INCLUSION IRELAND

National Association for People with an Intellectual Disability

The Distant Voice

A working paper on the first 50 Health Information and Quality Authority (Hiqa) inspections of residential services for people with disabilities

Prepared for

Inclusion Ireland

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Explanation of Terms

HIQA	Health Information and Quality Authority which regulates social services under the 2007 Health Act.
Medical model of disability	A way of thinking about people with disabilities which focuses on impairment and the impairment is seen as the problem.
Social model of disability	A way of thinking about disability which looks at the interactions between individuals and their physical and social environments.
Designated centre	A single house or group of homes which have registered as residential services for people with disabilities since 2013.
Outcomes	Different areas which impact on people's lives.
Regulatory regime	An independent system of registration, inspection and enforcement of standards.
Congregated settings	Large institutions where 10 or more people live together.
Collective reporting	Inspection reports which group several homes together in one report.
Independent advocacy	Defenders of rights acting solely on their clients behalf with no conflict of interests.

Compliant	Has achieved a standard according to rules or regulations.
Non-Compliant	Has not reached a standard in a small or larger or serious way.
Regulations	A way of implementing a law like the 2007 Health Act.
Care Quality Commission	Independent regulator for adult residential services in England (CQC).
Community Group Home	Individual houses – the homes of people with disability – outside of institutions and for which residents pay a rent and housekeeping contribution.

Inclusion Ireland

Inclusion Ireland is a national rights-based advocacy organisation that works to promote the rights of people with an intellectual disability.

Inclusion Ireland uses the Convention on the Rights of Person with Disabilities (CRPD) as the prism through which it conducts its work.

The CRPD is important because it provides the framework to ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities.

Article 12, which guarantees the right of people with a disability to participate to the fullest extent possible in decisions which concern them and to the assistance to enable them to do so, is particularly relevant.

In this context and in collaboration with the HSE, who is our primary funder, Inclusion Ireland carries out the following work:

- Communicates the HSE reform programme to people with a disability and their family members.

- Provides advice and information on disability services; appropriate individual and community-based services; social welfare; education; age-related disability issues; health and well-being; legal and policy; and advocacy issues.

- Supports and builds the participation of people with an intellectual disability, parents and family members in HSE and other representative policy structures.

- Provides and supports a broad-spectrum of advocacy.

- Represents its work and knowledge on various HSE and other policy fora.

- Promotes and advocates for best-practice service provision and partnership between service providers and people with a disability and their family members where appropriate.

- Monitors the development of disability legislation and policy.

- Inclusion Ireland is also funded to deliver project-based activity for other statutory and non-statutory agencies.

Main Findings

Voice of the individual with a disability is distant

Inspection reports in this study found that the voices or words of the resident with a disability were faint or absent entirely from reporting; they appear as objects of an inspection regime rather than citizens with entitlements and rights.

Some 89% of residents were excluded from inspection of their communication needs. Without supports to their communication, the residents with disabilities are without their own individual voice and without expression of their preferences and wishes.

There were few examples of independent advocacy, which gives people a voice to articulate their needs and concerns in order that others may listen to them.

The Aras Attracta abuse revelations in 2014 brings renewed focus to the value and importance of independent advocacy and self-advocacy services in safeguarding residents in their own homes. People with disabilities need to be around the table when decisions are being made and should know how to make complaints.[1]

Comprehensive inspection

In those areas of living concerning dignity and welfare, the majority of residents did not experience inspection. Inspections were generally partial as illustrated in Table 1 below. Contrary to the public belief that all standards and outcomes are inspected, we found little evidence of comprehensive inspection.

[1] Self advocate at Inclusion Ireland workshop 2014.

The medical model of disability

The challenge to service organisations is to devise supports and inputs for persons with disabilities which will lead to the experience of universally valuable outcomes.

These include having and growing in relationships; opportunities to be a contributing citizen; having authentic choices to make; having the dignity of valued social roles; and sharing in typical community places and activities. Such person-centred values and practices, when used in combination with other best practices, play a pivotal role in putting the human back into the centre of human services.[2]

The absence of inspection into such quality of life outcomes and the silence of the resident voice underpin an inspecting and reporting model heavily biased towards the medical model of disability.

The principles of person-centredness, articulated by both the regulations and the national standards, have not been meaningfully interrogated nor applied in this first round of Hiqa inspections. In the minority of inspections non-compliance was high.

[2] Thomas Golden, University of Cornell, Center for Disability and Employment, New York.

Table 1: Quality of life outcomes: % of centres inspected low inspection rates – high non-compliance

Regulation Number	Area of inspection	% Centres Inspected	Of those examined =	% Centre's non-compliance	% Centre's compliance
Outcome 1	Rights Dignity Consultation	17%		16.5	0.5
Outcome 2	Communication	11%		6	5
Outcome 3	Family and relationships	12%		3	9
Outcome 4	Admissions and Contracts	30%		29	1.0
Outcome 6	Safe/Suitable premises	29%		25	4
Outcome 9	Notification of incidents	17%		2	15
Outcome10	Welfare and development	11%		7	4

n=50

Risk assessment outcomes received high inspection rates but equally high non-compliance rates, indicating a medical model.

Risk assessment outcomes: high inspection rates – high non-compliance

Regulation Number	Area of Inspection	% Centres Inspected	Of those examined =	% Centres non-compliance	% Centre's compliance
Outcome 5	Social care needs	100%		86	13
Outcome 7	Health and Safety Risk Management	95%		94	1
Outcome 8	Safeguarding/ Safety	100%		82	18
Outcome 11	Healthcare Needs	70%		48	22
Outcome 12	Medication Management	61%		49	11

n=50

Designated centres, announced inspections and accuracy of reporting

For the purposes of Hiqa inspections, a designated centre describes the unit of inspection. This can mean a single house, a campus of houses or houses located in different neighbourhoods.

Regardless of the composition of the centre, inspection outcomes are published in a single report. Significant problems arise in the presentation of inspection findings for multiple units under the umbrella of a single report.

This manifests in what this report is referring to as collective inspections and reports. The issues that collective reporting has raised not only compromise the integrity of the reporting processes but fundamentally undermine the concept of person-centred inspections.

Collective inspections – collective reporting

- The inspection process in many instances was reported as collective inspections. This may be leading to an averaging of appraisal grades.
- Some collective inspections were partial – not all units were examined; some were omitted.
- It is not clear how many residents were included and how many fell below the inspection radar. Where, for example, an Inspection covers two out of five units, it is not possible to know which units/residents are included in the inspection.
- Partial inspections may be complicit with concealment of abusive care practices in unexamined units.
- It is not possible to identify which of the units under collective inspections were in compliance or not with the Regulations

- The accuracy of reporting is called into question, which may be a consequence of collective reporting. Casual report review practices by HIQA failed to identify a substantial number of errors, omissions and inconsistencies.
- The interchangeable and ambiguous of the term centre throughout compounds the interpretation difficulties for the public readership.
- A majority of inspections were announced, contrary to Hiqa's own guidelines.

Executive Summary

'The Distant Voice' is an analysis of the first 50 Hiqa inspection reports carried out on residential services for over 700 people with disabilities across Ireland during 2014. Focussing on quality of life, the analysis examines 12 of the 18 headings under which inspections are made.

The analysis found that more than half the inspection reports were of designated centres composed of two or more living places. It was not possible to identify which of the units inspected were in compliance or not with the regulations.

In many instances, the inspection process was reported as a collective or 'congregated inspection' which may be leading to an averaging out of the appraisal grades.

The majority of the 50 reports were partial inspections and were not comprehensive. They examined some - but not all - of the headings under which inspections might take place.

The areas most frequently ignored were those touching on quality of life for residents as such the inspection process was not inspired by a social model of disability.

The voice of the resident was extremely faint or silent in the inspection reports. There were few, if any, quotes from residents and scant references to comments by families or on completion of Hiqa questionnaires.

The inspection reports present a picture of extensive non-compliance with regulations in areas such as health and safety, independent advocacy, restrictive practices and correct checking of medicines.

The analysis argues that some non-compliant practices judged as moderately non-compliant by inspectors were, in fact, seriously non-compliant.

A significant issue with wide ramifications was whether residents could choose with whom they wished to live in community residences. Inspection reports provided evidence that living arrangements were sometimes bordering on the abusive.

Staffing arrangements were outside of the scope of this paper. But the adequacy of staffing arrangements – reflected in many of the outcomes under review – were called into question in 23 centres.[3]

Shortages were identified in some settings as impeding residents' community integration. This flags once again a model of service-centred rather than person-centred provision.

'The Distant Voice' presents some perspectives for the future including a review of the adequacy of staffing levels of services.

[3] Rpts 3193, 3230, 8089, 8561, 8582, 11102, 11174, 11216, 11221, 11293, 11297, 11414, 11463, 11464, 11478, 11481, 11512, 11520, 11607, 11854, 11870)

Chapter 1

Introduction

This report was commissioned by Inclusion Ireland as part of their ongoing commitment to the improvement of services to and with people with intellectual disabilities and their families.

Inclusion Ireland had long favoured a robust regulatory framework for residential services for reasons of public accountability, to bring transparency to a somewhat hidden segment of Irish social services and to improve the standard of care provided to residents and residents within a framework of rights.

The Regulatory Framework for residential centres providing services to people with disabilities was a long time in gestation. It was first raised in 1927 when a Report to the then Saorstát Éireann recommended that:

'Approved institutions for mental defectives should be visited and reported on by the Inspector of Mental Hospitals … The Minister should be empowered to make regulations as to the good management of such institutions.' [4]

It was not until 2013, some 84 years later, that a framework for the regulation of residential services for individuals with intellectual disabilities was finally enacted in law and commenced.

