Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

10 YEARS OF RECEIVING FEEDBACK

ABOUT SOCIAL CARE SERVICES

2014 - 2023

About the Health Information and Quality Authority

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

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

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Chief Inspector of Social Services within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

- **Regulating health services** — Regulating medical exposure to ionising radiation.

- **Monitoring services** — Monitoring the safety and quality of permanent international protection accommodation service centres, health services and children's social services against the national standards. Where necessary, HIQA investigates serious concerns about the health and welfare of people who use health services and children's social services.

- **Health technology assessment** — Evaluating the clinical and cost effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health and social care services, with the Department of Health and the HSE.

Visit www.hiqa.ie for more information.

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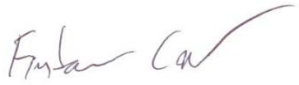
Foreword by the Deputy Chief Inspector of Social Services

Finbarr Colfer, Deputy Chief Inspector of Social Services, designated to fulfil role of Chief Inspector of Social Services

I am pleased to present this overview report which takes a look back on the period 2014 to 2023 and people's experiences of services under the remit of the Chief Inspector of Social Services in that time. The Heath Information and Quality Authority (HIQA) strives to promote safety and quality in the provision of health and social care services in Ireland. As part of this, we welcome feedback from service users, their relatives and friends and employees, amongst others, about their experiences of health and social care services. This includes positive feedback where a person has had a good experience, as well as feedback about times where a service could have been better.

Feedback received over the decade has helped inform how we regulate and monitor services. It helps us understand the real, lived experience of those using services outside of inspection activity. Hearing about people's experiences has helped us to keep track of what is happening within health and social care services, and allows us to identify potential trends or patterns that might have a direct impact on the overall care experience for all service users. This review is an opportunity for us to share with you an overview of what people have told us about their experiences with services and centres under the remit of the Chief Inspector from 2014 to 2023, and what regulatory actions have been taken on foot of this feedback.

Your feedback has helped, and continues to help us ensure that services continue to meet essential standards of care. I would like to thank all of the people who have taken the time to make contact with us over the years and provided their feedback about their experience of services.



Finbarr Colfer
Deputy Chief Inspector of Social Services
Designated to fulfil role of Chief Inspector
Health Information and Quality Authority

Terms used in this review

Advocate: A person who can provide information, advice or support to, or act on behalf of, a person who uses services or their family when dealing with a health or social care service, or making a complaint.

Follow up under a related piece of information: This means that inspectors had already been made aware of the same issues previously and have already taken, or are in the process of taking, the necessary actions to obtain assurance under the related piece of information received. The related information might have been identified by the inspector on a recent inspection, been received as part of a statutory notification or been contained within another piece of feedback.

Governance and management: An integration of corporate and clinical governance; the systems, processes and behaviours by which services lead, direct and control their functions in order to achieve their objectives, including the quality and safety of services for service users.

Line of enquiry: All pieces of feedback are considered by the inspector to inform lines of enquiry during an on-site inspection of the service.

Notification: The person in charge or the Registered Provider must notify the Chief Inspector of Social Services of the occurrence of certain events within designated centres. These are referred to as 'notifications'.

Personal protective equipment (PPE): Any device or appliance designed to be worn or held by an individual for protection against one or more health and safety hazards.

Protected disclosure: A protected disclosure is a disclosure of information which, in the reasonable belief of a worker, tends to show one or more relevant wrongdoings which came to the attention of the worker in a work-related context. A protected disclosure is often referred to as 'whistleblowing'.

Provider Assurance Report (PAR): A provider assurance report may be issued to the registered provider of a service on foot on information of concern being received. This report sets out the aspects of the regulations and or national standards that are applicable to the information of concern within the information received. The registered provider is required to complete this provider assurance report to assure the Chief Inspector of Social Services of how they are in compliance with the associated regulations and standards, to identify where there are areas for required improvement and details of how and when they intend on implementing those improvements. Assurances received via a provider assurance report are used by the inspector to inform lines of enquiry at the next inspection of the service.

Regulatory intelligence: The process of gathering, analysing and interpreting information that is related to regulatory requirements.

Regulatory risk assessment: Risk assessment identifies a potential risk and estimates the level of that risk in a situation, thereby focusing our response where it is needed most. The level of risk will be compared to the accepted standards and or regulations to determine an acceptable level of risk.

Regulatory risk rating: Inspectors conduct a risk analysis of all feedback received. Here, the inspector considers the likelihood of the particular issue(s) or incident(s) re-occurring and the impact on the service user(s). This gives a risk score rating to the piece of information which can range from very low risk to high risk. The regulatory action taken by an inspector will be proportionate to the risk level identified.

Restrictive practice: The intentional restriction of a person's voluntary movement or behaviour.

Risk: The likelihood of an adverse event or outcome.

Risk management: The systematic identification, evaluation and management of risk. It is a continuous process with the aim of reducing risk to an organisation and individuals.

Safeguarding: Putting measures in place to promote and protect people's human rights and their health and wellbeing, and empowering people to protect themselves. It is fundamental to high-quality health and social care. *(National Standards for Adult Safeguarding, 2019).*

Service provider: Any person, organisation, or part of an organisation delivering healthcare services, as described in the Health Act 2007 section 8(1)(b)(i)–(ii).

Solicited information: Information that the registered provider and person in charge must submit to the Chief Inspector of Social Services in order to fulfil their statutory obligations, or information requested from the provider or person in charge by HIQA. The most frequent type of solicited information we receive is monitoring and registration notifications, which providers or persons in charge must by law submit. These are mandatory and keep us informed about certain incidents and events in the designated centre.

Triggered inspection: A triggered inspection occurs on occasions where the information received is of such serious concern that the inspector deems a triggered inspection in direct response to the risks and matters raised as necessary to ensure residents' needs are met and that the care provided is safe and of a good standard. The feedback received and the impact on all residents living in the centre or people

using the services, is a primary focus on this inspection activity and where non-compliances are found, these are followed through by the inspector as part of HIQA's normal inspection process to ensure the provider comes into compliance.

Unsolicited information (UROI): Information which is not requested by HIQA, but is received from people including the public or people who use services who wish to provide feedback about their experience.

Updated compliance plan: Following an inspection, the registered provider is required to submit to the Chief Inspector of Social Services a compliance plan. This plan identifies how and when the registered provider intends to come into compliance with the regulations that were not found to be compliant during the recent inspection. Where concerns communicated within feedback received are related to the findings of a recent inspection, the inspector may request that the registered provider submits an updated compliance plan to assess the provider's progress in meeting the requirements of the regulations.

Introduction

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

Reporting to the Minister for Health and engaging with relevant government Ministers and departments, HIQA's corporate values include putting people first. This is done by putting the needs, voices, rights and protection of people who use health and social care services at the centre of our work.

As a regulator, HIQA receives information from a variety of sources. This information may be categorised into solicited (requested) and unsolicited information. This report is looking at the unsolicited information received from 2014 to 2023. Unsolicited receipt of information (UROI) is defined as information which is not requested by HIQA, but is received from people including the public or people who use services who wish to provide feedback about their experience. Unsolicited information is un-validated information that may indicate a deviation from the regulations or standards (information of concern), or it may be a compliment or a general comment about a designated centre, a hospital or a children's social care service.

The Chief Inspector of Social Services (referred to in this report as 'the Chief Inspector') welcomes feedback about centres and services under the remit of HIQA. HIQA wants people to tell us about their positive and negative experiences and make their voice heard. HIQA uses the information people tell us to understand the quality of care provided in nursing homes, residential services for people with disabilities and children's social care services. This helps make care better for everybody using these services and safeguards others. Inspectors consider the information carefully alongside other information, for example information received from the service itself, or what inspectors found at the time of the last inspection, and prioritise which action to take according to the level of risk.

This report sets out a summary of the information HIQA received about social care services from 2014 to 2023, and what HIQA did in response to that information.

Our inspection findings, and residents and their families or advocates, tell us that most designated centres and services are doing a very good job and are giving people a good quality of life.

There are a variety of ways by which people can provide their feedback to HIQA. This includes phone, email, post or by meeting with a member of staff in one of HIQA's offices. While the Chief Inspector has no statutory remit to manage or respond to individual complaints, all of the information received is treated seriously and used to inform our engagement with the relevant service or residential centre. It

this is the statutory responsibility of the service provider to respond to individual complaints. If a person has experienced or observed poor care, they have a right to make a complaint to the organisation that provided or paid for the care. By law, all health and social care services must have procedures in place to manage a complaint. People wishing to make a formal complaint about a health or social care service must contact the service itself and report their concerns in line with the services complaints policy. Further information on how to make a complaint has been included in Appendix 1 of this review.

HIQA aims to provide a positive experience for the person contacting us by providing a listening ear and supporting them in the next steps, such as signposting them to the correct complaints process, to the relevant supports available to them and assuring them that their feedback will be brought to the attention of the inspector. HIQA also has a memorandum of understanding with the Ombudsman. This allows us to exchange relevant information on health and social care services with the Ombudsman to ensure that members of the public are treated fairly and safely when accessing health and social care services.

HIQA has policies and procedures in place to manage the receipt of safeguarding concerns relating to children and adults. Where HIQA receives information relating to such concerns, it takes the necessary actions to report the information to the Child and Family Agency (Tusla), An Garda Síochána or to the Health Service Executive (HSE) Adult Safeguarding and Protection Team, as appropriate.

HIQA uses a framework to write and publish both its national standards and its inspection reports. This framework outlines which standards of care and regulations falls under one of two dimensions: quality and safety; and capacity and capability.

The quality and safety dimension focuses on the lived experience of people using the service and includes how people:

- make choices and are actively involved in shaping the services they receive
- are empowered to exercise their rights, achieve their personal goals, hopes and aspirations, and receive effective person-centred care and support at all stages of their lives
- are able to live in a safe, comfortable and homely environment
- have food and drink that is nutritious
- are protected from any harm or abuse.

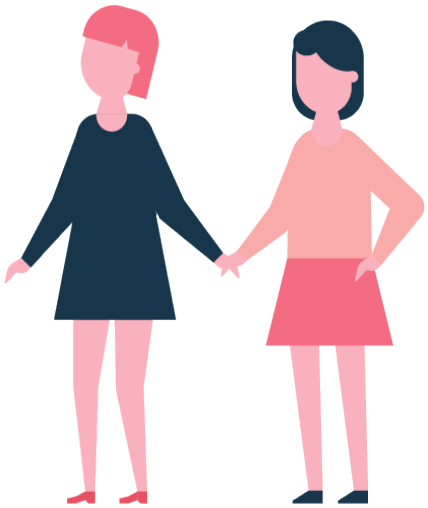
The capacity and capability dimension focuses on the overall delivery of the service and how the provider is assured that an effective and safe service is provided. It includes how the provider:

- makes sure there are effective governance structures with clear lines of accountability so that all members of the workforce are aware of their responsibilities and who they are accountable to
- ensures that the necessary resources are in place to support the effective delivery of quality care and support to people using the service
- designs and implements policies and procedures that will make sure the centre runs effectively.

Section 1 of this report gives an overview of HIQA's Information Handling Centre (IHC) and the key milestones and quality improvement initiatives introduced from 2014 to 2023.

Section 2 of this review provides an overview of the feedback received for all services under the remit of the Chief Inspector for the years 2014 to 2023.

Sections 3, 4 and 5 set out information relating to feedback received between 2014 – 2023 for designated centres for older people, designated centres for people with disabilities and children's services respectively under the remit of the Chief Inspector.



1. The Information Handling Centre 2014 – 2023

The below timeline sets out the key milestones in HIQA's Information Handling Centre's (IHC's) journey over the past decade. The timeline outlines how HIQA developed and enriched its response to information received, moving from using it to inform our interactions with individual services and residential centres to identifying key themes that are emerging from the information we receive and using it to inform our engagement with different social services sectors.

2014

In 2014, IHC staff worked across two different information management systems for documenting feedback for inspectors – one for services under the remit of the Chief Inspector and another for healthcare services. By the end of 2014, this had streamlined and information was captured within a new centralised information management system. During this period, HIQA recorded all feedback received in a transcript type manner. While there were some mandatory fields, the IHC team identified that there were gaps in the consistency of information gathered. Information received was treated individually, with no systems in place at this time for trending and analysis of the feedback received – this would come later.

2019

A review of the receipt of feedback was undertaken with input from colleagues in the older persons, disability and children's teams to ensure the processes were fit for purpose. This review gave rise to the capture of more consistent data through the addition of more mandatory fields within the information management system.

It also led to the development of HIQA's information booklets for people wishing to give feedback. Although HIQA was already signposting contact persons to the relevant supports, these booklets were produced to provide contact persons with practical advice about how HIQA uses their feedback, how to make a complaint to the provider, the different supports available to them, and to offer signposting to different support networks where contact persons could access additional advice and or advocacy services.

At the latter end of 2019, a review of HIQA's policies and procedures to receive protected disclosures and keep the identity of the reporting person confidential was carried out. HIQA's information management system was equipped with the function to capture when information received was or was not a protected disclosure. The IHC's Regional Manager was assigned delegations to receive protected disclosures, and a separate secure file storing platform was created to host a

protected disclosures register and all correspondence relating to protected disclosures.

2020

In 2020, HIQA heard a lot about the COVID-19 pandemic and the impact this was having on residents and people who use services across the health and social care services regulated and monitored by HIQA. This year saw HIQA receive its largest volume of feedback, particularly by phone. HIQA also made more follow-up calls with contact persons due to families' and staff experience at that time when residential services were closed to visitors and there were increasing levels of the COVID-19 virus.

It was notable over the course of 2020 that the feedback was becoming more complex in nature. A bespoke customer handling training programme was delivered at the end of 2020 for HIQA to support staff with handling calls from distressed and anxious callers.

Internal procedures were further developed to support the capturing of consistent, quality data and information to support the regulation of the centres and services under the remit of the Chief Inspector and HIQA.

Also in 2020, in order to quantify the volume of feedback received and identify what type of services we hear about, feedback outside of HIQA's remit was captured in its information management system for the first time. In addition, any complimentary feedback received about services under the remit of the Chief Inspector and HIQA were also logged.

2021

In 2021, HIQA began categorising feedback received into themes. These themes were created based on regulations and national standards. This information was used to identify overall trends within each social services sector.

2022

HIQA built on the quantitative reports developed in 2021 to include a qualitative element. This qualitative analysis allowed HIQA to start trending the information to determine what were the most common themes being raised as part of the un-validated feedback received each quarter. It also indicated the types of issues that may be having the most impact on those using services. This information and insight into the type of matters HIQA was hearing about was shared with the relevant teams to assist them in their ongoing regulation and monitoring of services.

In order for HIQA to complete the story of how it responds to people's feedback, it began to review the regulatory actions taken by inspectors in response to information received to determine what these actions were. For example, did the inspector seek assurances from the provider or did the feedback directly trigger an inspection.

In preparation for the commencement of the Protected Disclosures (Amendment) Act 2022 on 1 January 2023, HIQA reviewed its procedures and deemed that all employees contacting HIQA about services and centres under its regulatory remit would be treated as potential protected disclosures from 1 January 2023. HIQA also developed an infrastructure to support this function to assist in meeting its obligations under the amendments to the Act, including a dedicated and secure mailbox and a recorded phone line.

2023

The Protected Disclosures (Amendment) Act 2022, commenced on 1 January 2023. In line with the requirements of the Act, HIQA has an external reporting channel and procedure for workers to make a report of a relevant wrongdoing to the CEO of HIQA, as a prescribed person. Further information on HIQA's protected disclosures process can be found on our website www.hiqa.ie.

HIQA was nominated and shortlisted for a Customer Services Award for its commitment to providing meaningful support for people with concerns in relation to health and social care services. This was a testament to the team's ability to provide a compassionate, empathetic and listening ear to those who seek to provide their feedback to us, and to provide people with relevant and practical advice around the situations they may be in or issues they may be experiencing. Where HIQA may not have a role in a particular aspect of a person's experience, the team seeks to identify alternative supports that may be of benefit to the person and signposts them accordingly. The team's desire for ensuring people are responded to in a timely manner, that their voices are heard and that people are provided with good quality information in response to their feedback is reflected in the many emails and calls received from people who have been in touch with us, who wish to convey their thanks to the team.

Managing people's feedback

HIQA acknowledges all feedback received where contact details are provided. HIQA aims to respond to people within two working days and the majority of people are responded to within one working day. As HIQA has no regulatory remit to manage or investigate an individual complaint, staff in HIQA's IHC signposts the person to

the relevant complaints process and other appropriate supports that are available to them. A copy of the relevant HIQA information booklet is included in all written acknowledgments and are also available on our website www.hiqa.ie.

