Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Overview of HIQA regulation of social care and healthcare services 2017

May 2018

Overview of HIQA's regulation of social care and healthcare services in 2017

About the Health Information and Quality Authority

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

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

HIQA's mandate to date extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and 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.

About this report

This report outlines HIQA's regulatory findings in 2017. HIQA exercises all of its regulatory powers and monitoring activities through its Regulation Directorate and the Office of the Chief Inspector, as set out in the Health Act 2007. There are four distinct pillars delivering programmes of regulation in HIQA:

- Older people's services
- Disability services
- Children's services
- Healthcare.

The report contains an executive summary and the findings of each of the four pillars.

The chapters covering each pillar give an outline of the overall findings from HIQA's work in in the respective sectors. They detail the thoughts of the people who use services, the themes that have emerged through monitoring and inspection programmes, and where HIQA believes improvements are required. It should be noted that findings on inspection reflect what is found at a moment in time; services can fluctuate between demonstrating good levels of compliance and poor compliance.

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Executive summary

Introduction

Last year, we published our first overview of the work of HIQA's Regulation Directorate. That report was an opportunity to analyse the major themes arising out of our monitoring and inspection activities and see what was common across all of the health and social care services we regulate and monitor. This year's report looks at our experiences in 2017 and identifies the key challenges in providing care to some of our most at risk citizens.

Each of the four chapters in the report describe services which are at varying stages of monitoring and regulation. In older people's services, nursing homes have been regulated by HIQA since 2009. This means that nursing home providers have a good deal of experience in dealing with inspections, achieving compliance with the regulations and successfully registering their services. As a consequence, our data and findings on this sector are focused on areas where providers can enhance their services beyond mere compliance with the regulations and towards meeting the national standards.

Residential disability services have been subject to regulation by HIQA since 2013. This sector has faced a number of challenges in complying with the regulations and being registered by HIQA. The original deadline for registering all centres in 2016 was extended to 2018 in recognition of these difficulties. There remains a significant number of centres which have yet to be registered in advance of the 31 October 2018 deadline. This is reflected in the chapter on disability services where the findings show a sector which is still focused, for the most part, on achieving basic compliance with the regulations.

HIQA's function in relation to children's and healthcare services is markedly different to those in disability and older people's services. In 2017, the children's team monitored children's services against standards and relevant regulations in most children's services. From 1 January 2018 special care units became subject to registration, regulation and enforcement. Similarly, the healthcare team are only empowered to enter and inspect hospitals; there are no enforcement powers available under the Health Act 2007. The data and findings in both of these chapters present our monitoring findings against the relevant standards and regulations.

Older people's services

Consistent with our findings in the 2016 overview report, many nursing home providers are now striving beyond basic compliance with regulations and looking to achieve quality improvement by meeting the *National Standards for Residential Care Settings for Older People in Ireland*. This will have a positive impact on people living in nursing homes. Notwithstanding the progress, during the course of our regulatory work we have identified that privacy and dignity, safeguarding, good governance and fire safety still need to be addressed across many services.

Residents who spoke with our inspectors were mostly positive about their experiences of care. Feedback from residents and their families via questionnaires was also largely positive. Many nursing homes have well-established residents' committees where there is meaningful consultation on the running of centres.

Nursing homes have been regulated by HIQA since 2009, and prior to that were inspected by the Health Service Executive (HSE). As such, the sector is familiar with the regulatory process and our inspection data reflects that. For the first time last year, we published a list of all the nursing homes that were found to be fully compliant during an inspection in 2016. The same data this year shows that the number of fully compliant centres has almost doubled. This is a reflection of the maturity of the sector. We now expect to see nursing home providers go beyond basic compliance with the regulations and towards meeting best practice as set out in the National Standards.

Despite mainly positive feedback from residents and improved levels of compliance, our inspectors continue to find examples of poor practice and care settings that are impacting on people's privacy and dignity. The physical environment in a number of nursing homes is not conducive to providing person-centred care in a dignified and safe manner. For example, a lack of privacy during the provision of intimate care; lack of private, personal space for people to meet and talk with visitors; and concerns around fire safety and evacuation procedures. In 2016, the Minister for Health extended the deadline by which nursing homes are required to meet the regulations around the physical environment to 31 December 2021. Notwithstanding this, in the interim, providers are expected to put measures in place to ensure people's privacy and dignity and promote their safety.

HIQA continues to have safeguarding concerns around adequate staff vetting procedures and the management of residents' finances. Strengthened Garda Síochána (police) vetting legislation has put a greater onus on all service providers to ensure that new and existing staff have been appropriately vetted to ensure the safety of residents. It is a concern that some providers are still not complying with this important, and most basic, of requirements. Similarly, we continue to have concerns about the measures in place to safeguard residents from financial abuse; particularly around the accounting of residents' finances and a lack of transparency in terms of charges included in contracts of care.

The person in charge is a role of fundamental importance in providing good quality care. The person in charge is a legal entity as defined in the Health Act and they have specific duties and responsibilities under the Act and the associated regulations. A small number of services were found to be operating without a designated person in charge during 2017. This is not acceptable and we have taken action where appropriate.

In 2016, we published guidance on fire safety in older people's services to aid providers in achieving compliance with the fire safety regulation. If we have a particular concern about fire safety in a nursing home, HIQA has a Fire and Estates Inspector internally who assesses the risk. Where necessary, concerns in relation to fire safety can be referred to the relevant fire safety authority. During the course of 2017, the older people's team made three such referrals.

There is a need to reflect on the models of care for older people in order to increase the options available to them should they need care or support. The current system is heavily focused on long-term residential care. There are examples of certain smaller nursing homes – which provide a more homely environment – closing voluntarily due to concerns over the financial viability of running such services. This is coming at a time when the number of nursing home beds available nationally is increasing. HIQA has called for the provision of a range of funded services to cater for older people with low and intermediate levels of need. The Department of Health has commenced consultation of the provision of statutory home care services and HIQA is fully supportive of the introduction of such a scheme.

Disability services

HIQA has been regulating residential services for adults and children with disabilities since 2013. This sector has faced many challenges and some providers are struggling to attain a sufficient level of compliance in order to be registered by the October 2018 deadline set out in the Health Act. Nevertheless, our inspectors found many examples of well-run services where people were happy with the care and support they received.

Inspectors of residential services for people with disabilities spoke with more than 3,900 people using services during the course of 2017. The vast majority of people expressed that they were happy where they lived and felt supported by staff. A small number of people said that they were not satisfied with their homes, did not like sharing their homes, and looked forward to moving to a new house. The team also engaged with a number of resident and service-user advocacy groups in order to better understand the impact of regulation on their daily lives. This engagement proved extremely valuable and will be further developed in 2018.

Inspections found that the governance and management of centres for people with disabilities plays a key role in the safety and quality of life of residents. A large number of services fail to comply with governance and management regulations, and HIQA escalated concerns about a number of service providers in this regard in 2017. The team engaged in six-month escalated monitoring programmes with these providers in order to closely monitor the effectiveness of the governance arrangements in place to ensure the sustainable delivery of a quality and safe service. For the most part, these plans proved effective and we noted improvements for residents. However, three centres had their registration cancelled during the year due to poor governance and persistent non-compliance with the regulations.

The team also identified high levels of non-compliance in the areas of staffing, health and safety, risk management, safeguarding and social care needs. These findings impact on residents in a number of ways:

- inadequate protection against the risk of fire
- lack of access to meaningful social care opportunities
- poor physical environment
- inadequate protection against the risk of infection
- inappropriate use of restrictive practices
- lack of access to meaningful activities due to insufficient staff.

The HSE has committed to transitioning people out of congregated settings and into community-based services. HIQA fully supports this process and has seen the positive impact it can have on the lives of people who have already transitioned to homes in the community. However, the pace of change is slow and we are concerned that the policy of having a maximum of four people in each shared home is not being adhered to.

The legislative context in which we regulate these services continues to evolve. Recently, the Government ratified the United Nations (UN) Convention on the Rights of Persons with Disabilities. This, along with the measures in the Assisted Decision-Making (Capacity) Act 2015, will strengthen and protect the rights of many of our citizens. These are welcome developments and HIQA will continue to work with all stakeholders to ensure that all of our citizens with disabilities can avail of services that are high quality, person centred and safe.

Children's services

The children's team is responsible for regulating and monitoring compliance in a wide range of services for children who are in the care of the state. There were 6,189 children in care in 2017, primarily in foster care services, children's residential centres, special care units and Oberstown Children Detention Campus.

Children's residential centres

Most of the children in children's residential centres who spoke with our inspectors felt that they were well-cared for and received good support to learn and develop. There were examples of children being consulted in the running of the centre and working with staff to prepare meals. There were a small number of children who expressed dissatisfaction with their service and did not feel safe. Our inspectors identified issues relating to management and staffing, care plans, medication management, fire safety and the physical environment.

Special care units

There are currently four special care units in the country, one of which opened in November 2017. Children who spoke with our inspectors said, in general, they received good care from staff who were friendly and approachable. However, there were issues with the physical environment in all special care units inspected in 2017, and this impacted on the experiences of the children living there. In one centre, some children told us the centre was not clean, and in another centre that it was not kept in a good state of repair. Of the three centres inspected in 2017, our inspectors found that two of these were not fit for purpose in terms of the physical environment. Inspectors also has concerns regarding safeguarding, particularly in relation to staff training and Garda vetting.

Oberstown Children Detention Campus

Many of the children in Oberstown Children Detention Campus who spoke with our inspectors said they felt that staff were very supportive. They had good access to their families and loved ones. However, some children raised complaints in relation to the food and the system in place in the centre to purchase snacks. Moreover, when they raised complaints they did not feel that the issue raised was acted on. Inspectors had concerns around the use of single separation in the centre. They found that several children spent extended periods of time in single separation without sufficient management oversight. In addition, there were shortcomings in terms of medicines management practices and access to external medical services in a timely manner.

Foster care

HIQA carried out a programme of thematic inspections on foster care services in 2017 which looked at the process around the recruitment, assessment, approval, supervision and review of foster carers. In total, 14 of the 17 Tusla service areas were inspected. In general, our inspectors found that there was consistently good practice across all services in terms of the general assessment of foster carers, with improvement required in relation to the assessment of relative carers. However, supervision and support for foster carers was inconsistent across the country. For example, some foster carers did not have an allocated social worker. Further issues were identified in relation to safeguarding arrangements. Inspectors found poor practice around Garda vetting and the management of allegations of abuse.

Child protection and welfare services

In March 2017, HIQA was requested by the Minster for Children and Youth Affairs to carry out an investigation into Tusla's management of allegations of child sexual abuse against adults of concern. In order to facilitate conducting the statutory investigation, the children's team deferred the commencement of a programme of thematic inspections in child protection and welfare services. However, two inspections of child protection and welfare services were conducted during 2017 in response to identified risk.

Healthcare

In 2017, the Healthcare team focused on two key areas of service provision: medicines management and the prevention and control of healthcare-associated infections. Both programmes found significant variance across the country in terms of meeting the National Standards. We found that appropriately-resourced infection prevention and control teams, supported by senior management, were key to guarding against healthcare-associated infections. This again highlights the critical importance of effective governance and management in delivering good quality services. Hospitals that performed poorly in this regard are a concern as the *National Standards for the Prevention and Control of Healthcare-Associated Infections* have been in effect since 2009, and were updated in 2017.

Failure to meet these standards is placing patients at risk, especially in the context of antimicrobial resistance and the emergence of Carbapenemase-Producing *Enterobacteriaceae* (CPE – a very resistant type of bacteria) among some patients treated in hospitals in Ireland. Through our monitoring work in this area, HIQA has repeatedly highlighted the seriousness of this particular risk to both patients, and has called for a national approach to addressing this concern. In this regard, the Minister for Health's declaration in late 2017 of a national public health emergency in response to the CPE issue represents a significant, potential watershed moment in ensuring that such a national response occurs.

Medicines management is also a key factor in providing patient care. Where HIQA found good practice in our programme of medicines management inspections, it was usually founded on effective leadership, multidisciplinary involvement and the availability of specialist staff and IT (information technology) support. However, we again found inconsistencies across the country and among hospital groups. Our feedback to hospitals has been to foster greater collaboration and learning among and between hospital groups.

In 2017, the healthcare team also devoted significant resources to preparing for the regulation of medical exposure to ionising radiation. The legislation and regulations, due to be introduced in 2018 to meet the requirements of an EU directive, will give HIQA inspection and enforcement powers in respect of any service that exposes patients to ionising radiation for medical purposes (for example x-ray, CT scanners, radiotherapy). This is estimated to include in excess of 1,100 services, including public and private hospitals, dentists and certain clinics.

The National Patient Experience Survey, a joint initiative by HIQA, the Department of Health and the HSE, gave patients a voice to say what worked well and what required improvement in the public health service. Many patients were positive in their ratings of care while on a ward and of the answers they got from doctors and nurses. Patient experience in relation to emergency department waiting times and patient involvement in decisions about their care and treatment were less positive. This survey, which will be conducted annually, provides a benchmark for hospitals and will allow them to target areas for improvement.

There is no doubt that the health service is experiencing significant difficulties at present. In light of this, there were a number of significant policy developments for the healthcare sector in 2017. The publication of the Sláintecare report charts a way forward for the health service.

The Department of Health published draft legislation on hospital licensing and also identified the need for more hospital beds in the coming decade through its review of bed capacity. These policy initiatives have the potential to fundamentally change the way we provide healthcare. HIQA is supportive of these initiatives and will continue to work with all stakeholders in reforming the healthcare sector.

Enhanced monitoring approach

During the course of 2017, we undertook a large project to review our processes across our range of regulatory functions. This process has lead to an enhanced monitoring approach which will result in a number of improvements to our inspection methodology, escalation and enforcement, reporting structure and IT systems. We have also revised our approach to assessing the fitness of providers and have reemphasised the role of the 'registered provider representative'. All service providers will be required to nominate a person for this role.

During 2017, this work focused on revising our processes and preparing our staff for these changes. A dedicated project team with expertise in project management, business analysis, IT development and testing worked to deliver the necessary changes. We also provided training to staff and held information seminars around the country for more than 2,000 stakeholders. Services began to see these changes in early 2018.

Conclusion

In the majority of services, we found that people were receiving good quality care and were being supported to live meaningful lives in health and social care services. Our inspectors met and spoke with many people who use services and found that they were well looked after by competent and caring staff. Many of the service providers that we meet through our regulatory and monitoring work are committed to excellence and strive to continuously improve the quality of their services.

There are two principle findings and causes for concern evident in this report: governance and safeguarding. The issues relating to these key areas are described throughout this report.

Governance

Through our experience of regulation we have found that for any provider to deliver and sustain a good service there must be effective governance. A well-governed service is clear about what it does, how it does it, and is accountable to its stakeholders. In these services, it is obvious who has overall executive accountability for the quality and safety of the service and there are clear lines of accountability at individual, team and service levels. Clear accountability is a fundamental requirement of ensuring a safe service.

Many of the failures of care that impact on residents and people who use services can be traced back to poor governance and a lack of accountability. There are too many occasions where our inspectors are reporting on deficits in care that we would expect competent managers to identify and remedy themselves through assurance processes.

In order to address these failures, we are now requiring all providers of designated centres to identify to us a 'registered provider representative'. The person fulfilling this role will be required to have sufficient seniority and accountability within service provider organisations. They should be able to provide clarification regarding the executive governance arrangements in place to assure compliance with the Health Act, the regulations and nationally-mandated standards. They should also be in a position to promptly respond to, and act on, any queries or concerns that the Chief Inspector has in relation to the safety and quality of services being provided to residents.

Safeguarding

Too many social care service providers are failing in their duty to safeguard people in care and ensure that their individual rights are upheld. Adults and children in care are particularly at risk and service providers need to be constantly vigilant in order to prevent abuse occurring. In 2017, inspectors found non-compliances with some of the most basic features of safeguarding, such as ensuring that staff are appropriately vetted; residents' finances are protected; and that allegations of abuse are appropriately managed. Failures in this aspect of care can have serious consequences for the people who use services. As a result of these continued failings, HIQA is now working across sectors to influence national policy and legislation in respect of adult safeguarding, including the development of safeguarding standards in conjunction with the Mental Health Commission.

