

# OVERVIEW REPORT

ON THE REGULATION OF

## DISABILITY SERVICES

IN 2024



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# About the Health Information and Quality Authority

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

Reporting to the Minister for Health and engaging with relevant government Ministers and departments, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Chief Inspector of Social Services within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children’s special care units.
- **Regulating health services** — Regulating medical exposure to ionising radiation.
- **Monitoring services** — Monitoring the safety and quality of permanent international protection accommodation service centres, health services and children’s social services against the national standards. Where necessary, HIQA investigates serious concerns about the health and welfare of people who use health services and children’s social services.
- **Health technology assessment** — Evaluating the clinical and cost effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland’s health and social care services.
- **National Care Experience Programme** — carrying out national service-user experience surveys across a range of health and social care services, with the Department of Health and the HSE.
- Visit [www.hiqa.ie](http://www.hiqa.ie) for more information.

# About the Chief Inspector of Social Services

The Chief Inspector of Social Services within the Health Information and Quality Authority (HIQA) (referred to in this report as the Chief Inspector) is responsible for registering and inspecting designated centres in Ireland.

The functions and powers of the Chief Inspector are set out in Parts 7, 8 and 9 of the Health Act 2007 (as amended) (from now on referred to in this report as the Act).

The Chief Inspector currently regulates designated centres for:

- older people
- people with disabilities
- special care units for children.

The role of the Chief Inspector includes inspecting and registering designated centres for people with disabilities through assessing compliance with the regulations and nationally mandated standards. This is achieved through desktop inspection of information received from the provider and unsolicited information from other sources about the designated centre, on-site inspection in designated centres and ongoing assessment of compliance by providers with the regulations and national standards. The regulations and standards in effect for designated centres for people with disabilities are as follows:

- Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations as amended
- Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with disabilities) Regulations as amended
- *National Standards for Residential Services for Children and Adults with Disabilities* (2013)
- *National Standards for infection prevention and control in community services* (2018)
- *National Standards for Adult Safeguarding* (2019).

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# A message from the Chief Inspector Designate



*Finbarr Colfer, Chief Inspector Designate*

I am pleased to present this report on the regulation, monitoring and inspection of designated centres for people with disabilities in Ireland in 2024 by the Health Information and Quality Authority's (HIQA's) Chief Inspector of Social Services.

The year 2024 was significant in the regulation of designated centres for people with disabilities, as we reflected on the first decade of independent regulation.

By the end of 2024, there were 1,655 registered centres offering 9,246 residential places. The number of centres continues to increase year-on-year, and we have forecast further growth over the next five years. In such an expanding sector, strong regulatory oversight is essential to support service providers to deliver safe, high-quality care.

During 2024, we conducted 1,042 inspections. Our findings continue to show that the vast majority of providers are delivering good-quality care and support that meets people's needs, in line with the regulations and standards. We continue to see examples of good practice where providers go beyond the minimum requirements set out in the regulations to embed a human rights-based approach to care for residents.


Good governance and management is key to underpinning good practice, identifying deficits and ensuring any issues are addressed. However, there remains a small cohort of providers who are challenged to either make improvements effectively for residents, or to sustain those improvements.

In situations where providers fail to make improvements or address matters, and when we find non-compliance that impacts on the quality and safety of care for residents, we use our powers to take enforcement activity to drive improvements in

care. As a result, in 2024 we required two providers to engage in focused escalatory programmes which focused on improving governance and oversight of their centres and achieving better outcomes for people with disabilities. During the year, we also issued 20 notices of proposed decision to cancel a provider's registration of a centre. Most of these lead to improvements in the quality and safety of care delivered in centres, but five notices of decision were issued to cancel the provider's registration of those centres, and the HSE took over the operation of those centres under Section 64 of the Health Act 2007 while alternative arrangements were being put in place.

Throughout the year, we continued to engage with residents both during and outside of inspections. Their feedback is critical to us in understanding what is working well and needs to improve in services, but also in helping us to enhance our work and how we engage with them. We also continue to ensure open dialogue with providers through online and in-person events and our Provider Representative Forum to share learnings and feedback about the wider sector.

Our goal as regulator is for all people with disabilities to live active and fulfilling lives where their human rights are protected and promoted. We are committed to continue to work with residents, their families, friends and advocates, providers, staff, Government partners, and other stakeholders towards achieving that goal.



Finbarr Colfer  
Chief Inspector Designate  
Health Information and Quality Authority

# Introduction by the Interim Deputy Chief Inspector of Social Services (Disability)



*Ciara McShane, Interim Deputy Chief Inspector of Social Services (Disability)*

Welcome to our report on our work in the regulation of designated centres for people with disabilities in 2024.

Since the commencement of regulation of disability services in 2013, we have found one consistent indicator of a good service – governance and management is essential in delivering good quality services.

We know from our experience across the sector that effective governance and management by providers is key to residents living happily in their homes. It is also fundamental to delivering a human rights-based approach to care as it ensures care is delivered in a way that respects, protects, and promotes the rights of each person availing of services. During 2024, we took a number of actions to build awareness of and support providers to improve governance in their services. We collaborated with provider representative bodies to deliver an in-person seminar for CEOs and board chairs on 'Exploring the Importance and Value of the Relationship between Boards and Executive Management Teams: A Collaborative Learning Event'.

In 2024, we enhanced our focus on human rights, asking providers and staff working in services about how they embed a human rights-based approach in their services. This valuable information was captured throughout our inspection reports and aimed to highlight good practice and learning across the sector in upholding residents' rights.

We also continued to hold our Resident Forums, where we engage with residents of services outside of the inspection process, in more informal settings. Residents gave us feedback on their rights and how they are supported to uphold these in services, while also sharing their experiences of inspections with us. They highlighted the need for more accessible information about what HIQA does and what we find on

inspections to be shared with them, and I am pleased that we have worked to action these throughout 2025.

In 2024, we also marked International Day for Persons with Disabilities with residents attending our office and presenting to us about their experiences. They told us about the power and importance of people with disabilities having a greater awareness of their rights and of advocacy.

We know that there are challenges in the sector impacting on governance, staffing and delivering new accommodation. We continue to engage closely with providers on these issues and to work collaboratively with the Department of Children, Disability and Equality on how the regulatory framework can support providers to meet these challenges.



Ciara McShane  
Interim Deputy Chief Inspector of Social Services (Disability)  
Health Information and Quality Authority

# Regulation of Disability Services

## 2024 Overview

1,655  
designated centres



9,246  
residential places

117  
new centres registered



1,042  
Inspections

### Regulation Drives Improvements

Provider's compliance improving

78%	15%	7%
Compliant +9% since 2023	Substantially compliant -4% since 2023	Not compliant -5% since 2023

82% of inspections found staff had received training in human rights

## Regulatory Action

20

centres issued a Notice of Proposed Decision to cancel

5

centres were issued a Notice of Decision to cancel registration and alternative arrangements were put in place by HSE

## More residents moving into the community

Congregated settings\*

208

-4 since 2023

residential places

2,111

-145 places on 2023

\*Congregated settings are centres where more than 10 people live in the same building or in a group of buildings which are located together on campus. The increase in these settings is due to providers dividing existing large centres into multiple small centres.

## Setting the Scene

At the end of 2024, there were 1,655 designated centres with 9,246 residential places for persons with a disability. Of these, 174 centres were operated directly by the Health Service Executive (HSE), with 1,026 residential places and 1,481 centres funded by the HSE under Section 38 or Section 39 of the Health Act 2004, providing a total of 8,220 registered residential places. In 2024, there was a net increase of 81 centres compared with the end of 2023.

Of the total number of centres, 208 were based in congregated settings<sup>1</sup> which accounted for 12.6% of the registered centres and 22.8% of residential places across all centres. Congregated settings had a total capacity to support 2,111 persons with a disability at the end of 2024 — a reduction of 145 compared with the end of 2023.

Designated centres can be registered as centres for adults, for children or for a mix of adults and children. Mixed children and adults centres are mostly respite centres where there are separate respite breaks for children and for adults and they are not accommodated together. Mixed centres can also be those where children are transitioning to adulthood, and the provider is facilitating them, both children and adults to continue living together.

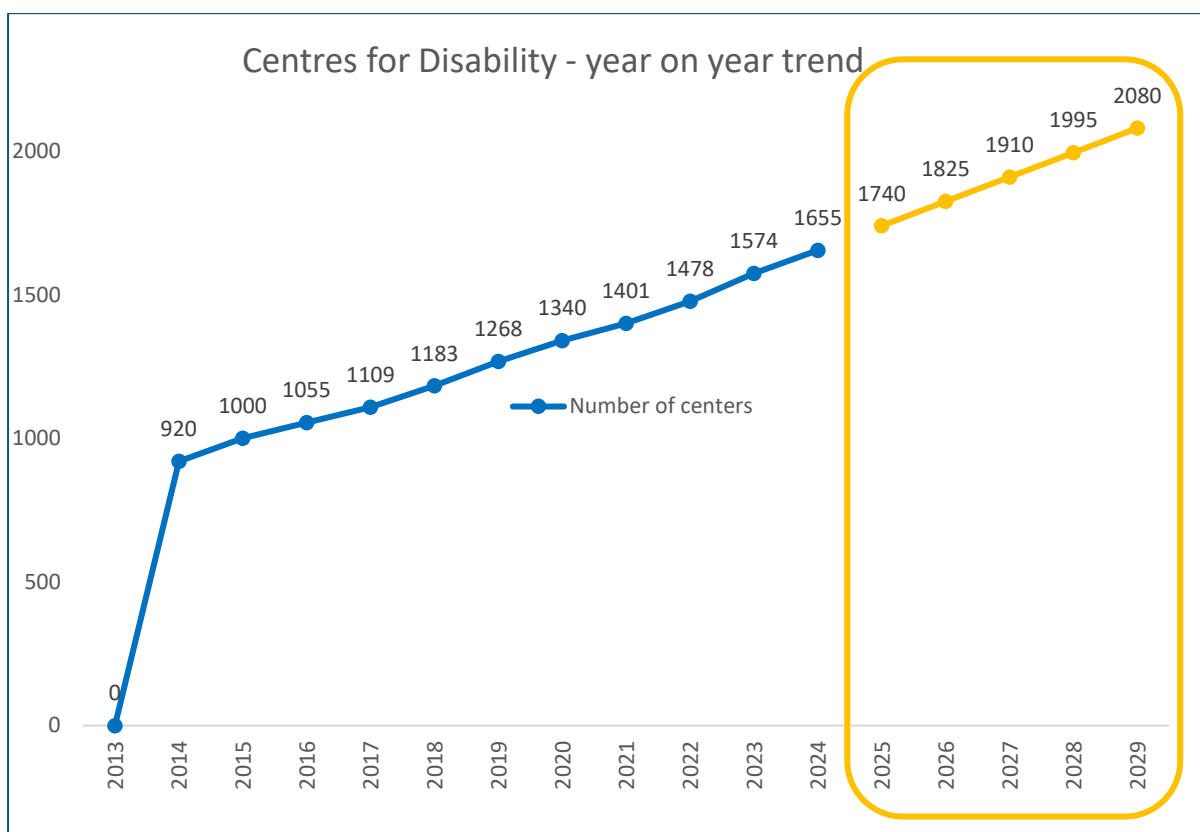
At the end of 2024, there were 1,490 centres for adults with a disability, with 8,524 registered places. There were 36 mixed centres for both adults and children, with capacity to support 204 registered places. There were also 129 children centres with 518 residential places. There continues to be an ongoing growth in the demand for children's centres with 29 new centres opening in the past two years.