Inclusion Ireland was the first organisation to focus on the need for Standards since the majority of children and adults with disabilities were living in large institutions or psychiatric hospitals.

[4] Saorstát Éireann (1927*) Report on the Relief of the Sick and Destitute including the Insane Poor*, Stationary Office, p.111 § 446 and p.132 Section L, Recommendation 11.

Annie Ryan's book 'Walls of Silence' was published in 1998 amidst the start of a campaign by Inclusion Ireland to move persons with intellectual disabilities out of psychiatric hospitals.[5]

The campaign to establish standards in residential centres went through several phases, which involved the National Disability Authority's first Draft Standards. After 2007 the new regulatory authority HIQA undertook consultations and published its own Standards for adults in 2009.

These were initially to be voluntary – a feature opposed by Inclusion Ireland who demanded a robust and independent Inspection regime. In 2011 a new version of the Standards for adults and children together, were researched by HIQA and published in spring 2013 and came into operation in winter 2013.

This report had a question to ask as the Regulatory process unfolded in 2013 and 2014. The question was what do we now know about residential services for people with disabilities and the standards attained in service provision? Inclusion Ireland looked to HIQA's own publications in seeking an answer to this question.

The public are informed of the results of regulatory monitoring through the publication of reports of Inspection of Designated Centres by HIQA. These published inspections are the subject of the analysis which follows.

The analysis is based on the first 50 Inspection reports published by HIQA during 2014. There are 18 headings under which inspections take place.

[5] Annie Ryan (1999) *Walls of Silence – Ireland's Policy towards People with an Mental Disability*, Red Lion Press, Callan, Ireland.

The analysis focuses on twelve headings or outcomes that have the most immediate and direct bearing on the lives of individuals with disabilities: respect for dignity, communications, participation and exercising choice.

A cursory look at other subsequent Inspection Reports upholds the findings in this review.

Chapter 2

Communications: The Distant Voice of Residents and Access to Independent Advocacy

The communication needs of residents are served by both the Regulations and the National Standards. These ensure that residents have a voice in determining positive outcomes in their everyday lives including access to independent advocacy services. Service providers are bound to consult with residents in supporting optimum outcomes. HIQA, are bound to monitor compliance in this area and in the course engage equally, in a consultative process with residents. The report found that:

Under Outcome 2 the Communications needs of 89% of residents were not examined.

In addition, the degree to which HIQA meaningfully consulted with residents is not evident. In light of this, generically reported levels of resident and or family satisfaction must be treated with caution.

This echoes research conducted in Ireland documenting the perspectives of people with intellectual disabilities and their families towards residential living arrangements. Overall, findings similarly reflect on lack of consultation and feelings of disempowerment.[6]

[6] From Congregated to Community Living: Moving Ahead. Living Arrangement Options for People with Intellectual Disability: A Scoping Review. Trinity College Dublin 2014. p.27.

Case Study

Inclusion Ireland in 2013 organised a training project for a group of self advocates with intellectual disabilities, or Experts by Experience, to facilitate countrywide, residents' workshops on the National Quality Standards. Key findings of the evaluation report identified that a range of residents' concerns were amplified as a direct result of this engagement process. This presents HIQA with the opportunity to review their commitment to resident communication.

HIQA in accordance with their own inspection guidelines[7], distribute resident/relative questionnaires to service providers in advance of an announced inspection. This is an important element of the process as it provides the opportunity for residents to anonymously evaluate their service.

However, it is difficult to establish if distributional and reporting practices are standard or discretionary,[8] and whether in fact HIQA are implementing their own guidelines and actively seeking resident input in the monitoring process. It is questionable whether questionnaires are suitable for obtaining the views of families and residents.

Of the 50 reports examined, just two reference completed questionnaires

Apart from formal questionnaires, reports across the range confirm that residents and some relatives when spoken with during the course of the

[7] *Guidance for Designated Centres – The Inspection Process.* Health Information Quality Authority

[8] This may be due to the inaccessibly formatted design of the questionnaire and absence of Plain English/Easy to read. See Appendix 1

inspection were happy with their service and said they felt safe. They could be safe but they could also be bored, depressed and lonely.

A minority of reports give more specific feedback from residents in relation to outcomes under inspection.

It is difficult for parents, family members and the public to judge that if standards are being met, that residents are experiencing and vouching for their impact in successful outcomes. In fact, the opposite is the case. There are findings of high levels of non-compliance across all Outcomes resounding to a near residents' silence:

There are no direct quotations, no firsthand accounts. The resident's voice is distant.

There are a number of possible reasons for this:

- They may not be uniformly sought.
- The method of engagement may be inaccessible for some residents, for example a poorly crafted questionnaire.
- Inspection circumstances may not be conducive to resident feedback.
- Residents may be fearful that expressed concerns might impact negatively on their daily lives. In this sense; 'User participation initiatives require continual awareness of the context of power relations in which they are being conducted. Exclusionary structures, institutional practices and professional attitudes can still affect the extent to which service users can influence change'.[9]

[9] Carr, Sarah., SCIE Position Paper., 'Has Service user participation made a difference to social care services'., March 2004.

The UK Approach

The UK situation is useful in this context in addressing this very issue. In line with a revised national regulatory care framework, new learning and change implementation is embedded in the delivery of revised and improved inspection processes for adults in social care settings. This is what they say about new inspection partnerships which are currently operational:

> We use the experiences of people who receive care to help us build a picture of each care service. Whether it's positive or negative, we need to hear about it. They take part in our inspections and can observe care and speak to people receiving it. Experts by Experience also contribute to our inspector's report of the service. Experts by Experience also attend events, consultations and staff training events and take part in activities that develop our processes. [10]

Quality supports contribute to quality outcomes for persons with disabilities. Research indicates that people with more support needs will typically experience poorer outcomes than those with fewer support needs.

In this context residents' rights to independent advocacy services are paramount.

In the wake of the Aras Attracta abuse case, Inclusion Ireland has reiterated a call to the Minister for Social Protection for the establishment of the Personal Advocacy Service and the introduction of the Community Visitors Programme in 2015.

[10] http://www.cqc.org.uk/.

Independent Advocacy Services

There is no universal understanding of Advocacy. As a concept it is often broadly misconstrued and frequently misunderstood. The legal profession has its own view on advocacy.

There are different Advocacy models, but each one has an underlying principle of empowering others to speak for themselves and providing unbiased representation to excluded persons who are unable to speak for themselves.

For persons with disabilities living in residential settings, Independent advocacy services are the cornerstone of the transition to the community, providing: 'people with the means to make choices based on an awareness of possibilities rather than choice based on limited life experience, which is the reality for many citizens with disability.'[11]

Where required, independent advocacy services support the rights of people to have a greater say in decisions which affect them. Training and awareness for residents and families and staff on how to make complaints would be useful.

Hiqa's understanding of advocacy services assumes such services to be objective – in particular in residential settings for people with disabilities that they be independent of the service provider.

For a variety of reasons this is often not the case. Practically, the public sector recruitment embargo prohibits the recruitment of independent advocates and access to the National Advocacy Service is not automatic.

[11] "Time to move on from Congregated Settings. A Strategy for Community Inclusion". Report of the Working Group on Congregated Settings. Health Service Executive, June 2011.

It is needs assessed for those over 18 and is area/region specific dependent on the availability of an advocate.

The fallback response intentionally or unintentionally is that key workers are frequently referenced as 'advocates on behalf' of their clients. This should be distinguished from their role in 'advocating for' their key person, for example, in pursuit of their personal plan. Consequently, residents' rights to access **independent** advocacy services, in accordance with national standards and statutory regulations, remain unfulfilled.

The independence of advocacy services goes hand in hand with objective complaints processes. They are not mutually exclusive rather in accordance with one another and are central to ensuring the confidence of residents, family, friends and the public. Consequently, staff members/key workers are not and may not act as independent advocates for residents. This is now glaringly apparent following the Aras Attracta abuse revelations.

The Winterbourne Final Review Report in England notes that patients had limited access to advocacy and complaints were not dealt with.[12]

Consequently, access to independent advocacy services is a central plank of the new Care Act 2014 in the UK.[13]

Local Authorities, subject to certain criteria must provide independent advocacy services to people with disabilities. It is regrettable that capacity legislation has still not reached the Statute Book and been operationalised.

[12] http://www.gov.uk/government/uploads/system/uploads/attachment data/file/213215/final-report.pdf
[13] http://www.scie.org.uk/care-act-2014/advocacy-services/commissioning-independent-advocacy/duties/independent-advocacy-care-act.asp

Chapter 3

The Regulatory Framework

In increasingly de-regulated economies the importance of regulation of services consumed by the public take on added importance. This importance is now appreciated by many non-governmental organisations, representative bodies and residents. Ideally, a regulatory framework[14] would:

- Promote openness and transparency
- Act as a safety solution in particular for adverse events
- Improve the quality of regulated services
- Focus the work of regulatory bodies on residents and stimulate public accountability

The regulatory framework for residential services for adults and children with disabilities is to be found primarily in Acts of the Oireachtas and accompanying Regulations in the form of Statutory Instruments.

- Health Act 2007
- Health Act 2007 (Commencement) Order 2013 (S.I. No. 365 of 2013)
- Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (S.I. No. 367 of 2013)
- Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (S.I. No. 366 of 2013)

[14] Extracted from Health and Social Care Regulatory Forum, 2009.

There are now several areas of social and health care provision which are regulated by statute and national standards such as Children's Homes, Nursing Homes, preschool services and centres under the Mental Health Act.

Simultaneously the regulatory framework for professional care staff has expanded through CORU under the auspices of the Health and Social Care Professionals Act 2005 which will eventually encompass social care professionals.