Looking ahead

There are a range of policy and legislative measures in the process of being introduced which will have a significant impact on the health and social care sector in Ireland:

- The ratification of the United Nations Convention on the Rights of Persons with Disabilities.
- The Assisted Decision-Making (Capacity) Act, 2015.
- The Sláintecare report.
- The ongoing process of moving people with disabilities out of congregated settings and into community-based residential services.
- The proposed expansion of regulation and enforcement powers to public and private hospitals via a system of licensing.
- The regulation of children's residential centres.
- The development of a statutory scheme for homecare.

Many of the measures outlined above represent a strengthening of people's rights in terms of health and social care and are to be welcomed. Some of the legislative proposals will also result in more effective regulation and monitoring of the quality and safety of services.

In preparation for some of these measures, HIQA has carried out a number of research projects internally. One such project, published in 2017,* focused on the need to re-think our approach to the regulation of services in order to meet the challenges of the 21st Century. The research examined the varying models of care available in Ireland today and analysed how these are regulated in other jurisdictions. Now is an opportune moment to reflect on our current system of care and regulation and ensure that it is fit to meet the needs of the population into the future. HIQA is of the view that this research can form part of the debate on how to meet this challenge and we look forward to positive engagement with all stakeholders in order to achieve this common goal.

* *Report on services for people with disabilities: https://www.hiqa.ie/reports-and-publications/key-reports-and-investigations/exploring-regulation-health-and-social-0*

Report on services for older people: https://www.hiqa.ie/reports-and-publications/key-reports-and-investigations/exploring-regulation-health-and-social-care

Chapter 1 - Older people's services

Introduction

In 2017, the older people's team found that most providers understood the regulations and are responsive to findings of regulatory non-compliance, while at the same time are striving beyond basic compliance with regulations and looking to achieve quality improvement by meeting the standards.

Throughout 2017, the team was responsible for regulating 579 nursing homes for older people with 30,732 registered beds. The team is divided into four geographical areas: South; West; East; and the Greater Dublin Area.

In 2017, three new designated centres for older people were registered. Five designated centres voluntarily closed and were removed from the register.

Regulatory activity over the past 12 months has been influenced by the requirement to re-register each designated centre every three years. In 2017, 268 designated centres for older people had their registration renewed.[†] This represents 46% of the total number of designated centres in operation in 2017.

The older people's team carried out 600 inspections in 2017, visiting 87% of all centres for older people. We completed 108 inspections with a focus on dementia care and the service offered by centres to assist residents who have dementia. The remaining 492 inspections assessed the general level of regulatory compliance.

During the year, our inspection activity identified 136 designated centres that were fully compliant with the regulations.[‡] A like-for-like comparison between 2016 and 2017 shows that the number of fully-compliant centres has almost doubled from 15% to 27% of all designated centres.[§] As per 2016, these services had one vital aspect of care in common – they had a strong and consistent governance structure in place that promoted a culture of person-centred care. This increase is evidence of the hard work and commitment to improve the lived experience for residents by those who work in designated centres for older people all over the country.

† *In 2017, HIQA published a paper which advocated for a system of regulation that removed the three-year cycle of registration in favour of a system of regulation that registered a provider on commencement of establishing a designated centre. That registration would then remain in place unless the centre closed or the Chief Inspector de-registered the designated centre because of regulatory non-compliances.*

‡ *The data is based on centres that had 10-outcome, 18-outcome or dementia thematic inspections during the course of 2017. Each of these centres would have had at least one of these inspections during 2017 and were assessed as compliant or substantially compliant in all outcomes inspected. It should be noted that inspection findings reflect what was found in a centre on the day of inspection and findings can change over time.*

§ *In 2016, approximately 78% of inspections, (471 out of 608) fit the criteria for inclusion on this list. In 2017, approximately 85% of inspections, (512 out of 600) were eligible for inclusion. This means that in 2016 15% of centres inspected using the criteria were compliant. In 2017, this figure had nearly doubled to 27%.*

List of fully compliant centres in 2017
Table A**

Carlow
Beechwood Nursing Home
Carlow District Hospital
Signature Care Killerig
St Fiacc's House
Cavan
College View Nursing Home
Esker Lodge Nursing Home
Fairlawns Nursing Home
Virginia Community Health Centre
Clare
Ennistymon Community Hospital
Kilrush Nursing Home
St. Theresa's Nursing Home
Cork
Bandon Community Hospital
Blarney Nursing and Retirement Home
Carechoice Ballynoe
Corpus Christi Nursing Home
Darraglynn Nursing Home
Deerpark House
Douglas Nursing and Retirement Home
Maryborough Nursing Home
Padre Pio House
St Joseph's Hospital
Strawhall Nursing Home
Teach Altra Nursing Home
Donegal
Brentwood Manor
Donegal Community Hospital
St. Eunan's Nursing Home
Dublin
Altadore Nursing Home
Anam Cara

** *The data in this table is based on centres that had 10 or 18-outcome inspections during the course of 2017. Each of these centres would have had at least one of these inspections and were assessed as compliant or substantially compliant in all outcomes inspected. It should be noted that inspection findings reflect what was found in a centre on the day of inspection and findings can change over time.Please note that some designated centres may not have had an inspection by HIQA during the course of 2017. Therefore, if a centre is not included in the list, it does not necessarily mean that it was found to be non-compliant. A record of all inspections and inspection reports is available on the website: www.hiqa.ie*

Annabeg Nursing Home
Beechlawn House Nursing Home
Beechtree Nursing Home
Cara Care Centre
Caritas Convalescent Centre
Catherine McAuley House
Clearbrook Nursing Home
Clonskeagh Community Nursing Unit
Glebe House Nursing Home
Glengara Park Nursing Home
Griffeen Valley Nursing Home
Harvey Nursing Home Terenure
Holy Family Residence
Howth Hill Lodge
Lisheen Nursing Home
Lucan Lodge Nursing Home
Marian House
Marian House Nursing Home
Maryfield Nursing Home
Marymount Care Centre
Mount Sackville Nursing Home
New Lodge Nursing Home
Orwell Private
Queen of Peace Centre
Raheny House Nursing Home
Riverside Nursing Home
Rush Nursing Home
Sacred Heart Residence
Shrewsbury House Nursing Home
St Doolagh's Park Care and Rehabilitation Centre
St Gabriel's Nursing Home
St. Joseph's Centre
St. Patrick's Care Centre
Swords Nursing Home
Talbot Lodge Nursing Home

Galway

Clarenbridge Nursing Home
Coral Haven Residential Nursing Home
Corrandulla Nursing Home
Hillside Nursing Home
Little Flower Nursing Home
Maryfield Nursing Home
Mill Race Nursing Home
Mystical Rose Private Nursing Home

Nightingale Nursing Home

Rosemount House Nursing Home

St David's Nursing Home

St Mary's Residential Care Centre

Kerry

Aras Mhuire Nursing Home

Ashborough Lodge Nursing Home

Cuil Didin Residential & Nursing Care

Heatherlee Nursing Home

Our Lady of Lourdes Care Facility

Riverside Nursing Home

Kildare

Cloverlodge Nursing Home

Larchfield Park Nursing Home

Lourdesville Nursing Home

Mill Lane Manor

Moyglare Nursing Home

Suncroft Lodge Nursing Home

Kilkenny

Brookhaven Nursing Home

Drakelands House Nursing Home

Strathmore Lodge Nursing Home

Limerick

Beech Lodge Care Facility

Caherass Nursing Home

Roseville House Nursing Home

St Paul's Nursing Home

St. Gobnaits Nursing Home

Thorpe's Nursing Home

Louth

Aras Mhuire Nursing Facility

Mayo

Abbey Breaffy Nursing Home

Ave Maria Nursing Home

Blackrocks Nursing Home

Brookvale Manor

Cuan Chaitriona Nursing Home

Queen of Peace Nursing Home

Sonas Nursing Home Riverview

Meath

Millbury Nursing Home

St Elizabeth's Nursing Home

Woodlands House Nursing Home

Monaghan

Castleross

Mullinahinch House

St. Mary's Hospital

Roscommon

Costello's Care Centre

Fearna Manor

Shannon Lodge Nursing Home

Sonas Nursing Home Cloverhill

St Eithne's Rest Care Centre

Tearmainn Bhride Nursing Home

Sligo

Summerville Healthcare

Tipperary

Acorn Lodge

Ashlawn House Nursing Home

Villa Marie Nursing Home

Waterman's Lodge

Waterford

Carechoice Dungarvan

Dunabbey House

Westmeath

Bethany House Nursing Home

Wexford

Knockeen Nursing Home

Lawson House Nursing Home

Middletown House Nursing Home

Oakfield Nursing Home

Ros Aoibhinn Nursing Home

Wygram Nursing Home

Wicklow

Blainroe Lodge

Dunlavin Nursing Home

Eyrefield Manor Nursing Home

Kinvara House Nursing Home

St Columban's Nursing Home

74% or 584 out of 792 dementia outcomes inspected were assessed as either compliant or substantially compliant.

Of the 504 centres inspected by HIQA in 2017, 489 had two or fewer inspections and 15 centres had three or more inspections. The number of centres requiring three or more inspections in a year continue to be in a minority. It is a concern that any nursing home would require this level of regulatory oversight and HIQA would have concerns around the ability of these registered providers to provide the required level of care to residents.

The voice of the resident

Feedback from residents who live in designated centres is a rich source of information on the day-to-day experience of people living there and on how well a service is being run. For this reason, HIQA inspectors ensure that the voice of the resident is central to the inspection process by spending time listening to residents and observing how residents are cared for. In addition, where appropriate, inspectors also speak with residents, relatives, friends and advocates.

Overall, feedback from residents and their families about the experience of living in their centres was mainly positive. Inspectors found many examples of residents' committees in place in centres, where residents could contribute in a meaningful way to the running of the nursing home. There were recorded examples of issues being raised and changes being made following decisions made at residents' committees. For example, in one centre the chef attended the residents' committee meetings following requests from residents for more choice on the menu.

A means to communicate effectively is vitally important to those residents who, through increasing frailty and advancing dementia, have a reduced ability to communicate. HIQA inspectors conducted thematic inspections focused on dementia care throughout 2017 in order to highlight the increased vulnerability of this vulnerable section of the population in residential care. Through discreet observation, inspectors assessed the nature of interactions between staff and residents to determine if the care was person centred and provided in a dignified manner. Inspectors found that the vast majority of centres were providing a good quality of care for residents who had dementia.

Key areas of concern and opportunities for improvement

During 2017, the older people's team identified the following key areas as requiring improvement across the sector:

1. Ensuring residents' right to dignity and privacy
2. Governance and management – the person in charge
3. Safeguarding (residents' finances & Garda vetting)
4. Fire safety
5. Contracts of care
6. Payment of annual fees

1. Ensuring residents' right to dignity and privacy

HIQA continues to find centres where each resident's right to dignity and privacy is not upheld. It is not acceptable that some of the most vulnerable people in Ireland live in an environment where the culture is for residents to spend their entire day within the confines of their bed space, with no access to their own belongings, social dining experiences or meaningful activities. In such a context, the lived reality of an older person quickly shrinks to that bed space and it is very difficult to reverse that institutional practice for a person.

In June 2016, the Minister for Health signed a statutory instrument, S.I. No. 293/2016, into law. This extended the time frame, until 2021, for a registered provider to demonstrate compliance with the regulations pertaining to the physical environment and bedroom sizes. As a consequence of this, a number of providers have not adhered to previous commitments to improve the physical premises and the quality of the accommodation in line with agreed time scales. This has resulted in a further generation of residents having to contend with the adverse effects of such premises on their quality of life.

HIQA has also encountered many situations where S.I. 293/2016 is proffered as an excuse for ongoing non-compliance with multiple regulations. The matter arose in court during enforcement proceedings where legal counsel for HIQA argued that the statutory instrument was specific to a small number of issues, primarily minimum floor space and number of people to be accommodated in a room. It was further argued that these provisions did not remove the requirement for registered providers to adhere to any of the other care and welfare regulations.

HIQA also acknowledges those proactive providers who devise practical and innovative solutions as they seek to improve regulatory compliance despite limitations to the physical environment. Examples include:

- having two meal sittings in centres with limited dining facilities, which allows more residents to avail of a social dining experience
- reviewing the use of rooms available and re-designating rooms to prioritise residents' access to social activities
- ensuring that the best available accommodation is offered to residents who are being cared for on a long-term basis
- reducing the number of residents accommodated in a given area and redistributing the available space to the remaining residents.

Good practice

Catherine McAuley House, Co. Limerick

This centre demonstrated a commitment to person-centred care, meaningful activities and made extensive use of outdoor areas.

An enclosed garden area in this centre had been totally renovated. A special soft surface had been installed for residents' comfort and safety. Flower beds were colourful and plentiful. Retractable awnings had been installed which provided protection from the sun, as well as providing outdoor space when the weather was less conducive to being outside. There was easy access to the garden and residents were seen to enjoy the gardens from early in the morning and throughout the day.

2. Governance and management – person in charge

In our 2016 regulation overview report, we highlighted the importance of good governance and management when providing a service. This was demonstrated by the correlation between governance and quality: where we found a service to be well-governed, we found good outcomes for people living in the service. In assessing the governance of a service, the person in charge is a key figure.

The requirement for a person in charge of a designated centre is clearly set out in Regulation 14 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Any designated centre operating without a person in charge is in breach of this regulation.

HIQA's programme of regulation in 2017 found that while the vast majority of registered providers are aware of this statutory requirement, others had at times operated a designated centre in the absence of a person in charge. Given that the person in charge has responsibility for ensuring compliance with over half (51%) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, the absence of such a role in any service, at any time, is unacceptable.

3. Safeguarding – residents' finances

Sometimes, service providers collect pensions and other social welfare payments on behalf of residents. This is a key area of concern for HIQA in the management of residents' finances. The practice of paying residents' social welfare payments into a central bank account (held by the centre), rather than into an individual interest-earning account in the person's own name, puts this money beyond the independent reach of residents on a day-to-day basis. There is also the possibility of residents losing their money, should the registered provider go bankrupt. Most providers respond positively when these issues are raised during the course of an inspection and move to establish more appropriate arrangements which afford more protection to the residents.

Good practice

Ocean View Nursing Home, Co. Kerry

This service valued the input of residents in the running of the centre.

An inspection found this centre was managed in a way that took residents' wishes and choices into consideration. The chef attended residents' meetings and discussed the food and the dining experience with residents.

Residents told the inspector that they were able to choose a special day menu once a month from starter, main course, dessert, wine and speciality coffees. Different combinations were available and all requests were facilitated over a period of time. The residents had recently participated in a 'bake off' competition, led by the chef and assisted by the activity co-ordinator and staff.

A newly appointed activities co-ordinator ensured that residents' social care needs were met. Mindfulness and yoga had been introduced to the centre, and residents were using tablet devices to contact family and friends who lived abroad.

During the past year, HIQA has engaged with the Department of Social Protection and established a referral pathway. In cases where HIQA has persistent concerns in relation to pension agent¶ arrangements, these can now be referred directly to the Department of Social Protection for follow up. As a result of inspections carried out in 2017, three referrals were made to the Department of Social Protection.

Safeguarding – Garda vetting

In 2017, HIQA found increased compliance with the requirement to ensure that each staff member has a vetting disclosure in place in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. Improved compliance in this area is a welcome development given the important role that police vetting plays in ensuring that residents are safeguarded and protected.

Notwithstanding this, and despite extensive engagement with the HSE over the past 12 months, there continues to be a high level of non-compliance on the part of the HSE with the requirement to keep vetting disclosures in the designated centre and to make them available for inspectors on request. Moreover, the inability to submit the necessary vetting disclosures with applications to register or renew the registration of a designated centre also impacts on HIQA's ability to process such applications. We will continue to engage nationally with the HSE, setting out the requirement to comply with all aspects of the Health Act 2007, as amended, and associated regulations.

¶ *Where a person is unable to collect their social welfare payment or manage their financial affairs, a person may be appointed as their agent. An agent can be appointed on a temporary or on a long-term basis, to collect payments or act on behalf of an individual.*

Good practice

Raheen Community Hospital, Co. Clare

Residents in this centre were embedded in the local community.

The centre was part of the local community and residents had access to radio, television, and daily and regional newspapers. Some residents told the inspector how they enjoyed reading the daily newspapers. Some residents attended the adjoining day-care centre. On the day of inspection, some residents were attending the day-care Christmas party which was being held in a local hotel.

Residents could choose to buy items from a mobile shop in the centre such as toiletries, drinks, snacks and sweets. Staff supported some residents to go on shopping trips. A mobile clothing and footwear shop also visited, and residents could select and buy clothes and shoes of their choice.

