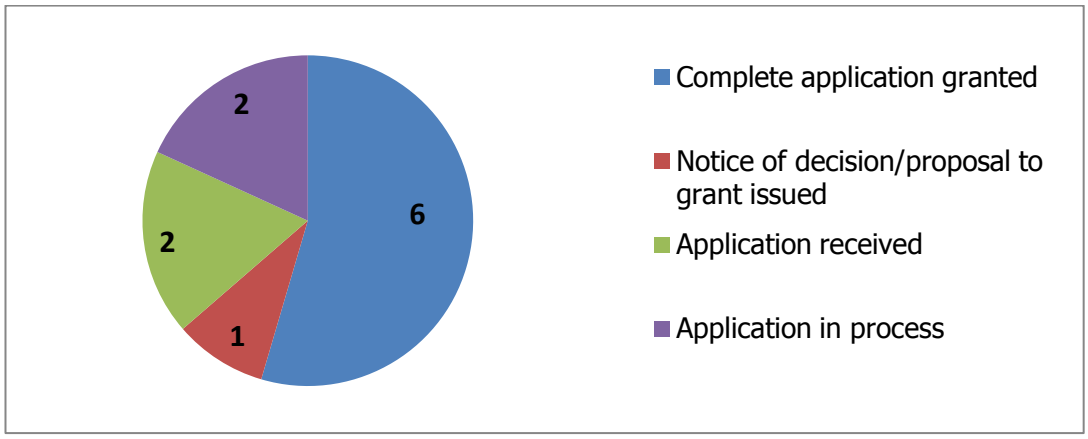
6.2 Applications to vary or remove a condition

HIQA recognises that designated centres can change and develop over time. The conditions of registration may need to change to reflect these developments. A provider who feels the need to vary or remove a condition may make an application to do so to HIQA.

There were 11 applications to vary or remove a condition during 2015. Six of the 11 applications to vary or remove a condition were granted in 2015. As of 31 December 2015 a decision was pending in relation to one centre, two applications were in process and two more applications had been received and were awaiting consideration.

Before an application to vary or remove a condition is granted, inspectors must be satisfied that the variation or removal of a condition will not negatively impact on the quality and safety of care provided to residents.

Figure 9. Applications to vary or remove a condition of registration during 2015



7. Communication

Throughout 2015, HIQA maintained a programme of communication and engagement with key stakeholders and organizations about our existing and developing programmes of regulation and their impact on the quality and safety of services.

A number of guidance documents were published in 2015 to help service providers enhance their compliance and safety levels. These include:

- Statutory Notifications – guidance for registered providers and persons in charge of designated centres (June 2015),
- Revised What constitutes a designated centre for people with disabilities (June 2015),

- Medicines Management Guidance (October 2015).

Additionally HIQA held a number of forum meetings during the year with representative groups for providers and representative groups for residents, including advocacy groups. HIQA values the feedback from these forum meetings regarding the implementation of regulatory processes.

8. Conclusion

2015 was the second full year of the regulation of designated centres for people with disabilities. During the year, HIQA undertook a programme of registration and inspections based on the assessment of risk within centres.

Overall, the inspection process has shown that where providers have a good understanding of the regulations and standards it significantly contributes to ensuring a high standard of care and support for residents in designated centres. While most inspections resulted in providers being required to take action to improve aspects of their services, providers were responsive in improving the service provided to residents and in bringing their centres into compliance with the requirements of the regulations and National Standards.

HIQA identified three characteristics of centres that demonstrated a good standard of care and support for residents:

- Staff were focussed on promoting and protecting the rights of residents. They were aware of the assessed, individual support needs of residents and of residents' goals and ambitions.
- The provider had appointed a knowledgeable, experienced person in charge who was able to manage the resources available to provide a good standard of service to residents.
- The provider had appropriate and robust governance arrangements in place which supported the work of the person in charge and which provided assurance to the provider that the service was being delivered to a high standard.

However, HIQA also identified a small but significant number of centres where the provider was failing to ensure that there was a good standard of service. This failure resulted in poor outcomes for residents in terms of their safety and quality of life. In these situations, HIQA used a range of measures that required the provider to improve the service for residents. Where there were risks to the safety of residents or where the provider had failed to address areas of concern repeatedly, HIQA took escalated action, up to and including court action to cancel the registration of the centre.

In April 2016, HIQA transitioned the regulation of centres for children with disabilities into its newly established Disability Team. The Disability Team now has responsibility for the centres that fell under the Adult Social Care section (centres for adults and mixed adults and children with disabilities) and centres for children with disabilities. Inspectors will continue with the programme of registration and will continue to acknowledge the good services provided in the majority of centres for both adults and for children. HIQA will continue to monitor the safety and the quality of life for residents, and where it identifies that the provider is failing in their duties to ensure a good quality of service, HIQA will take proportionate and timely action to ensure a positive outcome for residents.

APPENDIX 1: Extract from the Annual overview report on the inspection and regulation of children's services - 2015

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

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.

2. Profile of designated centres for children with disabilities

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 7 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.