Public and user engagement with the regulatory framework for residential services took the form of several rounds of consultations on draft standards. The first draft standards were published by the NDA in 2004. The finally approved Hiqa standards were then converted into Regulations which take the form of a statutory instrument in relation to the Health Act, 2007.[15]

Inspections of services take place primarily against the various articles of the 30 pages of the 2013 Regulations. This typical process of legislative reform has, however caused confusion among some user-oriented stakeholders who believe inspections are taking place in reference to the standards rather than the statutory regulations. The reference framework for service providers non-compliances are the regulations.

Action Plans do not reference the standards. There are now 8 Themes incorporating 18 outcomes, rather than 30 standards with 249 sub-standards.

[15] Inclusion Ireland wrote to the Minister for Health in 2012 querying the relationship between the Regulations and the Standards.

This is illustrated below:

No	Themes of Regulations	Outcomes
1.	Individualised supports and care	1,2 and 3
2.	Effective services	4,5,6 and 7
3.	Safe Services	8 and 9
4.	Health and Development	10,11 and 12
5.	Leadership, Governance and Management	13,14 and 15
6.	Use of resources	16
7.	Responsive workforce	17
8.	Use of information	18

There are additional standards also to be taken into account including standards for the care of older people, for the dispensing of medicines and for fire safety.

There are two main factors which contribute to the uniqueness of the regulatory Framework for residential services for persons with disabilities at this moment in time. The first is the absence of similarity in service provision spread across a multitude of distinct providers with a variety of ethos and some with a history dating back a hundred years or more.

The second unique factor is the regulation of an area undergoing considerable change in terms of the dismantling of large social institutions in favour of small group homes such as developed by the Brothers of Charity or the Daughters of Charity and alongside deliberative or intentional communities such as Camphill and L'Arche.

In this context, the first year of a Regulatory Framework may throw up anomalies, unexpected outcomes, or consequences, regulatory gaps and inconsistencies. These may require amendments to the regulatory framework or its application or both.

There were approximately 7, 850 adult persons availing of services in residential services in 2013.[16] About 16% (1,200+) are not covered by HIQA inspections in relation to disability because they are not living in what are, or will be, Designated Centres for disability services under the 2007 Act.

They are in Nursing Homes, Psychiatric Hospitals, or of no fixed abode or living in other places, and from which some will transfer into disability services.[17]

An additional number of identifiable persons – 2,200 – are awaiting or will require a placement in a residential service from 2014 onwards according to the Health Research Board (2014), so the pressure for places is high.

This can create a tension and tendency to understaffing in relation to offering person-centred services for individuals as well as complying with the demands of the new regulatory regime. The costs are significant.

A provider offering residential services to 1,000 residents in 200 houses will pay €100,000 for registration or the equivalent of the annual salary of three social care workers.

[16] HRB (2014) *Annual Report of the Intellectual Disability Database Committee 2013,* Dublin.
[17] Places such as hotels, guesthouses, youth hostels, religious communities, nursing homes, educational establishments, defence establishments, prisons, refuges, and ships boats and barges.

There is a second fee of €183 per year per resident which would come to €183,000 per provider of 1,000 residential places. The introduction of a new regulatory regime is complex and expensive and will eventually need refinement.

This report is an analysis of some selected features of the Inspection process as a contribution to the improvement of the lives of residents in receipt of services.

Chapter 4

Designated Centres, Announced Inspections and the Reliability of Inspection Reports

Designated centres

The ongoing slow transition for persons with disabilities from congregated settings to community based housing has created a somewhat sprawling landscape of residential service provision.

This is being discussed without consultation with people with disabilities and their families. This diversity, coupled with the introduction of statutory inspection and registration requirements[18], poses questions about the nature of a Designated Centre under the Health Act, 2007.

This is just one of the questions about which there has been little to no consultation with service providers, people with disabilities and their families.

What is a designated centre for people with disabilities?

- The centre must be an institution[19]. Institutions may include large, single site/congregated settings, community-based housing (including grouped houses) and single occupancy residential units.
- The centre must provide residential services to children and/or adults with disabilities.

[18] €500 registration charge per Designated Centre and €183 per resident annually.
[19] Defined in the Health Act 2007, as amended, as a home, centre or institution or part of a home, centre or institution

- Residential services must be provided by the HSE or funded under Section 38 of Health Act 2004, or Section 39 of Health Act 2004.

From a service provider's perspective Hiqa's Guidance Document on Designated Centres acknowledges this multiplicity of service and funding arrangements. It indicates a willingness to adopt a case by case approach in assessing registration applications.[20]

To register combined residential services as a single designated centre, additional criteria over and above the basic specifications must be met:

- The services are within the same geographic area (this may be a defined suburb of a large town or city, a small town or a townland).
- The services share a Person in Charge who is full time in that role, who is responsible for the day-to-day management of the residential services, who has adequate capacity to ensure the proper governance and oversight of the services and the provider is satisfied that the Person in Charge meets the requirements of fitness under law.
- Each residential service provides a similar type of service that can be described within a common Statement of Purpose and Function. [21]

In general, the guiding principles for grouped centres assume that common governance criteria will ensure common compliant practice across different units in different locations.[22] This remains to be seen.

What is significant is that the inspection process captures each unit of inspection and that inspection reports transparently reflect compliance levels within each

[20] http://hiqa.ie/system/files/What-constitutes-a-designated-centre
[21] http://hiqa.ie/system/files/What-constitutes-a-designated-centre.pdf
[22] http://hiqa.ie/system/files/What-constitutes-a-designated-centre.pdf See p.6

unit under inspection for each individual resident. The grouping together of inspection units may be driven by financial considerations. The more units can be grouped together, the lower is the annual fee paid to HIQA.

This Study examined 50 inspection reports encompassing a total of 24 service providers. We read over 1,000 pages of text three or more times. A detailed reading of the reports revealed that some Designated Centres consist of groupings or collectives where a single report examined two or more individual units.

Such arrangements include groups of community houses in close proximity to one another, community houses in separate locations, community houses together *and* in separate locations, multiple units on the one site, and independent apartments within the one complex.[23] Therefore, the term *Designated Centre* may describe:

- A single residence with an individual address, registered to accommodate and provide services to a specified number of residents
- Equally it may denote a relationship between groups of residences where a combined total of residents are accommodated. Whether there is one designated address, is not obvious. Whether policy document requirements are per unit or per centre is also not clear.

The use of centre as the descriptor is ambiguous for the public readership. On the one hand it is used in the singular sense. On the other, it describes a collective, where each unit is part of that collective with no single unit being the

[23] Reports 3199, 3230, 8254, 8257, 8582, 11206, 11221, 11222, 11293, 11296, 11297, 11298, 11993, 11102, 11174, 11293, 11354, 11464, 11478, 11481, 11520, 11528, 11607

centre.[24] For the purposes of Inclusion Ireland observations, it is not so much the number of units that are problematic. It is the questionable capacity of a single report, as currently designed, to account for collective inspections.

This has consequences for the accessibility and transparency of the regime. The Inspection process runs in three yearly cycles. The failure to capture the voice of persons with a disability in this first round of the regulatory process is unlikely to be addressed until the next regulation process in four years time.

This ambiguity about the meaning of a designated centre arises from the Health Act 2007 and was not an invention or interpretation of Hiqa or service providers.

For the purposes of this study, 50 inspection reports effectively examined 123 units. Of these 50 reports 25 accounted for more than one unit.

What we found was 'Congregated Reporting'.

Announced Inspections

Announced versus unannounced inspections is a topic of many views among Regulatory bodies in the field of social services. Most regulatory regimes in Ireland use both announced and unannounced visits.

From 2014, Hiqa decided to use more announced than unannounced visits on the grounds that it facilitated the presence of senior staff to answer

[24] The scope of this report examined the first 12 outcomes. However, in trying to gain a clear understanding of *Designated Centre,* Outcome 14 *Governance and Management* was looked at in some reports and is referenced accordingly.

queries and improve information on safety and governance issues.[25] The national broadcaster RTE has used covert investigative methods to reveal unacceptable standards of care in childcare facilities, nursing homes and in 2014, residential services for people with disabilities. Their impacts on public opinion would suggest that more unannounced visits may be necessary to restore confidence in the inspection regime.

The Reliability of Inspection Reports

The challenge when reporting collectively is to demonstrate to the readership that each home has been transparently assessed and that the outcomes for each individual in each home are clearly reflected.

Importantly, this guarantees that families may distinguish the status of their relative's home from other residents living in a different home in a different location, under the one Designated Centre and taking account of rights to privacy. This is not the case in many of the reports with more than one unit. These are some examples (see also Appendix 2):

- One centre reportedly comprises 11 community homes and **44** residents. The Inspection examined three homes accommodating 13 residents (3230). Which three units were examined and which **13** residents are not clear.

- Three separate Designated Centres, registered to the same service provider, each with multiple units were inspected by the same inspectors. The reports are confusing to read. There is much cross referencing of all three reports within each report and a copy and paste style of writing is

[25] Pharmaceutical Society of Ireland (2014) *Inspection Policy on Announced/Unannounced* Inspections, Dublin, p.25 and letter from Phelim Quinn (HIQA) to Marita Kinsella (PSI) of 16.01.2014 in same report.

strongly evident.[26] It is not clear if specific records, examined at Head Office level are apparent at individual unit level. Fire safety and risk assessment compliances were unclear.

Inspectors appear challenged when tasked with compiling a single report to reflect equally on separate groups of residents, in separate locations, each with their own unique home environments, staffing arrangements and site specific concerns.