Each piece of feedback is logged on the information management system and referred to the inspector for assessment and appropriate regulatory follow up. The inspector can take actions to ensure that providers are complying with the regulations and that there is not a negative impact on all of the people who are using the service. Inspectors have a variety of regulatory actions that they can take in response to feedback received and their other regulatory intelligence about a centre or service, which includes requesting assurances on the issues raised from the registered provider, using the information as a line of enquiry at the time of the next inspection, requesting an update to a compliance plan from the last inspection or carrying out a triggered inspection of the service. Where assurances are received outside of an inspection activity, the inspector will use the feedback and these assurances to inform lines of enquiry at the next inspection.

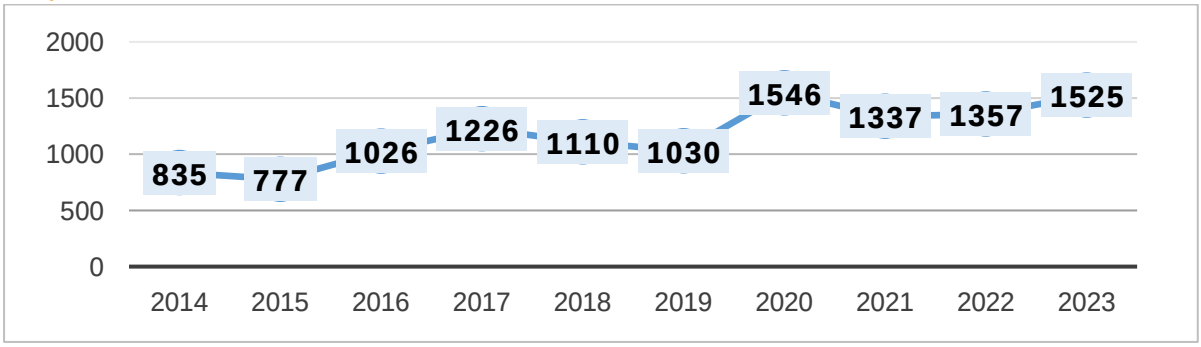
2. Feedback received under the remit of the Chief Inspector 2014 to 2023

The Chief Inspector is responsible for the regulation of residential services for older people, people with disabilities, and children's special care units, and for the monitoring of some children's social care services. Over the time period 2014 – 2023, HIQA has received 11,769 pieces of feedback about centres and services under the remit of the Chief Inspector. HIQA started recording positive feedback from 2021 and since then 108 pieces of complimentary feedback have been received. Although the volume of feedback received might seem large, when the number of registered services[1] and the number of people using these services is considered, the quantity of feedback received is very small by comparison. This, alongside our inspection findings, demonstrates that most designated centres and services are providing people with a good quality of life.

Looking back over these last 10 years, the number of pieces of feedback received by HIQA has almost doubled in 2023 when compared with 2014 figures. The volume of feedback has varied each year, but a significant spike in the volume of feedback received was observed in 2020. This was largely attributed to the COVID-19 pandemic, with people concerned with the restrictions on visiting and being able to see their relative, infection prevention and control measures and what they saw as the poor quality of care being provided to residents. Figure 1 below illustrates the volume of feedback received each year from 2014 to 2023. All of this information was used to inform our regulation of residential centres during this time.

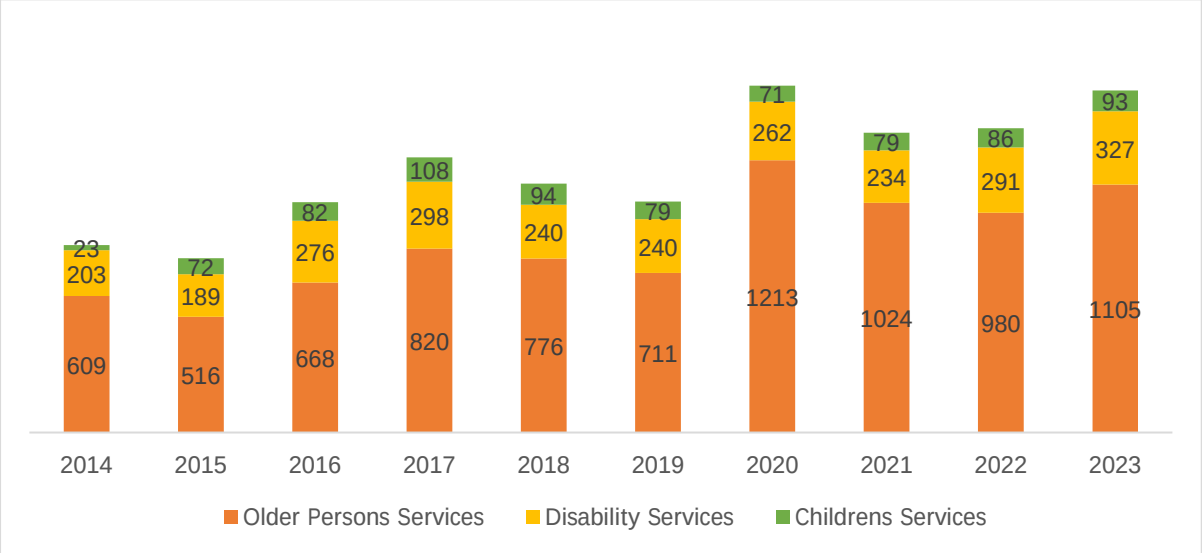
[1] Services for older people (nursing homes): As of 31 December 2023 there were 553 designated centres for older people registered with the Chief Inspector, which in total could accommodate 32,214 residents.
Disability services: As of 31 December 2023 there were 1,574 designated centres for people with disabilities registered with the Chief Inspector, which in total could accommodate 9,147 residents.
Children's services: As of 31 December 2023 there were three special care units, 18 Child and Family Agency (Tusla) child protection and welfare services, 18 Child and Family Agency (Tusla) foster care services, 37 statutory children's residential centres, five private foster care services and Oberstown Children Detention Campus.

Figure 1. Volume of feedback received per year under the remit of the Chief Inspector for 2014 - 2023



The proportion of feedback received for each team under the Chief Inspector has remained consistent each year, with designated centres for older people accounting for the largest share of feedback annually. Designated centres for people (adults and children) with disabilities accounts for the next highest share of feedback, with the least amount of feedback being received for children's services. Figure 2 below indicates the volume of feedback received for each of these three teams, per year, from 2014 to 2023.

Figure 2. Volume of feedback under the remit of the Chief Inspector received per team per year for 2014 - 2023

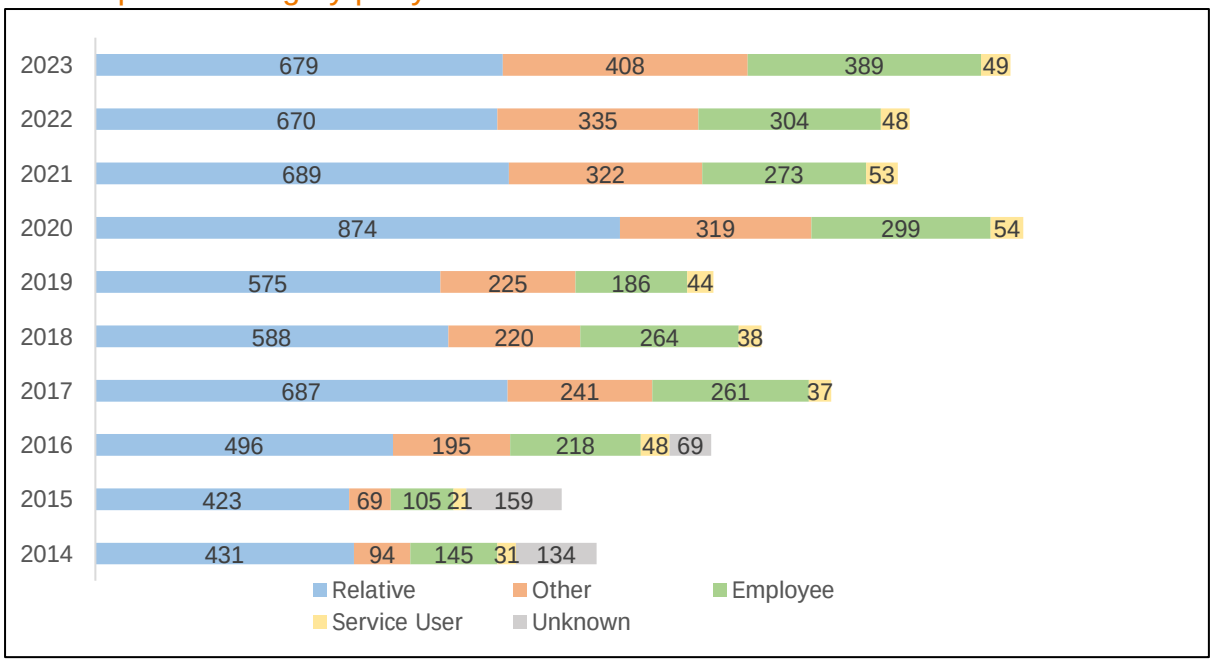


Over the 10 years HIQA has heard from 423 (4%) residents or people using services, 6,112 (52%) relatives, 2,444 (21%) employees and 2,428 (21%) others (see Figure 3). Others would include, for example members of the public, health and social care professionals and advocates.

In 2023, HIQA noted the largest number of employees to date provided feedback - an increase of 28% (75) on the previous year. This rise may be attributed to the commencement of the Protected Disclosures Act 2014, as amended which came into

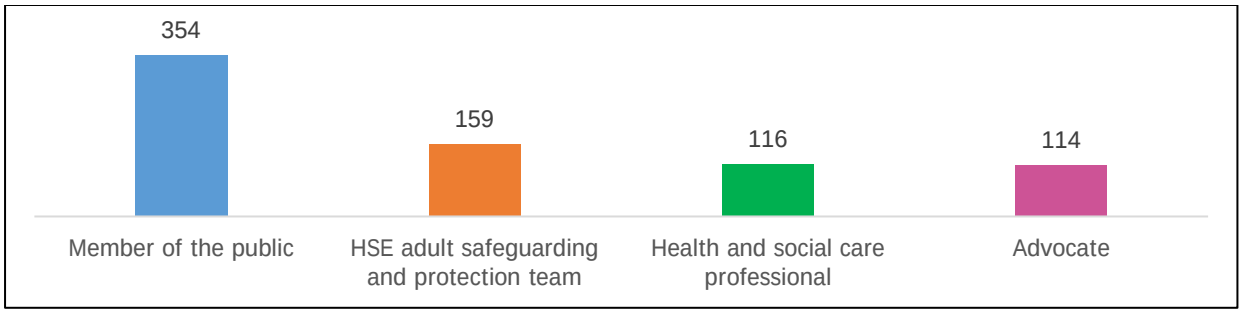
effect as of 1 January 2023 and afforded employees with additional protections when speaking up about wrongdoings in their place of work.

Figure 3. Volume of feedback under the remit of the Chief Inspector received per contact person category per year 2014 - 2023



Since 2021, HIQA has introduced the use of sub-categories of 'others' in order to improve data quality. HIQA has heard from 1,065 'others' between 2021 and 2023. Of these, the most frequent sub-categories of others included members of the public (354), HSE adult safeguarding and protection teams (159), health and social care professionals (116) and advocates (114) (Figure 4).

Figure 4. Most frequent 'other' sub-categories for Chief Inspector feedback 2021 – 2023

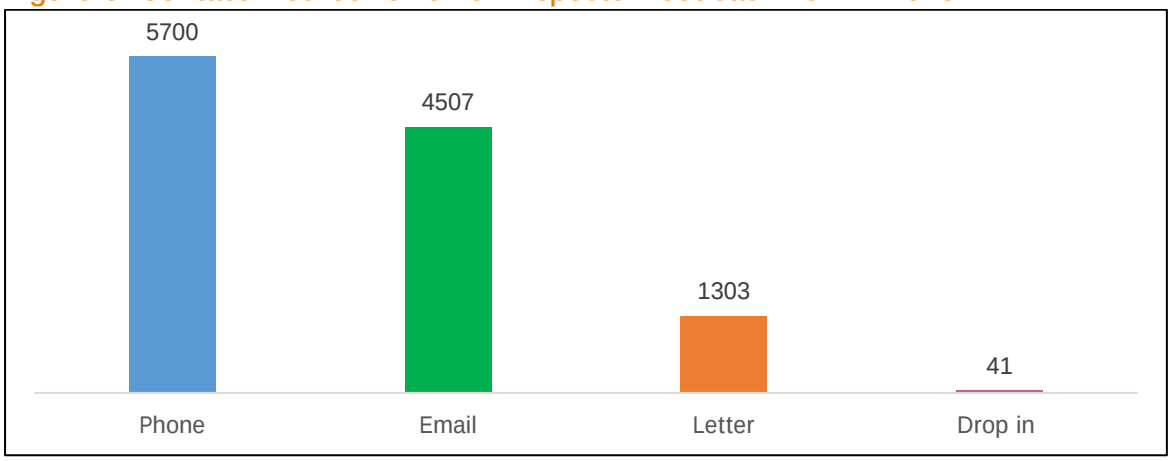


Contact method

Overall, people's preferred method of contact during the decade was phone call, with 5,700 (48.5%) received in this manner. HIQA also received 4,507 (38%) feedback by email, 1,303 (11%) by letter and 41 (0.5%) people attended a HIQA

office to provide their feedback (see Figure 5)[2]. However, in more recent times, email is the preferred method of contact and if required, HIQA will follow-up with the person by phone.

Figure 5. Contact method for Chief Inspector feedback 2014 - 2023



What have people told us?

Since 2021, HIQA has assigned themes to each piece of feedback received. These themes correlate with the regulatory obligations of the service provider and national standards. This practice allows HIQA to categorise the feedback received based on the types of issues being raised. From this, HIQA is enabled to identify and respond to the themes it hears about most and to key issues presenting within particular services.

Compliments

Since 2021, there were 108 compliments received about centres and services under the remit of the Chief Inspector, where people wished to share feedback about their positive experiences. The majority of these related to designated centres for older people (95), followed by designated centres for people with disabilities (11) with two compliments received about children's social care services.

Feedback

The issues that HIQA hears about tend to be related to the themes of safeguarding and rights of those using services, and the quality of care they receive. HIQA has also heard about poor communication between staff and those using services, between staff and families and between staff and management teams. Ineffective

[2] An additional 155 pieces of information (1.5%) were created based on internally sourced information (HIQA staff (133) and media articles (22)). The remaining 63 (0.5%) pieces of information (received between 2014 and 2016) did not specify a contact method.

complaints handling and governance and management systems have been other frequent themes.

In order to inform service users, family members and members of the public about what we do with their feedback, we have compiled the regulatory actions taken in response to the feedback received during 2022 and 2023.

Of the 2,882 pieces of feedback received over this two year time period, 1,746 (61%) were assigned an initial regulatory risk rating of low or very low. A further 1,105 (38%) were assigned a moderate regulatory risk rating and 31 (1%) were assigned a high regulatory risk rating.

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

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

Of the 2,882 pieces of feedback received during this two year time period, 1,219 (42%) pieces of feedback were used to inform the ongoing regulation and monitoring of the respective services to inform lines of enquiry at the time of the next inspection. A further 522 (18%) contained similar information to a previous piece of feedback or solicited information received. Here, inspectors reviewed the information, assessed the regulatory risk rating and then closed this piece of feedback as they were following the information up under the initial piece of information received.

Of the remaining 1,141, inspectors sought a provider assurance report for 1,002 (88%) of these and would have later used both the feedback and the assurances provided in the provider assurance report to inform lines of enquiry at the next inspection. A further 139 (12%) resulted in a triggered inspection.

The next section of this report takes a look back on the feedback received by HIQA for each of the teams under the remit of the Chief Inspector over the last 10 years.