The number of centres overall continues to increase year-on-year. For example, the number of centres has increased in a 10-year period from 920 centres at the end of 2014 to 1,655 at the end of 2024, an increase of almost 80%. Furthermore, based on the annual trend in the increase in designated centres, we anticipate that there will be approximately 2,080 designated centres in the next five years as forecasted in Figure 1 below.

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<sup>1</sup> Congregated settings are where 10 or more people with a disability live together in a single living unit or are placed in accommodation that is campus based. Taken from *Time to Move on from Congregated Settings A Strategy for Community Inclusion*, HSE 2011.

**Figure 1: Number of designated centres for disability year-on-year trend**



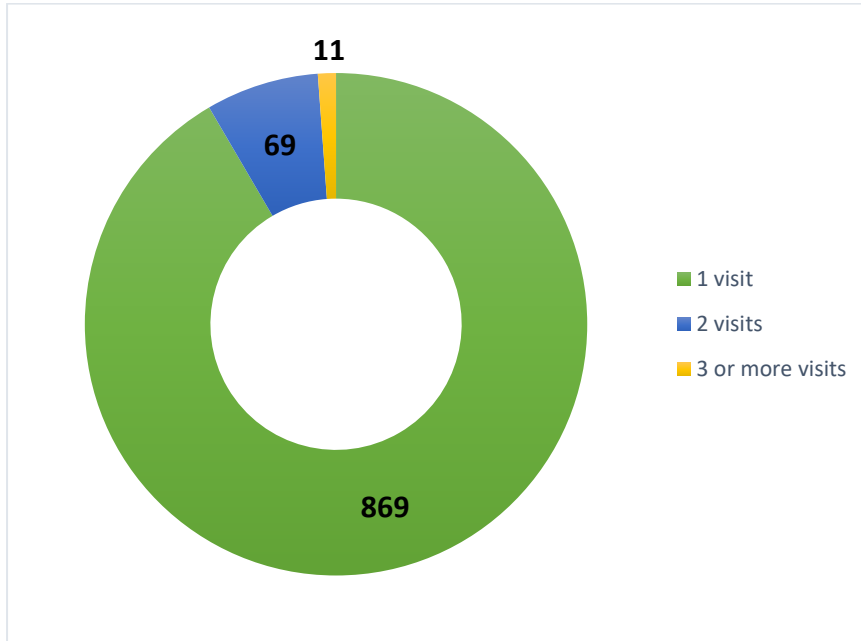
Each year our overview report has consistently reported there are higher non-compliance levels in rights-related regulations, such as individual assessments and personal planning, safeguarding and protection, general welfare and development and residents’ rights within congregated settings.

While there has been a small reduction in the number of congregated settings, with four centres closing in 2024, there remains 208 centres within congregated settings. Therefore, a large number of people are still living in congregated settings who continue to be at higher risk of receiving a poorer quality of support that does not uphold their rights. At the end of 2024, there were 2,111 registered beds in congregated settings. It is important to note, however, that this is not the experience for all who live in congregated settings (*see Appendix 1: Comparison of overall compliance in congregated settings and community settings 2024*).

A large number of designated centres in 2024 had their registration renewed. A total of 478 centres received an announced inspection as part of their renewal of registration. These centres are given four weeks’ notice of a registration inspection so that residents and their families are given an opportunity to meet with inspectors. This therefore accounted for the relatively higher number of announced inspections which took place in 2024. Of the 1,042 inspections that took place in 2024, 50% of these inspection were announced in advance.

Some centres required more than one inspection to follow up on areas of concern in order to ensure that actions the provider had committed to had been implemented and had brought about the required improvements for residents. *Figure 2* shows centres that received more than one inspection in 2024.

**Figure 2: Number of visits per centre**



Since the commencement of regulation of residential service for people with disabilities in November 2013, one consistent theme that has emerged from our regulatory activities is the importance of good governance and management. Where we find services that are well managed, supported by robust systems, we also find residents who are enjoying a good quality service and one that promotes their rights.



# Chapter 1: The Impact of Good Governance

Good governance is the cornerstone of a safe quality service. Effective management ensures that the vision and mission of the provider is implemented in practice. A culture of a safe, values-led, quality driven and learning organisation is ensured when good governance and effective management are both in place. It is well known that strong arrangements for governance and management leads to better quality of life and better outcomes for residents. In contrast, where there are poor governance and management arrangements, there is an increased risk of poor outcomes, ineffective support and unsafe services for residents.

Coming out of the COVID-19 pandemic, we found that governance and oversight of designated centres was particularly impacted as providers moved to a more remote system of management which meant they were not present in designated centres to assess the effectiveness of the care and support being provided to residents. We have reported on the decline in compliance with governance and management in previous overview reports and at the end of 2023, we found 24.9% non-compliance with governance and management which was of concern. We know that effective governance and management is a key component of any care service and is fundamental to delivering a human rights-based approach to care as it ensures care is delivered in a way that respects, protects, and promotes the rights of each person availing of services. For example, where systems and structures encourage listening to the voice of the resident this often ensures the delivery of care and support is based on individual needs, preferences and choices. Where governance and management arrangements are weak and lacking, we have found that residents are not supported in line with their needs and, in general, services provided are poor as a number of key areas are negatively impacted.

## 1.1 A Continued Focus on Governance and Management

In 2024, we maintained our focus on the importance of effective governance and management at a provider level as well at a centre level and we looked to see how we could effect change and drive improvement in the area of governance in a way that would support providers.

During 2024, we took an action to bring attention to and support providers to improve governance. We held an in-person provider seminar titled 'Exploring the Importance and Value of the Relationship between Boards and Executive Management Teams: A Collaborative Learning Event', aimed at Chief Executive Officers and board chairs. This event was developed in collaboration with provider

representative organisations and with the Health Service Executive (HSE) in its role as commissioner and as provider of disability services. A collaborative working group was established to plan and implement the programme for the seminar. We took a joint approach ensuring that the seminar reflected the concerns and interests of the participating stakeholders and ensuring the content was relevant and engaging.<sup>2,3</sup>

The working group consisted of representatives from:

- The Disability Federation of Ireland
- The National Federation of Voluntary Service Providers
- The National Disability Services Association
- The Health Service Executive
- The Chief Inspector of Social Services Directorate within HIQA.

As part of the event, residents, staff and management in Stewarts Care DAC and in St Gabriel's Foundation presented videos to remind participants of our shared goal of ensuring that strong governance delivers good outcomes for people with disabilities. The event explored the importance and value of the relationship between the board of directors and executive management team of provider organisations. This relationship is critical to executing effective direction, leadership and positively impacting on governance and oversight at all levels of an organisation, and most importantly ensuring good outcomes for people with disabilities who live in designated centres. The Chief Inspector recognised the potential of the event to draw on the collective learning, insights and expertise of all the stakeholders; provider representative organisations, providers themselves, the HSE and HIQA. This collaborative event aimed to build on the theme from our event for service providers in 2023—The Impact of Good Governance: The Right(s) Approach—which highlighted the impact of good governance on achieving good outcomes for people with disabilities living in designated centres. The event, which was opened by the Minister of State with Responsibility for Disabilities, Anne Rabbitte TD, created a forum of open dialogue between the regulator, service providers, the HSE as funder and the sponsor Department of Children, Equality, Disability, Integration and Youth.