The person in charge outlined how plans and funding were in place to develop an inter-generational garden area with the neighbouring school. The youth outreach group visited weekly and carried out art and craft activities with residents.

4. Fire safety

Fire safety remains a key area of concern in the regulation of designated centres for older people. To assist providers and to improve compliance, HIQA published guidance on best practice in fire safety management in February 2016.[1] This guidance provides clarity on the necessary arrangements and precautions that should be in place to satisfy all aspects of Regulation 28, such as:

- fire drills for staff and residents
- means of escape for staff and residents
- in-house fire safety checks
- record-keeping of training and equipment checks
- the roles and responsibilities of management and staff.

Providers should have oversight of all aspects of fire safety and are required to ensure that their approach to the management of fire safety is dynamic and cognisant of all residents accommodated in a centre at any given time. Fire evacuation plans must be reassessed on an ongoing basis and reflect residents' changing needs and dependencies. For the safety of residents and staff, fire evacuation drills must reflect the lived reality in a centre, with drills occurring to simulate times where the most and least staff are available to assit (for example, simulating both day and night fire drills).

Where fire safety concerns are identified, HIQA's specialist Inspector for Estates and Fire Safety is asked to undertake a desktop review or a follow-up inspection and to advise on further interaction with the provider. Most providers focus on ensuring that their designated centre is safe and they are proactive in taking any appropriate action necessary. On occasion, where we have significant concerns, referral to the relevant fire authority may be deemed appropriate. As a result of inspections carried out in 2017, the older people's team made three such referrals, in the context of fire-related risk and the aligned safety of residents, to the appropriate fire authority.

5. Contracts of care

In 2017, the contracts of care for residents in designated centres received a lot of public attention. HIQA inspectors have found good levels of compliance with the regulatory requirement to provide residents with contracts for the provision of services. Such contracts ensure that residents and their families are informed of the services provided, and provide clarity and transparency on the charges they are required to pay.

However, there remain some concerns in relation to residents' contracts, including:

- providers seeking to change existing contracts of care without proper consultation with residents and their representatives
- residents being charged for services that residents did not, or could not, avail of such as particular social activities

Good practice

Oakdale Nursing Home, Co. Offaly

A resident in this centre was accommodated to have his own garden as he enjoys growing vegetables. The vegetables grown in the garden were used by the catering staff to provide fresh vegetables to all residents.

Good practice

Ferbane Nursing Home, Co. Offaly

The registered provider had provided a guide to living in the centre in audio format for residents who had poor sight and could not read the written guide.

- charges for accessing the services of a general practitioner (GP) when the resident has free access to a GP through a medical card or GP visit card
- visiting charges for chiropody services, which is in addition to the charge for the actual treatment covered by their medical card
- charges for religious services.

The Competition and Consumer Protection Commission (CCPC) is currently engaged in a process to develop guidelines on contracts of care for providers of residential care. HIQA supports this initiative and has participated in the process of informing the development of these guidelines. The guidelines will set out the obligations and responsibilities of service providers under the European Communities (Unfair Terms in Consumer Contracts) Regulations 1995 and the Unfair Terms Regulations.

6. Annual fees

Regulation 8 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations, 2015 sets out the requirement for every registered provider to pay an annual fee in respect of each resident. These regulations, in conjunction with the Health Act and the Health Act 2007 (Care and Welfare Of Residents in Designated Centres for Older Persons) 2013, form an integral branch of the legislative framework which supports the regulation of older people's services.

The mandatory fees required under Regulation 8 are payable in three instalments; in January, May and September of every year. It is a matter of concern that during 2017, the team was obliged to send 49 warning letters to nursing homes who had failed to pay annual fees by the required due date.

What providers are telling us

During the course of the year, HIQA engaged with registered providers through our regulatory activity and stakeholder engagement initiatives. Common issues raised by registered providers included staff recruitment; how to balance promoting autonomy and resident safety; and promoting a social model of care.

Staff recruitment

Staff recruitment and retention is a key challenge across the health and social care sector. Registered providers have identified difficulties recruiting nursing staff and care workers. For example, in some centres, registered beds are not in use due to staff shortages. This is impacting on the availability of services now and into the future. This is of particular concern due to the increasing older population.

Balancing autonomy and residents' safety

Many service providers struggle to balance residents' rights to autonomy and liberty with their responsibility to ensure residents' health and safety. While living in residential care, people may wish to engage in activities that involve a certain level of risk. While a service provider should seek to mitigate risk to people's health and safety, this should not

be at the expense of people living a meaningful life. A positive approach to risk assessment considers possible harms, focuses on individual wishes and rights, and collaborates with people to meet their individual needs while incorporating appropriate safeguards. Certain features of the Assisted Decision-Making (Capacity) Act, 2015, will improve people's rights in this context.

Cultural shift

Registered providers have told us about the challenges they face in driving a programme of cultural change and the difficulties encountered when moving from a medical model to a social model of care. A medical model of care is strongly associated with institutional practices, where routines are task orientated rather than person centred. Centres which embody a social model of care are more likely to have residents:

- deciding when to get up and when to go to bed
- participating in a variety of social activities
- spending less time in bed or sitting beside their bed, with greater access to communal areas.

This is a concern for designated centres run by the HSE, as many of these facilities started out as district or community hospitals with a medical model of care provided. Service providers in the private sector tend to have facilities that were designed specifically for residential care and, as such, do not face the same cultural issues.

Future challenges

As a regulator, HIQA has a responsibility to embed into the regulation of services the human rights principles of:

- fairness
- respect
- equality
- dignity
- autonomy.

We are committed to protecting and safeguarding people who are at risk. In doing so, we adopt a human rights-based approach to our work. There are large numbers of people being cared for in a range of different care settings, many of which do not fall under the definition of a designated centre and are therefore in an unregulated environment. People being looked after in such care settings have the same rights to high-quality care as those living in designated centres. As such, there is a need to review and expand regulation to include oversight of these services and provide public assurance on the different models of care and service delivery.

Ireland's population of people aged over-65 years is increasing. This has implications for care services now, and into the future. By 2031, the number of people aged 65 and over is estimated to double to almost 17.8% of the population. The expected increase in those aged 80 and over is even more

dramatic, with their numbers set to more than double from 128,000 to 281,800 over the same period.[2]

In 2017, five registered providers advised HIQA that they had made a decision to close their nursing home. The five nursing homes, all small centres with less than 40 residents, were located in a variety of urban and rural locations across the country. This loss of smaller nursing homes occurred during a period when the number of nursing homes beds in Ireland increased by 301 beds from 30,396 in 2016 to 30,697 in 2017.

In some cases, the registered provider advised that the financial model underpinning a small nursing home was difficult to sustain, particularly in the context where extensive investment may be required to ensure regulatory compliance into the future. The closure of nursing homes that offer a smaller, homely setting is concerning and if it continues could impact on the choice of setting available to older people and their families in the future. A regulatory model which focuses on a service rather than a designated centre, and which offers separate regulations tailored to different service models, may facilitate smaller nursing homes to offer a service to older people who require lower or intermediate levels of care.

Official Government policy is that people be facilitated to maintain, where possible, their independence in their own home. Moreover, there is broad agreement among stakeholders that the preferred method of care for older people is that they receive care at home. HIQA welcomes the Government initiative to regulate the homecare sector and has contributed to the Department of Health's consultation process on this matterv.

Conclusion

Consistent with our findings from 2016, many nursing home providers are now very familiar with the requirements of the regulations. Many are striving beyond basic compliance and looking to achieve quality improvement by meeting the *National Standards for Residential Care Settings for Older People in Ireland*. This will have a positive impact for the people living in nursing homes.

Notwithstanding the progress we have identified during the course of our regulatory work, there remain issues which need to be addressed, such as privacy and dignity, safeguarding, good governance and fire safety. Our inspection teams will continue to focus on these areas to ensure that service providers meet the needs of our older population living in nursing homes.

Poor practice

Example 1

There was a lack of oversight by the registered provider to ensure staff were recruited in line with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the *National Standards for Residential Care Settings for Older People in Ireland*. There was an absence of vetting disclosures for staff, in accordance with the National Vetting Bureau. Failure to recruit staff appropriately and ensure they have the necessary vetting places residents at risk. The provider had also failed to ensure that senior staff, who had a significant level of managerial responsibility, had adequate knowledge of fire safety arrangements to guide other staff in the event of fire.

Example 2

Nursing staff had administered some medicines to residents without an original signed prescription that authorised them to administer those medicines. Nursing staff told the inspector that in the absence of an original signed prescription, they administered some medications by referring to unsigned sticky labels with the medication details at the front of the resident's medicines booklet, or to a copy of the pharmacy prescription which they retained at the back of the booklet. This put residents at increased risk of medication error and was not in accordance with best practice guidelines or prescription regulations.

Example 3

The provider failed to respond promptly and appropriately to a family's allegation of abuse of a resident by a number of staff. Significant failures to safeguard residents were found, including failing to put adequate measures in place to safeguard all residents in the immediate aftermath of the allegation and the lack of a robust system of staff supervision during the investigation. The failure to complete a timely and robust investigation did not prioritise the safety of at-risk residents in the provider's care.

Example 4

The measures in place to ensure the privacy and dignity of residents was maintained did not meet regulatory requirements in this centre. When personal and intimate care was carried out at residents' bedsides, there was only a screen dividing the beds which did not block out noise or odours. The insufficient spacing between some beds resulted in an increased risk of infection and cross contamination. Residents did not have enough room to receive visitors and sit out by their beds at the same time. The registered provider had prioritised maintaining the existing number of beds above ensuring the privacy and dignity of residents accommodated in the designated centre.

Example 5

Residents' wishes did not inform the daily routine. Night staff reported that they were required to have six to eight residents up and dressed before the day staff came on duty. Breakfast was served from 6am, and over half the residents were served breakfast before 8am, while sitting on the side of their bed. Many residents were in their night wear and did not have any slippers on at this time. This was reflective of institutionalised practices which were task oriented and suited staffing arrangements, as opposed to residents' needs and wishes.

Example 6

While practice in the centre was to serve texture-modified diets** in distinct portions on plates (to support people's dignity and improve the visual appeal of their meals), an inspector observed one resident being served their meal in a bowl. The various elements in the meal were mixed up by a staff member with a spoon before being fed to the resident. There was no clear rationale as to why the meal was served in this manner.

** *Texture-modified diets may include soft diets, minced and moist diets, smooth pureed diets and liquidised diets due to swallowing difficulties.*

Chapter 2 - **Disability services**

Introduction

HIQA's disability team experienced another busy year of inspecting and registering centres for adults and children with disabilities. The sector faces many challenges in providing a good quality of life for people living in residential care. While a number of service providers are responding positively to those challenges and are providing a good service, HIQA's disability team continues to engage with providers who are failing to deliver the standard of care and support that people are entitled to.

The Government has committed to moving people from congregated settings into community-based residential services. Our inspectors have seen many positive examples where such a transition has resulted in significant improvements in people's lived experience in residential care. Legislative developments in assisted decision-making and deprivation of liberty will also provide additional safeguards and supports to people who may lack the capacity to make choices that impact on their care and support arrangements.

These positive measures present significant challenges for service providers and funders in terms of ensuring residents' rights are upheld. Progress of the decongregation policy, as set out in the HSE's *Time to Move on from Congregated Settings*[3] report, has been slower than expected.

Advocacy organisations have expressed their concerns that, based on the current rate of progress, it may take up to 20 years to achieve the objective of decongregation. Figures published in 2016 by the HSE[4] showed that there were 2,579 people living in congregated settings. Data from the Health Research Board suggests that there are a further 2,164 people with intellectual disabilities who will need a residential service between 2017 and 2021.[5]

The *Time to Move on* policy also recommends that all new community residential services should have a maximum of four residents sharing accommodation. HIQA inspectors have found that this policy recommendation is not being fulfilled. Twelve of the 64 new centres registered in 2017 had more than four residents living in 13 houses. However, this is not a regulatory requirement.

Furthermore, Article 19(a) of the United Nations (UN) Convention on the Rights of Persons with Disabilities, recently ratified by the Irish Government, states that people with disabilities should be able to choose where, and with whom, they live. This does not always happen at present due to the limited availability of residential placements and resourcing issues.

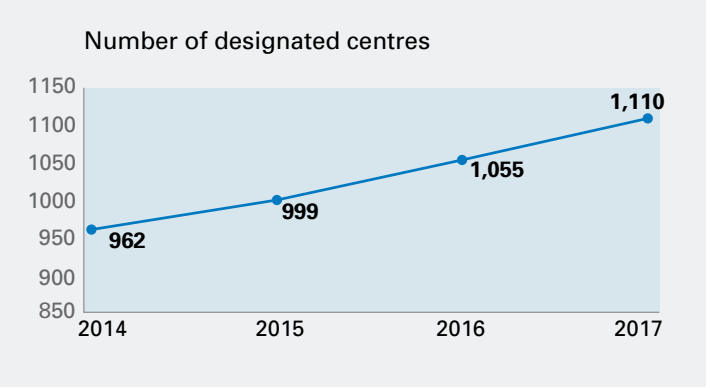
These changes, along with strong advocacy for change from national representative bodies such as Inclusion Ireland and the Disability Federation of Ireland, pose a significant challenge to service providers, service funders (primarily the HSE), the regulator and the State.

Overview of centres for people with disabilities

At the end of 2017, there were 1,110 designated centres providing services to adults and children with disabilities. This is an increase of 55 in the total number of centres from the end of 2016 (see Figure 2). Of these centres, 932 had been registered with HIQA. A large cohort of the remaining 178 centres have not yet demonstrated a sufficient level of compliance in order to be registered by HIQA. A registration decision on these centres must be made by HIQA before the end of October 2018, in accordance with the Health Act 2007.

During 2017, HIQA carried out 839 inspections of centres for people with disabilities.

Figure 1 – Number of designated residential centres for people with disabilities in 2014, 2015, 2016 and 2017



The 932 centres registered by HIQA provide a total of 7,036 residential places. While the vast majority of these centres provide services to adults, 46 centres, mainly respite centres, provide services to both adults and children. There are 74 centres which provide 319 residential places solely to children with a disability.

Since the commencement of regulation in this sector in 2013, the number of designated centres has increased by approximately 20%. Coupled with the significant requirement for risk-based regulation, we undertook a review of our inspection teams during 2017. To optimise the regulation of disability centres, the number of operational areas increased from four to five: Dublin, West, South, South East and North East. HIQA will continue to review these arrangements as the number of centres continues to increase.

During 2017, inspectors spoke directly with over 3,900 residents about their experience of living in a disability service.

The voice of the resident

The lived experience of residents is a core indicator of what it is like for a person to live in a centre. During inspection, inspectors spend time listening to and observing life for residents and, where appropriate, speaking with their relatives and advocates during inspections. We also invite residents and their families to complete questionnaires on what life is like for them in their service.

During 2017, inspectors spoke directly with over 3,900 residents about their experience of living in a disability service. This provided an insight into their lives, daily routines and the quality of service they received. For various different reasons, not all residents wished to speak with inspectors and inspectors respect that right at all times during the inspection process. In most cases, residents told inspectors that they were happy in their home, they felt safe and that staff were caring and helpful. Residents shared stories about engaging with their local community, planning holidays and celebrating important events such as birthdays.

In a small but significant number of cases, residents told inspectors that they were not happy in their home or were not happy living with the other residents in their home. Some residents informed inspectors that they were looking forward to moving to a new home.

HIQA is anxious to maximise the learning we gain from engaging with residents, and recognises that engagement outside of the inspection process may provide enhanced feedback from residents. Following suggestions from resident representative groups, HIQA began engaging with residents through existing resident or advocacy groups, where communication and other supports were already available for residents and where they were most likely to feel comfortable expressing their views.

We established a project during 2017 where providers were invited to identify resident or advocacy groups in their area. An initial random sample of groups was chosen and asked if they would be interested in staff from HIQA attending their meeting to hear their views of the work that HIQA does. As part of this project, inspectors met with four resident advocacy groups, consisting of between eight and 10 residents per group. A number of key themes emerged from these meetings:

- Residents felt that staff spent too much time on paperwork which took away from the time available to spend with them.
- Residents want to meet inspectors.
- Residents value the privacy of their personal space and want to be consulted before inspectors go into their rooms.
- Some residents said that the language used in reports needs to be improved to reflect and respect their rights.
- Residents said that sometimes their service cannot be provided in the way they want because the regulations are too restrictive.

HIQA is currently considering the feedback received from residents through this project and is looking at how we can use that information in planning our inspection activity. Feedback from residents is always valuable and helpful, and we intend to extend this consultation programme in 2018.