In its current format, this type of group reporting undermines the process of focused scrutiny producing dedicated results that a more targeted reporting process captures.

Key Point

In the meantime, it might be concluded that resource implications for service providers and the Inspectorate in their treatment of grouped Designated Centres, has trumped the value of quality, comprehensive, person-centred reporting outcomes. The 'Collective Reporting' system reflects a medical model of disability which does not take account of individual persons with disabilities in their interaction with their environments and relationships.

Transparency emerges as an issue of concern where collective reporting is used for several units of a single Designated Centre. It has been difficult and sometimes impossible to tease out individual circumstances in collective reports which will reflect fairly, transparently, accurately and consistently on residents, staff, service providers and inspectors themselves.

[26] With three Centres incorporating multiple units, such reporting practices should be avoided as mirror narratives undermine the person-centred ethos of the inspection process.

Inspection report grading inconsistencies

In general, compliance ratings are not uniformly applied and in some circumstances seemingly underrated. More specifically, the challenge of examining and rating multiple units, under the auspices of a single Designated Centre within a single report may be a major unintended contributor to grading inconsistencies.

In some cases compliance judgments appear to be unevenly applied. For example, under Outcome 5 *Social Care Needs* the following concerns were graded differently:

Centre 1	**Centre 2**
Residents were not involved in the development of their personal file. No assessment in advance of admission result in inappropriate, incompatible placement arrangements. Behavioural disturbances in the centre resulted in 1 resident temporarily returning home. This was not recorded in their plan, no transition plan was initiated and no formal plan was put in place to support the residents or family. The welfare and wellbeing of residents with disabilities is compromised due to staff shortages. One client was not showered till 5pm when centre was at full occupancy due to staffing constraints. One client self harmed – there was no behavioural support plan in place. (8561)	No resident involvement in planning; in-house day activities rather than community based; no meaningful activities; sketchy plans; no evidence of multidisciplinary assessment. Staff shortages were identified as contributory factors. Positively, independent advocacy service successfully supported residents to purchase a vehicle for their use. (11102).
Grading: Non compliant - moderate	Grading: Non compliant - major

As the above comparison demonstrates, the boundaries between moderate and major are unclear. Grading inconsistencies mostly range from minor to moderate, with a preference for moderation.

Sometimes similar breaches are graded differently. Specific elements of an outcome may receive emphases while other outcome elements do not feature.

It is not clear if exclusions represent good practice and are a foregone conclusion, or that specific elements of Outcomes were targeted, or they have just been overlooked. For example:

- A single issue inspection of a congregated setting examined four outcomes. Under Outcome 1, and without clarification, the inspection solely focused on the complaints policy. Residents' rights, dignity, privacy, opportunities for choice and promotion of independence, participation in the organisation of the centre and access to independent advocacy services are not mentioned. (8582)

Grading discrepancies might be an unforeseen consequence of collective unit outcomes being accounted for in the one report.

The diversity and volume of report material, from different units of varying compliance may in fact challenge standardised rating methods resulting in a tendency to average or to moderate.[27]

Are inspections accurately assessing the gravity of problems?

[27] Moderate is defined in the Oxford English Dictionary as *'average in amount, intensity, quantity or degree'*

Some grading shows inconsistency which poses questions over the use of moderate or average ratings (8257).

A centre incorporates two houses in separate locations which collectively accommodate 11 residents. The specific capacity of each unit is not identified. Across Outcomes 5, 7 and 11 the inspector identifies moderate deficits.

These include inadequate personal plans; no risk assessments for some residents – later it transpires there is no risk management policy in place; no plan for one resident with dementia; no falls prevention/management plan and no care plan for two residents at high risk of falls; inadequate management plans which placed residents with epilepsy at risk; not all staff had received manual handling training or fire safety training and inadequate risk assessment for the evacuation of residents with reduced mobility and wheelchair users.

Additional waking staff were required at one location in response to a number of incidents (11481).

It is commendable that the inspection has highlighted these issues. The report concludes with a comprehensive Action Plan. Nonetheless, report findings are bound to reflect circumstances on the day of inspection and until redress is complete, these identifications are not **moderate** or average issues.

They are **major** issues for the residents involved. This then becomes the remit of Follow-up inspections to review. In the interim, collective reporting moderates the potential life threatening concerns for individual residents.

Inspection report accuracy and consistency

Snapshot of inspection faults:

- One report records the service provider incorrectly on the cover page. This is a legal requirement (3199).
- The licensed numbers of residents accounted for in some reports do not agree (8561).
- An Inspection Report confirms a centre's capacity to be 32 people with disabilities. The cover sheet notes 29 present and one absent on the inspection date; a total of 30 (8582). Another cites a total of 9 on the cover sheet yet in the findings cites 6 (8257).
- One Centre with multiple units accommodates 40 residents in total. However the Report is not consistent in matching the accommodation with the number of residents. According to the narrative units may house 37/38 persons. It is not clear (11528).
- One inspection was categorised as a 'Monitoring Inspection.' The summary of findings confirms HIQA were in receipt of unsolicited information of concern in advance of the inspection. The inspection type is therefore unclear (11512).
- A one day inspection notes two separate inspection dates and times (8561). This would suggest a follow up inspection. However, no follow-up reporting has been published.
- There are variations in Inspection Report templates – uniform templates are not in use in the first 50 reports examined. The cover pages on some reports do not specify the Centre Type (7782, 7788, 7931, 8061, 8062, 8253, 8254, 8257, 8311, 8561, 11121, 11174, 11222, 11296, 11297, 11298, 11463, 11464, 11505, 11566). This indicates their source of funding under the Health Acts: whether they are Section 38, Section 39 or HSE funded.

Conclusions on designated centres, announced inspections and reliability of inspection reports

Contrary to what the engaged public, including relatives and friends of residents might assume, a Designated Centre constitutes not only a single unit but may represent a combination of arrangements of more than one unit. This has its basis in the Health Act, 2007.

However, a close reading of this body of 50 reports has identified some issues of concern in relation to multiple units under the one Designated Centre. This has identified the challenges in reporting the findings of all such units collectively in a single report. The ambivalent use of the word Centre does not consistently support the regulatory definition of a Designated Centre.

Issues of accuracy, transparency and grading consistency are of concern. These areas require particular clarification for providers as they are bound by the Regulations to visit and internally audit their Designated Centres at least every six months.

Key Point

A written report of outcomes and redress measures must be made available to residents, their representatives and the Inspectorate as required. The Inspection process needs to be made more accessible and user friendly.

The current standard inspection and reporting protocol in its 'one size fits all' approach may not be an appropriate audit tool for assessing units collectively under the auspices of a single Designated Centre. Finally, casual report review

practices have resulted in a failure to identify the substantial number of errors, omissions and inconsistencies evidenced in this section.

The current Inspection system compromises the integrity of the reporting process but by default undermines the concept of person-centred inspections.

The reports could usefully identify staff designation. This would include the numbers of nurses, care staff, catering staff, administration and ancillary staff on duty on the dates of inspection.

Significantly, in the interests of a public readership, where a Designated Centre comprises more than one unit, the adequacy or not of shared staffing arrangements needs to be transparent. This formed part of the earlier Nursing Home reporting protocols.

Chapter 5

Outcomes Evidence and Findings

The first 50 of Hiqa's published disability inspection reports encompassed a total of 771 residents. Inspection Outcomes 1-12 were the focus of examination in this report.

These Outcomes specifically interrogate issues of resident choice, control, decision-making, participation, relationships and community integration and so offer the richest insight into the commissioned theme of resident quality of life and experiences of assisted living.

Due to very low reporting levels evidenced under these themes this report found there was an absence of comprehensive Inspection into residents' quality of life and experiences of everyday living. Of the minority of Outcomes inspected non-compliance rates were high.

Outcome 1: Residents Rights, Dignity and Consultation

Under Outcome 1 only 17% of Centres were examined: 16.5% were non-compliant

Some positive practices were reported. In the main non-compliance mainly focused on:

- Complaints Policies
- Independent Advocacy Services

In addition, issues relating to residents' lack of choice, meaningful engagement and Independence were reflected in:

- Service-centred practices

- At risk settings

Outcome 1: Complaints policies

Within the low overall inspection rate for this Outcome, breaches of complaints processes were highlighted. Not one inspection found complete compliance:

- A lack of appeals procedures (8061)
- A recorded complaint was not responded to in the regulatory timeframe (8561)
- The complaints officer and the external appeals person were not identified (8234)
- Poor complaints log. An absence of specific date, signature and outcome details. The process was not objective and not in accessible format - exemplified by a detailed complaints flow chart (8582)
- Complaints log requires review (11206)
- No complaints records made available (11463)

The complaints process implicitly or explicitly underpins all other outcomes. Where support is required it goes hand in hand with the right to independent advocacy services.

Outcome 1: Independent Advocacy Services

- Four flagged the lack of advocacy services (8561, 11206, 11463, 11464)
- One centre's complaints procedures were inadequate, yet no mention was made of advocacy services (8582)

While well-intentioned, one example demonstrates a service provider's and seemingly the Inspectorates compounded misunderstandings of the concept of independent advocacy:

> One centre established an internal advocacy service; however, 'this service had never been used as residents were assigned a key worker who acted on behalf of clients'. Under the providers' planned actions, an advocacy committee made up of staff, residents and invited family members is to be established. Some advocacy skills training will also be sought (11463).