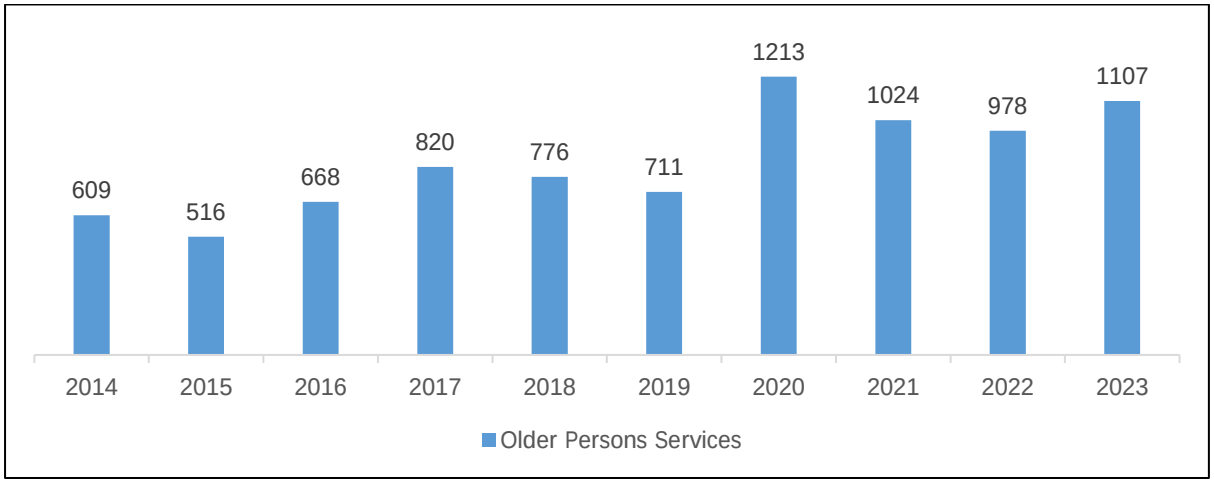
3. Feedback about Designated Centres for Older People 2014 - 2023

Overview

HIQA has processed 8,422 (71% of the total received) pieces of feedback relating to designated centres for older people (also known as nursing homes) from 2014 to 2023. Since 2021, 95 compliments have been received about individual nursing homes. As of 31 December 2023, there were 553 designated centres for older people registered with the Chief Inspector, which in total could accommodate 32,214 residents. While older people's services is the area that HIQA hears most about, when we consider the number of nursing homes and how many people are living in this type of setting, the volume of feedback received is low by comparison. Looking at 2023, HIQA received feedback relating to 61% (336) of the designated centres for older people. Of note, the older people's team also receives the largest proportion of complimentary feedback of all services under the remit of the Chief Inspector.

Figure 6 below demonstrates the volume of feedback received about older persons' centres per year. In 2020, there was a 70% increase in the number of pieces of feedback received compared to 2019. This increase in feedback can be mostly attributed to the COVID-19 pandemic which was a cause of worry and concern amongst residents, relatives and staff at that time. Since 2020, the number of pieces of feedback have reduced, but they have remained consistently higher than the pre-2020 numbers.

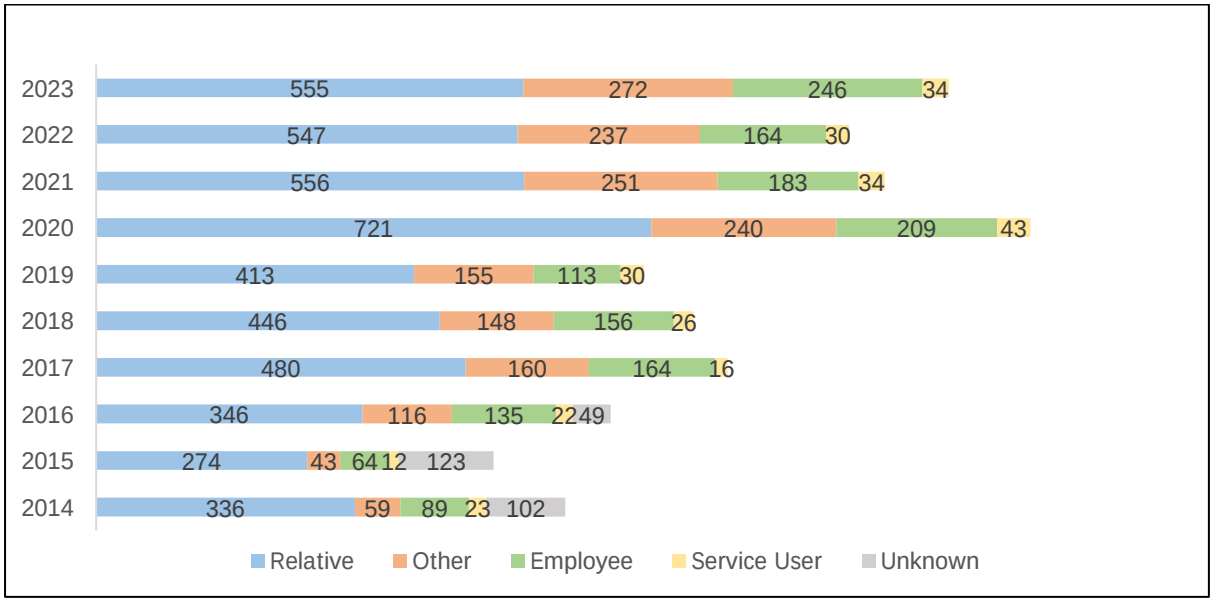
Figure 6. Volume of feedback received for older people's services per year for 2014 – 2023



Who has HIQA heard from?

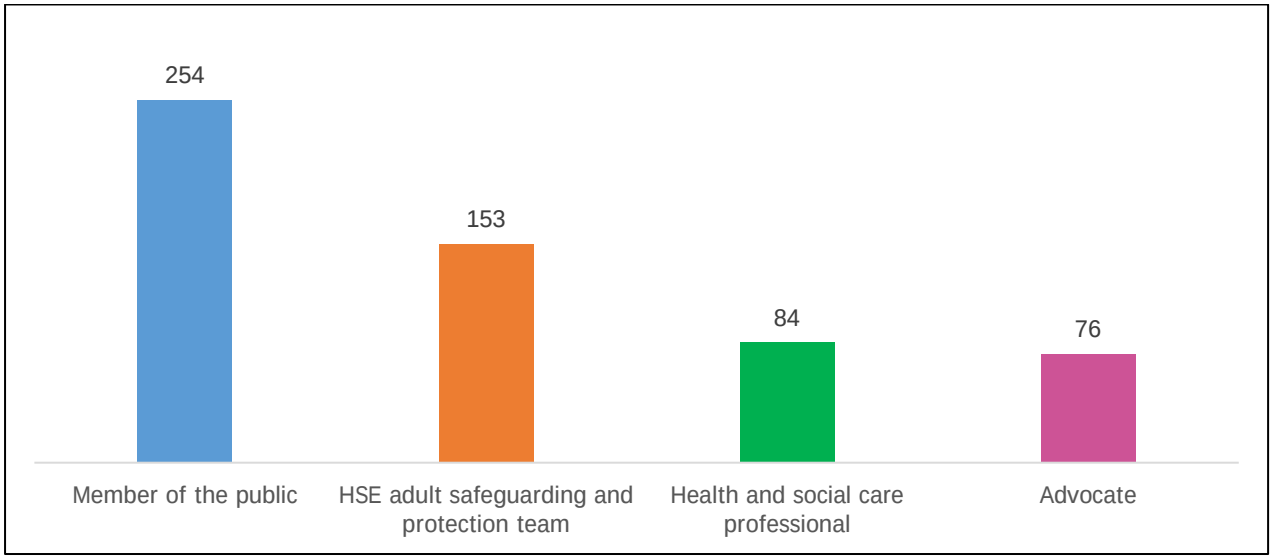
Over the decade, HIQA heard from 270 (3%) residents who were living in designated centres for older people. Relatives accounted for 55% (4,674) of the feedback received, with employees accounting for 18% (1,523). A summary of the breakdown of contact person category over the years 2014 – 2023 can be seen in Figure 7.

Figure 7. Contact person categories for feedback on older people's services 2014 - 2023



The 'other' category accounted for 20% (1,681) of the feedback. Since 2021, HIQA hears most frequently from members of the public, Health Service Executive (HSE) teams, health and social care professionals and advocates (see Figure 8). This is aligned to the overall profile of 'others' for the Chief Inspector.

Figure 8. Most frequent 'other' sub-categories for feedback on older people's services 2021-2023

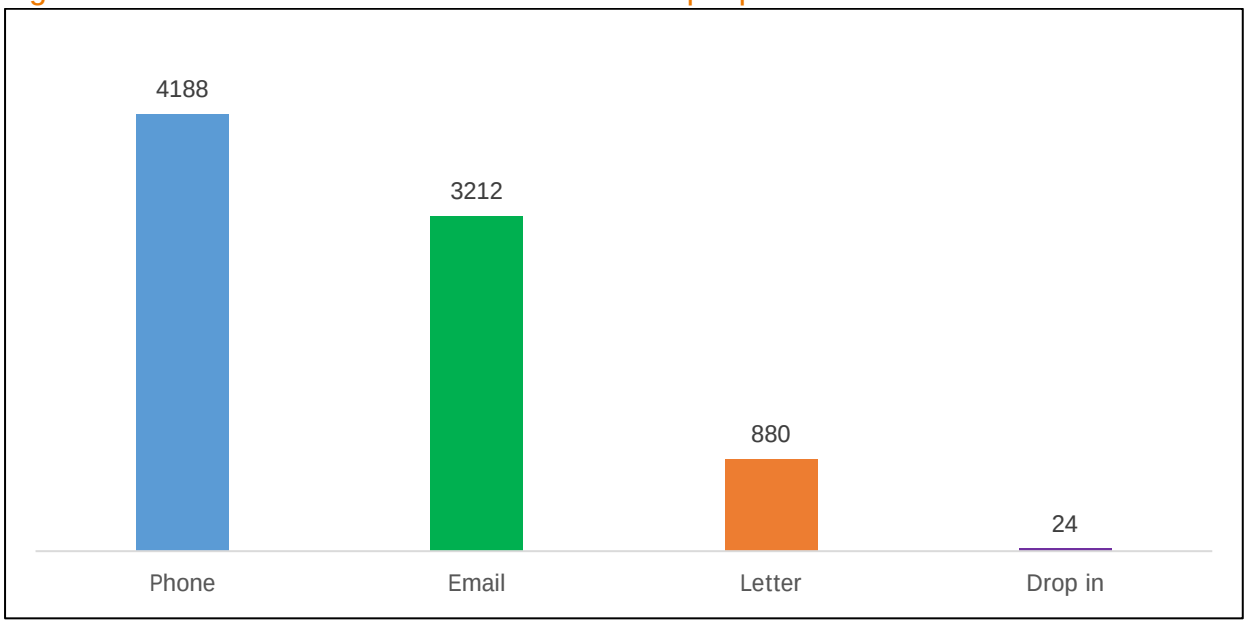


Contact method

Overall, people's preferred method of contact during the decade was phone call, with 4,188 (50%) of the feedback received in this manner. HIQA also received 3,212 (38%) pieces of feedback by email, 880 (10%) by letter and 24 (0.5%) people attended a HIQA office to provide their feedback (see Figure 9)[3]. This is aligned to the overall profile of contact methods for all services under the remit of the Chief Inspector.

[3] An additional 88 (1%) pieces of information were created based on internally sourced information (HIQA staff (81) and media articles (7)). The remaining 30 (0.5%) pieces of information (received between 2014 and 2016) did not specify a contact method.

Figure 9. Contact method for feedback on older people's services 2014 - 2023



What have people told us?

During 2021, HIQA started to categorise the feedback received into themes. These themes are aligned to the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and *National Standards for Residential Care Settings for Older People in Ireland*, and facilitate HIQA to categorise the feedback based on the types of issues being raised. This allows HIQA to identify what themes it hears about most and if there are key issues presenting within nursing homes. The pieces of feedback received may contain multiple themes. For example, feedback about the quality of care, may also have included feedback about safeguarding residents and promoting their rights. Over time, HIQA continues to hear about a number of the same key issues and examples of this feedback received is set out below.

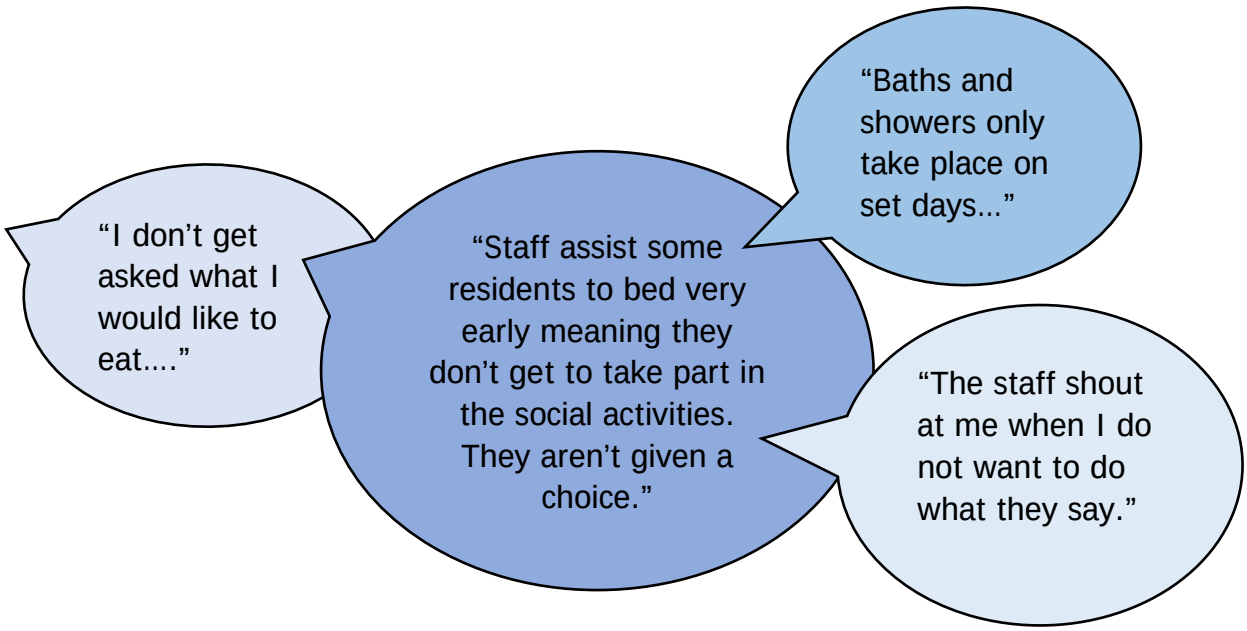
Each piece of information was individually risk assessed and used to inform regulatory actions which may range from informing a line of enquiry on the next inspection, seeking provider assurance reports through to a triggered risk inspection.

Compliments

HIQA welcomes positive feedback from people about nursing homes. This positive feedback usually compliments the good quality care provided to residents living in this type of setting and how good governance and management structures and effective communication can promote positive care experiences for residents. Here are some examples of positive feedback received.

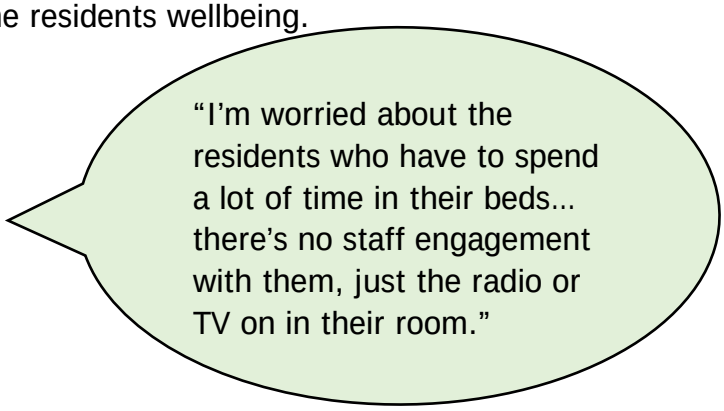
Safeguarding and Residents' Rights

Feedback received referenced times where staffing levels may not have supported the appropriate oversight of residents, which may have resulted in residents will and preferences not being promoted. HIQA also heard about institutionalised practices and times where residents may not have been afforded choice about different aspects of the care they received. People have also told HIQA about allegations of abuse and neglect within nursing homes, which may have been perpetrated by staff, another resident, or by family members of residents. HIQA has heard of times where staff may have rough handled residents when carrying out personal care, or have shouted at residents. HIQA has also heard about peer-to-peer physical and verbal abuse, or where a family member may have mismanaged their relative's finances.