Following on from that we held a series of webinars to support providers, and share learning with a view to strengthen key areas, such as residents' rights<sup>4</sup> and safeguarding.<sup>5</sup>

This renewed focus has continued to lead to improved compliance levels for Regulation 23: Governance and Management as reflected in Figure 3. In 2023

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<sup>2</sup> [HIQA Disability Services Provider Seminar Summary Output Paper 2024](#)

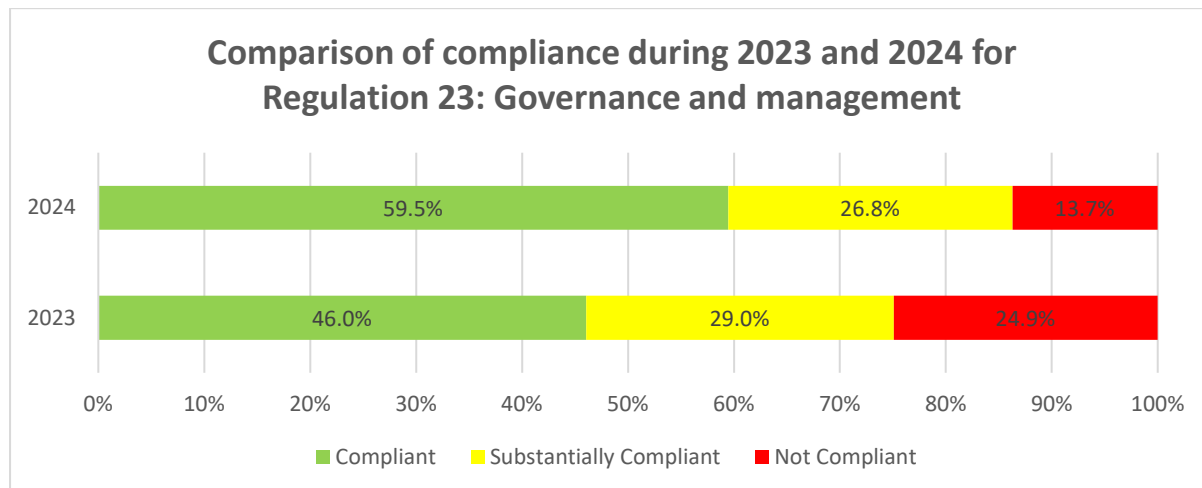
<sup>3</sup> [HIQA Shared Learning Event Slides 26 March 2024](#)

<sup>4</sup> [Human Rights Training - The value and impact for residents](#)

<sup>5</sup> [Adult Safeguarding Webinar for Providers](#)

Regulation 23 was found to be non-compliant on almost 25% of inspections, in 2024 this reduced significantly to 13.7%.

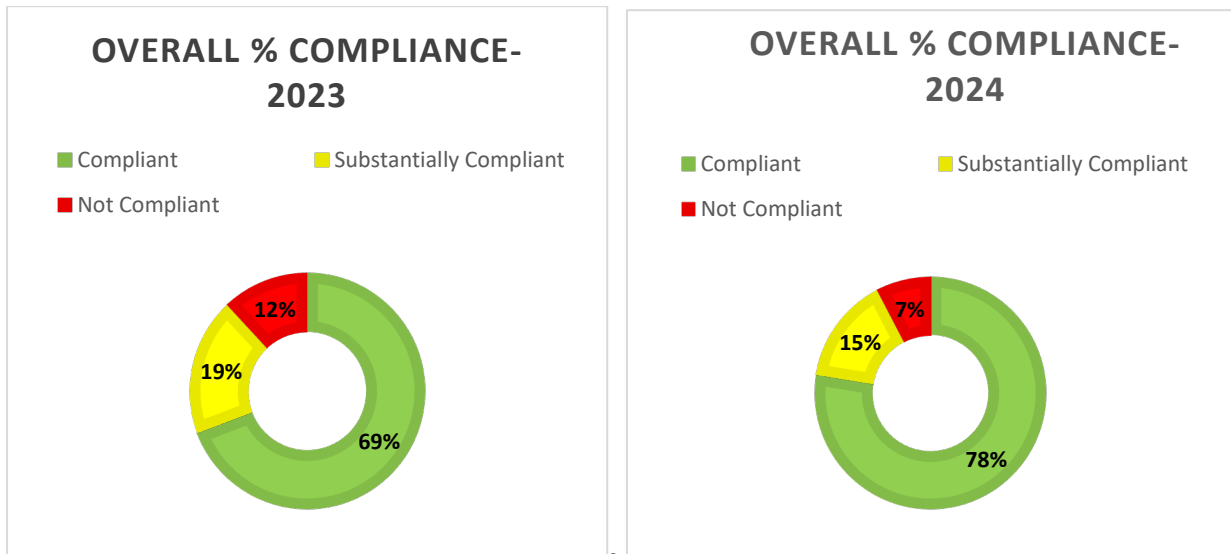
**Figure 3: Comparison of compliance during 2023 and 2024 for Regulation 23: Governance and management**



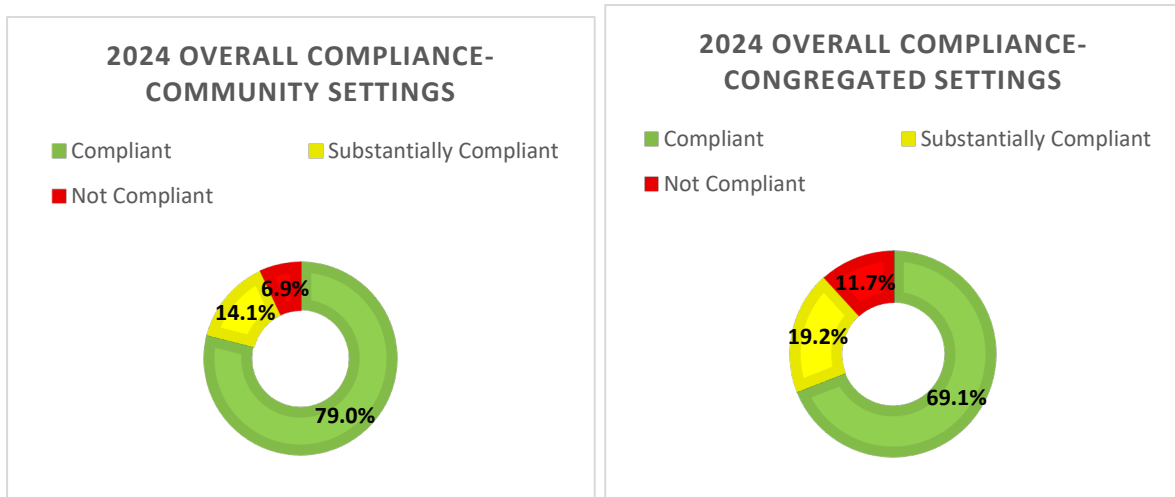
Throughout 2024, we continued to engage with providers outside of inspections. In addition to the seminar and the webinars, we also held 14 provider engagement sessions. The purpose of these was to meet with providers and their nominated representatives to share information and have discussions regarding emerging trends and topics such as the providers’ future development plans. These engagements take place outside of inspection and are a collaborative initiative to share information.

Overall in 2024, there was an increase in compliance across all regulations when compared with 2023, as reflected within *Figure 4*. This is positive to see after more than 10 years of regulation. The percentage of regulations deemed fully compliant has increased from 69% in 2023 to 78% in 2024. This reflects that, in an increasing majority of centres, we have found people with disabilities are being provided with good quality care and support and have meaningful and active lives. This was also true for those living in congregated type settings where we found higher levels of compliance in 2024 when compared to 2023. However, it still remained that those living in community-based settings experienced better outcomes when you look to levels of compliance as an indicator as shown in *Figure 5*.

**Figure 4: Overall compliance ratings 2023 v 2024\***



**Figure 5: Comparison of overall compliance in congregated settings and community settings 2024**



\*For a full breakdown of overall compliance for each regulation in 2024, please see Appendix 2.

## Chapter 2: Escalated regulatory activity

### 2.1 The Impact of Poor Governance and Management

During 2024, in the majority of centres, providers achieved good levels of compliance as described throughout this report. However, where providers did not ensure they had robust governance and management arrangements in place, this led to poorer outcomes for residents which required the Chief Inspector to take escalated action in some instances. We are aware of the disruptive and distressing impact that escalated regulatory actions can have on residents so, where possible, we work with providers giving them opportunities to improve services in advance of the Chief Inspector taking escalated activity. Providers are given opportunity to submit and implement compliance plans, outlining the steps they will take to come into compliance with the regulations. However, in situations where providers fail to make improvements or address matters, and when we find non-compliance that impacts on the quality and safety of care for residents, the Chief Inspector will take escalated regulatory action.

The Health Act 2007 gives the Chief Inspector a range of legal powers to be used when there are significant levels of non-compliance that adversely impact on the quality of residents' lives. The Chief Inspector is conscious of the impact of exercising those powers and the distress it can cause for residents and their loved ones. The Chief Inspector uses a phased, proportionate approach. The Chief Inspector can require providers to set out how they will address shortcomings in a compliance plan, have a cautionary meeting with a provider or issue a formal warning to a provider stating that enforcement action will be taken unless they address the shortcomings.

Should providers fail to come into compliance and demonstrate safe effective services the Chief Inspector may escalate using the powers available to them. The legal powers available to the Chief Inspector, as set out in the Health Act 2007, include prosecution, attaching restrictive conditions to the registration of a centre, refusing the renewal of registration and/or cancelling the registration of the centre. *Figure 6* below provides a list of all escalated actions taken by the Chief Inspector in 2024.

**Figure 6: Escalated activity that occurred in 2024**

<b>Escalation activity</b>	<b>Count</b>
<b>No. of cautionary meetings held</b>	28
<b>No. of providers subject to cautionary meeting(s)</b>	12
<b>No. of warning letters issued</b>	18
<b>No. of providers who received a warning letters(s)</b>	13
<b>No. of restrictive conditions applied during the year</b>	36
<b>No. of restrictive conditions in place at year end</b>	47
<b>No. of designated centres with restrictive conditions in place at year end<sup>6</sup></b>	41
<b>No. of Notice Of Proposed decisions to cancel registration issued<sup>7</sup></b>	20
<b>No. of Notice Of Decisions to cancel registration issued, with the centres taken over by HSE under Section 64<sup>8</sup></b>	5
<b>No. of NOPDs to refuse an application to register</b>	1
<b>No. of providers undergoing an escalated regulatory programme</b>	3

## 2.2 Escalated Regulatory Programmes

This overview report has reported on increased compliance levels overall throughout the country. However, where there is a risk that a range of centres within a provider organisation are at risk of being cancelled due to failures by the provider to respond appropriately to the needs of residents and to the findings of inspections, the provider may be required to submit a governance improvement plan at corporate level and to participate in an escalated regulatory programme. The focus of that programme is to verify that the actions of the provider result in improvements to the

<sup>6</sup> A centre's registration may have more than one restrictive condition attached to its registration.