While well-intentioned, the solution nonetheless reverts to the original subjective arrangement of an internal service. Independent advocacy services are the cornerstone of the transition to the community, providing: 'people with the means to make choices based on an awareness of possibilities rather than choice based on limited life experience, which is the reality for many citizens with disability.'[28]

Outcome 2: Communication

> Under Outcome 2, only 11% of Centres were examined: 6% were non-compliant

Both the Regulations and the National Standards insist on the Residents' rights to facilitated communications and accessibly formatted information. These rights are partners to all other Outcome requirements; they are the gateway towards a self-determined quality of life. The reported non-compliances were rated as 'minor':

[28] "Time to move on from Congregated Settings. A Strategy for Community Inclusion". Report of the Working Group on Congregated Settings. Health Service Executive, June 2011.

- failure to ensure that each resident has access to appropriate media, including newspapers and internet
- not all staff had completed communications training – three members are scheduled to attend in-service Lamh Training
- not all residents had communication passports[29]

Between the compliant and non-compliant categories all six were Registration Inspections - imposing a regulatory obligation to examine all Outcomes. It could be surmised that had they not been of this nature, the inspection process would have bypassed communications entirely.

Outcome 3: Family and Personal Relationships and Links with the Community

Under Outcome 3, just 14% of Centres were examined: 6% were non-compliant

A total of seven centres were inspected. Six of these, as Registration Inspections were obligatory. Just two were found to be non-compliant. One report stands out in using activity records to flag limited community participation;

> 'Daily activity records highlighted that residents involvement and integration into the local community was limited and could be developed further … residents needs assessments and care plans did not include a review of residents' education, training needs and opportunities'. (11464)

[29] This is a person centered way of supporting children and adults who cannot speak for themselves. It describes the person's most effective means of communication and how others can best communicate with and support the person. http://www.communicationpassports.org.uk/About/.

Otherwise other observations tended to be generic rather than specific:

- 'Another compliant report expresses similar sentiments, yet there is no appraisal of community integration (11206)
- Strong links to the community are mentioned in another report with no evidence cited (11615)

For those compliant, specific observations regarding family support noted:

- Four residents returned to their family home at weekends and a fifth to a host family. Resident's families organised all medical and allied health appointments (8262)
- One registration inspection received direct feedback from relatives. They spoke of the 'tender loving care…all the great staff here…normal stuff happens' (11206)

It is not possible within this report to establish the levels of family support for all residents. However, limited findings across ten reports indicate that inspectors met with and received feedback from some relatives in the course of their inspections. Many families wish to play their part in supporting their family members.[30]

The Inspectorate should make concerted efforts to consult with families where there is consent of the resident, and reports should resonate their voices more clearly. For those who have no living relatives or minimal contact with family or

[30] Health Service Executive (2009) *National review of HSE Funded Adult Day Services* in Report of the Disability Policy Review by Expert Reference Group on Disability Policy.

friends, of which there are a 'significant minority',[31] the role of other agencies such as advocacy services and community support services, assumes an even greater significance.

Outcome 4: Admissions and Contract for the Provision of Service

Outcome 4: Of the 30% of Centres examined 29% were non-compliant in contracts for provision of services

The Admissions and Contract for the Provision of Service is a seminal document in establishing, pre admission, the suitability of the accommodation for the resident, in outlining provisions of support and care consistent with their advanced assessed needs, in detailing fees to be charged and in pledging to protect residents from abuse by their peers.

As has been reported under other Outcomes the appropriateness of some residential placements is questionable in light of the aggressive environments in which some residents live out their daily lives.

The right of residents to choose with whom they live is provided for in the Convention on the Rights of Persons with Disabilities: 'Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis as others and are not obliged to live in a particular arrangement'.[32]

[31]Time to move on from Congregated Settings. A Strategy for Community Inclusion. Report of the Working Group on Congregated Settings. Health Service Executive. June 2011. p. 58.
[32] Article 19 (a) United Nations (2006) UN Convention on the Rights of Persons with Disabilities. Geneva: United Nations.

Thirteen out of 14 centres inspected under this outcome were non-compliant.

- Residents were not involved in agreeing their contracts for care. Contracts did not include information on support, care and welfare services nor fee liability. (8062, 8253 and 8254)

- Admissions policies and practices should take account of the need to protect residents from abuse by their peers. (11522)

One interesting action plan to address 'major' non-compliance included running a course to support residents' understanding of their contracts. This would include producing an easy-to-read version. (11505)

Outcome 5: Social Care Needs

Outcome 5 achieved an almost 100% Inspection rate: 86% of Centres were non-compliant

This high rate of Inspection might of necessity reflect HIQAs' obligations to 'person-centeredness' which this Outcome in particular articulates and upon which the Standards are based.

It is however, burgeoning with paperwork obligations and providers, persons in charge and staff appear overwhelmed in their endeavours to comply. The outputs of the administrative process are in danger of becoming the measure of success or failure rather than their impact on the person at the centre:

'There are warnings from several countries that the 'logics of management' is becoming more dominant than the 'logic of relationships' between staff and supported people in intellectual disability services, as human services become increasingly managerialist and focused on specified outputs, efficiency and compliance.'[33]

Each individual if desired and with support if required, should actively participate in their personal planning process. It should be accessibly formatted and copies made available to the resident.

The planning process and a right to access can be transformative. However its effectiveness relies on a number of factors. The plan alone is only one element. Realising satisfying outcomes with the appropriate supports is the challenge. Compliance levels were poor at 13%.

Care Plans, assessments of need, personal plans, risk assessments, personal outcome measures including reviews and evaluations of outcomes, all come in for criticism. Based on reported observations regarding impacts for residents some of the following questions may be asked:

Outcome 5: Are Personal Plans Transformative?

- Personal Plans were non-effective: 'Reviews were not meaningful and did not demonstrate that progress was being made to support the residents' goals and wishes. For example, in the case of a resident, identified as needing an independent advocate, there was a protracted delay in organising this.' (11478)

[33] From Congregated to Community Living: Moving Ahead. Living Arrangement Options for People with Intellectual Disability: A Scoping Review". Trinity College Dublin 2014

- Goals while reviewed were not documented and health care needs and communication needs not specified in personal plans (3199)
- Limited evidence that goals were being realised and had improved outcomes for residents – no up to date plan for one resident with an integrated pathway for dementia in place (11481)
- 'Personal plans had more of a health focus' (8234)
- Intimate care needs unspecified in care plan. One resident required the support of 2 carers, of which one was to be the same gender. This was undocumented in their care plan (7947)
- No up to date care plans; in one case a resident had not seen a consultant regarding a specific health issue in 5 years(11354)
- The person in charge pledged to 'collate information from the process of assessment of needs…and include it in each personal plan'. It is not apparent if residents will experience improved meaningful outcomes from such solutions unless there is a greater focus on the need to demonstrate the impact of these actions.

Outcome 5: How involved are Residents in Personal Planning?

- No resident involvement in planning and no risk assessments or assessment of needs carried out. Staff responsible for the development of assessment and personal plans had only received a 2 hour training session. (11221)
- Resident involvement in planning not evident. Day activation was in-house rather than community based. (8257 and 8561)

Outcome 5: What Supports do Residents receive in the Planning Process?

- Lack of evidence of multi-disciplinary consultation in the assessment and development of personal plans for residents with 'complex communication' needs. (11607)
- One respite centre was deemed non-compliant. The staff were unaware of resident personal goals or outcomes. The action plan confers a regulatory obligation upon the centre for all visiting residents; 112 stayed there in 2013. (8089)

While some reports varied in flagging many of the operational shortcomings, other more insightful inspectorate commentaries journeyed beyond the plan, seeking resident outcomes and impacts to be demonstrated:

- 'Personal plans did not include such details as the development of a network of personal supports…the resident's wishes or aspirations around friendships belonging and inclusion in the community and transport services in use' (8062)
- 'Detailed information on areas such as friendships, belonging and inclusion in the community, resident's short, medium and longer-term aspirations, life-long learning and employment supports, as well as their assistive devices and technology requirements was lacking…limited focus on tangible outcomes and/or whether the activities enhanced a person's quality of life or not.' (11464)
- 'Risk assessment…used…a number of residents were being supported to use public transport independently. While risks associated with using a bus stop along a busy road with no footpath was risk assessed

by staff, residents' preference to do so were recognised and encouraged.' (11293).

Many of the observations confirm that the person in charge and staff struggle with the sheer volume of procedural and policy paperwork in addition to the demands of personal planning paperwork.

Within the terms of reference for inspections, simply viewing someone's personal plan, ticking the boxes, suggesting improvements and review timeframes will not enhance the quality of a resident's life.

There needs to be a consistently greater expectation to produce evidence of outcomes which in turn needs to be consistently identified by the Inspectorate.

Outcome 6: Safe and Suitable Premises

Outcome 6: Of the 29% of centres examined, 25% were classed as non-compliant.

The following issues were noted:

Outcome 6: Privacy and Dignity

- No lock on bathroom door (8253)
- No downstairs bathroom for 1 resident unable to access 1st floor: 'Assistance with personal hygiene given in absence of bathroom'. Unacceptable redress plans submitted by provider – resident to be transferred by 30/04/14. (11221)

- A single room could only accommodate a small bed. The wardrobe was located in another twin room some distance away. Separate Male /female communal toilet, shower and bath facilities in one large room. This arrangement did not 'ensure resident's privacy and dignity… therefore not fit for purpose'. (11528)

Outcome 6: Accessibility of Premises

- Limited communal space. Cramped bedroom – no room for bedside locker or chair. Inaccessible passage from kitchen to utility room due to dangerous step. Damp Bathroom (8254)
- One inspection did not plan to examine Outcome 6 at the outset; however its complete inaccessibility for one resident prompted attention. In addition there was restricted kitchen access and some bedrooms locked in two out of three units: 'to promote the safety of residents'. There was no mention of restrictive practice documentation (11854)

Outcome 7: Health and Safety and Risk Management

Outcome 7: Achieved an almost 100% inspection rate. Non-compliance was high at 94%.