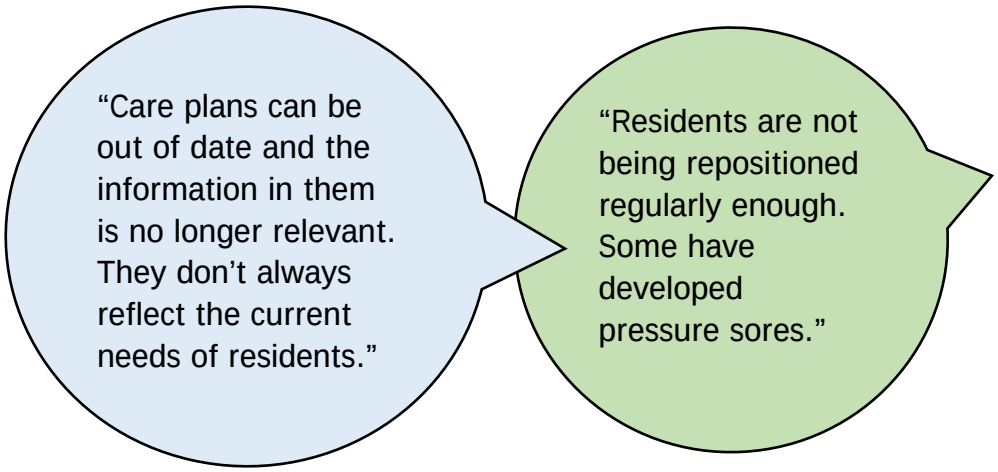
General Welfare and Development

Feedback has included times where meaningful activities for residents were limited, sometimes to one day per week. HIQA has also heard from people who have told us that residents who were not independently mobile were left in bed all day with no stimulating activities offered, and times where residents may have been left in day rooms with no activities other than the television and the negative impact this may have had on the residents wellbeing.



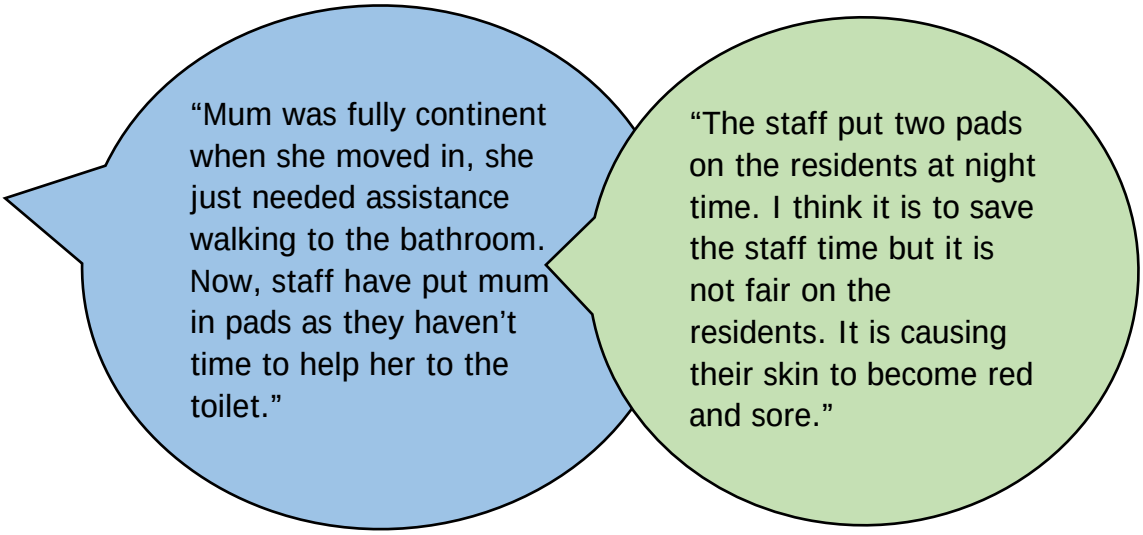
Quality of Care - Care Planning

HIQA has received feedback that care planning may not have been effective. Other people referenced care plans which may have been out of date and the impact that may have had on ensuring residents' needs were being met.



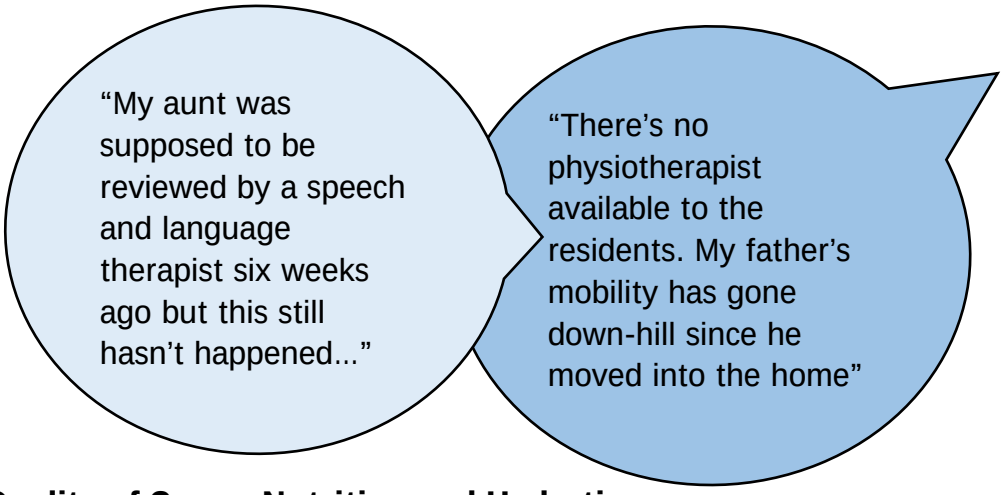
Quality of Care – Personal Care

Feedback has referenced times where residents may not have received appropriate support with their toileting or oral care needs. HIQA has also heard about times where residents presented in clothing that was visibly soiled, looking unkempt, where their nails, hair, teeth or dentures needed attention or they required assistance with shaving.



Quality of Care – Healthcare

Feedback received has provided examples of times where staff may not have been knowledgeable in aspects of residents’ care needs and which may have led to delays in response times to a residents deteriorating condition. HIQA has also heard about times where residents may not have had timely access to a general practitioner (GP), speech and language therapist or dietitian.

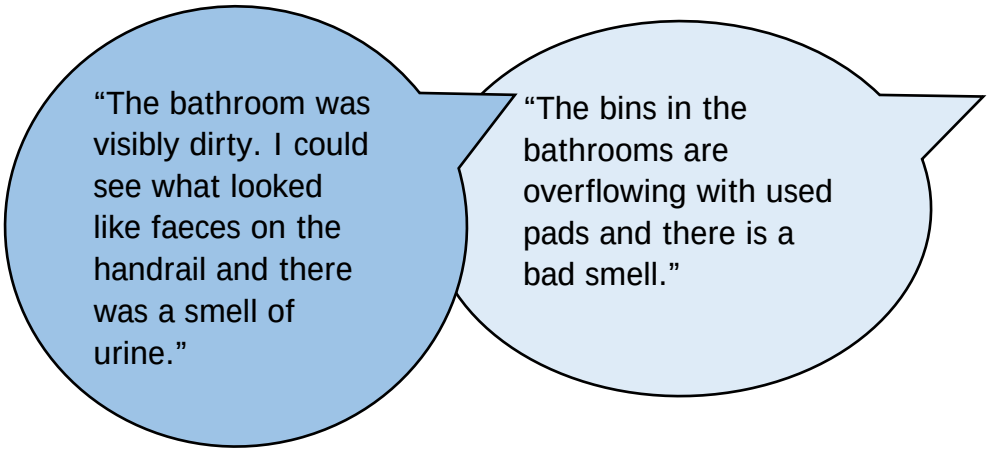


Quality of Care – Nutrition and Hydration

In the feedback received that referenced nutrition and hydration, HIQA often heard about occasions where residents’ meals were of small portion size and or not appealing to eat. HIQA also heard from people who told us that residents may not have been in receipt of the required support from staff in order for them to consume their meals and fluids, and times where residents who have specific dietary requirements did not have their needs met.

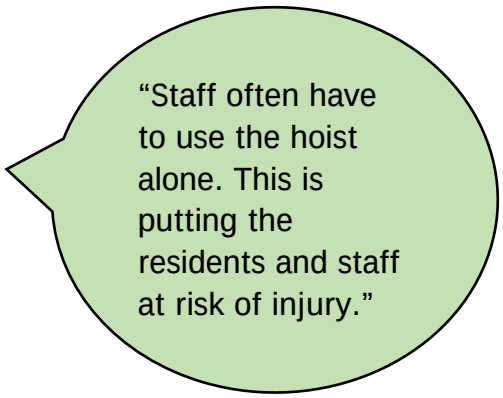
Infection Prevention and Control Measures

HIQA has received feedback referencing premises which may have been visibly unclean, with floors and surfaces damaged and dirty. HIQA also heard about times where staff may not have practiced appropriate hand hygiene, and times where staff may not have used personal protective equipment (PPE) appropriately.



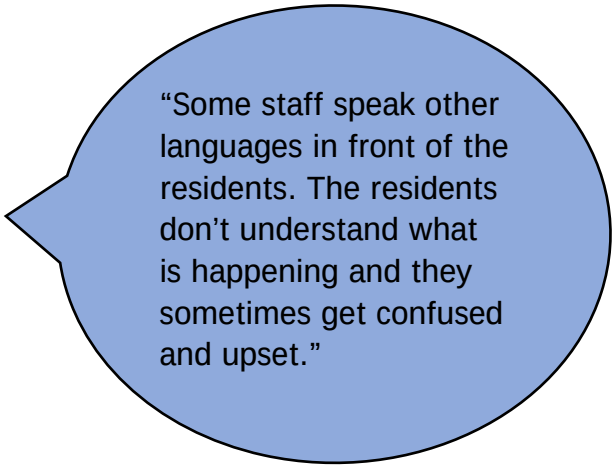
Risk Management

HIQA has received information about times where emergency exits may have been obstructed with equipment which people told us may have limited the ability to evacuate the building in a timely manner in the event of an emergency. HIQA also heard about times where the residents’ call bells had been unplugged as they felt residents were ringing them too frequently, and times where staffing levels or competencies may have prevented the correct use of equipment such as hoists.



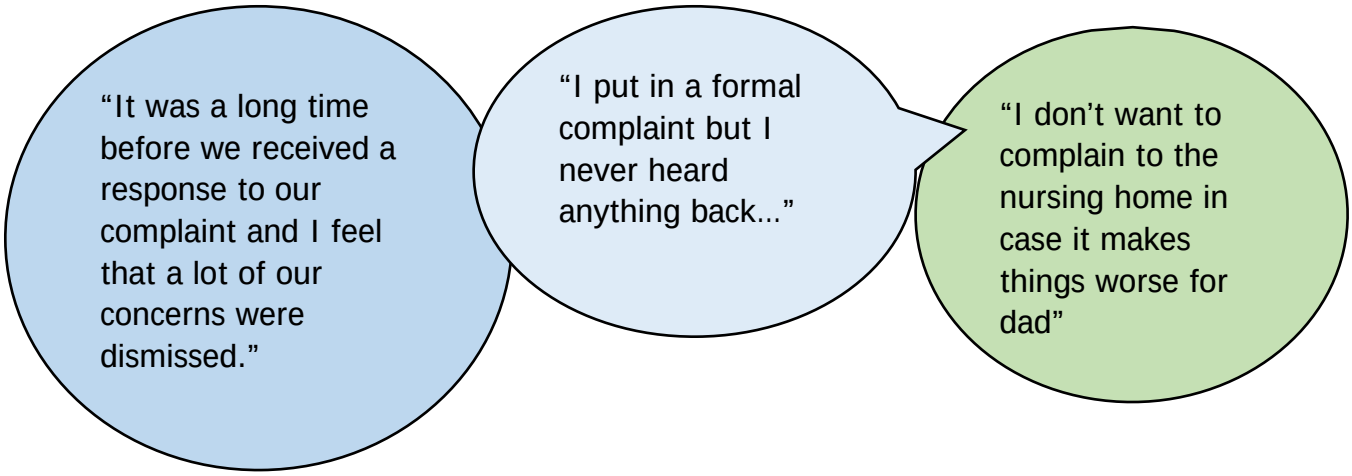
Communication

Some people told HIQA about times where there had been a lack of communication with families in respect of the changing care needs of residents. HIQA also heard about times where staff who may not speak English as a first language, were speaking in their own native tongue in the presence of residents, which may have resulted in residents feeling excluded from their own care or confused as to where they might be.



Complaints Handling

In 2023, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2022 were commenced. The purpose of these regulations is to ensure residents have access to independent advocacy services and provision for registered providers having effective complaints mechanisms in place for residents. However, HIQA has continued to hear about two key issues in respect of complaints handling. HIQA heard from people who told us they had made a formal complaint to the registered provider but were dissatisfied with how their complaint was managed. HIQA also heard from people who told us they were afraid to make a formal complaint to the registered provider as they feared doing so may have negative repercussions for the resident or their family.



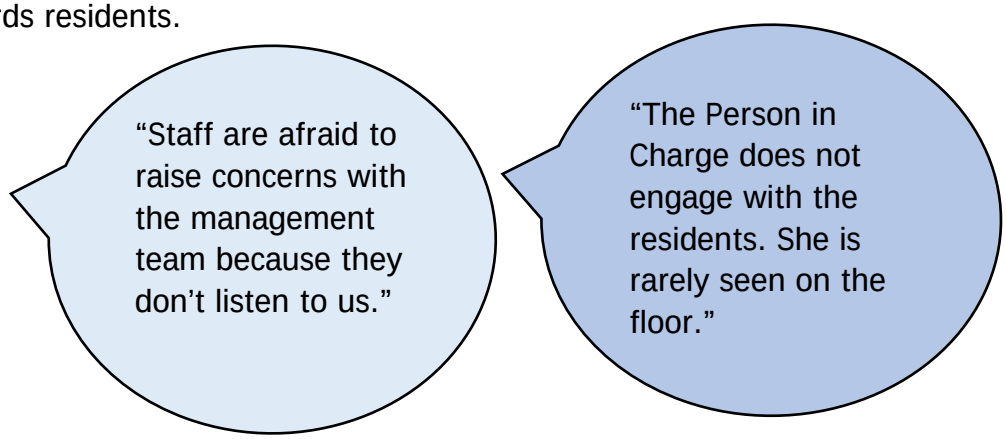
Staffing

Feedback often referenced the impact of staffing shortages or the time taken for residents' call bells to be answered, and how insufficient staffing levels may have resulted in residents experiencing delays in having their personal care needs met. HIQA has heard about times where there may have been insufficient staffing available during mealtimes, which may have left residents without the appropriate supports to consume their meals. HIQA has also received feedback that references how nursing homes may at times be reliant on staffing agencies to fill their rosters, and the impact that unfamiliar staff can have on the quality of care provided to residents.

Governance and Management

The vast majority of feedback received references governance and management issues. This indicates how the majority of clinical and operational issues within nursing homes can be associated with failures in the oversight, monitoring or management systems in place. Feedback received sometimes referenced a culture of favouritism in centres, resulting in times where staff feel they cannot approach the

management team to report events, and a lack of a person-centred approach towards residents.



This feedback gives us an insight into the real lived experiences of residents residing within nursing homes in Ireland. It is important that HIQA recognises how the experiences, both positive and negative, of residents, relatives, workers and others can contribute to how HIQA regulates these services, and the impact this can have on improving care experiences for those living within designated centres for older people.

What has happened with the feedback provided about nursing homes?

All feedback received by HIQA is brought to the attention of the inspector. While it is not the remit of HIQA to investigate individual complaints, the inspector reviews the feedback in line with the information they already know about the service, they apply a regulatory risk rating and determine what is the appropriate regulatory action to take.

Of the 2,085 pieces of feedback received over this two-year time period, 1,240 (60%) were assigned an initial regulatory risk rating of low or very low. A further 823 (39%) were assigned a moderate regulatory risk rating and 22 (1%) were assigned a high regulatory risk rating.

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

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

Of the 2,085 pieces of feedback received during this two year time period, 828 (39.5%) pieces of feedback were used to inform the ongoing regulation and monitoring of their respective services and included as lines of enquiry at the next inspection. A further 425 (20%) contained similar information to a previous piece of feedback or solicited information received. Here, inspectors reviewed the information, assessed the regulatory risk rating and then closed this piece of feedback as they were following the information up under the initial piece of information received.

Of the remaining 832 (40.5%), inspectors sought a provider assurance report for 752 of these and would have later used both the feedback and the assurances provided in the provider assurance report to inform lines of enquiry at the next inspection. An additional 80 resulted in a triggered inspection.