<sup>7</sup> The Health Act 2007 allows the provider to make representation to a Notice of Proposed Decision outlining the actions they are taking to address the issues identified and where this is accepted, the centre continues to be monitored but we do not proceed with the cancellation process.

<sup>8</sup> Section 64 of the Health Act 2007 (as amended) allows the Health Service Executive (HSE) to take over the management of a designated centre where there are serious concerns about the safety, quality or standard of care being provided.

quality of support provided to residents. Escalated regulatory programmes were being implemented for three organisations during 2024: Sunbeam House Services CLG, Western Care Association and Ability West.

### 2.3 Sunbeam House Services CLG

Sunbeam House Services CLG is a registered provider of designated centres for adults with disabilities. It provides a wide range of services to adults with intellectual disabilities including residential and respite services and day services. In 2024, this provider operated 34 designated residential centres.

Due to repeated poor findings on inspection, there was an increasing risk to the registration of a number of its residential centres.

An escalated regulatory programme was commenced with the provider in January 2024 and the overview report of Governance and Safeguarding in designated centres operated by Sunbeam House Services CLG was subsequently published in early 2025.<sup>9</sup>

During the programme, the registration of one of the centres was cancelled due to ongoing non-compliances and a failure of the provider to demonstrate that they had the capacity to improve the safety and quality of support within the centre. The HSE took over the operation of that centre under Section 64 of the Health Act 2007, as amended.

Inspectors continued to monitor the centres operated by Sunbeam House Services CLG during 2024 and overall, found that the actions of the provider were beginning to result in effective improvements for residents. Throughout 2025, inspectors have found that the provider has continued to build on these improvements and details of this will be included in the 2025 Overview Report.

### 2.4 Ability West

Ability West is a registered provider of designated centres for adults and children with disabilities. It provides a wide range of services to adults and children with intellectual disabilities including residential and respite services and day services. Ability West had 28 registered designated centres operating in 2024.

Following a series of concerning inspection findings and increasing non-compliance and risk to residents, in 2023 an escalated regulatory programme was initiated which extended into 2024. While notices of proposed decision to cancel the registration were issued for three centres during this time, due to poor compliance

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<sup>9</sup> [HIQA publishes report on governance and safeguarding in Sunbeam House Services CLG | HIQA](#)

levels which impacted on the safety and quality of support for residents, the provider took appropriate action and it was not necessary to proceed with the cancellations.

The provider submitted an organisation-wide governance improvement plan and inspectors monitored the effectiveness of the provider's actions.

While inspectors found incremental improvement in most centres during 2024, a small number of centres continued to have high levels of non-compliance. As the inspection programme extended into 2025, inspectors found that the provider was making progress in addressing the areas of continuing non-compliance and this will be included in the 2025 Overview Report.

## 2.5 Western Care Association

Western Care Association is a registered provider of designated centres for adults and children with disabilities. It provides a wide range of services to adults and children with intellectual disabilities including residential and respite services and day services. Western Care Association had 43 registered designated centres operating in 2024.

Escalated regulatory engagement with Western Care Association continued into 2024. An enhanced regulatory programme initially commenced in March 2023 following receipt of information of concern regarding the governance of the organisation and in response to the outcome of inspections completed in 2022-2023. The enhanced programme resulted in a programme of targeted inspections being undertaken in March 2023 across the organisation's designated centres.

Following the completion of the initial inspection programme in 2023, monitoring of compliance continued in 2024 across the organisation through regular formal engagement with the provider on progress made towards achievement of objectives established in an agreed improvement plan with the Chief Inspector. In addition, continued inspections of the provider's designated centres continued in 2024, with escalation action being taken in three centres where continued non-compliance with the regulations was identified. These actions included the issuing of a warning letter for two designated centres and a notice of proposed decision to cancel the registration of one other designated centre.

Due to continued escalation and the findings of the inspections in 2024, the enhanced regulatory programme was extended into 2025 to ensure the quality of care received by residents was sustained and enhanced.

## 2.6 Operation of unregistered centres under section 46 of the Act

Section 46 assessments refer to an assessment of a residential service that may be a designated centre that is operating unregistered, which is a breach of the Health Act

2007. Most often, through our engagement with providers, we learn that these arrangements are in response to a genuine safety concern for the resident and have been implemented as an emergency measure.

The Chief Inspector has been engaging with the Department of Health in relation to addressing this legislative gap and continued to do so in 2024 with the Department of Children, Disability, Equality, Integration and Youth. The current legislation does not provide for responding to people with disabilities who find themselves in need of urgent accommodation. Each year there are a number of incidents where providers respond to the accommodation needs of residents where there is a risk to the safety of a resident or a risk to the safety of others and operate an unregistered centre for a brief period while alternative arrangements are put in place.

In 2024, inspectors undertook nine Section 46 assessments, four of these were found to be in response to emergency accommodation requirements and the remaining five were found not to be operating unregistered.

## 2.7 In Summary

This chapter provided information about how the Chief Inspector of Social Services has used the escalation powers set out in the Health Act 2007, as amended, to take proportionate and effective action to ensure that providers improve the quality of support and care to residents in designated centres.

The information in this chapter also highlights the impact that governance and management arrangements have on the quality of life of residents. Where there are poor governance and management arrangements, the provider is not effective in identifying service deficits and their impact on residents, and does not demonstrate their capacity to address issues when things go wrong.

Use of the powers of the Chief Inspector in a proportionate manner has been effective in requiring providers with poor governance and management arrangements to make improvements which impact positively on the experience of residents. In doing so, this reduces the risk of disruption and upset for residents that can occur when the Chief Inspector is required to cancel the registration of a centre.

## Chapter 3: Human Rights Based-Approach- the positive outcomes for residents

The year 2024 brought a renewed focus on a human rights-based approach to care and support. Our experience of regulation of the sector over 10 years showed us that person-centred care was most effective where staff had a knowledge and understanding of human rights. In 2023 we commenced a pilot project to look at and report on designated centres which had trained their staff in human rights. Inspectors asked front-line staff and managers if they had received training in human rights. Where staff had this training, inspectors asked them for explicit examples as to how it had positively impacted on the everyday lives of the residents. We then reported on the impact of this training in our inspection reports.

It is important to note that providing human rights training to staff is not a requirement of the regulations. As such, it was not mandatory for service providers to provide training in human rights, and the lack of such training did not lead to a finding of non-compliance. The aim of this initiative was to promote best practice and to acknowledge the work many providers were doing to promote the human rights of their residents. Inspectors use the inspection process and published reports as a platform to inform a wider audience of some of the excellent work and initiatives underway where services are supporting and promoting the rights of the people they support.

Human rights e-learning training and information is available to providers and their staff through the HIQA website<sup>10</sup> to help staff understand how they can apply a human rights-based approach to their work. This e-learning course was also available to all staff through HSE LanD (HSE Learning and Development platform). Since its launch in 2021 to end of 2024, over 215,000 people completed modules within the online learning course 'Applying a Human Rights-based Approach in Health and Social Care: Putting national standards into practice'.

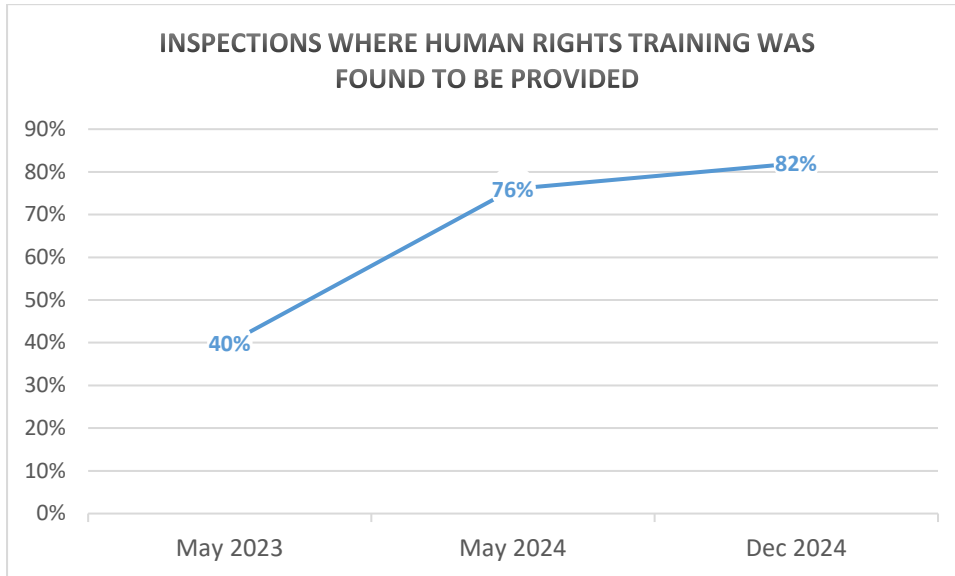
This pilot programme was rolled out across the country throughout 2024. On all monitoring inspections, the question was asked as to whether staff were trained in human rights, and what the impact of this training was. This created a ripple effect and month on month we were able to see the number of centres where human rights training was provided continue to increase. For example, as demonstrated in *Figure 7* below, during the pilot phase in May 2023 it was found that 40% of staff were trained in human rights. By contrast, in May 2024 it was found that on 76% of

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<sup>10</sup> [Guidance on a Human Rights-based Approach in Health and Social Care Services | HIQA](#)

inspections staff had received training in human rights, and by year end this figure had increased to 82%.