We also consider other ways of hearing about the experience of residents. HIQA's disability service inspection teams meet a number of times each year and a standing agenda item at these meetings is the 'voice of the resident'. This has generated discussion and increased awareness about the experiences and views of residents. At one meeting, teams had a video presentation where a resident told us of their experience of moving from a congregated setting to a new home. Another presentation was a video of the views of people with disabilities on the role of HIQA and how we carry out our work, presented by the National Federation of Voluntary Bodies.

Key areas of concern and opportunities for improvement

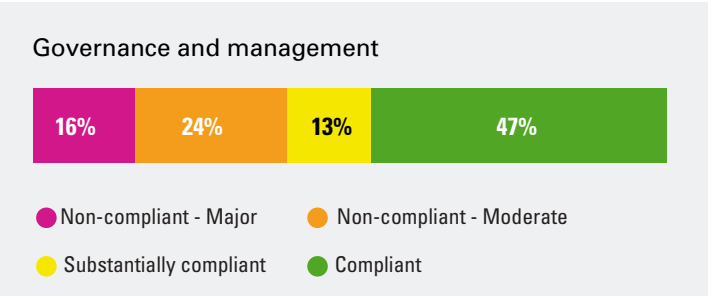
In 2017, the majority of services demonstrated a good level of compliance across a broad range of outcomes. Table B lists all of the centres that were inspected in 2017 and found to be fully compliant on that inspection. Staff and management in these centres are to be commended for providing a good quality service.

Notwithstanding this, we continue to find that many services are failing to comply with regulations on a consistent basis. This is impacting on a whole range of outcomes for residents. Non-compliances identified in inspection reports which have the most significant negative impact on the quality of life of those using services include:

- Governance and management
- Health and safety and risk management
- Workforce
- Safeguarding and safety
- Social care needs

Governance and management

Figure 2 – Level of compliance with the governance and management outcome in 2017 inspections



Similar to our findings in 2016, governance and management continues to be a key area of concern in disability services. As shown in Figure 3, 40% of all inspections in 2017 found this outcome to be non-compliant. Good governance and management requires the establishment of clear lines of

accountability and arrangements that enable service providers to assure themselves that the rights of residents in their care are protected and promoted. The number of services failing in this key area is high and it is leading to poor outcomes for people using services.

In November 2017, HIQA published an overview report of the regulatory monitoring of Áras Attracta, a centre operated by the Health Service Executive (HSE) in Co. Mayo. Overall, the findings were that:

- the provider had failed to establish effective governance and oversight of the centre
- the provider had failed to implement sustained improvements in the centre
- residents were experiencing a very poor quality of support and care
- residents' rights were not being protected and promoted.

In response to notices of proposal to cancel the registration of the centres on the campus, the provider submitted a governance improvement plan which set out clear milestones to be achieved in improving the quality of service to residents. A decision was made to conduct an inspection in early 2018 to determine whether there had been improvements for residents as a result of the provider's actions, and to use the findings to inform a decision on whether to proceed with the cancellation of registration.

During 2017, the disability service inspection team also had significant concerns about the quality of governance and oversight in a range of other centres for people with disabilities and had to undertake escalated regulatory action in relation to those centres. In particular, four disability service provider organisations did not demonstrate sufficient improvement and there was a risk that a range of their centres would have their registration cancelled. These providers were required to submit a time-

Good practice

Dinan Lodge, Co. Kilkenny

Transition to community-based living had a positive impact on the lives of residents.

Following a programme of actions by the provider to strengthen the management and oversight of centres operated by St Patrick's Centre (Kilkenny), and the engagement of staff and management at service level, inspectors found a significant improvement in the safety and quality of life for residents in their centres. As part of their improvement plan, some residents transitioned from the congregated setting to community-based living arrangements. In Dinan Lodge, inspectors found significant improvements in the quality of life for residents. Some residents had previously required significant levels of support in relation to managing their behaviour. In their new home, inspectors found that they no longer required such interventions. No incidents had occurred in their new home since their move and the risk of reoccurrence had reduced significantly. This had a very positive impact on the quality and safety of residents' lives.

bound governance improvement plan to the Chief Inspector. Inspectors then undertook a six-month escalated regulatory monitoring programme to verify whether the provider was implementing their actions and whether the provider was ensuring that those actions were resulting in improvements in safety and quality of life for residents. The four organisations were:

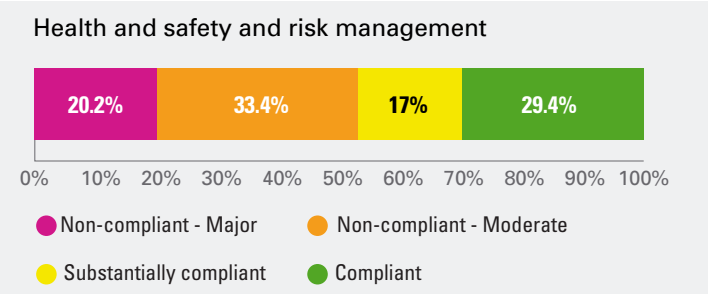
- Cheshire Foundation in Ireland
- St John of God Community Services
- NUA Healthcare
- HSE Community Health Organisation (CHO) Area 1.

Overall, inspectors found that the six-month plans led to improvements in the governance and oversight arrangements in place for all four providers. Where providers established clear accountability for the safety and quality of service, there were subsequent improvements in residents' quality of life. As a result, we are extending this approach to a number of other providers in 2018. Inspectors will continue to carefully monitor these providers to ensure that the improvements to date are sustained and that the residents living in those services see the benefits.

Health and safety and risk management

The health and safety and risk management outcome focuses on the measures a service has in place to ensure that residents are cared for in a safe environment and that risks are appropriately managed. This includes fire safety, infection control, managing violence and aggression, and maintenance of the physical environment. As demonstrated in Figure 4, more than half of services were found to be non-compliant in this area on inspection.

Figure 3 – Level of compliance with the health and safety and risk management outcome in 2017 inspections



Our inspectors identified trends in serious incidents that compromised the safety of residents. There was inadequate oversight and management of these incidents, which impacted on the lived experience of residents affected. In some centres, providers were unable to demonstrate that they could keep residents safe or control the number of incidents occurring. In some cases, services were unable to meet residents' assessed care and support needs and the inappropriate placement of residents was resulting in incidents occurring.

Fire safety issues were identified in multiple centres. These related to inadequate fire containment measures, including the absence of fire doors. In some instances, residents were at risk due to locked or blocked fire exits. The absence of emergency lighting also posed a risk to residents. In some centres, inspectors found that staff and residents had not participated in fire drills.

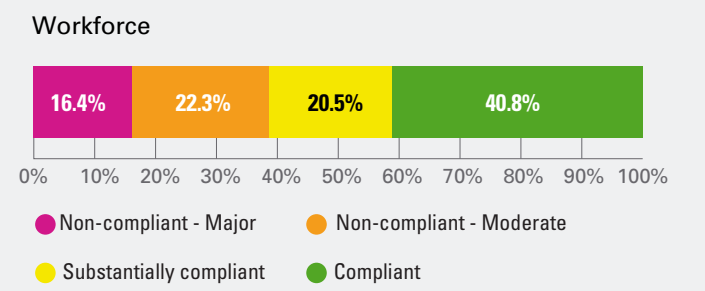
In addition, emergency evacuation plans for residents who required assistance to evacuate their centre were not up to date or practiced.

Workforce

Having dedicated staff who are appropriately trained and qualified to meet the needs of the people they work with is an essential component of a good service. Our inspectors visit many centres where they observe staff providing care and support to residents in a respectful and dignified manner. Many people living in services tell us about the important relationships they develop with staff who are supporting them.

However, there are instances where we find failings in staffing arrangements in centres. This may be that the number of staff is insufficient, that staff do not receive appropriate training, or that recruitment and vetting procedures do not adequately safeguard residents. Figure 5 shows that over one in three centres were non-compliant with this outcome.

Figure 4 – Level of compliance with the workforce outcome in 2017 inspections



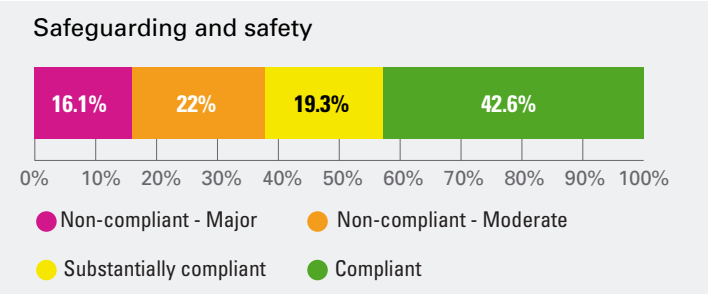
The care and support some residents received was impacted by the use of unfamiliar staff who may not have been given a proper induction to the centre and the support needs of the residents. The lack of support staff also impacted on residents. The staffing levels available in some centres did not always meet the assessed needs of the residents. As a result, residents could not access the community or engage in activities to achieve their goals.

Inspectors also identified that the required staff documentation was not being maintained by some providers. Inspectors found missing documentation, and gaps in employment history and Garda vetting to ensure staff suitability for working with residents.

Inspectors identified services where supervision of staff required improvement. Supervision is important for monitoring and improving care practice. Some centres did not have formal supervision arrangements or a schedule in place to ensure all staff received supervision appropriate to their roles. Inspectors also identified some centres where staff were not receiving training in key areas related to residents' safety and support.

Safeguarding and safety

Figure 5 – Level of compliance with the safeguarding and safety outcome in 2017 inspections

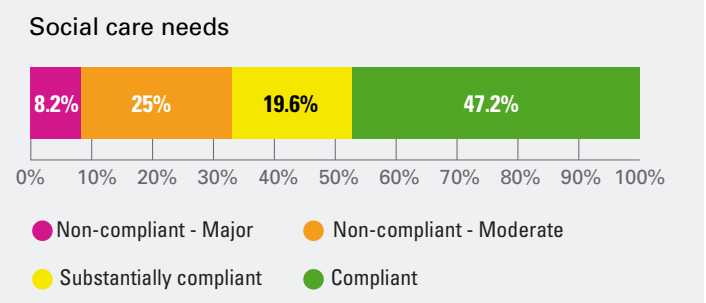


HIQA has highlighted the need for providers to ensure robust safeguarding arrangements are in place to protect residents. While the majority of our inspections found that residents were safeguarded, a significant number of inspections identified trends and patterns of abuse that residents have been subjected to. This included residents being subjected to ongoing and sustained abuse from their peers where the providers had failed to act in order to adequately protect residents. In some centres, inspectors found safeguarding plans were not reviewed or implemented, leaving residents at risk to abuse. The use of restrictive practices, including physical holds on residents by staff, that were not prescribed or implemented in line with best practice, posed a risk to residents.

In addition to these areas of concern, we have also identified that some providers were not reporting safeguarding incidents to HIQA as required by the regulations. In some centres, staff were not provided with training in safeguarding practices.

Social care needs

Figure 6 – Level of compliance with the social care needs outcome in 2017 inspections



Good practice

Glenbow Services, Co. Sligo

Good governance and management systems ensured that residents received a good quality service.

An annual review of the service and six-monthly unannounced provider visits were occurring within the centre. Action plans were developed following each visit and demonstrated how the provider planned to address the areas of non-compliance identified. The person in charge informed the inspector that a number of other audits were regularly undertaken in the centre to increase oversight of the centre's general operations. The inspector observed various audits were being conducted in areas such as hygiene, finance, medication, complaints and fire safety. This had a very positive impact on the quality and safety of residents lives.

Residents' social care needs were adequately met in the majority of centres inspected. However, one in three inspections identified the need for substantial and significant improvement in this area. In some centres, residents did not have their social care needs assessed. This meant that meaningful life goals could not be set for residents. In many centres, inspectors found that residents could spend long periods unoccupied and alone in their residential setting, with a lack of meaningful activities provided.

The lack of planning and adherence to social care plans resulted in residents not being afforded the opportunity to develop and learn new life skills to improve their independence and autonomy.

Inspectors identified many instances of good practice in terms of goal setting and well-structured and documented social care plans. Where this was in place, residents were observed to gain meaningful life experiences and showed signs of personal development and growth which was rewarding to the person and to the staff supporting them in their daily lives. For example, in a centre operated by St Patrick's Centre (Kilkenny) residents who had previously lived in a restrictive, campus-based environment were now living in a community setting. Residents told the inspector about their first trip to the cinema and a recent holiday experience, experiences that might seem ordinary to many but were very important and meaningful new life experiences for these residents.

What providers are telling us

During 2017, we held three provider forum meetings where HIQA management met with disability service providers. Members of this forum include the Deputy Chief Inspector (with responsibility for services for people with disabilities) and representatives from the National Federation of Voluntary Bodies, HSE, Disability Federation of Ireland, Irish Council of Social Housing and the Not-for-Profit Business Association. These meetings provided a forum where provider representatives and HIQA could communicate and exchange information. Issues discussed during 2017 included:

- Providers informed HIQA of their concerns regarding the Department of Housing, Planning and Local Government's new fire safety guidance, and the potential impact this may have on the rights of residents and the cost implications of implementing the guidance.
- The cost of implementing necessary improvements in existing premises.
- Ongoing challenges in relation to the limitations of the regulations and the regulations' restrictions on a provider's ability to be innovative in response to residents' support needs.
- The need for an appropriate balance between regulation and residents' autonomy.

Providers sought clarification on regulatory requirements in such areas as:

- complying with the National Garda Vetting legislation
- qualifications necessary for the person in charge of designated centres
- appropriate management of residents' finances
- review of staff files for large service providers.

Enforcement

Due to repeated non-compliance, poor management of safeguarding and risk, poor quality of life for residents and a failure to take effective action to improve their services, HIQA cancelled the registration of three centres during 2017. These centres were operated by:

- Cheshire Foundation of Ireland
- St Vincent's Centre Ltd
- Camphill Communities of Ireland.

The HSE arranged for one of those centres to be operated by another service provider. The operation of the other two centres was taken over by the HSE under Section 64 of the Health Act 2007, as amended.

Since the commencement of regulation by HIQA in 2013, seven centres have had their registration cancelled. While this number represents a small percentage of services, the impact on residents' lives can be very significant. That is why HIQA, where we can, endeavours to engage with providers to drive improvements for residents rather than cancelling registrations.

Future challenges

The significant difficulties a number of centres are having in meeting the basic requirements set out in the Health Act 2007 (as amended), the regulations and the National Standards presents a significant challenge for HIQA, service funders and service providers over the coming year. As a result, there remains a significant number of centres that require registration by HIQA before the deadline of 31 October 2018. In December 2017, HIQA met with the Department of Health and the HSE in relation to the challenges regarding the registration of these centres. HIQA and the HSE are currently reviewing and monitoring this situation closely.

A further challenge facing the sector is the implementation of a proactive strategy to plan to meet the future needs of people with disabilities. Some centres are finding that they are not equipped to meet the changing needs of residents over time. This may be due to changes in residents' support needs due to ageing or compatibility with other people using the service. In addition, inspectors continue to find that there has been inadequate planning for some young people to transition to adult services and, as a result, those young people continue to live in children's services.

Providers have told HIQA that the current definition of a designated centre as described in the Health Act 2007 is too restrictive and can limit innovative approaches to meeting the residential support needs of people with disabilities. This point is echoed in the research paper[6] published by HIQA on the regulation of services. In addition, while the UN Convention on the Rights of Persons with Disabilities requires the State to de-institutionalise residential services, the language of the Health Act 2007 refers to all residential centres as 'institutions'. In light of these developments, now may be an opportune time to review the Health Act and its associated regulations.

There are also challenges for the regulator in an ever-changing service environment. Since commencement of regulation, the number of designated centres has grown over 20%. This number is expected to continue to grow in the years ahead as people move from larger congregated settings to smaller community-based services.

Transition from congregated settings

A key driver for change in this sector is the national policy of moving people from congregated settings to smaller, community-based residential services. The movement from congregated settings, or de-institutionalisation as it is referred to in an EU context, is consistent with similar actions in other EU States and is considered part of meeting the fundamental rights of citizens with disabilities as set out in the UN Convention on the Rights of Persons with Disabilities.

Our inspection teams have found many instances where the quality of life of people has been improved after moving from congregated settings to community-based residential services. Understandably, this transition may raise concerns for people and their families. Nevertheless, it is our experience that when the transition is planned and well managed, people experience positive outcomes.