In many cases fire safety breaches received a moderate grading. In 2012, a Hiqa analysis of their own Nursing Home inspections noted that fire is a 'low probability event which has catastrophic consequences.'[34]

As such, there is no moderate ground; any breach in our opinion, is major.

[34]Hiqa "Designated centres for older people: an analysis of inspection findings during the first 15 months of inspection" Feb. 2012. p.23

Breaches were identified in the following areas:

- Staff Training
- Safe Evacuation Procedures
- Restrictive Practices
- Risk Management

Outcome 7: Staff Training

- No up to date fire safety training for staff. (8061, 8253, 11293, 3199, 3230, 11481) The staff in one centre had received no training. Instead; 'Staff had been asked to watch a DVD on fire safety that was not centre, or disability specific.'(11870)
- In another centre staff were unaware of the whereabouts of fire-fighting equipment.(11478)

Outcome 7: Safe Evacuation Procedures

- Personal Emergency Evacuation Plans were inappropriate; 'In one plan it was noted that the resident was advised to test the heat of the door and use the window to call for help. However, it was known that the resident could not reach the window and also had significant memory problems so this strategy would not be appropriate' (11296).
- Lack of training compromised safe evacuation procedures. (3193)
- In one house not all staff were familiar with evacuation procedures – of particular concern at night when staff are alone from 8-8.(11293)
- Fire doors in some centres were permanently wedged open. (3199, 8253)
- Fire exit inaccessible for wheelchair users in another centre (3230)

Outcome 7: Restrictive Practices

- Doors in some centres kept locked. (3230, 8146 and 8561) This poses a risk in the event of an evacuation but it also may amount to an environmental restrictive practice in accordance with HIQA's own guidelines on same.[35]
- Other possibly restrictive practices, as entrapment risks, included the use of bed rails (8146) and stair gates (11221)

Outcome 7: Risk Management

- Risk Management breaches were widespread ranging from minor to major. (3199, 7782, 8061, 8089, 8311, 8561, 11354) Specifics included incomplete or out of date risk assessment registers, no risk management policy and no risk assessment training since 2005.
- Individual risk assessments were lacking in one centre: 'No risk assessment in place for a resident whose behaviour may have placed staff at risk' (8257). In the same centre there was no risk assessment for a resident who lived alone.

Example: Medical model of disability v Social model of disability

'Not all bedrooms had wash hand basins available and residents shared a bathroom. This needs to be kept under review, if staff need to assist residents with personal hygiene in their bedrooms, they would need to be facilitated to

[35] http://www.hiqa.ie/system/files/Restrictive-Procedures-Guidance.pdf

abide by best practice in relation to infection control with appropriate hand-washing facilities.'(8253/54)

These issues have been rightly flagged as risk management concerns but they also represent breaches of residents' privacy and dignity under Outcome 6 - Safe and Suitable Premises. This suggests an adherence to the medical rather than the social model of disability.

Outcome 8: Safeguarding and Safety

Outcome 8: All centres were examined under this Outcome. Non-compliance was high at 82%.

The following consistent themes arose:

- Training in Adult Protection and Behavioural Management
- Complaints Procedures
- Risk Assessments and Restrictive Practices
- Resident Finances

Outcome 8: Training in Adult Protection and Behavioural Management

Staff training in adult protection and behavioural management were recurring themes of concern. (8061, 8062, 8089, 3193, 8253, 8254, 8257, 8261, 8561, 11121, 11174, 11206, 11293, 11296, 11297, 11354, 11463, 11464, 11512, 11520, 11607 and 11854) Some or all staff in particular centres had received no training.

Key Point

If the disregard for the safeguarding of residents is allied with other findings such as poor complaints processes, a very weak focus on service user communications and limited access to independent advocacy services and staffing constraints, it places residents at a severe disadvantage in their own homes.

The following are some examples:

- One centre had inadequate abuse protection systems. Staffs were unfamiliar with protection protocols. Resident allegations of inappropriate physical contacts by another service user were not recorded on incident reports and no risk assessments. Restraint procedures were also inadequate. (11464)
- The Person in Charge who delivers protection training had not been trained as a trainer in the area of protection.(11520)
- 'Staff unaware what steps to take if abuse suspected and unaware of their responsibilities regarding safeguarding residents.; (8228)
- Staff were unable to identify the five common forms of abuse.(3193)
- In one centre, the designated person for complaints had received no training. Staff at this centre had received no restrictive practice training and overall risk management practices were weak.(8257)

Outcome 8: Complaints Procedures

Some complaints processes were not fit for purpose. This issue also arose under Outcome 1- resident's rights. Access to a comprehensive and transparent complaints process is a rights issue. Standards 1.7 and 3.1 clearly outline safeguarding supports and procedural requirements. Omissions are a breach of both regulations and standards.

- Adult Protection Policy was non-compliant. It did not nominate an independent person to evaluate incidents and it failed to highlight all steps in the event of an allegation of sexual abuse such as protecting the scene. Allegations of abuse and incidents were included in the complaints log, but follow-up investigations were insufficient and non-compliant. This inspection was a single issue inspection following notification to the Authority. A provider led investigation was requested by HIQA. These breaches were considered to be minor. (8582)

- Similarly it was recommended for one centre, deemed compliant, that 'improvements were required on the policy of protection for vulnerable adults to include clear guidelines on the investigative process.'(11102)

- Another compliant centre had no designated person responsible for dealing with allegations of abuse. Also the policy didn't describe procedures for abuse investigations. Ranking these practices compliant is questionable (11478)
- Two incidents were not investigated in one centre and there was no incident report form completed (11520)

Outcome 8: Risk Assessments and Restrictive Practices

The implementation of these protocols was weak. Many centres' policies were incomplete or non-existent. Risk assessments in many cases were inadequate in justifying restraints and restrictive practices were ongoing without review. Notations were made in some resident's files regarding challenging behaviour and appropriate redress measures with the required input from multi-disciplinary teams. Other files, although required, contained no such notations. Some centres had not followed last resort protocols before implementing

restrictions. The following are some examples drawn from a range of different reports:

- 'External doors locked to safeguard five residents. No risk assessment in place and no evidence of all alternatives considered and ruled out.'(7947)
- There was no restrictive practice policy. Personal plans did not include restraints usage or consent signatures. Staff had not received training in challenging behaviour (11463)
- 'Risk assessments in place for one resident, who had made allegations – no record of the incidents or response.' A Rights Committee made up of 60% volunteers and some residents had met 9 times – no mention of this issue ever being reviewed (8257)
- One resident was locked into a room following an altercation with another resident. This was noted in the resident's behavioural support plan, however no risk assessment had been carried out (8561)
- 'Not all service users were protected from abuse at all times. It was documented in daily notes that service users hit out at other service users…These incidents were not all formally recorded, investigated or analysed…the inspectors were unable to ascertain if the service users felt unsafe.' In this house, there were no behavioural supports plans for all those who needed them (8561)
- Behavioural support plans and risk assessments were not in place for some residents. There were no risk assessments for the use of restraints and no alternatives tested (11221)
- Risk assessment and restraints review not up to date – one case of use self injury had not been reviewed since 2012 (11222)
- Inspectors directed one centre to 'Stopping the automatic practice of automatically shutting off the supply of water to the bedrooms' (3193)
- No guidelines in place for the use of a CCTV camera (3193)

- Front door locked at all times as resident had absconded over a year ago. This practice had not been reviewed since (8561)
- On the day of inspection all unit entry doors and one unit's internal doors were locked[36](11222)
- Inspectors recommended the practice of hourly night checks which impinge on residents' privacy and dignity be discontinued (11854 and 11870)

Outcome 8: Residents' Finances

The safeguarding of residents' finances was usually referenced positively (7788, 7947, 8146, 8234, 8253 and 11354) however not all reports mentioned this theme – whether this was due to compliance or reporting oversight it is not clear.

Breaches of signing off protocols were identified and in two centres residents did not receive invoices or statements of charges for care provided. (8253 and 8254) One centre had no residents' money management policy. (11520)

Outcome 8: Positive Practices

As part of one resident's personal plan, an individual rights assessment is undertaken annually to review their right to access the community and right to smoke. This account stands out amongst the 50 reports: 'The Human Rights Committee recommended that a resident should not have their access to the community restricted or imposed if the primary motivation is not risk but staff

[36] The practice of locked internal doors has since ceased and a review is underway for locking entry doors. This appears to be as a result of the inspection.

shortage. As a result of this extra staffing hours were made available.'(11174)

Outcome 9: Notification of Incidents

Outcome 9: 17% of Centres were examined: 15% were compliant

This Outcome focuses solely on the Notification of Incidents – whether there was a policy in place, that the person in charge understood what constituted a notifiable incident and if records of such incidents were being kept.[37]

Of those centres inspected six were Registration Inspections, two were Single Issue Inspections and one was an Announced Inspection. There are three circumstances of note:

- There were no detailed records of accidents/incidents and numerous such events were not reported to the Authority as required. Restrictive practice procedures were not being followed. 'Staff told inspectors there was not enough time to record all incidents and accidents.'(8561)
- 'The Person in Charge not aware of the legal requirement to notify the Chief Inspector regarding any allegation, suspected or confirmed abuse of any resident.'(11520)

Outcome 10: General Welfare and Development

Outcome 10: Only 11% of Centres were inspected of which 7% were non-compliant

[37] Certain events called *Notifiable Incidents* must be reported to the Authority. HIQA outline 26 types of such events with appropriate time frames within which they must be reported.