**Figure 7: Inspections where human rights training was found to be provided**

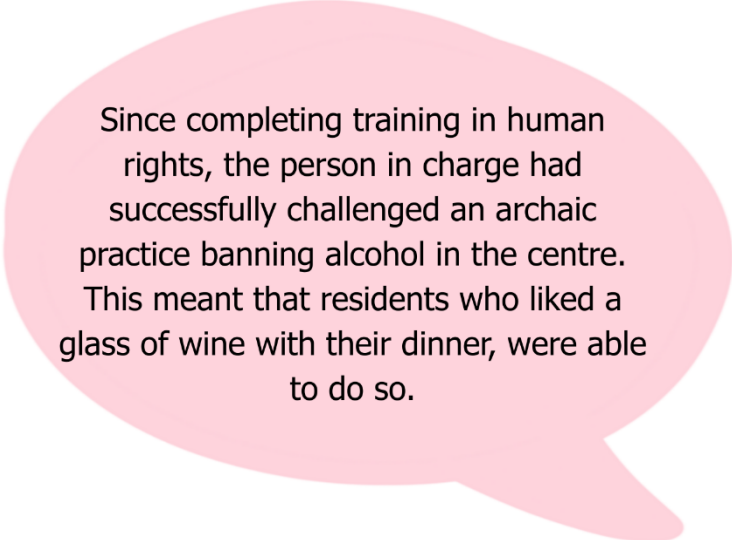


It was positive to observe the impact this training had for residents in designated centres in relation to the everyday lives. A number of examples of this from inspection reports are set out below.

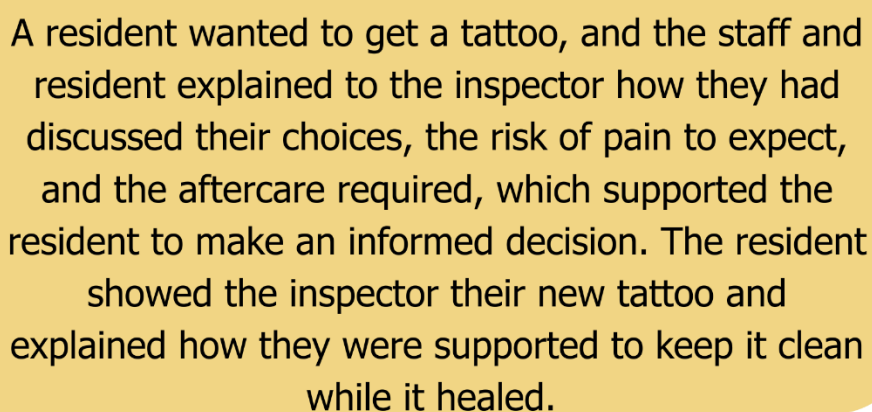
For example, one resident had a pet dog and another had a pet cat and the staff member said it was the right of the residents to have pets.

The admission procedures to the respite centre had been recently reviewed and updated to ensure that they prompted the rights of the respite users. As a result, the relationship status of respite users was recognised, and they could now request to attend at the same time.

A resident wanted to get a tattoo, and the staff and resident explained to the inspector how they had discussed their choices, the risk of pain to expect, and the aftercare required, which supported the resident to make an informed decision. The resident showed the inspector their new tattoo and explained how they were supported to keep it clean while it healed.



Since completing training in human rights, the person in charge had successfully challenged an archaic practice banning alcohol in the centre. This meant that residents who liked a glass of wine with their dinner, were able to do so.

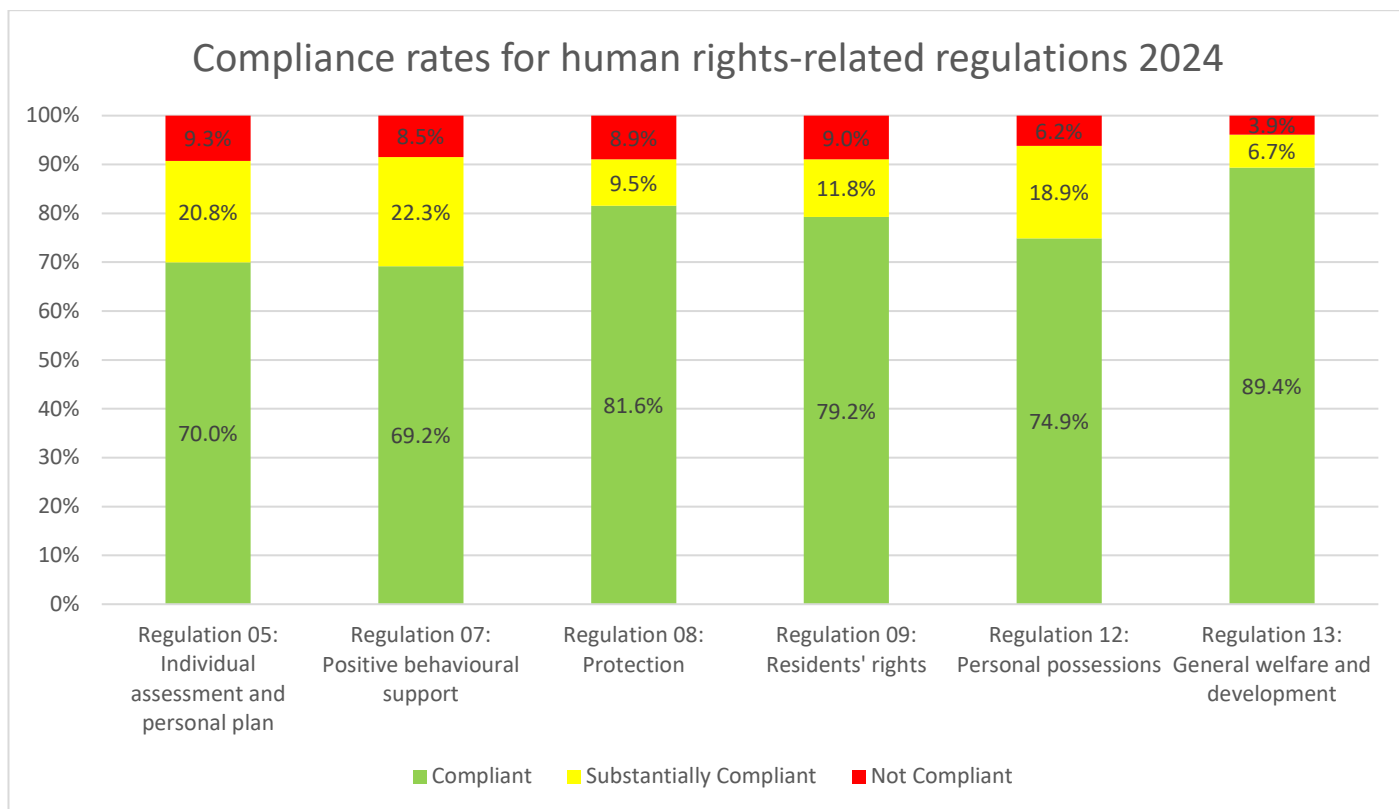


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### 3.1 Rights-based regulations

While all of the regulations in some way uphold the rights of people with disabilities in designated centres, *Figure 8* below highlights six which were identified in 2024 as regulations directly impacting on the rights of residents and which provide an indication of the extent to which the human rights of people with disabilities are upheld.

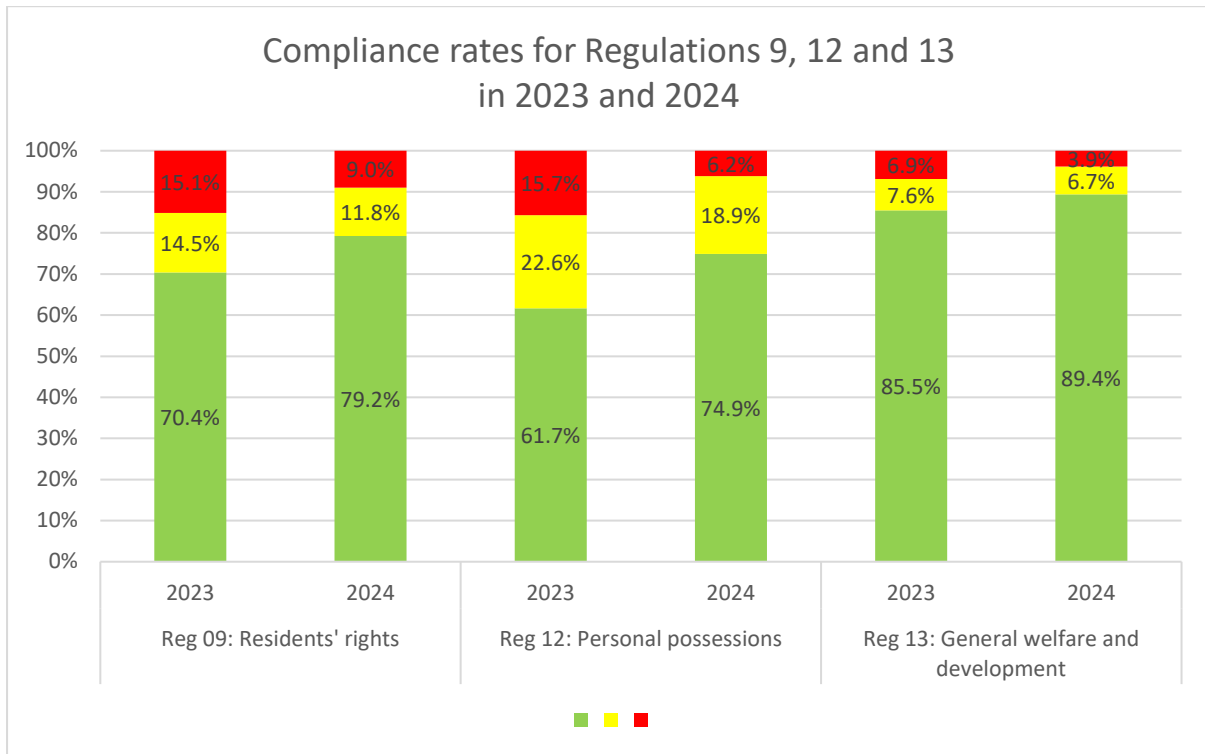
**Figure 8: Compliance rates for human rights-related regulations**



### 3.2 In Summary

Inspectors found an improvement in compliance levels for all six regulations with significant improvements in Regulation 9: Resident’s rights, Regulation 12: Personal possessions and Regulation 13: General welfare and development as shown in *Figure 9* below. This shows that the renewed focus on human rights by providers and their staff have brought about significantly better outcomes for residents. This also indicates that the increased provision of human rights training for staff as outlined in the opening section of this chapter is having a positive impact for residents.