Good practice

Hillview House, Co. Longford

There was meaningful consultation with residents on the running of the centre.

Good practice regarding residents' rights, dignity and consultation was observed in this centre. Residents were consulted with, and participated in decisions about their care and in the operations of the centre. Advocacy services were available to residents and information on how to access these services was displayed in the centre. Residents' meetings took place on a weekly basis, where residents were consulted with to develop the centre's weekly plan including menu choices and activity scheduling. Residents who spoke with the inspector said that staff consulted with them very regularly and they had access to a key worker to help them organise activities that they wished to participate in. Inspectors found that residents were listened to and their needs were met in the way they wanted which had a very positive impact on the quality and safety of their lives.

We have worked closely with service providers who are in the process of transitioning people from congregated settings. HIQA has committed to prioritising applications to register new residential centres, given that these applications relate to people moving out of congregated settings or people who are experiencing crisis in their current living arrangements. We have been able to register such centres within much shorter time periods (six weeks) once they have satisfied the regulatory requirements.

During 2017, HIQA registered 64 new residential centres, 22 of which accommodated people moving from congregated settings. HIQA recognises that not all people moving from congregated settings move to registered centres and some may move to living arrangements that are not within the regulatory framework. While not all of the residents who moved to live in these 22 new centres were from congregated settings, most were, and the total number of residential places in these 22 centres was 93.

The *Time to Move On from Congregated Settings* report sets out a policy that all new residential services for people with disabilities will accommodate no more than four residents. While this is not a regulatory requirement, the HSE has committed to adhering to this policy. However, HIQA's 2017 data shows that 12 newly-registered centres (comprising a total of 13 houses), had more than four residents living in them. While it is not in line with the HSE's policy, HIQA has no option but to register such centres as they have met the regulatory requirements.

Conclusion

While HIQA recognises there are challenges ahead for providers and internal challenges for us as a regulator, residents have also told us that since regulation began in the sector, the quality of service delivered to them and the quality of their lives has improved.

The first cycle of registration will be completed on 31 October 2018 when a registration decision will have to be made for all designated centres. At that point the sector will have been regulated for five years and all centres should be operating in compliance with the regulations and standards. We look forward to working with all stakeholders in the coming years to continuously improve the level of service made available to people with disabilities.

Table B††

Ability West
Galway
Holly Services
Teach Michel Services
An Breacadh Nua
Wexford
Belford House
Autism Spectrum Disorder Initiatives Limited
Wicklow
The Bay
Brothers of Charity Services Ireland
Clare
Lee View
Scariff Respite
Woodlands
Cork
No.1 Heather Park
Galway
Acorn Services
CoisSaile Services
Seiribhisna Beanna Beola
Limerick
Elmwood
Tipperary
Nagle Adult Residential Service
Carriglea Cáirde Services
Waterford
Deise Residential Services
White Strand Respite Services
Co Wexford Community Workshop (Enniscorthy) CLG
Wexford
Lemongrove House
COPE Foundation
Cork
Cork City North 10
West County Cork 5
Daughters of Charity Disability Support Services Limited by Guarantee
Dublin
Green Meadows
Rossan View
Special Dementia Unit - Sonas Residential Service
Limerick
Group B - St. Vincent's Residential Services
Group I - St. Vincent's Residential Services
St. Vincent's Residential Services Group M
St. Vincent's Residential Services Group A

†† The data in this table is based on centres that had 10 or 18-outcome inspections during the course of 2017. Each of these centres would have had at least one of these inspections and were assessed as compliant or substantially compliant in all outcomes inspected. It should be noted that inspection findings reflect what was found in a centre on the day of inspection and findings can change over time.*Please note that some designated centres may not have had an inspection by HIQA during the course of 2017. Therefore, if a centre is not included in the list, it does not necessarily mean that it was found to be non-compliant. A record of all inspections and inspection reports is available on the website: www.hiqa.ie*

Tipperary
St. Anne's Residential Services - Group G
St. Anne's Residential Services - Group P
St. Anne's Residential Services - Group S
Delta Centre Ltd
Carlow
Delta Willow
Dundas Ltd
Co. Dublin
Bower House
Louth
Carlinn Heath
Meath
Pinewood Lodge
Springfield House
Enable Ireland Disability Services Limited
Clare
Eden Lodge
Tipperary
Teach Saoirse
G.A.L.R.O. Limited
Laois
Arya House
Carriglea
Westmeath
An Áit Chonaithe
Garden Lodge

Health Service Executive
Cork
Youghal Kilcoran and West Waterford Community Houses
Mayo
Moy Service
Westmeath
Castleview
Joanstown, Rathowen
KARE, Promoting Inclusion For People With Intellectual Disabilities
Kildare
Abbey Park / The Grove
Ailesbury Park
Brownstown/French Furze/Clonmullion
Poplars
MCC Children's Services Limited
Louth
Leaby Lodge
Moorehall Disability Services Ltd
Louth
My Life-Baile
My Life-Chara

Muiríosa Foundation
Kildare
Community Living Area 1
Community Living Area 10
Community Living Area 11
Community Living Area 12
Community Living Area 13
Community Living Area 16
Community Living Area 3
Community Living Area 5
Community Living Area 6
Community Living Area 9
Laois
Community Living Area 19
Community Living Area P
Offaly
Community Living Area M
Community Living Area R
Community Living Area T
Tipperary
Community Living Area T24
Westmeath
Delvin Centre 1
Longford Centre 1
Meath Westmeath Centre 1
Mullingar Centre 3
Woodview 2

North West Parents and Friends Association for Persons with Intellectual Disability
Leitrim
Sunbeam Lodge
Nua Healthcare Services Unlimited Company
Cork
The Abbey
Valley View
Laois
Rathbeag
Leitrim
Mount Eslin
Peacehaven Trust CLG
Wicklow
Peacehaven Trust
Redwood Extended Care Facility
Meath
Orchard Vale Apartments
Redwood Extended Care Facility (Avalon)
Redwood Neurobehavioural Services Limited
Meath
Meadowview Bungalow 3 & 4
RehabCare
Kerry
Laccabeg Accommodation Service
Leitrim
Ballinamore Accommodation

Limerick
Seoidin
Louth
Drogheda Supported Accommodation
Maria Goretti Respite
Meath
The Meadows
Tipperary
Shalom
Tus Nua
Resilience Healthcare Limited
Kerry
Luchanna
Limerick
Belltree
Tipperary
An Diadan
RK Respite Services Ltd
Tipperary
Northfields Respite Centre
S O S Kilkenny Company Limited by Guarantee
Kilkenny
No 86 Melville Heights

Saint Patricks Centre (Kilkenny)
Kilkenny
Bramble House
Clannad
JULA
Tóchair
Tús Nua
St Catherine's Association Limited
Wicklow
Fair Winds
St John of God Community Services Company Limited By Guarantee
Kerry
St. John of God Kerry Services - Supported Living
Kildare
St John of God Kildare Services - Designated Centre 16
Louth
30 Seaview
An Diadán
An Sli
Four Winds
Silver View
The Ferns Grove
Tin Tean
Weavers Hall

St Joseph's Foundation
Cork
Cooleens House
Teach Mhuire
Limerick
Edel Quinn House
St Michael's House
St Margaret's Centre
Dublin
St Margaret's Centre
St Michael's House
Dublin
B Middle Third
Collins Avenue
Del Val
Landscape Park
The Cheshire Foundation in Ireland
Waterford
Waterford Cheshire

Waterford Intellectual Disability Association Company Limited By Guarantee
Kilkenny
Hazelbrook
Waterford
Meadowview
Moonvoy
Summerville Respite House
Western Care Association
Mayo
Áit Ellie Residential Service
Cheile Creidim Respite Services
Greenlands Residential Service
Lannagh View Residential Service
Riverside Residential Service
Rose Cottage Residential Service
The Acres Residential Service
Tús Nua Respite Services

Poor practice

Example 1

Inspectors reviewed the safeguarding risk and found that safeguarding concerns had occurred or were present for residents in all of the five houses in a centre. However, appropriate safeguarding procedures were not being implemented to ensure residents and staff in this centre were safe. While inspectors were told that all staff had received the mandatory safeguarding and safety training, inspectors found that they did not demonstrate knowledge of the safeguarding issues in the centre, how to follow up on the management of reported risks or implement safeguarding plans in the centre. In addition to the physical and psychological risks identified in the centre, the environmental practices in one house were restrictive in nature, and had not been identified as restrictive practices. This resulted in poor quality of service for residents as they were not safe and staff were not dealing with risk appropriately.

Example 2

HIQA found very poor practice in relation to overall governance and management on a campus-based setting. A lack of governance had failed to identify risks, ensure residents were safe and their needs were met, and ensure residents' basic rights were upheld. This meant that residents had not been safeguarded against incidents of alleged abuse and adequate measures were not in place to safeguard residents which resulted in injury and negative experiences for residents. There was inappropriate use of restrictive practices, which impacted on residents' rights, wellbeing and safety. Environmental risks were not identified or managed appropriately and identified control measures to mitigate risks not implemented. This had resulted in adverse incidents for residents and exposed residents and staff to known risks.

Exampe 3

There was evidence of institutional practices in a centre which were impacting on the rights of residents. Residents' privacy and dignity was not upheld, respected or maintained in the centre. In one unit of the designated centre, two residents remained sharing a modest sized bedroom which contained no privacy screens or curtains. In a separate area of the centre, inspectors found a bathroom area with two steel toilets in place. One toilet had a door in place; however, the second toilet only had a plastic shower curtain in place to maintain the privacy and dignity of residents.

Chapter 3 - **Children's services**

Introduction

The children's services team is responsible for HIQA's statutory function in statutory children's residential centres, special care units, statutory and privately-provided foster care services, child protection and welfare services, and Oberstown Children Detention Campus in Co. Dublin.

As part of this monitoring programme, HIQA conducted thematic inspections across 14 of the 17 Tusla‡‡ service areas which focused on the recruitment, assessment, approval, supervision and review of foster carers. These thematic inspections were announced and covered eight standards relating to this theme.

In addition to the above programme of monitoring and inspection, on 2 March 2017 HIQA was directed by the Minister for Children and Youth Affairs to undertake an investigation into the management of allegations of child sexual abuse against adults of concern by Tusla under Section 9(1) of the Health Act 2007. The investigation is ongoing at the time of writing.

In 2017, the children's team carried out 43 inspections across services:

- **21 inspections of children's residential services**
- **3 inspections of special care units**
- **2 child protection and welfare inspections**
- **1 inspection of Oberstown Children Detention Campus**
- **16 inspections of foster care services.**

Child protection and welfare services

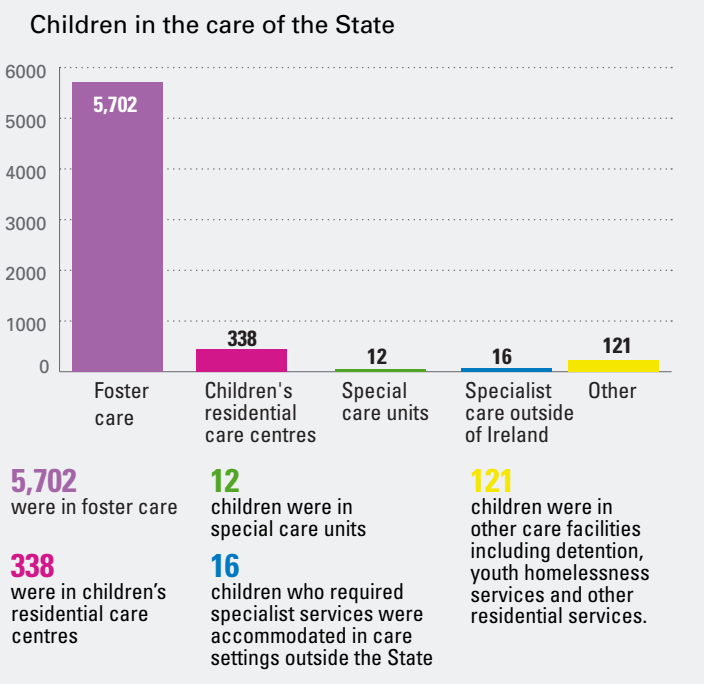
Tusla is responsible for protecting children and promoting their welfare under both the Child Care Act, 1991 and the Child and Family Act, 2013.

‡‡ The Child and Family Agency (Tusla) is the dedicated State agency responsible for improving wellbeing and outcomes for children in Ireland. Tusla operates across 17 local service areas.

Child protection and welfare services are provided by Tusla in 17 service areas, located within four national regions.

Where children cannot live at home, alternative care services, such as foster care or residential care are provided by Tusla. Tusla also funds private providers to provide these services on its behalf. At the end of 2017, Tusla reported that there were 6,189 children in the care of the state.[7] Figure 8 illustrates the care settings for each of these children.

Figure 7 – Children in the care of the State at 31 December 2017

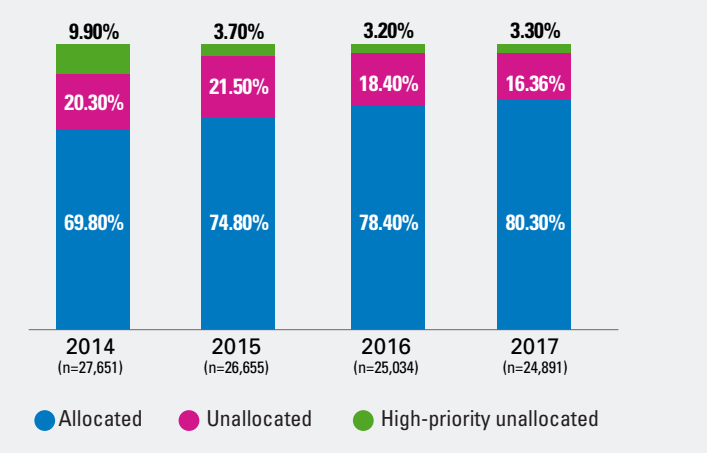


Of the children living in foster homes, 5,307 (93%) were in foster care services provided by Tusla and 395 (7%) were in private placements.

At the end of 2017, all children on the Child Protection Notification System[§§] had an allocated social worker. This is similar to the 2016 data returned to HIQA which showed that social worker allocation to these children at most risk was prioritised.

Tusla also reported a reduction in the number of unallocated cases, including high-priority cases (see Figure 9), at the end of 2017. However, these metrics do not include unallocated adult cases related to retrospective allegations of abuse. All of these unallocated cases represent potential risk to children.

Figure 8 – Allocation of open cases



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

In order to facilitate conducting the statutory investigation requested by the Minister for Children and Youth Affairs, the children's team deferred the commencement of a thematic inspection of Tusla's management of child protection referrals up to the point of initial assessmentuntil 2018. Two inspections of Child Protection and Welfare Services were conducted during 2017 in response to risk.

The voice of the child

The following section describes what children told our inspectors living in care is like.

Children's residential centres

Children's residential centres are run by Tusla or a voluntary or private agency, and provide homes for children who come into the care of the State when they cannot live with their own family. HIQA monitors and inspects children's residential centres run by Tusla. Over the course of the 21 inspections of statutory children's residential centres, inspectors met with 61 children. The majority of children told inspectors that they were given information about the centre and were aware of their rights, such as how to make a complaint. Most centres held children's meetings to discuss issues related to the running of the centres. Some spoke about being involved in choices regarding the decor of their bedrooms and being able to choose the activities they wanted to be involved in outside of the centre. Children told inspectors that they were supported to maintain contact with their family and friends. They also told inspectors that they felt like they were part of a family while living in a residential centre.

The importance of food was also highlighted by children, many of whom liked the food that was provided for them. In addition, children often had opportunities to work with staff in preparing meals.

While the majority of children expressed general satisfaction, a small number of children told inspectors that they were unhappy where they were and some did not feel safe due to the behaviour of other children and a lack of confidence in the staff team's ability to intervene and manage those behaviours. Some said that they did not get on with staff and felt that even if they made a complaint they would not be listened to.

Special care units

Special care units, run by Tusla, are for children who require the provision of care to address their behaviour and the risk of harm to their life, health, safety, development or welfare. Children are placed in a special care unit by a special care order for a specific period of time.

Inspectors met with eight children during inspections of the country's three special care units in 2017. Children told inspectors about some of the good things that happened during their time in special care. For example, one child spoke about developing independent living skills and preparing meals, including a meal she cooked for her parents when they came to visit. Other children said that their families could visit and they enjoyed this as it kept them motivated. A number of children were engaging in school for the first time in several years and one child told inspectors they were now enjoying school.