This outcome statement expresses its intent to examine; 'residents opportunities for new experiences, social participation, education, training and employment.' That a mere 11% of residents' needs in this area were inspected represents a lost 'opportunity' on the part of HIQA to press for meaningful improvements in the quality of people's lives. Notably, all those inspected were Registration Inspections and so obliged by virtue of this to be inspected.

Key Point

Regrettably much of the commentary reflects upon routine practices, which will do little to raise resident, family or friends expectations. This is not consistent with the social model of disability.

Part 2 of the Disability Act 2005 contains a statute based right for people with disabilities to an assessment of disability-related health, personal social service and education needs. This provision awaits a Commencement Order. The process is independent of existing services or cost constraints.[38]

The following examples reflect the flavour of reporting for this outcome:

- 'The Inspector saw that residents were supported to achieve their potential…for example setting tables for meals' (11463)
- 'Inspectors observed residents involved in special tasks and roles including housekeeping, managing laundry, setting table for meals and cleaning up afterwards as well as food preparation, but these were not reflected in their support plans'(11464)

[38] Report of the Disability Policy Review. Expert Reference Group on Disability Policy.

Outcome 11: Healthcare Needs

Outcome 11: 70% of Centres were examined of which 48% were non-compliant

Themes

In terms of preventative measures, commentary focused on diet and nutrition which for the most part was positive. Residents were usually involved in meal planning including preparation and mealtimes were witnessed by inspectors as social events. Residents were supported to eat more healthily and to monitor their weight.

However, there was a distinct lack of reporting on more socio-based healthcare such as walking clubs, cycling, gym activities and holistic therapies. Importantly, such activities are community based rather than service centred, however they are not a feature of the reports under examination.

The following issues were commonly identified:

- Epilepsy Management
- Assessments and Referrals
- End of Life Care

Outcome 11: Epilepsy Management

The provision of safe, dignified care for residents with epilepsy is compromised in a number of centres (3230, 8257, 11221, 11481 and 11520).

'Staff members did not demonstrate competence in the provision of care to residents with epilepsy and had not received training to manage seizures or administer as required medications. There was no policy or procedures to guide

staff in the management of epilepsy. There was an epilepsy management plan for residents who had a diagnosis.

However, the inspector found that if these were followed they may place residents at risk. Improvements were required in the development of the care plan for residents especially in the area of care during and post seizures and responding to any potential complication or for recording of epileptic activities to guide future interventions.' (11481 and 3230)

Epilepsy management commonly involves the administering of PRN [39] or 'as required' medication. Stringent protocols govern their usage to minimise the margin for error.

There is a maximum dose permitted in any 24 hours and this must be clearly referenced for staff. If administered, the exact time must also be recorded. It is not sufficient to simply note 'morning' or lunchtime' or 'evening'.

As noted under Outcome 12 there are frequent breaches relating to PRN medications. The Inspector rightly identifies in the example cited, potential risks relating to current practice. In this light, a moderate grading of non-compliance is not in the interests of safe resident healthcare. Lapses identified under this Outcome and Outcome 12, Medication Management can be further undermined by staff scheduling concerns. Staff management issues must not compromise care management.

[39] Abbreviation for "pro re nata" - Latin for 'when necessary'

Outcome 11: Assessments and Referrals

- Access to occupational therapist discontinued in one centre. Incomplete risk assessment for bed rail usage. (8146)
- "Some residents on waiting list for dementia assessments for example, one resident had been waiting for 8 months". In the same centre there was no access to an out of hours GP service and only residents over 40 had annual healthcare assessments. (11221)
- Appropriate healthcare assessments hadn't been carried out in relation to back pain management for a number of residents. (11281)
- Service provider did not facilitate access to allied health professional. This was organised by residents themselves to encourage residents to connect directly with community-based care. There were no multi-disciplinary reviews of residents care needs. (11364
- 'In relation to residents' sexual and reproductive health, the majority health assessment documents reviewed by the inspector were blank.' (11464)
- 'In the case of a resident who was identified as needing a skin assessment and review by the physiotherapist there was no evidence that these matters had been followed up''. (11478)
- Referrals for allied healthcare professionals were not followed up. One resident was awaiting a psychiatric consultation since 2012. There was no evidence that this had been followed up by staff. (11512)
- Speech and Language and Psychiatric referrals were outstanding in another centre. (11607)
- Inspectors graded the following as major breaches: 'Assessments by Allied Health Professionals not consistently recorded…a resident had been reviewed by psychiatry this was not recorded sufficiently in the care plan… where another resident was referred for an assessment staff were not

knowledgeable about this assessment… no evidence that a resident had been referred for assessment by Speech and Language Therapist (SALT) for communication difficulties.' (11102)

Outcome 11: End of Life Care

There was no end of life care policies or intervention arrangements in a number of centres. Staff require training where residents profile is changing, with regard to dementia and also in the management of what is perceived to be increasing significant health care needs – wheelchair users with catheter care needs.[40] (11296 and 11297)

Health care records and personal plans were not up to date/out of date (11206). Personal plans in particular care plans not up to date or lacking specific detail. In one case it was not updated to reflect an acute medical condition and for another no record of an adverse incident (7947).

Outcome 11: Positive Measures

- 'One staff is a facilitator for and runs a 'Cook it!' Programme in the centre (a community-based nutrition education programme') (8228)
- 'Residents spoken to told the inspectors that they planned their own meals each week following consultation with one another and that they were currently trying to cook healthier options'(7782)

An ageing resident profile frequently combined with the onset of dementia, in many cases early onset, may require the appropriateness of some residential placements to be reviewed. Service providers need to be mindful in these circumstances of their duties of care under the Regulations for Older People.

[40] What were significant health care needs in the past may not be so in the future with the development of self management techniques.

In particular that staff have the professional skills for caring for people with dementia.

Outcome 12: Medication Management

Outcome 12: Of the 60% of Centres examined, 40% were non-compliant

According to HIQA's own guidelines on Medication Reconciliation; 'Medication safety involves giving the right person the right medication in the right dose at the right time and by the correct rate.'[41]

The working environment is a critical factor in terms of medication safety. In particular where there is a consistent demand for replacement cover and where the use of agency staff is regular, requirements for residents' photo identification on prescription sheets assume an even greater significance.

In particular, in the event of a resident transferring from their home to an acute hospital setting, exact medication reconciliation is paramount: 'In Ireland the medication incidents most commonly reported to the Clinical Indemnity Scheme (CIS) in 2012 were medication reconciliations incidents,'[42]

The most frequent infringements are in relation to the use of PRN medications – already referenced under Outcome 11 in relation to epilepsy.

[41] Guidance for Health and Social Care Providers: Principles of good practice in medication reconciliation (GHSP1)

[42] HIQA *Guidance for Health and Social Care Providers: Principles of good practice in medication reconciliation.* May 2014

Seizure management is exacting and requires trained staff to administer to the client's needs. Practice should be informed by comprehensive policies and rigorous protocols to ensure client safety and dignity.

Oversights in staff training and a lack of individualised purposeful record-keeping pose a danger to the resident. In line with HIQA's Judgement Framework [43] such practices are unsafe and as such are major breaches of both the Regulations and Standards:

- Commonly the PRN maximum dosage in 24 hours is not recorded and times administered are also not recorded. This potentially could result in a resident being over or under administered their medication (8146, 8228, 8557, 11121, 11206, 11221, 11279, 11281, 11293, 11463, 11520, 11528, 11566).
- Medication administration and prescription sheets were incomplete. In some cases there was no resident photo identification or address, no GP contact details, no staff signature, no time of administration and the stated dosage not on prescription for all medications (8089, 8146, 8228, 11206, 11293, 11520, 11522,11615, 11528 and 11174)
- Medication Management policies were not comprehensive; individual medical management plans were incomplete and there were no guidelines on out of date medications (8311); one centre had four medication errors in one week however no errors or near misses had been recorded in 12 months (11221) .The policy in two compliant centres had not been reviewed since 2009. (8353 and 8354) Inspectors were not satisfied that residents in one centre were adequately protected by its policies and procedures (11279).

[43] HIQA.

- Staff had insufficient/no up to date medication management training (11481, 11296, 11297, 11298, 11354). In one centre 'Staff had received no medication management training…and staff told inspectors they were not competent to administer medications' (11520). In another centre the person in charge had no training in medication management practices (11121)

Some positive practices were evidenced:

- 'Efforts were being made to inform residents about the medications they are prescribed. A pictorial booklet on the use of an inhaler had been prescribed to inform a resident about the benefits of taking this medication.' (11870)
- 'Residents were being supported to self-administer in line with their wishes and capacity with clear evidence of ongoing assessment to support this practice.' (11293)

It may or may not be appropriate for some to self medicate. We noted that responsible regard for medical matters is not to be confused with the medical model of disability.

All individuals should be supported to self manage medication, and where this is not possible consultations with residents and services should take place.

Chapter 6

Perspectives for the Future

There is a need for caution in the field of progress in residential services for people with disabilities. In some European countries there is a regression towards re-institutionalisation. This was identified by the European Disability Forum and by the Trinity College study of 2014.

There is a risk of importing institutional and restrictive practices into community group home settings. Unannounced visits should be increased. There is a need for clarity on community settings, the numbers of residents, their needs and staffing arrangements. Residents should assist in the Inspection process. An example is where two staff are available to four residents who want to do four different activities.

Staffing, staffing ratios and training all critically impact on residents experiences of a quality way of life. There is a need to review staffing ratios to increase options for more community living.

There is changing resident profile which should be constantly reviewed and mortality rates should be studied.

The average size of a household in Ireland is 2.7 persons. The numbers in community group homes appear to greatly exceed this. Maybe community homes ought to approximate to the mainstream average.