Figure 1. Number of designated centres end 2015

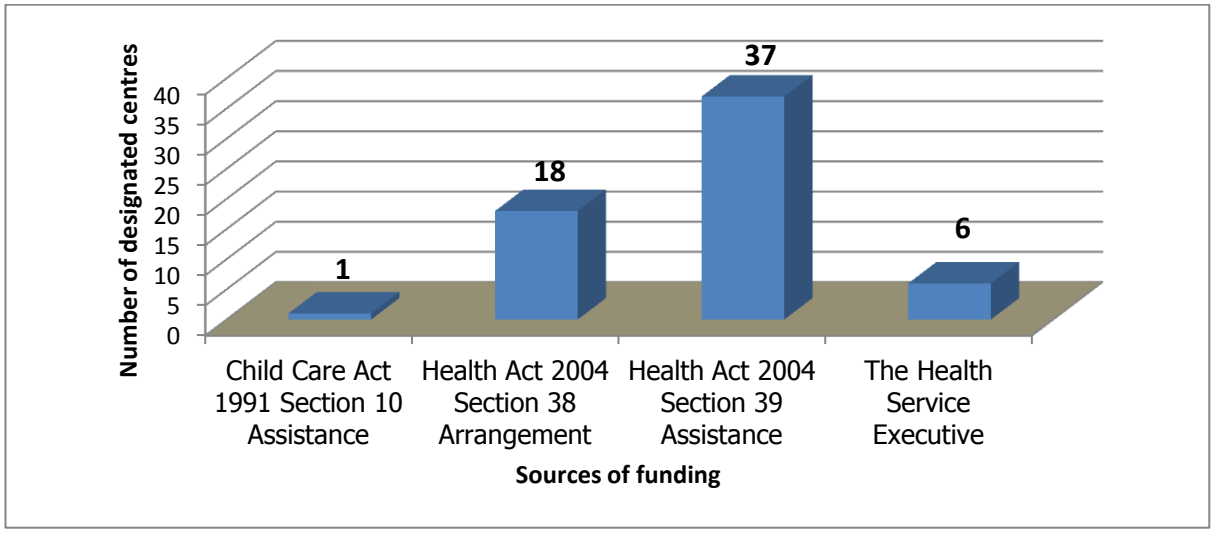
County	Number of centres for children with disabilities on 31 December 2014	Number of centres for children with disabilities on 31 December 2015	Variation in number of designated centres between 2014 and 2015
Carlow	1	1	0
Cavan	0	0	0
Clare	3	3	0
Cork	7	6	-1
Donegal	0	0	0
Dublin	13	18	+5
Galway	3	4	+1
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

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
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
Tipperary	4	4	0
Waterford	0	0	0
Westmeath	0	0	0
Wexford	1	1	0
Wicklow	8	8	0
Total	**55**	**62**	**+7**

2.2 Funding of services

Of the 62 designated centres, 6 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 2. Sources of State funding for designated centres for children with a disability

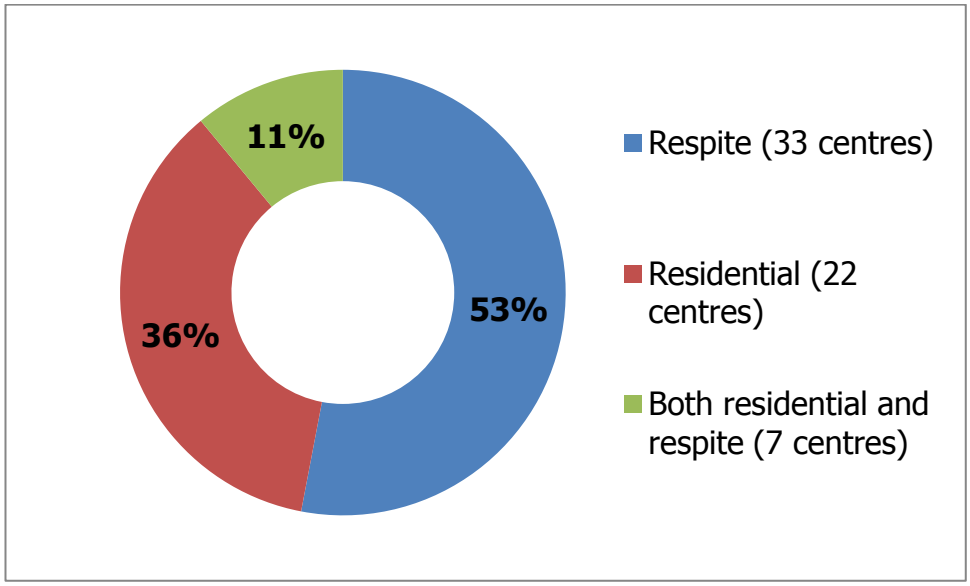


2.3 Types of residential services

Figure 2 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 3. Types of services offered at designated centres for children with disabilities



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 six and 10 residents and the remaining centre had one resident.

3 Regulatory activity

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.

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.

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.

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 Figure 4:

- 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.

Figure 4. 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.

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.

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 176 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.

Figure 5. 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.	2
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
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		732

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).

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 Figure 6.

Figure 6. 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**

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 7. 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.

Health Information and Quality Authority
Dublin Regional Office
George's Court
George's Lane
Smithfield
Dublin 7
D07 E98Y

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