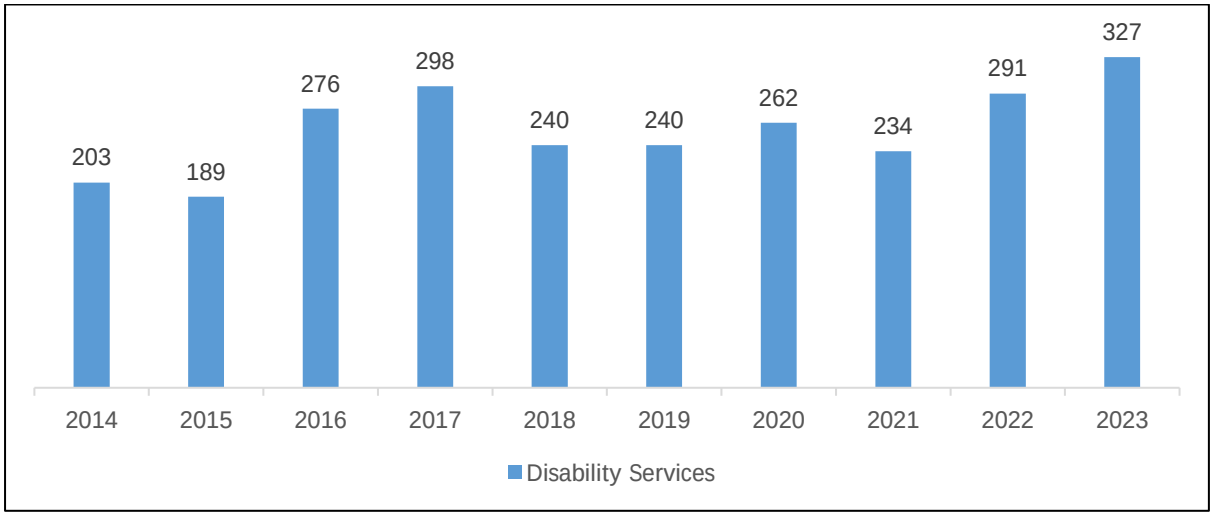
4. Feedback about Designated Centres for People with Disabilities 2014 - 2023

Overview

HIQA has processed 2,560 (22%) pieces of feedback relating to designated centres for people with disabilities from 2014 to 2023. Since 2021, 11 compliments have been received about disability centres. As of 31 December 2023, there were 1,574 designated centres for people with disabilities registered with the Chief Inspector, which in total could accommodate 9,147 residents. When the number of designated centres for people with disabilities and how many people are living in this type of setting is considered, similar to nursing homes, HIQA only hears about a small proportion of these centres. In 2023, HIQA only received feedback relating to 13% (204) of designated centres for people with disabilities. This indicates that most services are doing a good job at meeting the needs of those living in designated centres and that issues raised are being well managed.

Figure 10 below demonstrates the volume of feedback received about designated centres for people with disabilities per year. In 2023, the volume of feedback received about designated centres for people with disabilities exceeded 300 for the first time.

Figure 10. Volume of feedback received for disability services per year for 2014 – 2023



Who has HIQA heard from?

Over the decade, HIQA heard from 119 (5%) residents living in designated centres for people with disabilities (see Figure 11). Relatives accounted for 999 (39%) of the pieces of feedback and 812 (31%) were from employees. The 'other' category accounted for 21% (546) of the feedback including members of the public and advocates (see Figure 12).

Relatives accounted for the majority of feedback received up to 2021, but over the last two years, employees have been the most frequent contact person in relation to designated centres for people with disabilities.

Figure 11. Contact person categories for disability services feedback 2014 - 2023

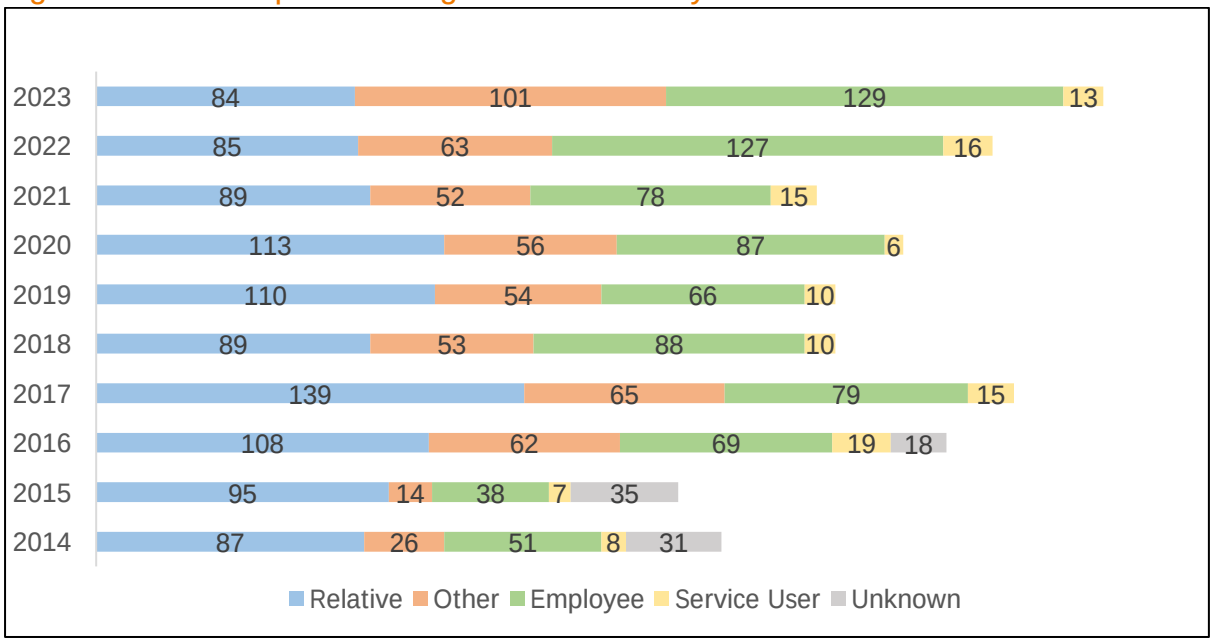
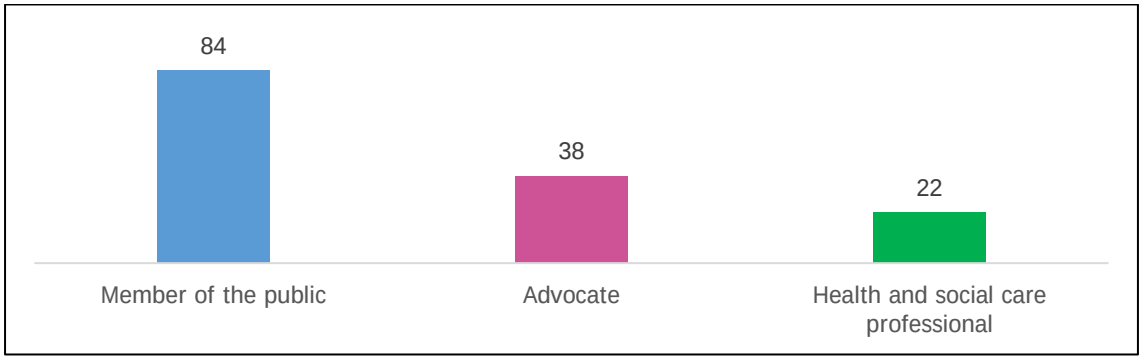


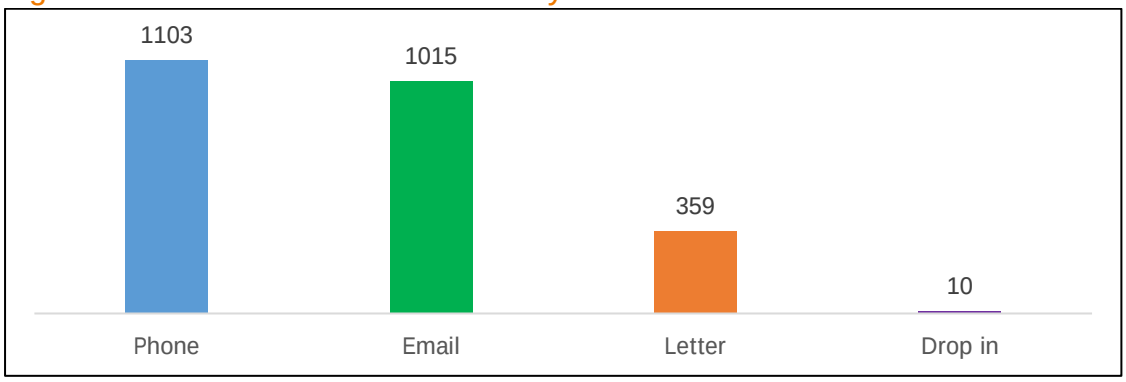
Figure 12. Most frequent 'other' sub-category for disability services feedback 2021 - 2023



Contact method

Overall, people's preferred method of contact during the decade was phone call, with 1,103 (43%) pieces of feedback received in this manner. HIQA also received 1,015 (39%) by email, 359 (14%) by letter and 10 people attended a HIQA office to provide their feedback (see Figure 13)[4]. This is aligned to the overall profile of contact methods for all services under the remit of the Chief Inspector.

Figure 13. Contact method for disability services UROI 2014 – 2023



What have people told us?

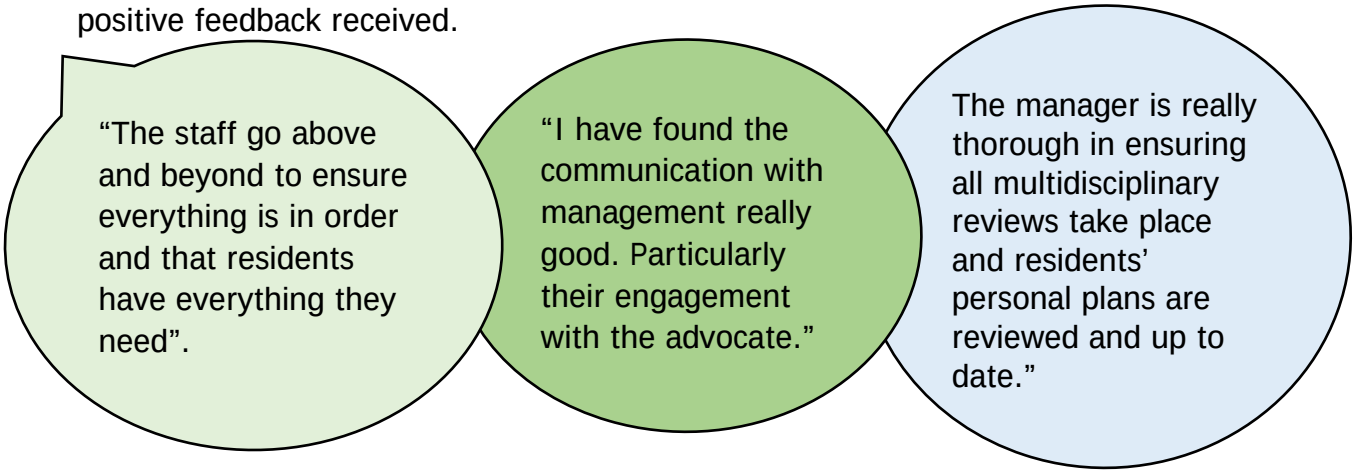
During 2021, HIQA began to categorise the feedback received into themes aligned to the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and *National Standards for Residential Services for Children and Adults with Disabilities*. This allows HIQA to identify what themes it hears about most and if there are key issues presenting across the designated centres for people with disabilities. It is important to note that the feedback received may contain multiple themes. Over time, HIQA continues to hear about a number of the same key issues and examples of this feedback received is set out below.

[4] An additional 46 (2%) pieces of information were created based on internally sourced information (HIQA staff (40) and media articles (6)).

It is important to note that each piece of information received was individually risk assessed and used to inform regulatory actions which may range from informing a line of enquiry on the next inspection, seeking provider assurance reports through to a triggered risk inspection.

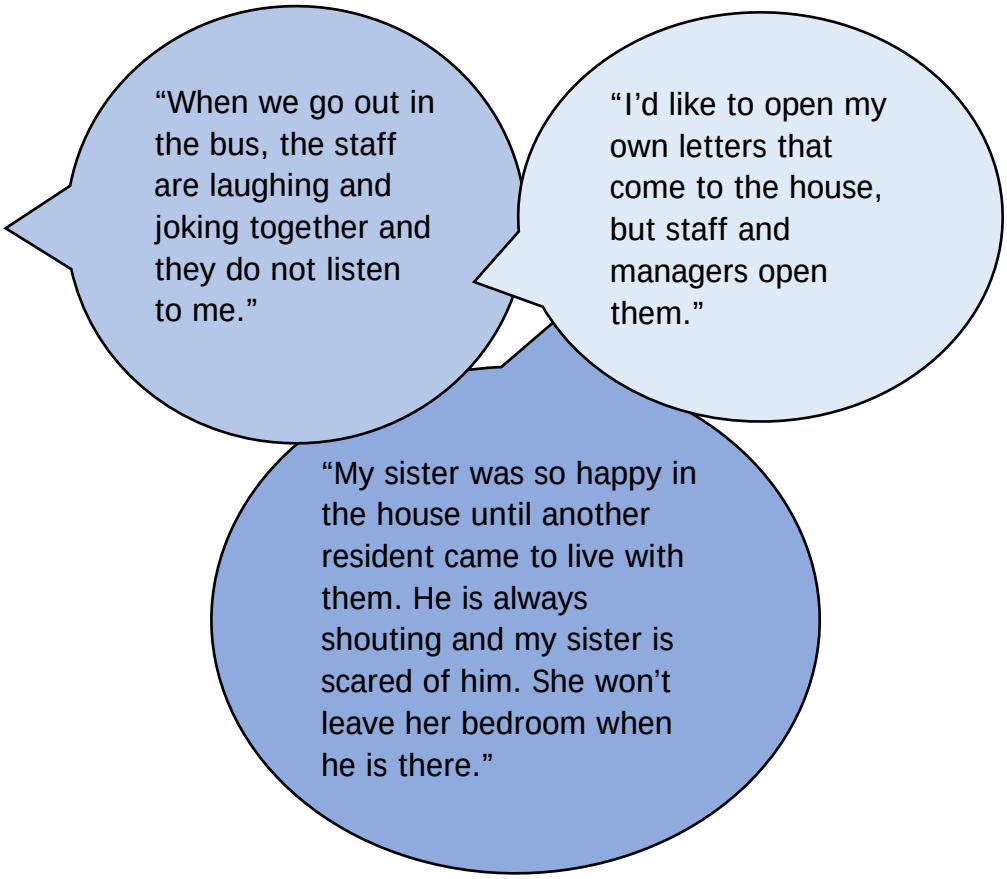
Compliments

It is important to note that HIQA welcomes and passes on positive feedback from people about designated centres to the inspector. This positive feedback usually compliments the good quality care provided to residents living in this type of setting and how good governance and management structures and effective communication can promote positive care experiences for residents. Here are some examples of positive feedback received.



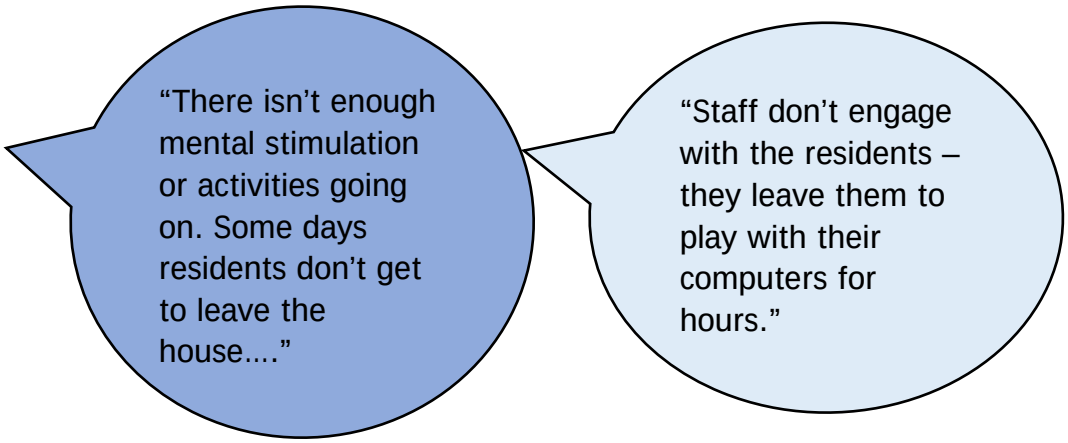
Safeguarding and Rights

Feedback received referenced times where residents may not have been supported to exercise choice in relation to aspects of their care, such as the activities they undertake or their choice of food and mealtimes. HIQA has also heard about subtle restrictive practices, including residents who may not have been allowed to access snacks outside of set meal times, and residents who may not have been given access to showers outside of set times, which people told HIQA could have resulted in residents becoming upset and agitated. HIQA also heard about allegations of abuse and neglect within centres which may have been perpetrated by staff, peers or by family members of residents. Feedback received has included times where staff may have rough handled residents when carrying out personal care, or where staff may have shouted at residents. HIQA also heard about peer-to-peer physical and or verbal abuse and where residents may not have had access to their own money.