**Figure 9: Compliance rates for Regulations 9, 12 and 13 in 2023 and 2024**



# Chapter 4: Engagement, and communication, with residents and providers

## 4.1 What residents told us

As a regulator, we continue to conduct the inspection process in a way that protects residents living in designated centres, upholds their rights and ensures their safety and the standard of care and support which they receive in their home.

When on inspection, we meet with residents in their home and listen to their feedback. We also gather their views through a [residents' survey](#), which is sent to them prior to announced inspections. The survey is also available on HIQA's website and we welcome completed surveys at any time from residents.

Residents told us they would like more opportunities to speak with us outside of the inspection process and over the past few years we have actioned this by meeting residents in a place of preference to them.

Resident forum meetings allow us to meet with residents outside of the formal inspection process, in a setting that they feel comfortable with. These residents' forums provided an environment where they could speak openly, share their lived experience and offer feedback on the inspection process.

In 2024, we held 13 face-to-face residents' forums across the country, with 103 residents participating from centres operated by 13 different service providers.

These residents shared their thoughts about what HIQA does and HIQA's inspections in their homes. The key themes which emerged from the forums included that residents wanted more involvement and interaction during the inspection process.

Residents told us they felt HIQA's role was to support them and check they were safe, listening to their views, and ensuring the care provided to them and all aspects of the designated centre was up to standard. Most residents were positive about the inspection process, especially when inspectors took the time to sit and chat with them. They explained that they would prefer inspections to be relaxed and not too formal.

Following the inspection, some of the residents said they had access to the inspection reports, either at their home or were given a copy, and that these reports were discussed with them.

However, a large number of residents said that they did not readily have access to inspection reports. Residents agreed it was important to see the inspection report to find out what said about their homes and wanted the reports shared with them.

Where residents had access to the inspection report, some residents said they did not understand the report and told us that they would like more easy-to-read inspection reports or alternative formats available. As a result, we are exploring ways in which we can provide information from our reports in a more accessible way for residents. We also publish reports on our resident forum engagement and the 2024 report is now available [Resident Forums Report 2024 | HIQA](#). Additionally and in line with providing reports in a more accessible way, the 2024 resident forums report is also available as a video with Irish Sign Language (ISL) translation which is available [here](#).

Residents spoke positively about the residents' forum itself. They valued the opportunity to engage with inspectors outside the formal inspection process and in a setting that was not their home. They appreciated having a space to share their views, discuss their rights and provide feedback on their lived experiences. *Appendix 3* provides an infographic capturing the feedback from residents.

The insights gained from these forums have been invaluable and will play a key role in shaping future inspections, particularly, in how we conduct inspections with and for residents. This approach aligns with our commitment to a human rights-based approach, ensuring residents' voices remain at the heart of our work.

For instance, following feedback from a residents' forum meeting held in 2024, we have published [Your Guide to HIQA Inspections in Disability Services](#), for residents. This guide helps to explain how HIQA inspections work and it contains a step-by-step process of what happens when a HIQA inspector visits, and uses easy-to-read language. A copy of the guide will be included for residents in our announced inspection information pack, and it is also available on our website. This guide is also available as a video version with ISL translation.

Our aim is to promote greater accessibility to information about our work for residents in an easy-to-understand format using simple language and different formats.

In December, staff gathered at our offices in Cork, Dublin, and Galway to celebrate International Day of Persons with Disabilities. Residents from HSE (Dublin) Southside Intellectual Disability Services presented a screening of "We Will Not Sit Down and Be Quiet," a powerful video created by and featuring the residents which showcased their insights and challenges regarding unconscious bias against individuals with disabilities.



*Pictured above: HIQA CEO Angela Fitzgerald (far left) and Chief Inspector Designate Finbarr Colfer (far right) with Deirdre, Theresa and Ronan, residents of HSE (Dublin) Southside Intellectual Disability Services.*

We continue to enhance our visibility, communicate our activities, and seek opportunities to promote awareness and understanding of our work.

#### 4.2 Stakeholder engagement

In 2024, our engagement with external stakeholders included a series of meetings, collaborative initiatives, webinar and publications aimed at further developing meaningful relationships.

Our successful external collaborations included meetings with national organisations and advocacy groups, which improved our communication channels and strengthened our relationships, leading to more impactful engagement.

In March 2024, we organised an in-person provider seminar titled “Exploring the Importance and Value of the Relationship between Boards and Executive Management Teams: A Collaborative Learning Event”, aimed at CEOs and board chairs. This seminar was developed in collaboration with provider representative organisations through a Planning & Implementation group, ensuring the content was relevant and engaging and embodied the essence of the Partnership Principles<sup>11</sup>. The agenda included workshops on Leadership, Ethics and Culture, Internal Compliance & Accountability, as well as discussions on the evolving landscape of governance practices in the sector. The event featured a keynote address by then Minister for Disabilities Anne Rabbitte, who engaged with participants and addressed

<sup>11</sup> [Partnership Principles](#)

their feedback during discussions. Further details of this event can be found in the [Disability Services Provider Engagement Seminar - Summary Output Paper](#).

In September, we hosted a provider webinar entitled "[The Value and Impact of Human Rights Training for Residents](#)," which attracted 677 attendees. This high turnout and the numerous follow-up questions demonstrated providers' strong interest and active participation in the topic of human rights.

Regarding our national provider engagement, we conducted 15 meetings with providers outside of our inspection activity. These meetings were highly effective for information sharing, providing valuable opportunities for both providers and regional teams to exchange relevant information.

To complement the ongoing provider engagement meetings described earlier in this report, we also held five provider representative forums during the year with representatives from the Disability Federation of Ireland, the National Disability Services Association, National Federation of Voluntary Service Providers and the HSE. This creates a communication channel with the disability sector provider representatives and the office of the chief inspector offering an opportunity for feedback and meaningful engagement.

Through our meetings with HSE and the Department of Children, Disability and Equality, we are fostering a cohesive approach and shared understanding in addressing key issues within the disability sector. Likewise, we have cultivated partnerships with Inclusion Ireland and the National Advocacy Service and provided forums to address mutual topics of interest ensuring targeted responsiveness to the unique needs of advocacy organisations within the disability sector.

### 4.3 In Summary

We will continue to build on and explore new ways to engage with our key stakeholders to help and to seek their views on how we work and what is important to them. The views of residents are very important to us and inform how we do our work. We continue to hear from residents through the inspection process and through the feedback provided through residents' questionnaires, which are issued prior to announced inspections.

Given the value of these residents' forums, we will continue them into 2025, to ensure we continue to have meaningful engagement with residents and can make improvements in how we do our work.

We would like to sincerely thank all of the residents who took part and shared their valuable feedback, which has informed our work and will help us to improve our approach going forward.

## Chapter 5: Feedback about designated centres for people with a disability

The Chief Inspector welcomes feedback about people's experiences of services to inform the assessment of the quality of care received within designated centres for people with a disability. This information is referred to as unsolicited information (UROI) and can be received from residents, their family members or advocates, health and social care professionals, employees and the general public.

While the Chief Inspector has no legal remit to investigate an individual complaint about care under the Health Act 2007, as amended, we use this information to monitor the quality and safety of care. All information received is reviewed and risk rated and used alongside the other information gathered about a service to inform regulatory judgments.

This section of the report provides a summary of all unsolicited information the Chief Inspector received in 2024 about designated centres for people with a disability. It also sets out how the Chief Inspector used this information to inform our work.

During 2024 the Chief Inspector received 348 pieces of feedback in relation to designated centres for people with disabilities. This was a 6% increase on the 327 pieces of feedback received in 2023. When the number of designated centres for people with disabilities and how many people are living in this type of setting is considered, HIQA only hears about a small proportion of these centres. Of the 1,649 registered designated centres for people with disabilities, HIQA received feedback about 230 (14%) of these centres throughout 2024.

### 5.1 Who contacted us?

The majority of people who contacted the Chief Inspector about disability residential services were employees of designated centres accounting for 165 pieces of information (47.5%). Of the 348 pieces of information received, a further 18 (5%) were received from service users and 95 (27.5%) were from relatives. HIQA also received 70 (20%) pieces of information from 'others' including members of the public, advocates and health and social care professionals.

### 5.2 Regulatory management of unsolicited information

All unsolicited information received is acknowledged and logged by HIQA's Information Handling Centre and examined by inspectors of social services. The information is reviewed by an inspector to establish if the information received indicates a risk to the safety, effectiveness, and management of the service, and the

day-to-day care and support that residents receive. Unsolicited information allows the Chief Inspector to use the information of concern to examine:

- if services continue to meet high standards of care and support for residents
- how well providers handle complaints and use them as opportunities to improve care and support for residents
- any trends or patterns that could indicate that something unacceptable is happening in a service
- inform assessment of compliance with regulations and standards.

Depending on this assessed risk of the information received, the inspector will decide on the most appropriate action to take. The inspector's decisions will be proportionate to the assessed risk. Some information received may require no action, while in other cases, inspectors will need assurance that the risk is being appropriately managed by the provider. In addition where the information indicates that people may be at immediate risk, the Chief Inspector will use its full legal powers and report the incident, where appropriate, to An Garda Síochána, the Child and Family Agency (Tulsa) or the HSE's Adult Safeguarding Team. Figure 5 in *Appendix 4* shows the initial regulatory risk rating of unsolicited information received in 2024.