Children's experience of staff was mixed. They told inspectors that they liked some staff but not others. Some children said that they could talk to staff about their day-to-day lives. Other children told inspectors that, although they knew how to make a complaint, they felt that there was no point in doing so.

Children in each special care unit expressed their dissatisfaction with the physical environment in the units. Children in one unit spoke about the unit not being kept clean and not being a nice place to live. In another unit, children told inspectors that the units were not homely and did not have soft furnishings such as bean bags, or pictures on the walls.

Oberstown Children Detention Campus

Oberstown is a detention centre for children who have been sentenced or remanded by the courts. It is the only centre of its kind in Ireland. Inspectors met with 20 children on the Oberstown campus in 2017.

Good practice

Louth/Meath foster care service

Foster carers were well supervised and supported in this service.

There was good practice in this area in relation to formal supervision of foster carers as it was completed every three months and covered key issues. A formal template was used to record the session and this was audited by team leaders. The supervision of carers had good oversight by managers.

The majority of children told inspectors that they enjoyed attending the school. Some children told inspectors that they had good relationships with staff and were spoken to with respect. Others said that one of the good things about the campus was being able to talk to staff who supported them. Children told inspectors that they could have frequent contact with family members, by visits or over the phone. However, some children were unhappy that their family visits were screened and that they could not have direct, physical contact with family members.

Children in one unit felt there was a lack of choice and variety regarding food. Some children were unhappy that their choices in purchasing small items were limited by the financial card system used on the campus. While all children were given information on how to make a complaint, several children told inspectors that they were dissatisfied with, and had little faith in, the complaints process.

Key areas of concern and opportunities for improvement

The children who come to the attention of social care services are some of the most vulnerable in our society. Their needs must be assessed properly, and help and support must be timely. This section outlines the key findings and challenges in each of the different children's services we monitored and inspected during 2017.

Child protection and welfare services

In order to facilitate conducting the statutory investigation requested by the Minister for Children and Youth Affairs, the children's team deferred the commencement of a programme of thematic inspections in child protection and welfare services until 2018. This thematic programme was to focus on Tusla's management of child protection referrals up to the point of initial assessment. However, two inspections of child protection and welfare services were conducted during 2017 in response to identified risk in these areas.

The first of these inspections took place to assess whether the actions required following a previous inspection in 2016 had been implemented. Inspectors found that a number of improvements had been made within the service to ensure children who were identified as being at immediate risk received a timely service and emergency action was instigated when required. The service had reduced the number of cases awaiting allocation and there was a more robust system for the management of notifications from An Garda Síochána and ongoing engagement with the Gardaí. The child protection notification system was well managed and comprehensive child protection plans were in place.

Some children continued, however, to experience delays in being allocated to a social worker and having their needs assessed in a timely way. While a number of management systems were in the process of being implemented, our inspectors found oversight, monitoring and risk management processes were in need of improvement.

In addition, in the absence of an integrated information management system, the service was failing to identify re-referrals.

The second child protection and welfare inspection was triggered by:

- concerns identified following an inspection of the area's foster care services
- concerns related to the management of child protection referrals arising from an inspection of a children's residential service in the same area
- HIQA's receipt of unsolicited information with regard to the area's child protection and welfare service.

Overall, inspectors found significant systemic deficits across a number of areas of practice, including:

- the quality of screening of child protection referrals
- the variance in the quality of initial assessments – where assessments were poor, children's needs were not adequately assessed and risks were not satisfactorily addressed
- ineffective oversight of waitlists
- poor recording of staff supervision
- and the systems in place for notifying An Garda Síochána of allegations of abuse were not effective.

Inspectors escalated a number of cases to the service director for assurance that appropriate action had been taken to address outstanding risks. A satisfactory response to these cases was subsequently received.

Thematic foster care inspections

HIQA is authorised by the Minister for Children and Youth Affairs, under Section 69 of the Child Care Act, 1991, as amended by Section 26 of the Child Care (Amendment) Act 2011, to inspect foster care services provided by Tusla. This requires the children's team to report on its findings to the Minister for Children and Youth Affairs and to inspect services taking care of a child on behalf of Tusla, including non-statutory providers of foster care. HIQA monitors foster care services against the 2003 *National Standards for Foster Care*.[8]

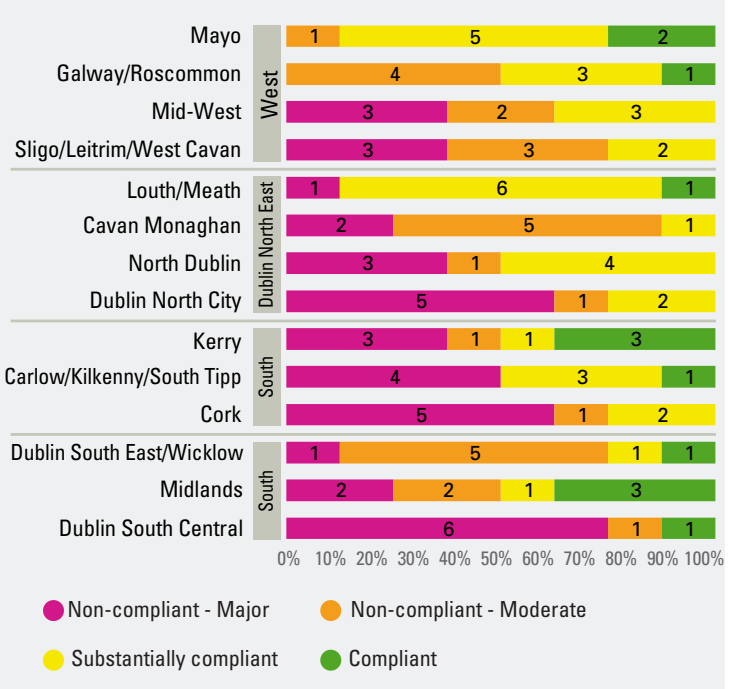
HIQA appeared before the Oireachtas Committee on Children and Youth Affairs in May 2017 to present on the monitoring and inspection of foster care services in Ireland. HIQA presented findings from our inspections to the Committee, such as the efforts made by many foster carers and social workers to ensure that family contact occurred in line with children's care plans, and children's largely positive relationships with their foster carers. However, we also detailed poor practice in statutory foster care services, such as:

- delays in the assessment and approval of relative foster carers (foster carers who are related to the child) who had children placed with them

- varying levels of support provided to foster carers
- ineffective safeguarding practices such as the poor management of allegations against foster carers
- inadequate oversight of allegations made by children in care against foster carers
- and the lack of service-level agreements in place with private foster care agencies, with the exception of emergency out-of-hours placements.

As part of the 2017 monitoring programme, HIQA conducted thematic inspections across 14 of the 17 Tusla service areas focusing on the recruitment, assessment, approval, supervision and review of foster carers. These thematic inspections were announced and covered eight standards relating to this theme. Figure 10 shows the levels of compliance.

Figure 9 – Compliance with eight standards in 14 foster care services inspected in 2017¶¶



Good practice

Louth/Meath foster care service

Well-developed pre-placement procedures in place.

When a child comes into care social workers seek, in the first instance, and where possible, to place a child with a relative, in order to maintain family ties. In advance of placing the child in the care of their relatives, social workers must ensure that there are no known concerns about the family. This is done by undertaking a number of checks including An Garda Síochána vetting and relevant area child protection checks. The Louth/Meath foster care service had well-developed and well-managed pre-placement procedures in place.

In all areas, general assessments of general foster carers (who were not relatives) were comprehensive and of good quality. This was a consistent finding across all areas inspected. All general foster carers had participated in foundational training***

¶¶ *Standard 10 - Safeguarding; Standard 14a - GFC Assessments; Standard 14b - RFC Assessments; Standard 15 - Support and Supervision; Standard 16 - Training; Standard 17 - Reviews; Standard 21 - Recruitment and Retention; Standard 23 - Foster Care Committee.*

*** *The Foundation for Fostering training programme is for prospective foster carers and their families. Foster carers are required to participate in this training as part of the approval process.*

before approval to foster. However, improvements were required to the assessment of relative carers. Some areas had a number of relative carers who had children placed with them, but who had not been assessed as to their suitability to provide foster care in a timely manner.

The level of support provided to foster carers varied across service areas. Some areas were providing a good level of supervision and support to foster carers. However, others had foster carers who were unallocated a link worker, and were not receiving the level of supervision and support that is required.

In all areas, except Mayo and the Midlands, reviews of foster carers were not taking place in line with National Standards. This meant that the service could not ensure that foster carers had the continuing capacity to provide safe care or had their Garda vetting updated. Where reviews were occurring, the quality of the reviews was excellent in some areas, while in others it was inadequate.

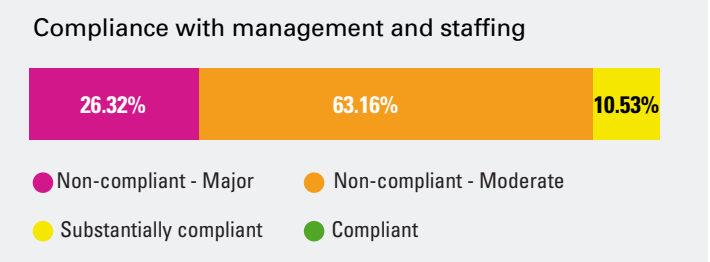
Significant risks were identified in some areas in relation to safeguarding. Some areas did not manage allegations against foster carers in line with *Children First: National Guidance on the Protection and Welfare of Children* 2001.[9] In addition, systems to ensure that all carers and other adults living in foster care households were Garda vetted were not effective in a number of areas. There were no systems in place in some areas to ensure that foster carers without an allocated link worker were visited, and not all foster carers had received training in Children First. These shortcomings reflected poor governance arrangements and had the potential to place children at risk. Where significant risks were identified on inspection, these were escalated to Tusla.

There were some good initiatives in place in some areas. For example, two areas had good training programmes in place for foster carers. Four areas were proactive in recruiting foster carers resulting in high retention of foster carers. The pre-placement procedures in the Louth/Meath area were particularly well developed and well managed, while the Galway/Roscommon area also adhered to good pre-placement procedures.

Children's residential centres

A review of the compliance levels in children's residential centres throughout 2017 shows that the area of most concern related to management and staffing.

Figure 10 – Compliance with management and staffing standard



Of all 10 standards for children's residential centres, this was found to have the highest level of non-compliance. Figure 11 demonstrates that, of the 19 inspections where this standard was assessed in 2017, over one in four services were found to be major non-compliant. In addition, no service

inspected was found to be fully compliant with this standard in 2017.

All of the centres inspected during 2017 needed to improve their management systems, including risk management and oversight of care practices. Similar to the findings in 2016, the risks identified in four centres included:

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

Staff in children's residential centres continued to work with a combination of regional and locally adapted policies, some of which had not been kept up to date to ensure they were fit for purpose. Other improvements required related to the need to ensure the frequency and quality of staff supervision reflected the requirements of the policy and gaps in mandatory training requirements.

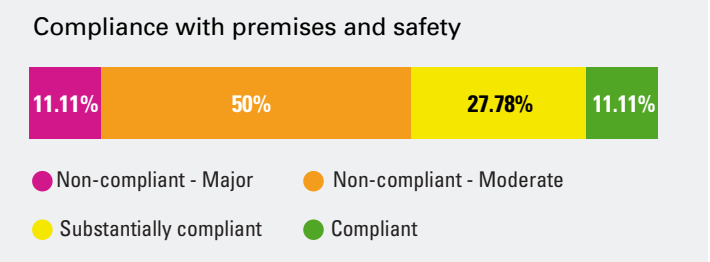
The *National Standards for Children's Residential Centres* and the Child Care (Placement of Children in Residential Care) Regulations, 1995 require each child's social worker to develop, review and update a care plan in consultation with the child, their parents, guardians and the staff team. Care plans were an issue in the majority of centres inspected in 2017. Some centres did not have care plans in place for children and in others the care plans were not always up to date. Inspectors were also concerned about the quality of some care plans. This impacted on children whose needs were not adequately assessed or whose care did not fully address their needs.

The absence of appropriate leaving care plans for some young people was of particular concern. These plans are an important component for children who are transitioning out of a care service as their purpose is to set clear goals with associated supports. Poor planning in this regard can result in poor outcomes for children leaving care. Failure to have good quality, up-to-date care plans and make adequate provision for children transitioning out of care is ultimately a failure of management and indicates poor governance.

While the majority of children were attending school or educational placements, children in some residential centres were not. This issue was a particular challenge when children had long histories of absence from school. The task of engaging these children in educational placements required persistence and determination from the staff team and the provision of encouragement and, sometimes, creative alternatives.

Inspectors also identified failures in the premises and safety standard:

Figure 11 – Compliance with premises and safety standard



The graph above shows that just over 10% of inspections found a major non-compliance with this standard; moderate non-compliance was found in half of all inspections. This level of non-compliance was caused by a range of issues, many of which relate to fire safety. Issues of concern included fire doors not operating effectively; the lack of accessibility of some fire fighting equipment; the lack of servicing of fire safety equipment; and poor checks on the fire safety precautions.

A small number of centres were unsuitable for the provision of children's residential care. The layout of the premises made it almost impossible to create a homely atmosphere and this impacted on children's rights and privacy. As a result, institutionalised practices were more common in these centres. For example, children eating their main meals in a canteen-type facility and children being unnecessarily accompanied by staff on the very short walk to the campus school.

Medication management was unsatisfactory in the majority of centres. Issues of concern included lack of appropriate training for staff; some medications not being administered correctly; poor record-keeping; the lack of adequate policies and procedures; and the absence of appropriate oversight by managers.

Oberstown Children Detention Campus

HIQA attended the Oireachtas Committee on Children and Youth Affairs on 28 November 2017 to present the findings of the March 2017 inspection of the campus. HIQA reported that all children's educational needs were assessed on admission and all children attended education at the time of the inspection. In 2016, 20 children successfully undertook the Junior Certificate Examination, while 74 were awarded Quality and Qualifications Ireland (QQI) certificates. Children and their parents were positive about the educational arrangements on campus.

Further improvements were required in relation to:

- the provision of a stronger complaints process for young people
- training in Children First for all staff
- informing all young people's care by placement planning
- ensuring that all young people had access to an offending behaviour programme
- and ensuring that all staff received regular formal supervision.

Areas of particular concern arising from the 2017 inspection related to healthcare and the use of single separation. These non-compliances were also identified on previous inspections of Oberstown. Children had access to a GP, dental and nursing staff and their needs were assessed on admission or shortly afterwards. However, they were not always provided with access to the external medical services they required in a timely manner and some medicines management practices were unsafe. The campus director was required to provide a written response to these issues and inspectors observed new controls being implemented over the course of the inspection.

Poor practice was found in the management of behaviours that challenge. Several children spent prolonged periods of time in single separation and there was a lack of robust management oversight in the monitoring of this practice. On some occasions, the methods used by staff to restrain children or move them to the protection room were not recorded. Records did not always show that single separation was the least restrictive practice available at that time, or outline what other interventions were used before or during the use of single separation, in line with national policy. In the absence of good quality records, assurances could not be provided to senior managers or to the members of the board that periods of separation were in line with safe practice or that they were given adequate consideration and deemed necessary by the relevant managers.

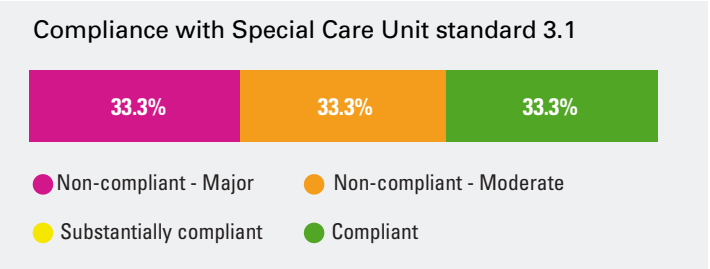
Special care units

All special care units were found to be in major non-compliance with Standard 2.3 of the *National Standards for Special Care Units*.[†††] None of the units were homely, child-centred or sufficiently stimulating for the children living there. In addition, the living environment in two of the three special care units inspected during 2017 was found to not be fit for the purpose of providing safe and effective care to children.

The difficulty of finding suitable onward placements impacted negatively on children's wellbeing and on the special care process itself. Several children were in special care for longer than three months due to difficulties in locating follow-on placements. The delays led to frustration for the children. There was also a risk that progress made by children while in the special care setting would be undermined as they waited lengthy times to be discharged.