General Welfare and Development

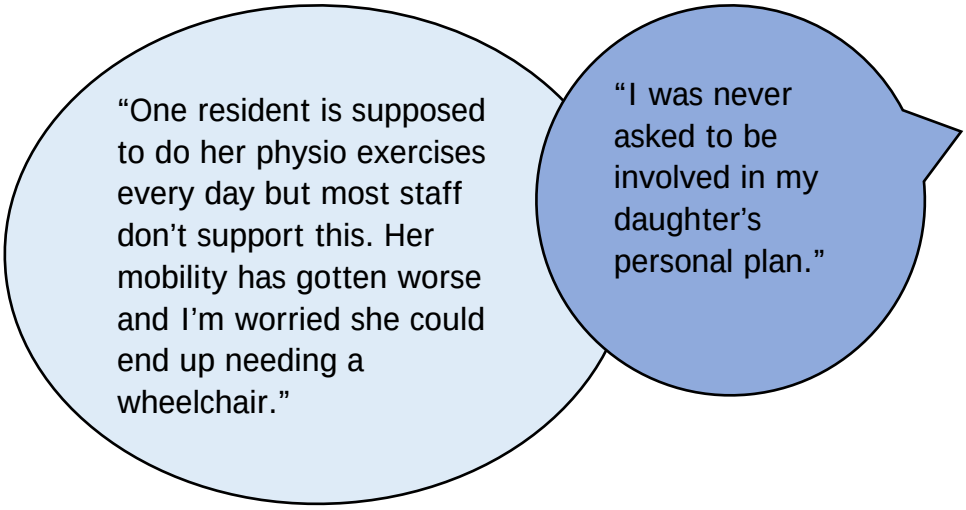
Examples of the feedback included times where residents may not have been supported to experience variety in their daily activities, with some examples referencing that residents may have been left alone on their tablets and phones all day with no access to meaningful activities and little engagement from staff.



Quality of Care - Personal Planning

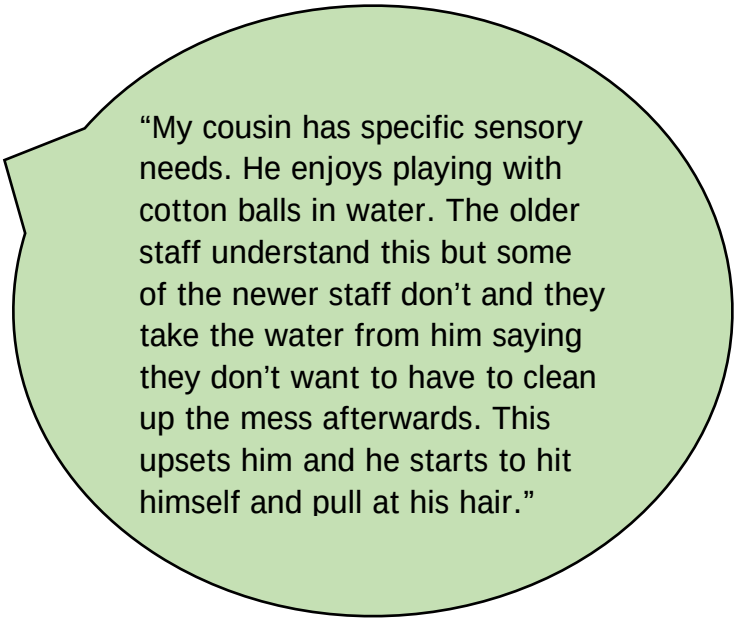
HIQA regularly received feedback that personal planning may not have been effective, and how personal plans may have been out of date and the impact this

may have had on ensuring that residents' needs were being met. HIQA also heard about times where staff may not have been appropriately supervised to ensure that the care being delivered to residents was aligned to the residents' personal plans.



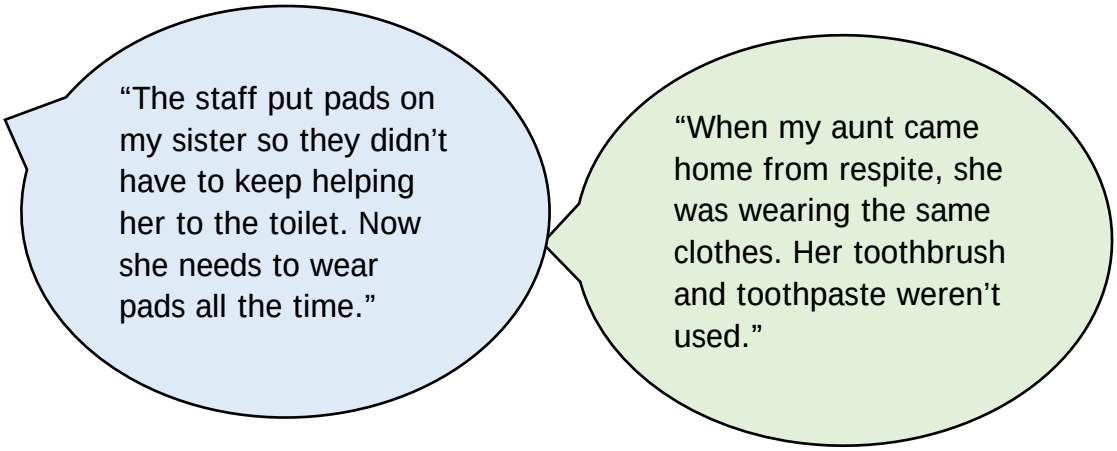
Quality of Care – Positive Behavioural Supports

Feedback often referenced occasions where staff may not have been operating in line with the residents' behavioural support plans to ensure that the residents' needs were being met. Examples included times where residents may have been denied access to sensory aides or other supports for which they were assessed, and as a result, people felt that residents may have been subject to unwarranted restrictive practices.



Quality of Care – Personal Care

People often provided feedback that residents may have experienced delays in having their personal care needs addressed by staff. HIQA has heard of times where residents may not have been provided with the most appropriate size of incontinence wear, and occasions where residents who were continent but required the assistance of staff to access the toilet, were placed in incontinence wear which people told us may have had a negative impact on the residents' dignity and rights.

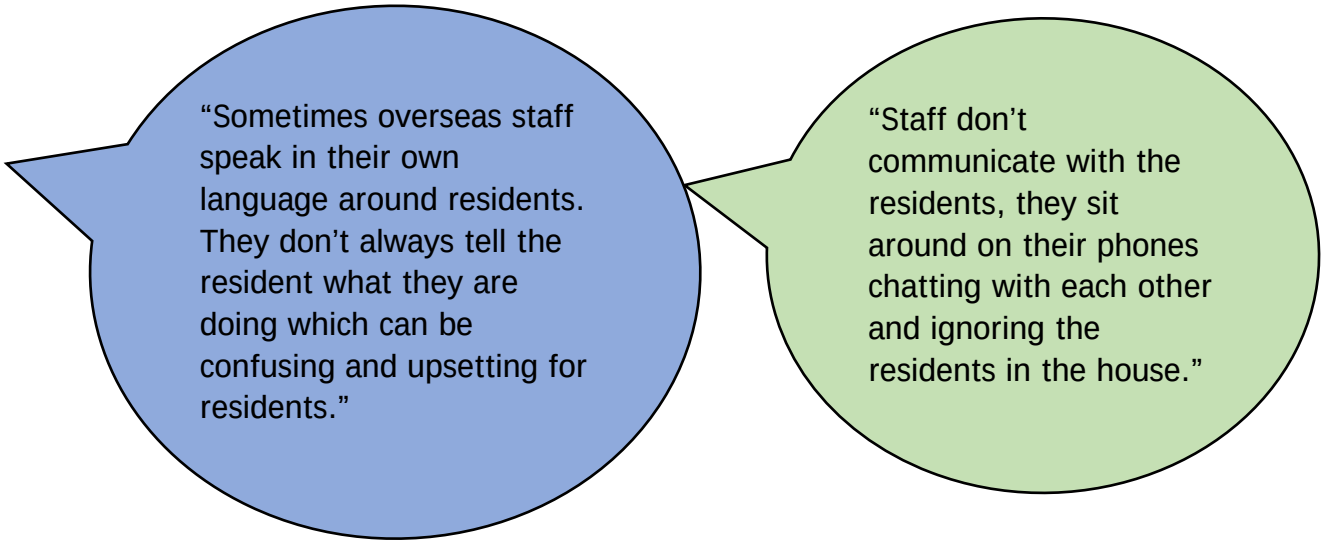


Risk Management

HIQA received information about times where corridors may have been obstructed with equipment such as hoists, which people told us may have limited the ability to evacuate the building in a timely manner, in the event of an emergency. Feedback received has also referenced adverse events that may not have been documented by staff and the incorrect use of equipment, including hoists, which people felt could have put residents and staff at risk of harm. Other examples referenced how appropriate actions to manage residents' behaviours that challenge and promote the safety of residents and staff may not have been effectively addressed by managers within the service.

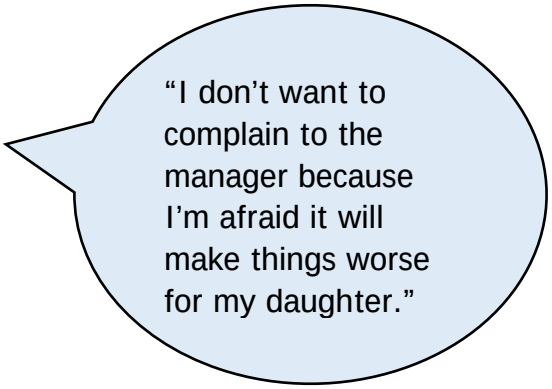
Communication

Some people told us about times where there had been a lack of communication with families in respect of the changing care needs of residents. Relatives sometimes told us that they did not feel listened to by managers within centres, regarding aspects of a resident's care. HIQA also heard about times where staff who may not speak English as a first language, spoke in their own native language in the presence of residents, which may have resulted in residents feeling confused and upset.



Complaints Handling

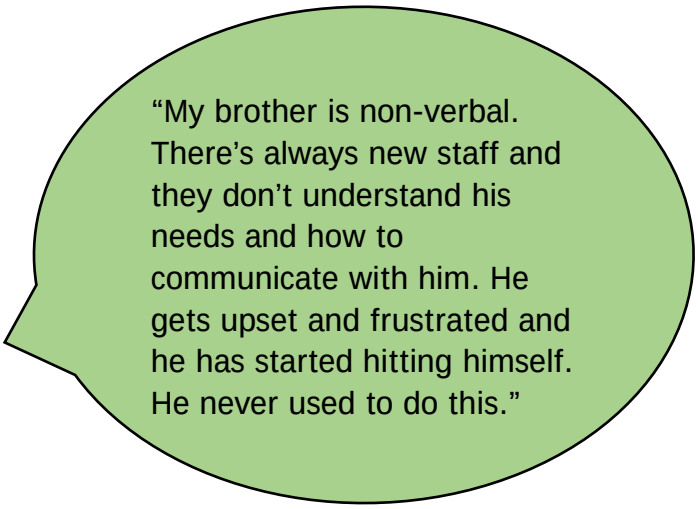
HIQA heard about two key issues in respect of complaints handling. People have told HIQA they have made a formal complaint to the registered provider but were dissatisfied with how their report was managed. HIQA also heard from people who told us they were afraid to make a formal complaint to the registered provider as they feared doing so may have had negative repercussions for the resident or their family.



Staffing

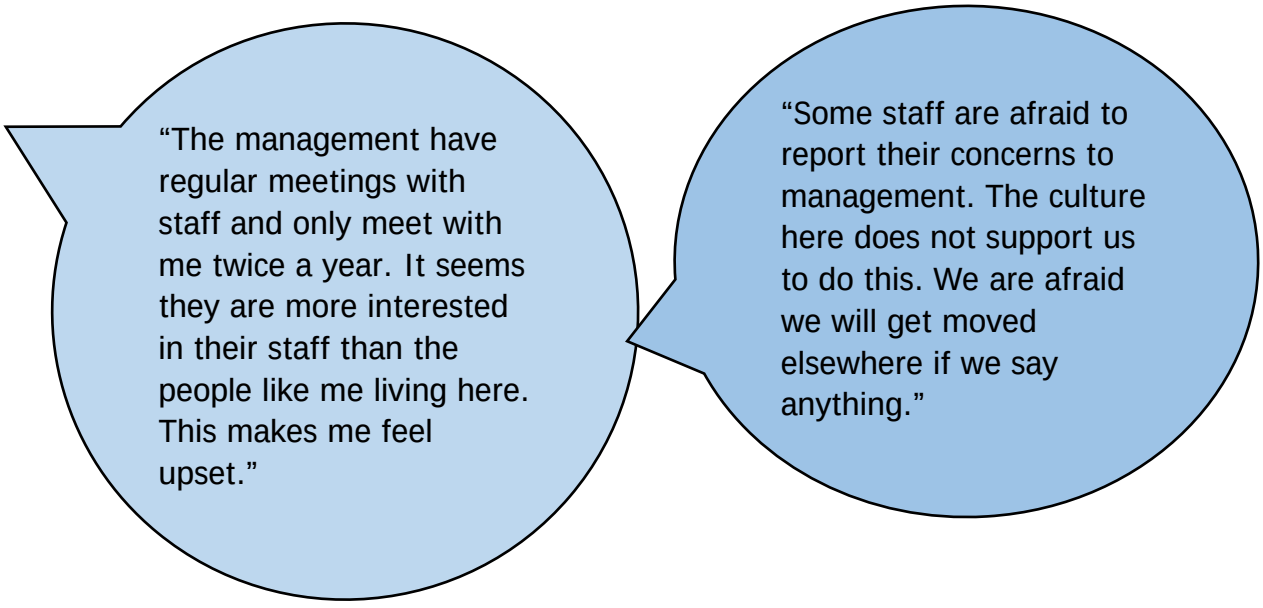
Examples of feedback included times where the staffing levels within designated centres may not have supported the residents who required the support of more

than one staff member to carry out aspects of their care to receive this. Some examples referenced how unfamiliar staff within centres may have caused upset and confusion for residents and how this may have had a negative impact on the care that residents received.



Governance and Management

The vast majority of feedback received referenced governance and management issues. This demonstrates that the majority of feedback received made reference to failures in oversight and shortfalls in management systems, which people told us may have had a negative impact on the safety and quality of care received by residents. Feedback received sometimes referenced a culture of favouritism in centres, resulting in times where staff felt they could not approach the management team to report events, and a lack of a person-centred approach towards residents.



This feedback gives us an insight into the real lived experiences of residents residing within disability centres in Ireland. The experiences, both positive and negative, of residents, relatives, workers and others contributes to how HIQA regulates these services. This has a strong impact on improving care experiences for those living within designated centres for people with disabilities.

What has happened with the feedback provided about disability services?

All feedback received by HIQA is brought to the attention of the inspector via the information management system. Whilst it is not the remit of HIQA to investigate individual complaints, the inspector reviews the feedback in line with the information they already know about the service, they apply a regulatory risk rating and determine what is the appropriate regulatory action to take.

Of the 618 pieces of feedback received over this two-year time period, 365 (59%) were assigned an initial regulatory risk rating of low or very low. A further 249 (40%) were assigned a moderate regulatory risk rating and four (1%) were assigned a high regulatory risk rating.

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

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

Of the 618 pieces of feedback received during this two year period, 257 (42%) pieces of feedback were used to inform the ongoing regulation and monitoring of their respective services and considered as lines of enquiry at the next inspection. A further 88 (14%) contained similar information to a previous piece of feedback or solicited information received. Here, inspectors reviewed the information, assessed the regulatory risk rating and then closed this piece of feedback as they were following the information up under the initial piece of information received.

Of the remaining 273 (44%), inspectors sought a provider assurance report for 215 of these and would have later used both the feedback and the assurances provided in the provider assurance report to inform lines of enquiry at the next inspection. An additional 58 resulted in a triggered inspection.