### 5.3 Regulatory action

Inspectors have a variety of regulatory actions that they can take in response to feedback received. This is informed by their regulatory intelligence about a centre which would include other feedback received, solicited information including statutory monitoring and registration notifications and the regulatory compliance history of the centre.

The regulatory actions available to the inspector include using the information to inform lines of enquiry for the next scheduled inspection of the centre, seeking an updated compliance plan, seeking a provider assurance report or triggering a risk inspection.

Of the 348 pieces of feedback received during 2024, 136 (39%) pieces of feedback were used to inform the ongoing regulation and monitoring of the respective centre and considered as lines of enquiry at the next inspection. A further 69 (20%) contained similar information to a previous piece of feedback or solicited information received. Here, inspectors reviewed the information, assessed the regulatory risk rating and then closed this piece of feedback as they were following the information up under the initial piece of information received. Of the remaining 143 (41%), inspectors sought provider assurances for 122 of these and both the feedback and the assurances provided would be then used to inform lines of enquiry at the next

inspection. An additional 21 pieces of information resulted in inspectors undertaking a risk inspection of the centre.

#### 5.4 In Summary

The Chief Inspector welcomes and encourages members of the public to contact the Information Handling Centre helpdesk when they have feedback about the support and care provided to people with disabilities living in designated centres. This is valuable information which informs inspectors about what it is like to live in a designated centre.

If you would like to give feedback or raise a concern about the care or support in a health or social care service, you can contact us at:

**Phone:** 021 240 9646

**Email:** [concerns@hiqa.ie](mailto:concerns@hiqa.ie)

**Website:** [Report a Concern or Give Feedback](#)

[| HIQA](#)

## 6. Looking forward

There are a number of current and future challenges in the disability sector which impacts on the people operating or working in services, those accessing or using services, and on HIQA and the Chief Inspector as the regulator.

### 6.1 Legislation and regulatory reform

The Health (Miscellaneous Provisions) (No. 2) Act 2024 was signed into law on 17 July 2024 and commenced on 23 September 2024. It amended the Health Act 2007 to amend and add new powers for the Chief Inspector of Social Services. These changes included:

- Changes to allow the Chief Inspector to remove a condition of registration, and reduced time frames within which registration decisions will take effect.
- Extending the powers of inspection to premises which are not registered

There are other areas where we believe regulatory reform is needed. We recognise the importance of ongoing review of the regulatory framework to ensure that it is fit for purpose. As with previous years, we have engaged in discussions with the then Department of Children, Equality, Disability, Integration and Youth in reviewing potential areas for reform. One such area which is discussed earlier in the report is the introduction of provisions to allow providers to respond to need for emergency accommodation for people with disabilities who are in crisis.

We have had and continue to have constructive and positive discussions with the Department of Health and the Department of Children, Disability and Equality on such areas as proposals around the protection of liberty of residents, proposed safeguarding legislation and enhancing a human rights-based approach within the regulatory framework.

### 6.2 Challenges in sector

As the Chapter on 'Setting the Scene' of this report sets out, there is ongoing growth in the sector with the number of designated centres for people with disabilities forecast to grow to over 2,000 in the next five years.

As the regulator, we must remain agile and adapt to register new centres quickly to ensure that the sector can meet this need and respond to residents' changing needs.

Through our engagement with providers over the past number of years, they have told us about particular challenges that they are experiencing which include those relating to the rising costs of service delivery, staff recruitment and retention and the

impact that shortage of appropriate housing is having on their ability to respond to the needs of people with disabilities.

While we recognise these challenges for providers, as a regulator we must continue to give consideration to the quality of support and care for residents and whether providers are meeting the minimum standards of service set out in the regulatory requirements.

### 6.3 Stakeholder engagement

Going forward, HIQA and the Chief Inspector are committed to maintaining effective stakeholder engagement with providers, management, staff and residents in services.

As set out in Chapter 4, these engagements are a valuable tool to inform our work and allow us to share learning.

In 2025, we are committed to actioning the feedback we received from residents through the Resident Forums. To ensure greater accessibility for residents, we will develop information about our role in various formats for people using services. These will include through leaflets, videos (including Irish Sign Language and Lámh videos), and easy-to-read materials. We will work with the Residents' Forums to make our inspection reports more accessible for them as well, so that residents can get information about their home that they can understand.

We will build on the momentum from the Resident Forums into 2025 and continue to meet with them and hear their views.

In 2025, we will engage with and meet persons in charge and persons participating in the management of centres across the country to sustain the focus on good governance and its impact in services. We will also continue to hold webinars where needed to share information with the sector.

Furthermore, we will continue to meet with the Provider Representative Forum as we have since the commencement of regulation, as it is a valuable forum for open communication and feedback.

### 6.4 Conclusion

Looking ahead over the next few years, HIQA is committed to continuing its human rights-based approach, as embedded as a core value of the organisation. We will engage with all relevant stakeholders on the areas of regulatory reform and evolving legislation, as well as the challenges and opportunities being faced by the sector.

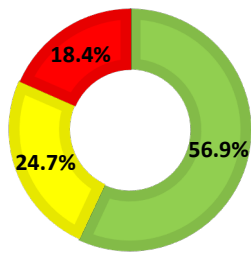
We will build on our engagement with the sector to share learning and drive improvement, and to further the development and promotion of accessible information for residents.



# Appendix 1: Comparison of overall compliance in congregated settings and community settings 2024

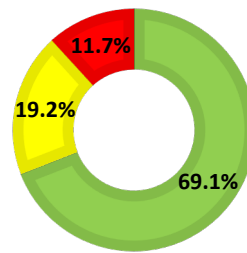
**2023 OVERALL COMPLIANCE-  
CONGREGATED SETTINGS**

■ Compliant ■ Substantially Compliant ■ Not Compliant



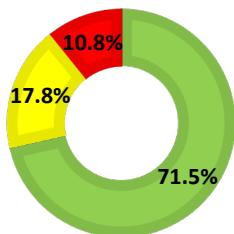
**2024 OVERALL COMPLIANCE-  
CONGREGATED SETTINGS**

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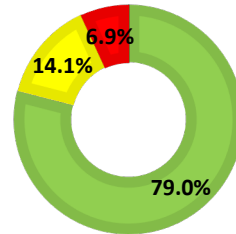
**2023 OVERALL COMPLIANCE-  
COMMUNITY SETTINGS**

■ Compliant ■ Substantially Compliant ■ Not Compliant

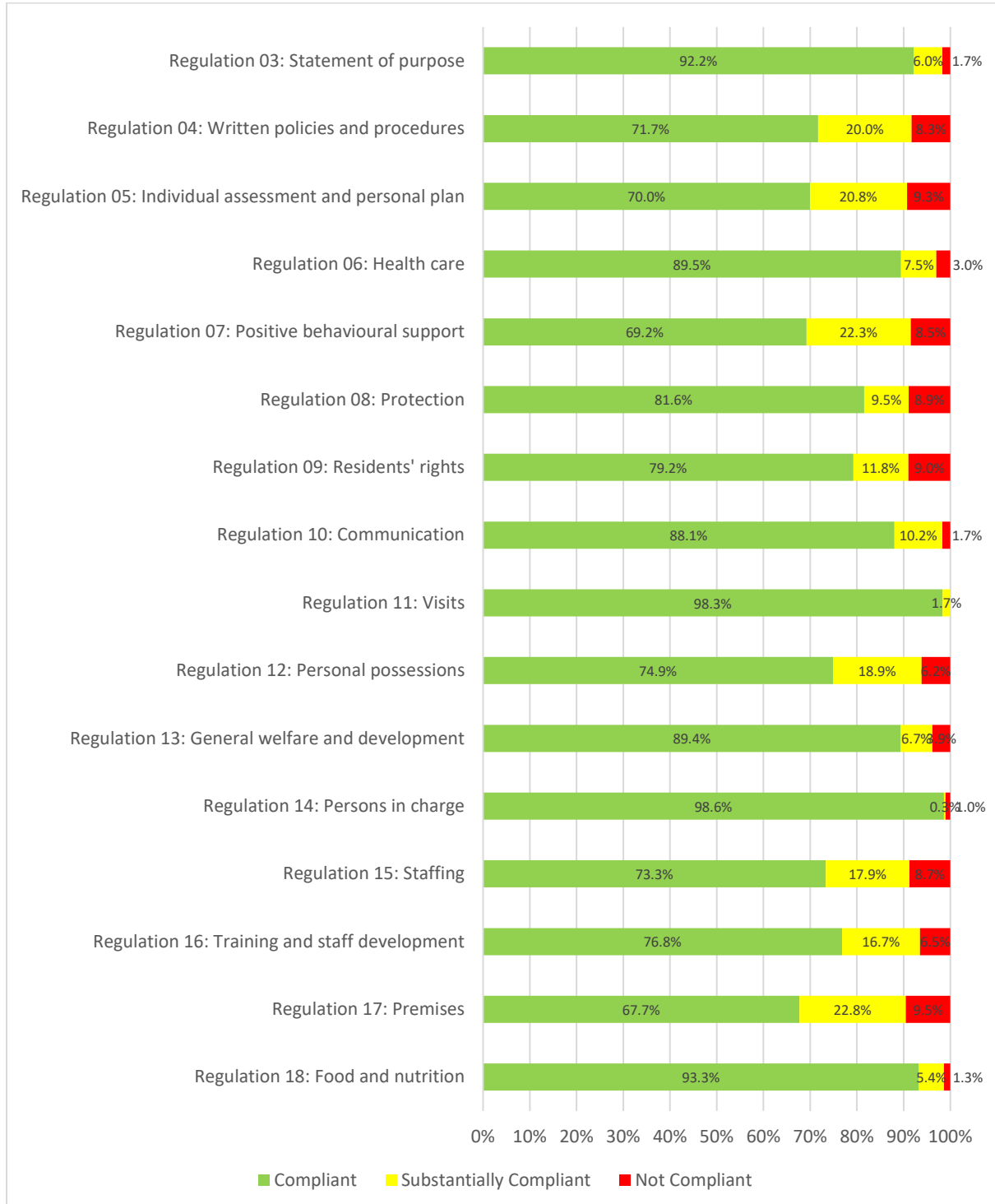


**2024 OVERALL COMPLIANCE-  
COMMUNITY SETTINGS**

■ Compliant ■ Substantially Compliant ■ Not Compliant



## Appendix 2: Breakdown of overall compliance for each regulation in 2024



## Breakdown of overall compliance for each regulation in 2024 (Continued)



## Appendix 3: Resident Forums 2024



### Topics discussed

included:



### What residents told us:



## Appendix 4: Summary of feedback received in 2024 about designated centres for people with a disability

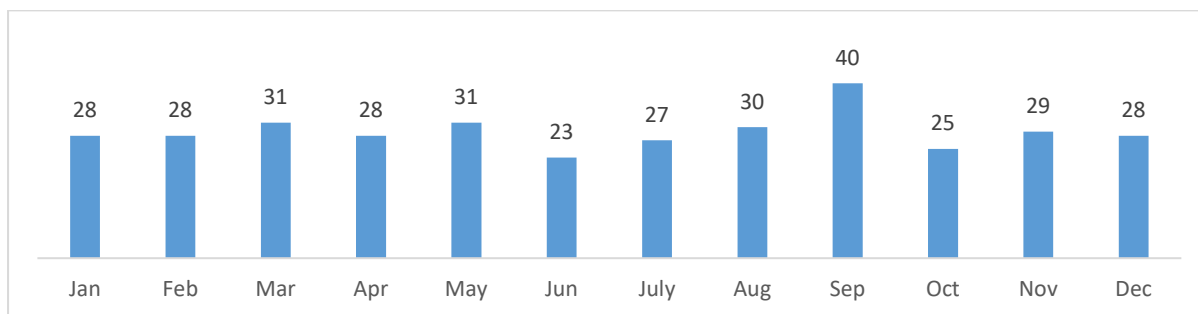


Figure 1: Comparison of number of UROIs received per month in 2024 about designated centres for people with a disability

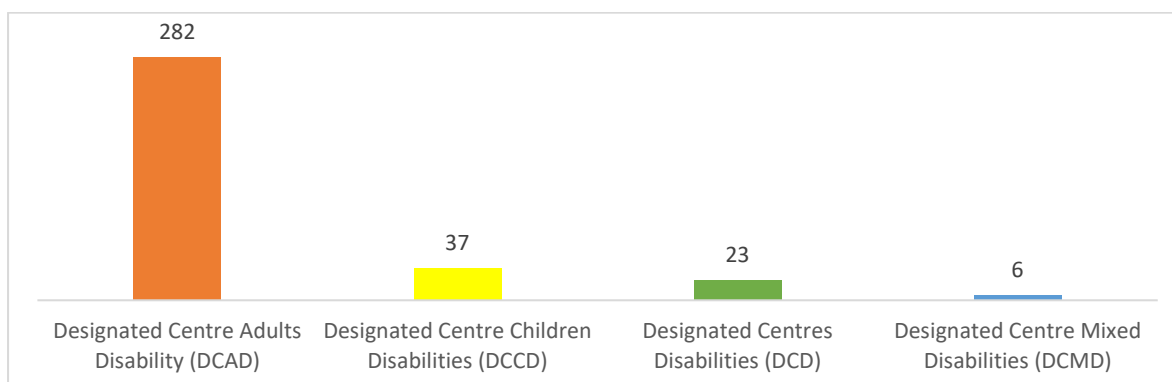


Figure 2: UROIs received by service type for designated centres for people with a disability in 2024

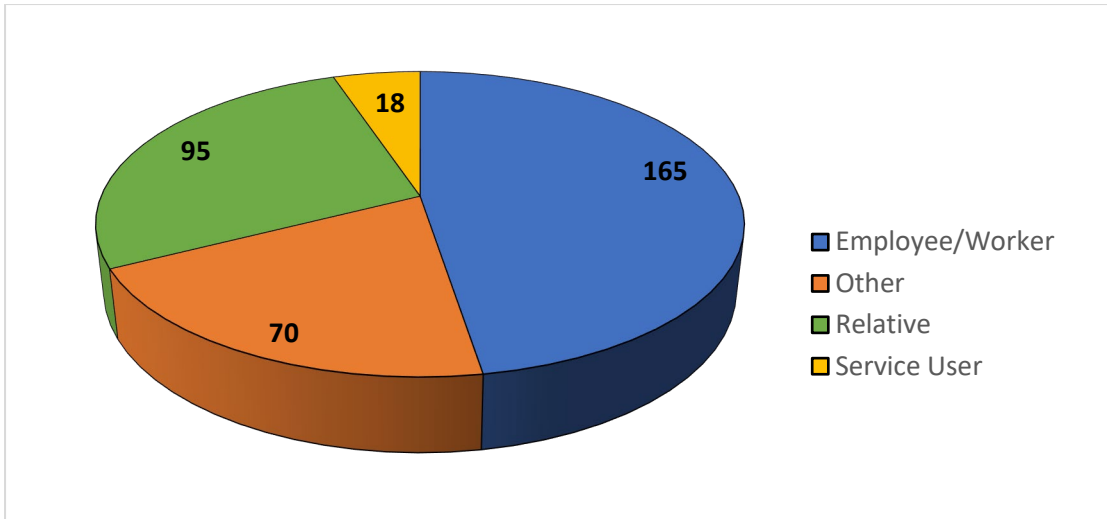


Figure 3: Contact person for designated centres for people with a disability UROIs in 2024

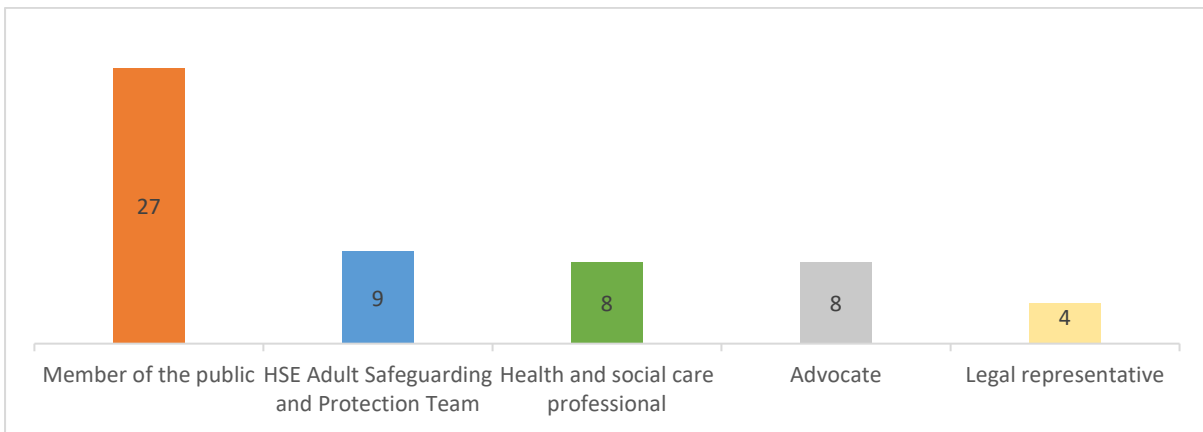


Figure 4: Most frequent 'other' contact persons for DCD UROI in 2024

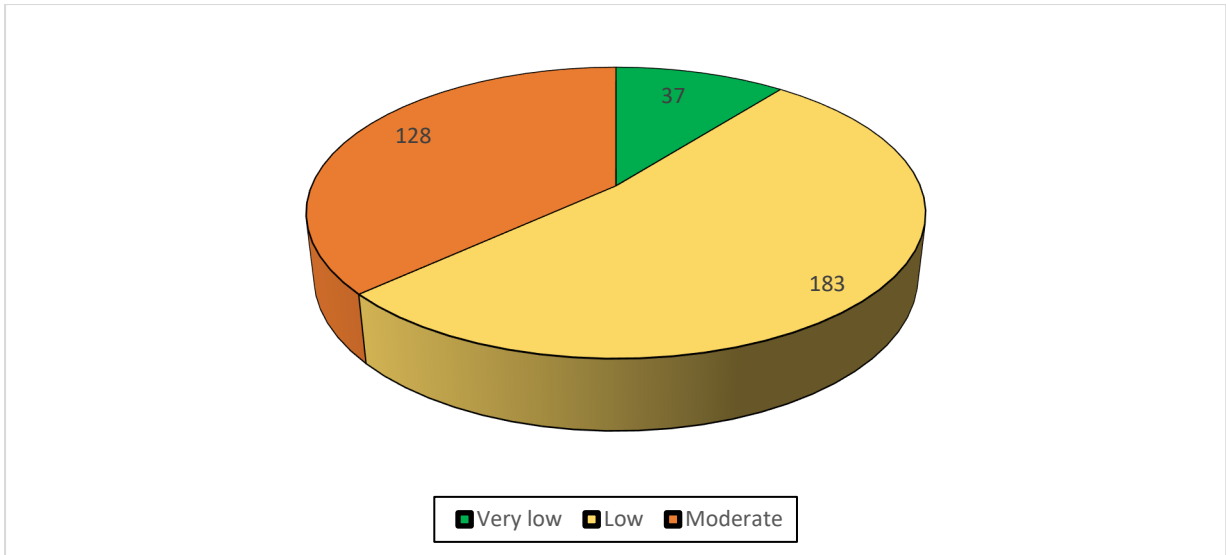


Figure 5: Initial regulatory risk rating of DCD's UROIs received in 2024



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