Inspectors found poor levels of compliance with Standard 3.1[‡‡‡] relating to safeguarding, as demonstrated in the graph below:

Figure 12 – Compliance with Special Care Unit Standard 3.1



Appropriate safeguarding arrangements were in place in two of the three special care units. However, in the other special care unit, some, but not all, children were safe while living in the unit. Effective measures to reduce risk were not taken for children who continued to abscond and place themselves at significant risk while living in the unit.

The staff team in one unit was depleted in numbers and some of the staff working there did not have formal qualifications in social care. Contract staff working in another unit had not been Garda vetted and appropriate service-level agreements were not always in place between Tusla and provider of the contract staff. In the third unit, a significant proportion of staff had not received up-to-date

††† *Standard 2.3 - The special care unit is homely and promotes the welfare, dignity and safety of each child, consistent with the provision of safety and security.*

‡‡‡ *Standard 3.1 - Each child is safeguarded from abuse and neglect and their protection and welfare is promoted.*

training in supporting positive behaviour and emotional wellbeing. Moreover, some care practices in this unit did not promote a positive approach to behaviour that challenges.

Children did not always have timely access to psychiatric services and medical records were not consistently maintained or comprehensive. Fire plans were of poor quality and were not specific enough to ensure children would be safe during a fire.

Future challenges

Special care units

On 1 January 2018, special care units became designated centres under the Health Act. The children's team previously monitored the country's special care units and reported publicly on their findings. However, as designated centres these centres must now be registered by HIQA in order to continue to operate.

HIQA's decisions to register centres are informed by the provider's capacity to deliver a safe and effective service that complies with the Health Act, the regulations and the National Standards that apply to special care units. Where providers do not have the capacity to do this, they can be refused registration or have specific conditions placed on their registration. Our enforcement powers for special care units are in line with other designated centres such as nursing homes and residential disability services.

Currently, there are four special care units operating nationally. HIQA must register these units by 31 December 2018, and thereafter, these units will be re-registered every three years.

Children's residential centres

HIQA continues to work with the Department of Children and Youth Affairs to plan for the transfer of the registration and inspection function for non-statutory children's residential centres from Tusla to

Good practice

Children's residential centre — Children were treated with respect in a child-centred environment.

Children were supported and encouraged in all aspects of their lives by the staff team. There was a relaxed and calm atmosphere in the centre which reflected the caring and nurturing approach of the staff team. Children's rights were respected and promoted and complaints were well managed. Children attended school or training programmes and this was encouraged and facilitated by the staff team. The staff team was respectful in their interactions with the children and encouraged them in all their endeavours.

HIQA. As with special care units, once all children's residential centres – private, public and voluntary – become designated centres, they will all require registration by HIQA in order to operate and will be subject to enforcement powers under the Health Act.

Conclusion

Children in care are a particularly vulnerable group. Failure to meet their needs can inhibit their ability to learn and develop at a key stage of their formative years. Many of the children who spoke with our inspectors expressed satisfaction with their residential service and spoke positively about the support they received from staff. However, our inspectors continued to find services that were not adequately safeguarding children and failing to address their social and educational needs. The expansion of HIQA's regulatory remit in regard to the formal regulation of all children's residential centres will further enhance the protections available to at-risk children and better equip the children's team to take appropriate enforcement action against poorly-performing service providers.

Poor practice

A children's residential centre

Inspectors found that this centre had difficulties in managing behaviour that challenges for a period of approximately five months. Despite the fact that there were several meetings with professionals to address this, involving both the residential service and the social work department, the issues were not resolved in a timely manner. This resulted in children being subjected to bullying, intimidation, physical assault, property damage, and an atmosphere of fear during that time.

A foster care service

Inspectors found drift and delay in the completion of 41 outstanding relative foster carer assessments. All of these relative foster carers had children placed with them, and this issue had also been highlighted in 2016. Not all children received a timely and appropriate response when a child protection concern was made and other safeguarding components were inadequate within the foster care service. Due to an insufficient number and range of foster carers in the area to meet the demands of the service, foster care placements for children were vacancy-led. This compromised potential matching and child-centred practice.

A foster care service

While there were immediate actions taken to ensure children were safe, as required, not all child protection and welfare concerns or allegations about foster carers were managed and fully investigated in line with Children First (2011). In addition, child protection and welfare concerns and allegations about foster carers were not consistently responded to in the appropriate manner. There were no formal systems in place to ensure the Foster Care Committee was notified of child protection and welfare concerns or allegations. Appropriate safeguarding arrangements, such as Garda vetting and adequate home visits by link workers, were not in place for all foster carers.

Chapter 4 - **Healthcare**

Introduction

HIQA's healthcare team promotes safety and quality in healthcare services in Ireland. To do this, we inspect hospitals to determine if they are meeting National Standards.

The healthcare team does not have the same powers of registration, inspection and enforcement as are available in some of the other areas regulated by HIQA. Instead, the healthcare team inspects public acute hospitals and publishes monitoring reports to encourage shared learning and best practice, and for transparency. The team also identifies areas of high risk to service providers who are ultimately responsible for the quality and safety of the service they provide.

In 2017, we continued to monitor the implementation of the *National Standards for Safer Better Healthcare*.[10] We revised our approach to monitoring against the standards in the area of infection prevention and control, in parallel with the publication of new *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services*,[11] which was published in May 2017.

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

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

Our monitoring activities have been prioritised, on the basis of likely risk, towards the 49 public acute hospitals and publicly-funded ambulance services. Our current programme allows for targeted monitoring in high-risk areas. We identify areas of high risk through:

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

During 2017, the healthcare team also started to prepare for taking on functions as a 'Competent Authority' in the regulation of practices related to medical exposure to ionising radiation. This regulatory function is due to commence in 2018, in line with the requirements of a European Commission directive. Three staff were appointed to the team to assist with the preparatory phase of this project in 2017. Further staff increases will be made in 2018 to enable HIQA to assume the full range of functions required by the directive.

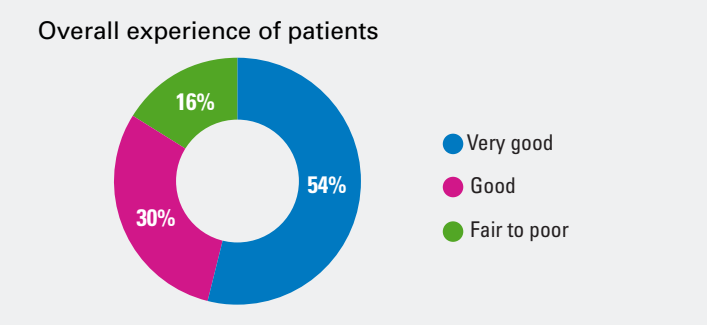
The National Patient Experience Survey gathered the views of over 13,000 recently-discharged patients.

The voice of the patient

Wherever possible, HIQA seeks patients' views as to how services are being provided. In 2017, HIQA's Health Information and Standards Directorate conducted, in collaboration with the Department of Health and the HSE, the first National Patient Experience Survey. This survey received the views of over 13,000 recently-discharged patients in public acute hospitals. The methodology used was evidence based and internationally validated, and allowed for a degree of comparison locally, regionally and nationally in relation to patients' experiences in using services.

The healthcare team has carefully considered the findings of this survey, alongside other relevant data in informing its ongoing approach to monitoring of services.

Figure 13 – Overall experience ratings from the National Patient Experience Survey



In general, most patients were positive about their experience of being cared for and treated in hospital. There were also positive findings in terms of patient perceptions of hospital cleanliness, with 96% of respondents reflecting that they felt their room or ward was clean. The clarity with which doctors and nurses provided answers to questions also rated well. However, patients identified a number of areas where improvement was required:

- 36% people said they were not always involved enough in the decisions about their care and treatment
- 43% of people said that they did not receive sufficient information to manage their condition after they were discharged from hospital. Moreover, patients who were admitted to hospital in an emergency gave lower ratings of overall experience when compared to those whose stay in hospital was planned in advance.

Full details around the National Patient Experience Survey may be found at www.patientexperience.ie.

Reflecting on the current state of the health service

While good care is provided on a daily basis across the Irish health service, considerable and familiar challenges persist. Hospital overcrowding and waiting lists for procedures, as evidenced in nationally-reported data, continued to worsen during 2017.

However, a number of important developments for the future planning of healthcare services occurred in 2017 which have the potential to address these issues.

A specially-formed Joint Oireachtas Committee on the Future of Healthcare concluded the formulation of the Sláintecare report.[12] As part of the consultation process for this document, HIQA provided a formal submission and presented to the Committee. We believe this report to be an important development for reform of health and social care services, if implemented.

In addition, HIQA acknowledges the work conducted by the Department of Health in 2017 to review current and future bed capacity needs.[13] HIQA provided a formal submission as part of the consultation phase of this body of work. Additional capacity will be required to meet the needs of the population into the future. In keeping with the Sláintecare report, any move to increase bed capacity in acute settings should be done in tandem with a move away from hospital-centric services, towards more primary and community care.

However, all of the proposed reforms for the health service require having the workforce available to provide this care. Again, policy efforts[14] to better define this problem and seek solutions during 2017 were welcomed by HIQA.

These policies have the potential to address many of the root causes of the problems in the Irish healthcare system. It is critically important that such plans are enacted in a timely fashion under effective leadership. This is imperative to eliminate overcrowding, reduce waiting lists, improve patient outcomes, and provide a system fit for purpose in the 21st Century.

Good practice

Beaumont Hospital

A dedicated infection prevention and control team proved effective in combatting healthcare-associated infections.

An inspection conducted at Beaumont Hospital identified the presence of a well-established and effective infection prevention and control programme. This programme was managed and implemented by an appropriately resourced multidisciplinary infection prevention and control team comprising relevant medical, nursing, pharmacy, surveillance scientist and other staff. The programme has successfully embedded key safety interventions such as infection prevention care bundles, clinical intervention at the bedside, and a relatively comprehensive programme of infection surveillance. Clear lines of reporting on patient safety and risk from the programme to senior management was also identified.

Overview of monitoring work conducted by HIQA in healthcare settings

Our healthcare team frequently encounter instances where services are not in a position to meet the National Standards. The HSE has been undergoing a period of structural reform which has seen changes to management structures and reporting arrangements across services. This reform has included the:

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

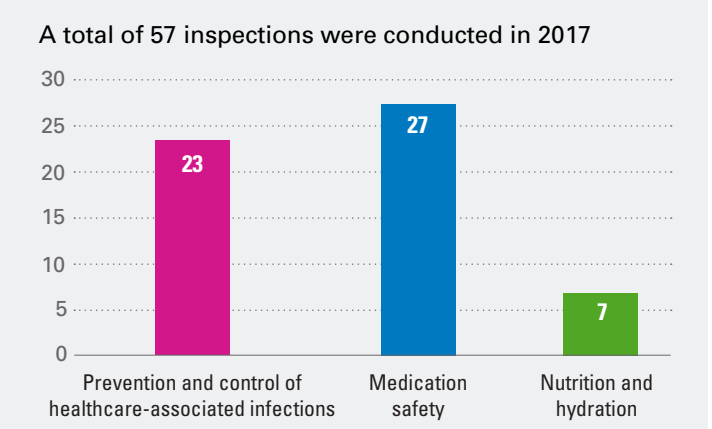
During 2017, the healthcare team monitored the health service in areas known to represent a high potential risk to patient safety. This focus mainly included a detailed evaluation of how hospitals organise themselves to ensure safety for patients in the key thematic areas of infection prevention and medicine safety – two areas that are internationally recognised as being major contributors to potentially preventable patient harm as a consequence of healthcare provision. Both areas have been cited by the World Health Organization as global patient safety challenges.[15,16] In line with this, HIQA monitors hospitals to determine if they have national and international best-practice measures in place to make conditions safer for patients. Many of these measures are determined by HIQA to be implementable within current resources.

In 2017, the healthcare team's monitoring work included:

- the completion and publication of a high-level service review which aimed to determine the level of progress achieved following on from HIQA's 2014 report into pre-hospital emergency care (ambulance) services
- monitoring compliance with the *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services*
- monitoring the governance of medication safety in hospitals
- monitoring how hospitals ensure that inpatient nutrition and hydration needs are best met in the seven remaining eligible hospitals that were not included in monitoring activity in 2016.

A total of 57 inspections were conducted in 2017.

Figure 14 – Number and type of healthcare inspections carried out in 2017



Summary of high-level findings from thematic monitoring programmes

Inspections in 2017 showed substantial variation in performance in the thematic areas monitored, and considerable scope for shared learning across hospitals. This work continued to highlight the importance of strong and effective leadership, governance and management arrangements in supporting hospitals with implementing the National Standards. The following sections outline key findings related to monitoring activities in the thematic areas of infection prevention and control and medication safety, which were the main areas of monitoring in hospitals by HIQA in 2017.

Prevention and control of healthcare-associated infections

In any health service, the potential for healthcare-associated infection as a consequence of hospital admission is one of the main causes of complication for a patient undergoing treatment. In line with international norms, studies have consistently identified that approximately 1 in 20 patients in hospitals are actively being treated for a healthcare-associated infection every day in Ireland. Many of these infections may have been preventable if best practice measures to reduce the risk of infection had been vigorously adhered to.

In recognition of the importance of reducing patient harm associated with healthcare-associated infection, HIQA has prioritised monitoring with the aim of reducing healthcare-associated infection, both through the development of National Standards, and specific monitoring against these standards.

Good practice

The Rotunda Hospital

The overall approach to the strategic planning and implementation of a medication safety programme proved effective in this hospital.

Medication safety was prioritised at an organisational level in the Rotunda Hospital and the medication safety programme had developed a number of quality improvement measures over a significant period of time. The hospital had introduced a medication safety bundle using multi-faceted risk-reduction strategies to reduce the risks associated with the use of high-risk continuous infusions in the Neonatal Intensive Care Unit (NICU). Risk-reduction strategies included an electronic dose calculator for high-risk continuous infusions, standard concentration intravenous infusions, electronic prescriptions and syringe labels for high-risk continuous infusions, and smart pump technology.

A revised monitoring approach

In 2017, revised *National Standards for the prevention and control of healthcare-associated infections in acute healthcare services* were published by HIQA, specifically for the acute healthcare setting.[§§§] As such, the healthcare team significantly revised its approach to monitoring against these standards.

The new monitoring approach aimed to determine each hospital's compliance against the revised Standards, with a particular focus on how each hospital had worked to establish and embed an effective infection prevention and control programme at the hospital.

Assessment against these standards comprised of two phases in 2017. A self-assessment tool was circulated to all hospitals to allow hospitals to evaluate their own perceived relative strengths and weaknesses. This acted as a basis for on-site inspection by HIQA throughout the year. In 2017, HIQA conducted 23 inspections against the revised Standards.

In parallel with this work, we also began to devise an additional supplementary monitoring programme with a specific focus on decontamination of reusable medical devices. This programme is being developed with the assistance of an external advisory group and will commence in 2018.

§§§Work is currently ongoing to complete specific standards designed for use in community care settings.

Key findings

Inspections found significant variation across hospitals in meeting the National Standards. HIQA found that some hospitals had embedded very effective infection prevention and control programmes, while other hospitals had more to do to attain the level of effectiveness achieved by leading hospitals.

Hospitals with established arrangements, such an appropriately resourced infection prevention and control team relative to the size and complexity of the services provided at the hospital, met the Standards. Infection prevention and control teams

Good practice

Tallaght Hospital

A team-based approach to medication safety led to safer management of medicines.

The configuration of the clinical pharmacy service at Tallaght Hospital was changed from a ward-based model to a team-based Collaborative Pharmaceutical Care in Tallaght Hospital model (PACT). This followed a study in 2014 to improve care and reduce the rate of serious adverse medication events. The new way of working protected against potentially severe medication errors and improved the quality of prescribing in older patients.

in these hospitals were effectively supported by senior managers and other key personnel. This again shows the critical importance of good governance in delivering safe services.

Our inspections found that the key elements of an effective infection prevention and control programme include:

- the provision of advice and expertise
- conduct of clinical intervention
- surveillance activities appropriate to the level of risk in the service
- effective quality improvement to address risk in a timely and effective way.

Other hospitals had not successfully implemented an infection prevention and control programme. This was often as a consequence of deficits related to their inherent ability to meet capacity and capability elements of the National Standards (Leadership, Governance and Management; Workforce; Use of Resources; Use of Information). The ongoing variation in performance remains a concern, particularly in the context of the emergence of ever-increasing antimicrobial resistance in Ireland. This includes the emergence of Carbapenemase-Producing *Enterobacteriaceae* (CPE) in Ireland – a strain of bacteria which are very resistant to antibiotics, harder to treat, and therefore carry a very high risk to patient safety in our hospitals.