5. Feedback about Children's Services 2014 - 2023

Overview

The Chief Inspector has responsibility for the regulation and inspection of three children's special care units, and for the monitoring of the Child and Family Agency's (Tusla) 18 child protection and welfare services and 18 foster care services, along with 37 statutory children's residential centres operated by Tusla, five private foster care services and Oberstown Children Detention Campus.

HIQA has processed 787 (7% of total received) pieces of feedback relating to these children's services from 2014 to 2023. This includes two pieces of complimentary feedback received since 2021, one in relation to a statutory foster care service and the other relating to a children's residential centre. Children's services consistently receive the smallest proportion of UROIs received under the remit of the Chief Inspector.

Figure 14 below outlines the volume of feedback received for these children's services per year. The busiest year of the decade was 2017, where 14% of feedback was received, before this steadily reduced in the subsequent years up until 2020. Since 2020, the volume of feedback received has shown slight increases year on year.

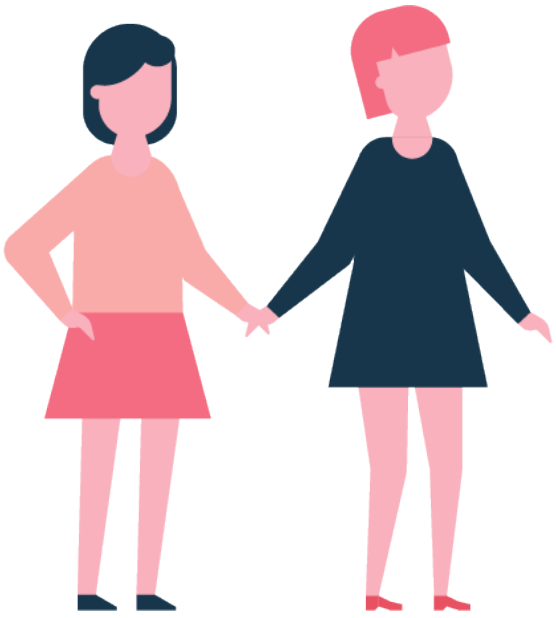
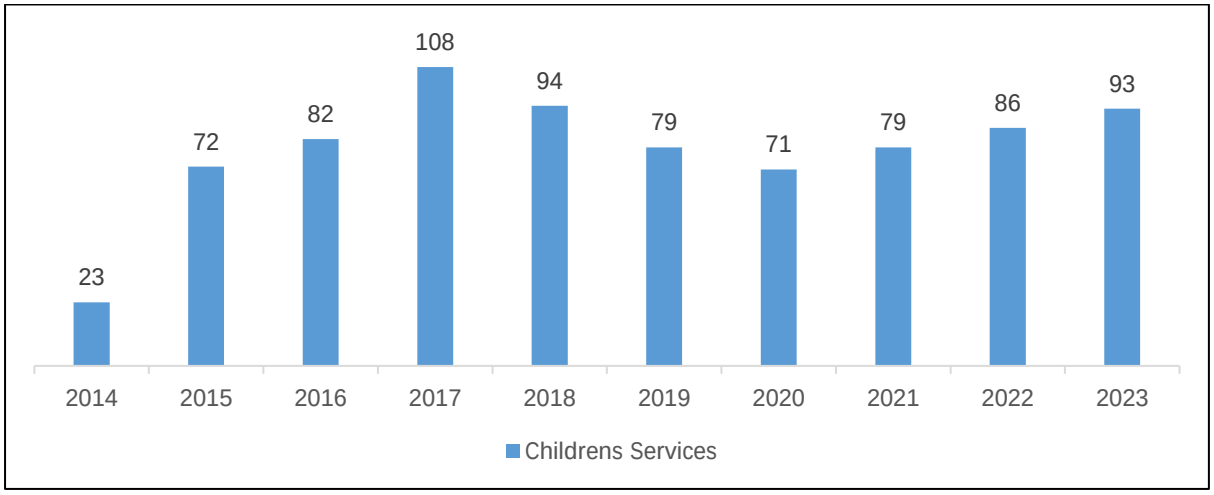
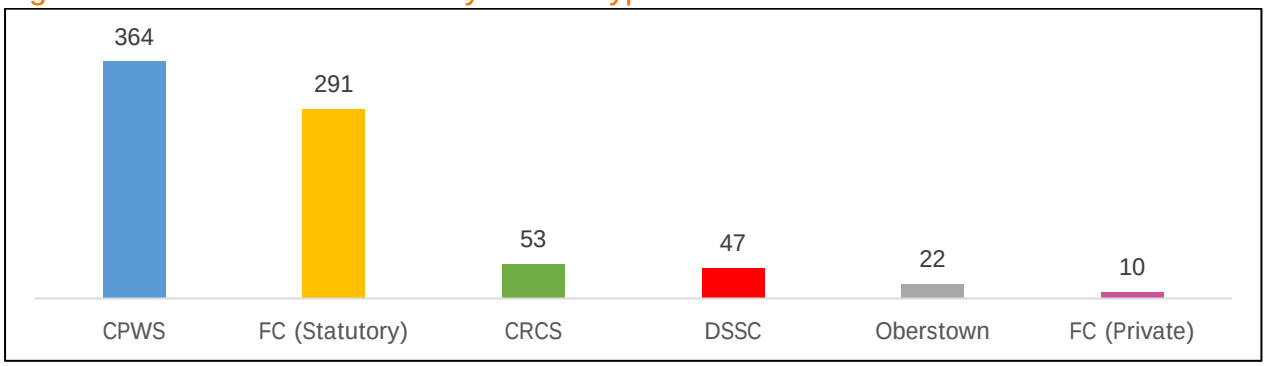


Figure 14. Volume of feedback received for children's services per year for 2014 – 2023



Of the feedback received during the period, 364 (46%) related to child protection and welfare services (CPWS), 291 (37%) related to statutory foster care services, 53 (7%) related to children's residential centres (CRCs), 47 (6%) related to designated centres for special care (DSSCs), 22 (2.5%) related to Oberstown Children Detention Campus and 10 related to private foster care services (see Figure 15).

Figure 15. Volume of feedback by service type for children's services 2014 - 2023



Who has HIQA heard from?

Over the decade, HIQA heard from 34 (4%) children who provided feedback on their own experiences. Relatives accounted for 439 (56%) of the feedback and 109 (14%) were from employees (see Figure 16). The 'other' category accounted for 25% (201) of the feedback including foster carers, members of the public and health and social care professionals (see Figure 17).

Figure 16. Contact person categories for children's services feedback 2014 - 2023

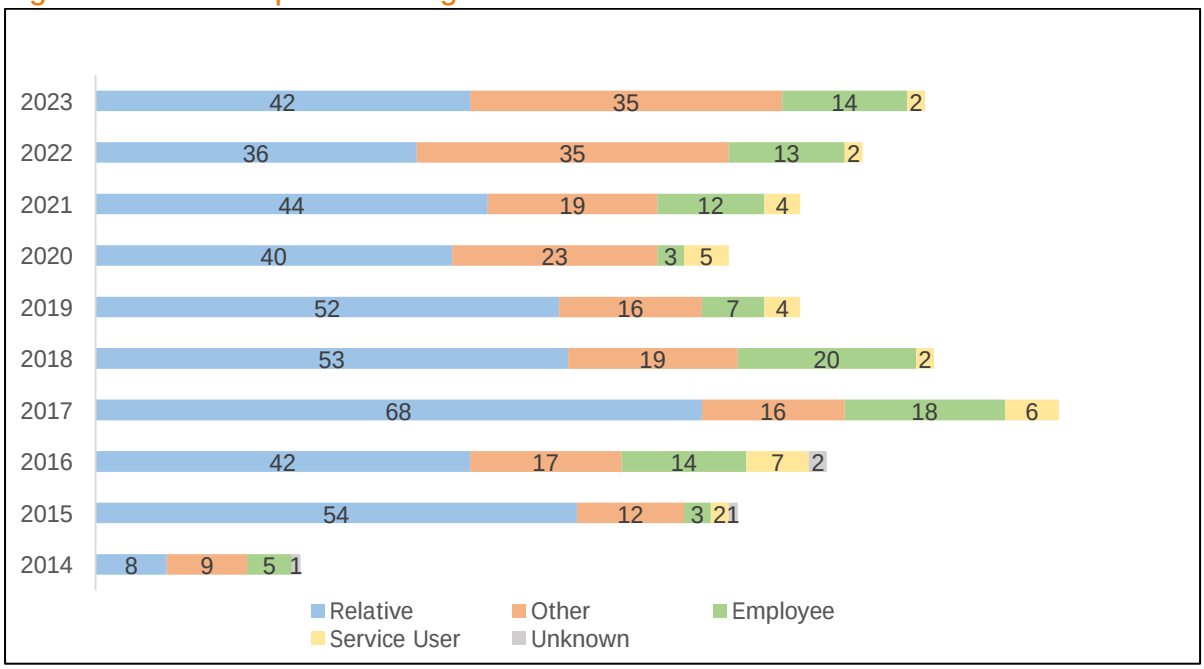
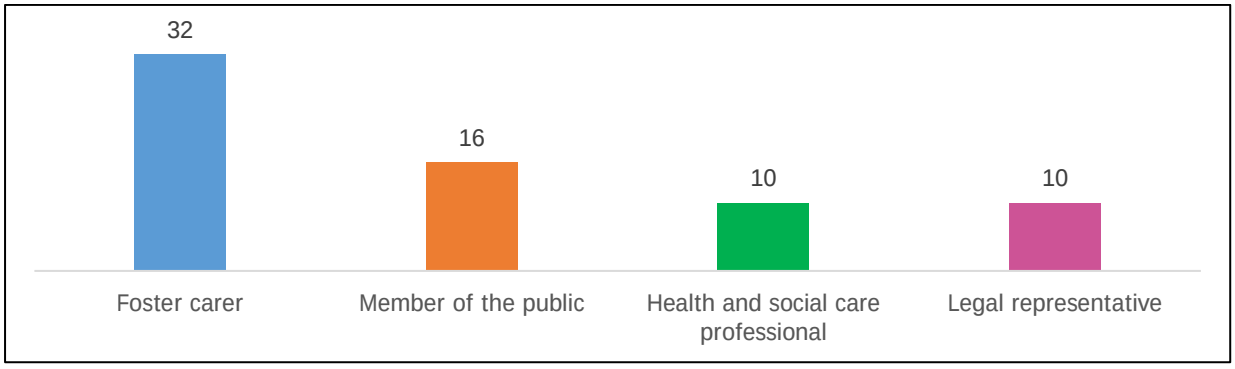


Figure 17. Most frequent 'other' sub-category for children's services feedback 2021 - 2023

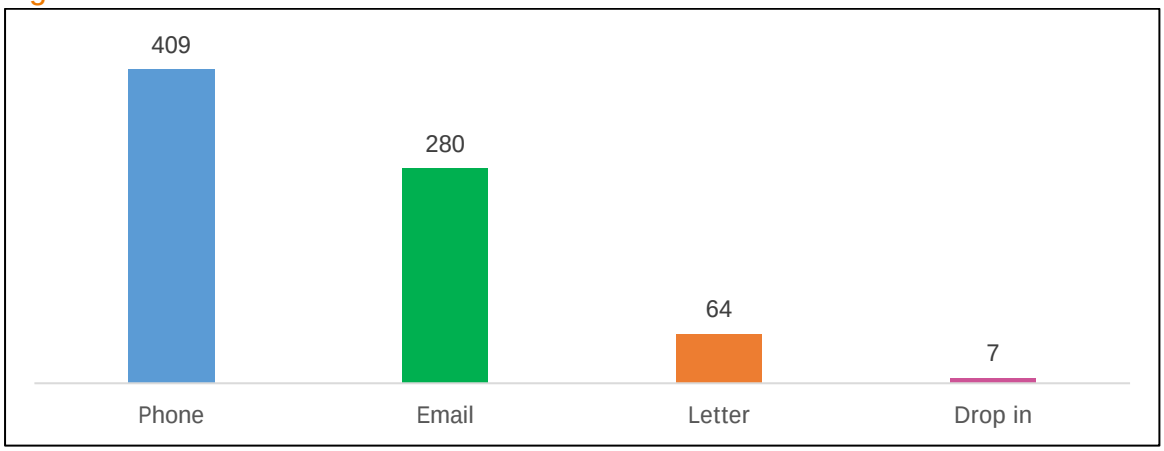


Contact method

Overall, people's preferred method of contact during the decade was phone call, with 409 (52%) UROI received in this manner. HIQA also received 280 (35%) pieces of feedback by email, 64 (8%) by letter and seven people attended a HIQA office to provide their feedback (see Figure 18)[5]. This is aligned to the overall profile of contact methods for all services under the remit of the Chief Inspector.

[5] An additional 21 (3%) pieces of information were created based on internally sourced information (HIQA staff (12) and media articles (9)).

Figure 18. Contact method for children's services feedback 2014 - 2023



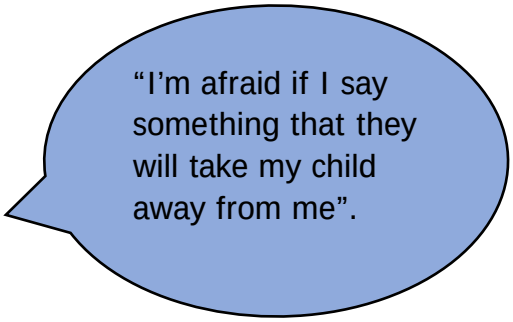
What have people told us?

During 2021, HIQA began to categorise the feedback received into themes aligned to the relevant regulations and national standards. This allows HIQA to identify what themes it hears about most and if there are key issues presenting within the different types of children's services. It is important to note that the feedback received may contain multiple themes. For example, a concern about safeguarding, may also have included feedback about a child's rights and the quality of care they receive. Over time, HIQA continues to hear about a number of the same key issues and examples of this feedback received is set out below.

Each piece of information provided under the themes below was individually risk assessed and used to inform regulatory actions which may range from informing a line of enquiry on the next inspection, seeking a provider assurance report through to a triggered risk inspection.

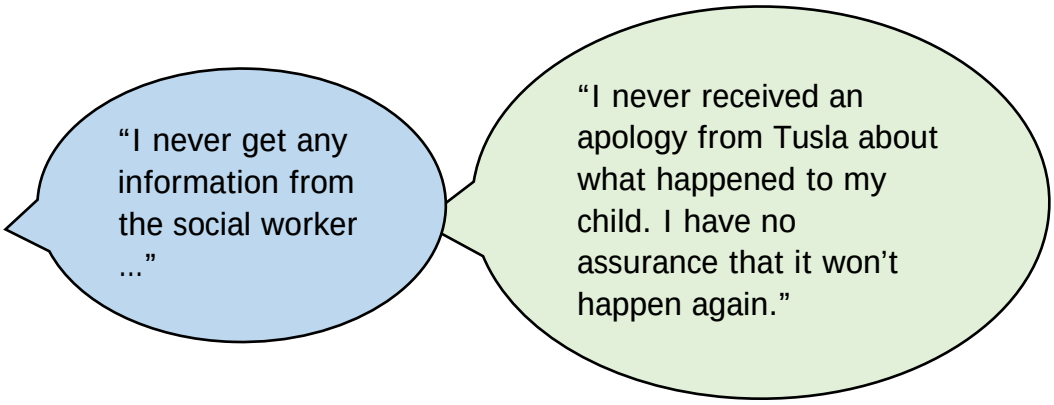
Child protection and welfare services

HIQA has received feedback that referenced poor communication about aspects of a child's care and times where children either had no access, or limited access to a social worker. Feedback also referenced delays in the assessment of a child protection concern, a view that the assessment was unfair or poor communication with families in relation to the assessment process. More recently, HIQA began to hear about concerns of children being placed in unsuitable accommodation that was not inspected by either HIQA or Tusla. HIQA also heard from people who were frustrated as they may not have received a response having made a formal complaint to Tusla, or in some cases they felt that they were not listened to. HIQA also heard from parents who told us they were afraid to raise their concerns in case it had negative consequences for them and or their children.