Residents appear to have little or no choice in terms of with whom they live. This trend should be reversed

The role of independent living is rarely included in the lifestyle evaluations in residential services.

Inspection Reports might be redesigned to incorporate a clear representation of the units inspected in line with Statement of Purpose and floor plans. This could reflect the particular centres' regulatory Statement of Purpose and Function.

Mapping a floor plan including room size and function as well as the number of residents for each unit, onto the reporting template might be a transparent method of giving account while also reducing the risk of oversight.[44] It might also help to keep inspections focused as to time, date and place.

There is a need to amend the Health Act 2007 in relation to what is a Designated Centre.

[44] http://hiqa.ie/system/files/publications/Guidance%20on%20Statement%20of%20Purpose.pdf

Appendix 1

Centre ID: **(For office use only)**

Questionnaire for Residents/Residents

Hello, we are interested in your views about what it's like to live here. Please fill out this questionnaire. If you like, ask a staff member, a friend or a relative to assist you.

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Name of Residence/Home:

Address:

Name: (optional)

Approximately how long have you lived here?

1. Do you like living here?

Tick as appropriate.

Yes ☐
No ☐
Most of the time ☐
Sometimes ☐

Can you tell us why?

2. Is there anything you do not like about living here?
Can you tell us about it?

3. What do you like doing during the evenings and/or at weekends?
Can you tell us about it?

4. Is there anything in your house that you would like to see changed/improved or done differently?

5. Who would you talk to or tell if you had a concern/ worry or complaint?

6. Do you feel safe here?
Can you tell us why?

7. Can you family and friends visit you here?

8. Do you take part in the plans and decisions that are made about your life?
Can you tell us about that?

9. Do you feel well cared for here? Tell us about it.

10. Do you know what your rights are living in the centre?
Can you tell us about your rights?

11. Is there anything you would like to tell us about the centre that we have not asked you?
Yes ☐ **No** ☐
Comments:

Thank you for taking the time to fill in the questionnaire. Your views are important to us. A public report will be written following the inspection. You may prefer to speak to an inspector instead of, or as well as filling in the questionnaire. The centre staff will inform you of the date for inspection of your centre.
Please note that if your identity has to be disclosed for any reason, the Health Information and Quality Authority will discuss this with you first.

On completion of this form
You can post it to your regional Health Information and Quality Authority office or if you wish, place it in an envelope and give it to inspectors when they are in your centre or ask staff to give it to the inspectors. The address of your regional office is highlighted below:

If you live in:
Cavan
Clare
Donegal
Dublin
Galway
Kildare

Health Information and Quality Authority
Regulation Directorate
Georges Court
Georges Lane
Smithfield
Dublin 7

Laois
Leitrim

Please send to → Longford

Louth
Mayo
Meath
Monaghan
Offaly
Roscommon
Sligo
Tipperary North
Westmeath
Wicklow

If you live in:
Carlow
Cork
Kerry
Kilkenny
Limerick
Tipperary South
Waterford
Wexford

Please send to →

Health Information and Quality Authority
Regulation Directorate
Unit 1301
City Gate
Mahon
Cork

DQ01

Appendix 2

Table A1 Location of Centres of Inspection 2014
First 50 Inspection Reports

Number of Locations	Centre Location	Total
1.	Carlow	0
2.	Cavan	0
3.	Clare	4
4.	Cork	3
5.	Donegal	0
6.	Galway	1
7.	Kerry	1
8.	Kildare	7
9.	Kilkenny	1
10.	Laois	0
11.	Leitrim	0
12.	Limerick	2
13.	Longford	0
14.	Louth	0
15.	Mayo	0
16.	Meath	2
17.	Monaghan	0
18.	Offaly	1
19.	Roscommon	0
20.	Sligo	0
21.	Tipperary	3
22.	Waterford	1
23.	Westmeath	2
24.	Wexford	2
25.	Wicklow	5
	Dublin Locations	
26.	Fingal	0
27.	Dublin City	3
28.	Dublin South	6
29.	Dun Laogh. Rathdown	2
30.	Dublin Anywhere	4
	Total	50
Counties not inspected		12

Table A2 Inspection Type
First 50 Inspection Reports

Inspection Type	Total
Registration	6
Scheduled - Announced	35
Scheduled - Unannounce	6
Follow-up Inspection (1)	0
Thematic	0
Single Issue	3
Total	50

Note 1 Report may constitute follow-up.
Trigger Inspection carried out in Dec 2013

Table A3 Centre Type by Funding Arrangement
First 50 Inspection Reports

Centre Type	Total
Health Act 2004 Section 38 Arrangement	16
Health Act 2004 Section 39 Assistance	16
Centre Type not reported on published Inspectio Report	18
Total	50

Table A4 Inspections by Service Provider
First 50 Inspection Reports

Service Provider	Number of Inspections
Daughters of Charity Disability Support Services	4
Camphill Communities of Ireland	4
St John of Gods Community Services Ltd	4
Sunbeam House Services Ltd	3
COPE Foundation	3
WALK	3
Acquired Brain Injury Ireland	2
NUA Healthcare	2
Prosper Fingal Ltd	2
St Hildas	2
Enable Ireland Disability Services Ltd	2
Ard Aoibhinn Services	2
Stewarts Care Ltd	2
Brother of Charity Services Clare	2
St Michaels House	2
Dara Residential Day Services Ltd	2
Redwood Extended Care Facility Ltd	1
Multiple Sclerosis Society of Ireland	1
Autism Spectrum Disorder Initiatives	1
Brother's of Charity South East	1
Cheshire Foundation of Ireland	1
Brothers of Charity Limerick	1
KARE	1
Moorehaven Centre (Tipperary) Ltd	1
Ability West	1
Total	50

The first 50 Inspections covered 25 different service providers. Some service providers experienced Inspections of four of their centres; others experienced Inspection at one location. Some providers did not figure in the first 50 Inspections. Some 21 of the first 50 Inspections were 'concentrated' on just six providers – the top six in Table A4 above.

Appendix 3 - Tables Outcomes 1-12

Table 1

Outcome 1: Residents Rights, Dignity and Consultation

Not Reported Reports	Non-compliant	Compliant	Total
41	8	1	50
No. of Residents	No. of Residents	No. of Residents	
639	128	4	771
83%	16.5%	0 .5%	

Table 2
Outcome 2: Communication

Not Reported Reports	Non-Compliant	Compliant	Total
44	2	4	50
No. of Residents	No. of Residents	No. of Residents	
685	49	37	771
89%	6%	5%	

Outcome 3: Family and Personal Relationships and Links with the Community

Table 3

Not Reporte Reports	Non-Compliant	Compliant	Total
43	1	6	50
No. of Residents	No. of Residents	No. of Residents	
676	24	71	771
88%	3%	9%	

Table 4

Outcome 4 Admissions and Contract for the Provision of Service

Not Reported Reports	Non-Complian	Compliant	Total
36	13	1	50
No. of Residents	No. of Residents	No. of Residents	
540	226	5	771
70%	29%	0.6%	

Table 5

Outcome 5: Social Care Needs

Not Reported Reports	Non-Complian	Compliant	Total
1	34	15	50
No. of Residents	No. of Residen	No. of Residents	
6	661	104	771
0.7%	86%	13%	

Table 6
Outcome 6: Safe and Suitable Premises

Not Reported Reports	Non-Complian	Compliant	Total
36	10	4	50
No. of Residents	No. of Residen	No. of Residents	
545	197	29	771
71%	25%	4%	

Table 7
Outcome 7: Health and Safety and Risk Management

Not Reported Reports	Non-Compliant	Compliant	Total
2	46	2	50
No. of Residents	No. of Residents	No. of Residents	
36	726	9	771
5%	94%	1%	

Table 8

Outcome 9: Safeguarding and Safety

Not Reported Reports	Non-Complian	Compliant	Total
0	35	15	50
No. of Residents	No. of Residents	No. of Residents	
0	627	144	771
0	82%	18%	

Table 9
Outcome 9: Notification of Incidents

Not Reported Reports	Non-Compliant	Compliant	Total
41	2	7	50
No. of Residents	No. of Residents	No. of Residents	
643	12	116	771
83%	2%	15%	

Table 10

General Welfare and Development

Not Reported Reports	Non-Compliant	Compliant	Total
44	2	4	50
No. of Residents	No. of Residents	No. of Residents	
685	55	31	771
89%	7%	4%	

Table 11
Outcome 11: Healthcare Needs

Not Reported Reports	Non-Complian	Compliant	Total
5	23	22	50
No. of Residents	No. of Residents	No. of Residents	
236	364	171	771
30%	48%	22%	

Table 12

Outcome 12: Medication Management

Not Reported Reports	Non-Complian	Compliant	Total
9	30	11	50
No. of Residents	No. of Residents	No. of Residents	
309	378	84	771
40%	49%	11%	

Appendix 4

HIQA's 18 Inspection Outcomes

Outcome 1	Residents Rights, Dignity and Consultation
Outcome 2	Communication
Outcome 3	Family and Personal Relationships and Links with the Community
Outcome 4	Admissions and Contract for the Provision of Service
Outcome 5	Social Care Needs
Outcome 6	Safe and Suitable Premises
Outcome 7	Health and Safety Risk Management
Outcome 8	Safeguarding and Safety
Outcome 9	Notification of Incidents
Outcome 10	General Welfare and Development
Outcome 11	Healthcare Needs
Outcome 12	Medication Management
Outcome 13	Statement of Purpose
Outcome 14	Government and Management
Outcome 15	Absence of the Person in Charge
Outcome 16	Use of Resources
Outcome 17	Workforce
Outcome 18	Records and Documentation