This inspection programme also identified that ever-increasing overcrowding in Irish hospitals makes compliance with the National Standards more difficult. The lack of single rooms in many hospitals hinders a hospital's ability to appropriately isolate patients in single rooms for infection control purposes. HIQA also continued to identify a deficit in relation to infection surveillance in many hospitals. The practice of surgical-site infection surveillance, while in place in some hospitals, remains *ad hoc* nationally. The absence of adequate surveillance systems means that hospitals remain unable to fully assure themselves of the safety of certain types of surgery or other types of healthcare-associated interventions, such as invasive medical device use. Going forward, this should be a key area of focus for hospitals.

Good practice

Naas General Hospital, and St Luke's General Hospital, Kilkenny

Collaboration between these hospitals improved medication safety measures.

Naas General Hospital and St Luke's General Hospital, Kilkenny collaborated on a joint initiative for using computer software to support medication reconciliation, and therefore reduce medication error that may result from confusion around the medicines patients should be taking on admission and discharge from hospital. This project was conducted in collaboration with e-Health Ireland, the School of Pharmacy at University College Cork, and an industry sponsor.

Carbapenemase-Producing Enterobacteriaceae (CPE) – Declaration of a national public health emergency

During the course of monitoring infection prevention and control, HIQA has repeatedly highlighted

concerns around the emerging risk of antimicrobial resistance, in particular in Gram-negative organisms such as *E. coli* and *Klebsiella pneumonia.* An increase of CPE in Ireland, when considered alongside the experience of the emergence of this problem in other health systems globally, is a major concern for HIQA and has been highlighted over the years, including following an inspection at University Hospital Limerick in 2017.

In 2017, the Irish Government published a *National Action Plan for Antimicrobial Resistance*.[17] On launching this policy on 25 November 2017, the Minister for Health declared CPE to be a national public health emergency. HIQA welcomes and fully supports State recognition of the gravity of this issue, and believes this declaration to be a proportionate and necessary measure to fully address this critical public health concern. Given the seriousness of this safety issue, HIQA intends to continue allocating resources to monitoring of infection prevention and control in 2018. This focus will examine measures enacted to address the CPE threat, with a particular focus in the first instance on compliance with national guidance around patient screening for colonisation with CPE.

Medication safety

In 2017, HIQA continued to monitor against the *National Standards for Safer Better Healthcare*, with a thematic focus on medication safety. The importance of medication safety in hospitals is internationally recognised as it presents a high risk to patients. This programme focuses on the arrangements hospitals have in place to ensure patients receive medication in a safe, effective and well-monitored manner. The healthcare team started announced medication safety inspections in November 2016.

In 2017, HIQA conducted a further 27 medication safety inspections in hospitals. Some hospitals were able to demonstrate mature medication safety programmes, which had been established over a significant period of time. Other hospitals had made little progress in advancing medication safety programmes that would match up to international best practice. Good performance in this area was contingent on:

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

Encouragingly, our inspectors found that some hospitals were proactively learning from previously-published inspection reports. This was evidenced in enhanced governance arrangements; the fostering of a multidisciplinary approach; and the adoption of initiatives that were proven to be effective elsewhere.

In the interest of supporting collective learning across the health service, HIQA produced an overview report of findings from the first 12 months

of this inspection programme. Inspection reports from November 2016 to November 2017 outlined numerous examples of good practice which, in many cases, could be readily applied to other hospitals. Based on findings over the 12 months, HIQA made a number of key recommendations for collective improvement in medication safety. These included:

- A need for improved collaboration and sharing of expertise across hospital groups to ensure that good practice is spread across the health service.
- The need for the formulation of a national plan to outline a desired direction of travel for the health service in driving collective improvement in the area of medication safety.
- Stemming from this plan, the need for targeted investment in clinical pharmacy services and Information and Communication Technology (ICT).

This overview report was published on 1 February 2018.[18]

Overall, the medication safety monitoring programme identified that a lot of good practice exists in many of our hospitals nationally. Efforts to further improve safety for patients should aim to replicate this good practice in hospitals that have performed less well in inspections. This will ensure that all patients are suitably protected from potential harm associated with medicine use, insofar as possible. We have identified that many of the necessary changes required can be readily achieved through better sharing of expertise between hospitals and more effective multidisciplinary organisation on the ground in poorer-performing hospitals. In this context, targeted investment may also yield improvement if properly prioritised and supported by an overarching vision for medication safety across hospitals which is nationally coordinated.

Radiation protection

During 2017, the Healthcare team dedicated considerable time and effort towards preparation for the taking on of functions as a Competent Authority in the area of medical exposure to ionising radiation. This preparation was prompted by the transposition of an EU Directive into Irish Law in 2018 which will confer additional powers and responsibilities on HIQA in the area of radiation protection.

Medical procedures which emit ionising radiation include x-ray, other diagnostic equipment such as Computerised Tomography (CT) scans, radiotherapy, and some diagnostic or therapeutic medicines. Under the newly-proposed legislation, HIQA will monitor compliance with regulations and, where necessary, exercise enforcement powers. The new legislation will extend HIQA's powers and remit to include regulation of the private healthcare sector for the first time. HIQA will therefore be responsible for regulating in excess of 1,100 healthcare providers in this area, including dental practices, private hospitals and some clinics.

To prepare for this, we have been working closely with the legislative drafting team in the Department of Health, and in close collaboration with the

Environmental Protection Agency (EPA) – who will continue to regulate this area in regards to the protection of workers and members of the public. HIQA has also been closely liaising with the Medical Exposures Radiation Unit in the HSE, who will be handing over existing functions to HIQA under this new legislative change.

It is anticipated that the signing of new legislation in this regard, and therefore the transference of powers as a Competent Authority to HIQA, will occur in 2018. HIQA intends to fully engage with all stakeholders in this regard on conclusion of the legislative drafting process.

Future challenges

The expansion of HIQA's remit and powers, indicated by new legislation in the area of radiation protection, will for the first time allow the healthcare team right of entry into private healthcare providers and, where necessary, to exercise enforcement powers. Further proposed legislative changes may also expand HIQA's remit and powers beyond its current role of monitoring against National Standards in publicly-funded hospitals.

The proposed Health Information and Patient Safety (HIPS) Bill also outlines an expanded role for HIQA in monitoring against National Standards in private hospitals. In addition, in 2017 the Irish government reaffirmed its commitment to establish a system of licensing for healthcare providers, as proposed by the Commission on Patient Safety and Quality Assurance in 2008.[19] A system of licensing will fundamentally alter the regulatory framework in public and private hospitals and will introduce, for the first time, extensive enforcement powers. HIQA will continue to engage with all stakeholders to prepare for these proposed significant developments.

Conclusion

Overall, in 2017 the healthcare team continued to find inconsistent performance across the acute hospital sector. The National Patient Experience Survey offers valuable insight into how patients' rate the care they receive while staying in hospital. This will serve as a useful measure for quality improvement initiatives in the future.

While some hospitals were found to be meeting the National Standards, others continue to struggle to do this, and this impacts on the experience of patients. Given the healthcare team's limited enforcement powers, we will continue to monitor compliance with standards in key areas that have an impact on the quality and safety of care for patients.

Examples of poor practice

- Surveillance related to healthcare-associated infection rates, including surgical-site infection rates, remains very underdeveloped in most hospitals inspected.
- Arrangements around access to on-site consultant microbiologist availability remain limited in some hospitals.
- There was no clinical pharmacy service in one model 3 hospital that provided acute complex care for patients.
- There was significant under reporting of medication safety incidents in a number of hospitals.
- There remains significant variation in performance in meeting standards in hospitals across the country. In particular, HIQA has identified an emerging trend whereby some HSE-run mid-sized hospitals perform comparatively poorly. Scope for improvement in local leadership and management, increased resourcing with respect to ensuring staffing levels for certain staff groupings are comparable with peer hospitals, and better learning from others could assist in bridging this gap in these hospitals.

Submissions

There may be occasions where service providers are not satisfied with the findings and regulatory judgments in HIQA's inspection reports. If this is the case, registered providers are facilitated to make a submission to the Regulation Directorate outlining why they object to the contents of an inspection report. HIQA has put the submission process in place to ensure that our decisions are fair, reasonable, based on evidence, in compliance with relevant statutory provisions and accord with the principles of good public administration and natural justice.

In 2017, 19 inspections resulted in a submission from a registered provider. This represents less than 1.5% of inspections carried out and is in line with the proportion of inspections that resulted in a submission in 2016.

The most common judgments challenged for in older people's services were related to 'safe and suitable premises' and 'governance and management'. In disability services, the judgments most commonly challenged related to 'health and safety and risk management' and 'governance and management'.

Enhanced monitoring approach

HIQA expects service providers to learn from their experiences of providing care – to prevent mistakes from reoccurring and to embed good practice across all of their centres. We expect the same standards of ourselves. As such, we constantly monitor our processes and practices to ensure that we are using our resources for the maximum benefit of the people using health and social care services. With this in mind, we undertook a significant project in 2017 to review our own processes to ensure we were delivering a quality service. The review involved an in-depth analysis of our current practices and a reflection on what we had learned over the past 10 years of regulatory activity.

One of the biggest changes we have made is to how we will report on the quality of residential services. Our report structure has changed to bring the voice of the resident to the fore of our inspection reports. The residents' questionnaire has also been revised based on resident feedback. In addition, our new assessment approach involves more engagement with residents during the inspection. We have extended our advanced notice time frame for announced inspections to facilitate more residents to engage with inspectors while they are in their home.

Our new report layout reports across two dimensions: the capacity and capability of the provider and person in charge to deliver a safe, quality service; and the quality and safety of the service. Good practice in both of these dimensions means that services:

- focus on the resident, their individual needs and supports
- use the best available evidence to deliver best outcomes for residents - a human rights-based approach
- recognise and effectively manage their service when things go wrong
- identify and promote residents' good health, personal development and wellbeing - residents are safe.

Through our experience regulation over the last number of years, we have found that in order for any provider to deliver and sustain a good service there must be effective governance. The provider must have robust governance arrangements in place to ensure, and to assure themselves, that a safe quality service is being run. This means having a competent and capable workforce to deliver care and putting structures in place to make sure that the provider knows what is happening. For larger organisations this may be having sub-committee structures that review the quality of care and risk management. The governance arrangements put in place by the person who has legal responsibility for the service must be effective to ensure that residents, patients and children who use the services are safeguarded and receive the highest quality of care.

The service provider plays a critical role in leading, building and maintaining a culture that places the resident, patient and child, and the quality and safety of services, at the centre of the delivery of care. The importance of having a clearly-defined and formalised governance arrangement that identifies clear lines of accountability at individual, team and service levels cannot be underestimated for delivering and sustaining a quality service. Where responsibilities are delegated, the provider must be confident that this is done to ensure that everyone working in the service is acutely aware of their individual operational and professional responsibilities and accountability.

Many providers are organisations made up of a multiple of people such as companies, voluntary bodies or statutory bodies like the Health Service Executive (HSE). In order that we as the regulator can speak with the person legally responsibility for the delivery of care, the Office of Chief Inspector is requiring that all providers (excluding sole traders) put forward the name of their representative. This person is known as the registered provider representative. The role of this person is to answer questions and provide clarification regarding the executive governance arrangements in place to assure compliance with the Health Act, the regulations and nationally-mandated standards in relation to safely carrying on the business of a designated centre. This person does not replace nor negate the legal responsibility of the provider but is involved in the executive governance and management of the service and can provide clarity as to the governance of that service.

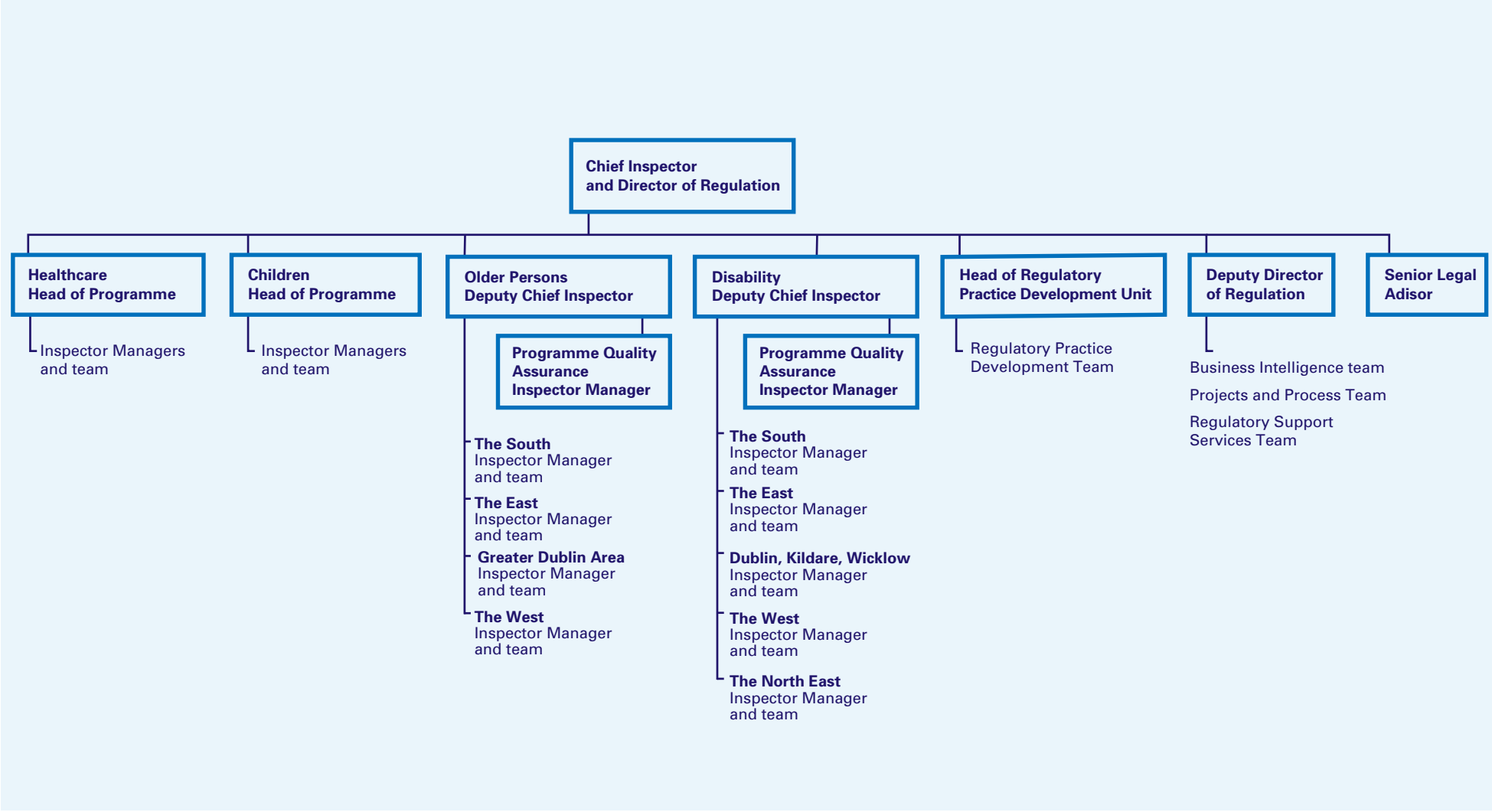
In preparation for the roll out of the enhanced monitoring approach, a large programme of training was required for all staff in the Regulation Directorate. A total of eight modules were designed and developed, five of which were delivered towards the end of 2017. In total, 124 staff attended training over 24 sessions delivered in Cork, Dublin and Athlone. We also engaged with service providers through information seminars in Cork, Dublin and Galway. A total of 2,000 people, primarily registered providers and persons in charge, attended these sessions to hear about the upcoming changes and how these would impact their services. The presenters informed those attending about improvements to our online portal, changes to our inspection and reporting processes, and the importance of the new registered provider representative role.

The enhancements to our processes will provide greater assurance to the public that people living in designated centres are receiving a safe, high-quality service that meets the requirements of the regulations and standards. Service providers will begin to see these changes rolled out on a phased basis throughout 2018.

Guidance on the enhanced monitoring approach is available on www.hiqa.ie.

Appendix A

Structure of HIQA's Regulation Directorate



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Published by the Health Information and Quality Authority.

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

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