Statutory and private foster care services

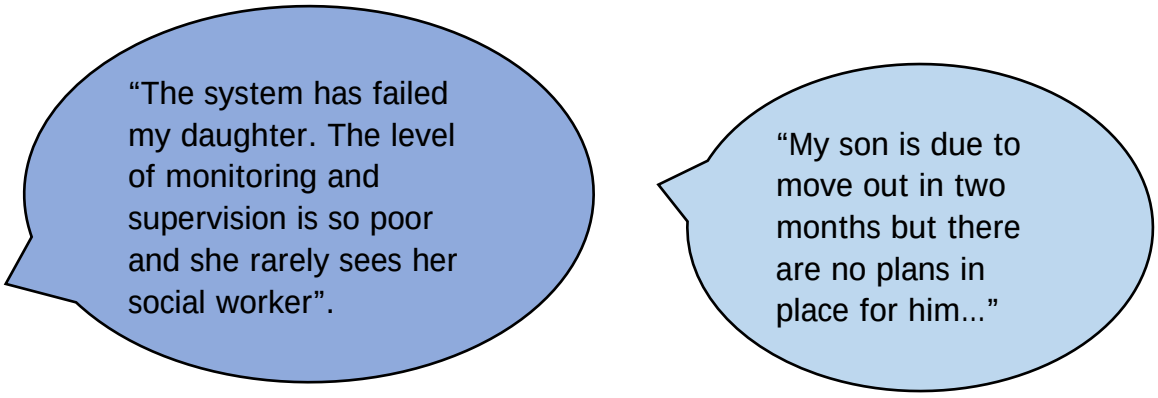
People provided feedback that referenced how ineffective communication between social workers, children and foster carers may have resulted in poor experiences for children in the care of the state and their families. HIQA has also received feedback relating to the negative impact that ineffective care planning may have had on children. Foster carers raised concerns about delays in children accessing specialised assessments and or supports such as psychology or behaviour support therapy aligned to the child’s care plan. People have also provided feedback that children have presented unkempt when meeting with family members. HIQA also heard from some relatives who felt that raising questions about their child’s care could result in negative repercussions for them or their children.



Statutory children’s residential centres

Examples of feedback received about children’s residential centres include times where children may not have been appropriately supported to have their health and social care needs met. Every child needs the support and care of a trusted adult. Many children in care have not had a consistent trusted adult in their lives due to a variety of extenuating circumstances. The presence of the same social worker for a child can help them build trust and develop a relationship with a trusted person. HIQA heard about times where children had limited access to their social worker or multiple changes in social worker. HIQA also heard about poor communication with families about aspects of a child’s care. Feedback also gave examples of where there

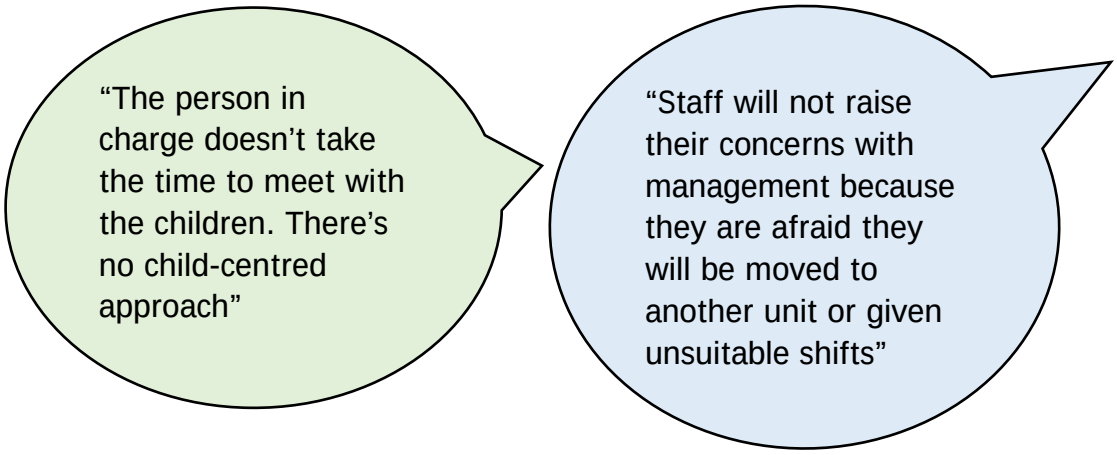
were delays or ineffective planning for young people who were preparing to leave care.



Special care units

Feedback relating to special care units included examples of poor communication with families in respect of aspects of their child's care. HIQA heard from people who told us how staffing shortages impacted on the staff's ability to manage situations or respond appropriately to incidents. Other examples referenced how the use of agency staff meant that there were unfamiliar staff working with the young people. HIQA heard about times where these staff may not have understood the young people and their needs, which sometimes may have led to the young person becoming frustrated and upset.

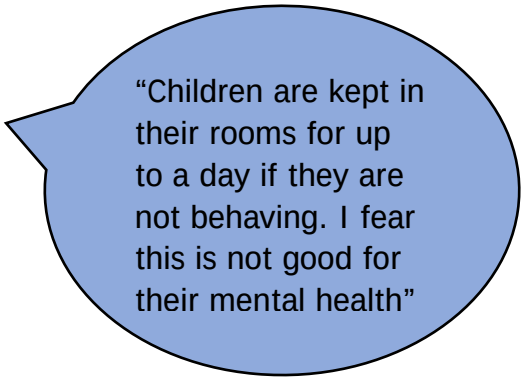
Other feedback referenced governance and management issues, including a lack of a person-centred approach in the care being delivered to young people, and times where staff were afraid to raise their concerns with management teams as they felt doing so would have negative consequences for them.



Oberstown Children Detention Campus

Examples of feedback received referenced how young people's social care needs may not have been appropriately met, and times where the young people may have

been confined to their rooms or restricted for long periods of time following an episode of behaviour that challenges.



This feedback gives us an insight into the real lived experiences of children using these services. It is important that HIQA recognises how the experiences, both positive and negative, of children, relatives, workers and others can contribute to how HIQA regulate these services, and the impact this can have on improving care experiences.

What has happened with the feedback provided about children’s services?

All feedback received by HIQA is brought to the attention of the inspector via the information management system. Whilst it is not the remit of HIQA to investigate individual complaints, the inspector reviews the feedback in line with the information they already know about the service, they apply a regulatory risk rating and determine what is the appropriate regulatory action to take.

Of the 179 pieces of feedback received over this two year time period, 141 (79%) were assigned an initial regulatory risk rating of low or very low. A further 33 (18%) were assigned a moderate regulatory risk rating and five (3%) were assigned a high regulatory risk rating.

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

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

Of the 179 pieces of feedback received during this two year time period, 134 (75%) pieces of feedback were used to inform the ongoing regulation and monitoring of their respective services and considered as lines of enquiry at the time of the next

inspection. A further nine (5%) contained similar information to a previous piece of feedback or solicited information received. Here, inspectors reviewed the information, assessed the regulatory risk rating and then closed this piece of feedback as they were following the information up under the initial piece of information received.

Of the remaining 36 (20%), inspectors sought a provider assurance report for 35 of these and would have later used both the feedback and the assurances provided in the provider assurance report to inform lines of enquiry at the next inspection. An additional one piece of feedback resulted in a triggered inspection.

6. Conclusion

Between 2014 and 2023, HIQA processed 11,769 pieces of feedback received about social care services under the remit of the Chief Inspector. Of these, 108 were complimentary pieces of feedback received about services. The majority of information received related to designated centres for older people (8,422), followed by designated centres for people with disabilities (2,560) and children's services (787).

People using services accounted for the smallest proportion of feedback (423) (4%). HIQA heard the most from relatives (6,112) (52%), followed by employees (2,444) (21%), and others (2,428) (21%).

The preferred method of contact amongst people over the 10 years was phone, followed by email, letter and in person.

The largest volume of information received was in 2020 (1,546 pieces of information) (13%), which can be largely attributed to the COVID-19 pandemic.

In 2022, HIQA initiated the tracking of regulatory activity taken by inspectors on foot of information received, in order to complete the story of what happens with the feedback that people provide to us. This analysis demonstrates that of the 2,882 pieces of information reviewed, 40% (1,141) resulted in an immediate regulatory activity being taken, 18% (522) were followed up under a related statutory notification or similar piece of feedback and 42% (1219) were used to inform the ongoing regulation and monitoring of the respective service.

HIQA treats all information it receives very seriously and recognises the value in the feedback, both positive and negative, on the lived experience of residents living within care services in Ireland. It is important that the voice of the person using the service is heard, and HIQA continues to use this information to ensure that the services provided are person-centred, and that people using services are in receipt of safe, quality care. In addition to providing a listening ear to people who contact us with their feedback and sharing this information with the inspector, HIQA also signposts people to other sources of support and advice relevant to their experience, and provides encouragement to people to make their complaints known to the service provider, who is best placed to manage their individual concerns under their local complaints procedure.

The future

HIQA is looking forward to welcoming new commencements to its function under the Chief Inspector of Social Services, such as the regulation of home support services. HIQA will play its part in ensuring the voice of the person using a service is heard

through the valuable feedback received. HIQA is also preparing information on the trends in the feedback it receives and has begun to issue bulletins to service providers on these key issues, which aims to help inform the sector to drive quality improvement within individual services.

Appendix 1. Making a complaint about a designated centre or a children's social care service

Sir Robert Francis set out in the Mid Staffordshire NHS Foundation Trust Public Enquiry Report (2013) that "*A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public's trust in the service*."

Responding effectively to comments, compliments and complaints received and learning from them is key to providing high quality customer-focused services.

By law, all health and social care services must have a procedure for dealing efficiently with complaints. The person or organisation that is providing a service is responsible for investigating the complaint.

If a person would like to provide feedback about the care or treatment they received or observed, they should talk to the service directly (speak with the person delivering the care or ask to talk to the manager) as this gives the service the chance to try and put things right, to listen to the concerns and identify areas that can be improved upon.

Persons wishing to make a formal complaint about a health or social care service must contact the service itself and report their concerns in line with the services complaints policy.

When making a complaint it is of value to the service to include the following information:

- who was involved
- what happened and when
- what the concerns are
- if the complainant has done anything to resolve the matter
- what they would like to happen now
- include any additional information and copies of any relevant documents.

When you make a complaint or communicate your concerns to the person or organisation providing the service they must:

- acknowledge your complaint
- look into and investigate it (this person should not be involved in the complaint)
- respond to you in a timely manner

- update you on what they found.

The legal responsibility to investigate and manage complaints in all designated centres rests with the registered provider (the named person, legal entity, or company who is registered to provide the service). This legal requirement is detailed in the relevant regulations in place for each type of designated centre.

1.1 Designated centres for older people

In 2023, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2022 were commenced in designated centres for older people. The purpose of these regulations is to ensure residents have access to independent advocacy services. The registered provider is required by law, to have an effective complaints procedure in place, ensure it is made available and known to all, and to appoint a designated complaints person.

They must also ensure that all complaints received are investigated promptly and that the person who raised the complaint is informed of the outcome of the investigation. They are required to record if the person is satisfied with this outcome or not. The regulation also requires the registered provider to maintain records of the complaint, its investigation, and the outcome, and keep this record separately from any resident's care files.

1.2 Designated centres for persons with disabilities

In designated centres for people with disabilities, Regulation 34 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, the registered provider must also have an effective complaints procedure in place, and ensure it is made available and known to all in a manner appropriate to the person's disability. This regulation states that the registered provider must appoint a person not involved in the complaint to investigate it, that the person who raised the complaint is informed promptly about the outcome of the complaint and also that clear records of the complaint and subsequent investigation are maintained. Each centre must also ensure that residents have access to advocacy services.

Both the relevant regulations for older people's and disability services also state that the registered provider must:

- ensure measures are taken to improve the issue(s) raised in the complaint
- ensure there are no adverse effects to the resident on foot of them raising their complaint
- display the complaints procedure in a prominent location within the designated centre

- appoint another person (in addition to the person investigating the complaint) to review the complaints process and records.

1.3 Special care units

In special care units, Regulation 29 of the Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations, 2017 also places the legal responsibility for the investigation of complaints with the registered provider. These regulations state that there must be a complaints procedure which includes an appeals procedure. The procedure must be appropriate to the child's age and displayed in a prominent location within the designated centre. All complaints should be investigated promptly and records of the investigation maintained. The person in charge maintains the complaint record in the 'care record' of the child involved in the complaint.

In all three types of designated centres the person raising the complaint, should expect that:

- they are made aware of the complaints procedure and should know where it is displayed within the centre
- the services a child is receiving should not be impacted as a result of a complaint being raised
- the complaint will be investigated promptly
- they should be informed about the outcome of the investigation into the complaint
- they will be asked if they are satisfied with the outcome or not
- records will be maintained on the investigation and outcome of their complaint
- action will be taken by the registered provider to improve the issue(s) raised in their complaint.

1.4 Health Service Executive (HSE) complaints process ('Your Service Your Say')

Part 9 of the Health Act 2004 outlines the legislative requirements to be met by the HSE, and relevant providers in the management of complaints. The regulations include requirements such as designation of complaints officers and review officers, development of procedures by the HSE and service providers for the management of complaints, timeframes for the management of complaints and a review process.

It is the right of a patient or person using a service of the HSE to make a complaint if they believe that standards of care, treatment or practice fall short of what is acceptable. If a person wishes to raise a complaint about a service provided by the HSE, they can do so through the HSE's complaints policy 'Your Service Your Say'.

Further details on the HSE's complaints process can be found on the HSE website: www.hse.ie.

1.5 The Child and Family Agency (Tusla) complaints process ('Tell Us')

Part 9 of the Child and Family Agency Act (2013), requires Tusla to have a complaints procedure. Under this legislation and relevant national standards, anyone who uses Tusla's services has a right to complain to Tusla under their complaints policy 'Tell Us'. Part 2 of the legislation, requires Tusla to have due regard for the best interests of the child which would include their views if they or someone else complains on their behalf.

Further details on Tusla's complaints process can be found on the Tusla website: www.tusla.ie.

1.6 Advocacy services

Advocacy services can play an important role in supporting people using services or residents to make a complaint.

> "Advocacy is a means of empowering people by supporting them to assert their views and claim their entitlements and where necessary representing and negotiating on their behalf. Advocacy can often be undertaken by people themselves, by their friends and relations, or by persons who have had similar experiences. Delivering a professional advocacy service means providing a trained person who, on the basis of an understanding of a client's needs and wishes, will advise and support that client to make a decision or claim an entitlement and who will, if appropriate, go on to negotiate or make a case for him/her."[6]

There are a number of bodies providing advocacy services to the residents of designated centres including the Patient Advocacy Service, National Advocacy Service, SAGE Advocacy and EPIC (providing advocacy for children in care).

1.7 Role of the Office of the Ombudsman and Ombudsman for Children

The Ombudsman's role is to examine complaints from members of the public who believe that they have been unfairly treated by certain public service providers including the HSE, agencies, such as charities and voluntary bodies, that deliver health and social services on behalf of the HSE, public hospitals, and public and private nursing homes.

Before contacting the Ombudsman or Ombudsman for Children, the person should try and have the complaint resolved with the relevant service provider and if

[6] Advocacy Guidelines, Citizens Information Board.

unhappy with the outcome, then make a complaint to the Ombudsman or Ombudsman for Children.

Further details on the Ombudsman and Ombudsman for Children can be found on their respective websites: www.ombudsman.ie or www.oco.ie.

Ombudsman referrals

The Memorandum of Understanding (MOU) between HIQA and the Office of the Ombudsman is under review.

The current MOU sets out that:

> *"where HIQA receives a complaint by phone or in person, from a service user, which is within HIQA's remit and has already been dealt with by the relevant service provider and may be within the Ombudsman's remit, it will, provided consent from the service user has been received, share information in respect of the relevant concerns. Where consent is not provided, HIQA will provide full contact details for the Office of the Ombudsman to the service user so that a complaint can be made directly to the Office of the Ombudsman."*

In practice all persons who contact HIQA by phone, email, letter and or drop into a HIQA office about a centre or service within HIQA's remit are advised of:

- HIQA's role and remit
- the role of the provider to manage and investigate a complaint
- the role of the Office of the Ombudsman or Ombudsman for Children, as appropriate if the person is not satisfied that their complaint has been investigated appropriately, and their contact details.

HIQA's information booklet (relevant to the sector the person is contacting HIQA about) is also provided to all persons who contact HIQA by email or letter (and at the request of the person during phone calls and or who drop into an office) which sets out all of the above and what HIQA does with the feedback provided.

If HIQA is contacted by an individual who has already made a formal complaint to the provider of a service, they are, in the first instance, advised of the role of the Ombudsman. The individual is also asked if they wish for HIQA to share their contact details and the name of the service with the Office of the Ombudsman. If they consent to do so, the information is forwarded to the Office of the Ombudsman in line with our data sharing agreement.

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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