



An Chomhairle Náisiúnta Eacnamaíoch agus Shóisialta  
National Economic & Social Council

# Quality and Standards in Human Services in Ireland: Residential Care for Older People

No. 128 July 2012

## National Economic and Social Council

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An Chomhairle Náisiúnta Eacnamaíoch agus Shóisialta  
National Economic & Social Council

Quality and Standards  
in Human Services in Ireland:  
Residential Care for Older People

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## Abbreviations

<b>CEO</b> Chief Executive Officer	<b>INECMA</b> Irish National Extended Care Medicine Association	<b>NFs</b> Notification Forms
<b>DEIS</b> Delivering Equality of Opportunity in Schools	<b>INHO</b> Irish Nursing Homes Organisation	<b>NGOs</b> Non Governmental Organisations
<b>DoH</b> Department of Health	<b>ISO</b> International Organisation for Standards	<b>NHI</b> Nursing Homes Ireland
<b>EU</b> European Union	<b>ISQSH</b> Irish Society for Quality and Safety in Healthcare	<b>NMPDU</b> Nursing and Midwifery Planning and Development Units (HSE)
<b>EIQA</b> Excellence Ireland Quality Association	<b>JCI</b> Joint Commission International	<b>NTPF</b> National Treatment Purchase Fund
<b>FETAC</b> Further Education and Training Awards Council	<b>NCAOP</b> National Council on Ageing and Older People	<b>OECD</b> Organisation for Economic Co- Operation and Development
<b>HCI</b> Health Care Informed	<b>NESC</b> National Economic and Social Council	<b>SAT</b> Single Assessment Tool
<b>HIQA</b> Health Information and Quality Authority	<b>NESF</b> National Economic and Social Forum	<b>UN</b> United Nations
<b>HSE</b> Health Service Executive		
<b>IHSAB</b> Irish Health Services Accreditation Board		



Quality and Standards in  
Residential Care for Older People -  
Non-Technical Summary

This report is one of a series in a NESC<sup>1</sup> project which looks at how quality processes, standards and regulations contribute to continuous improvement in delivery of services. This report focuses on the standards regime in place for care of older people in residential settings.

At the end of 2010, there were approximately 21,000 people in long-stay residential care, with 63% of beds provided by the private sector, 9% by the voluntary sector, and 28% by the HSE. Since July 2009, strong regulations have covered care in all residential centres for older people, which must comply with the requirements of the *National Quality Standards for Residential Care Settings for Older People in Ireland*. These 32 standards cover the rights, protection, health and social care needs, and quality of life of older people; as well as the staffing, care environment, and governance and management of residential centres.

HIQA<sup>2</sup> inspects all residential centres for older people to ensure they comply with the regulations and standards, and on this basis, registers the centres so that they may operate. The person-in-charge and the owner of each centre are also required to adequately understand, and have the capacity to comply with, the standards, and this is assessed through the 'Fit-person assessment'. If a residential centre does not meet these requirements, HIQA can refuse to register it; or close it. HIQA can also prosecute for breaches of the regulations.

Twenty-eight stakeholders representing the public, private, and voluntary sectors were interviewed as part of this research, and they welcomed these new standards for residential centres. They found them much more robust than the regulations which applied previously, and considered that they have increased the quality of, and confidence in, care in this sector.

A number of particular strengths were identified, including:

- The standards apply to all centres, public, private and voluntary; and are enforced by an independent and powerful inspectorate.
- Centre owners and managers have more responsibility to provide a high standard of care than was the case under previous regulations.

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<sup>1</sup> NESC, the National Economic and Social Council, is an agency which analyses and reports to the Taoiseach on strategic issues relating to development of the economy, and social justice.

<sup>2</sup> The Health Information and Quality Authority, an independent agency set up by statute in 2007. It inspects and regulates residential settings for older people, in order to register them to operate.

- The standards are very person-centred, requiring residents’ agreement on the organisation of many aspects of their care.
- There is a strong emphasis on collecting and analyzing data on risks to promote continuous improvement in the services provided in the residential centres. While this can lead to paperwork for managers, it helps to protect older people.
- Centre managers have discretion to decide what mechanisms they will use to meet many of the standards.
- Private sector organisations and the HSE provide supports to help centres meet the standards.
- Information on implementation of the standards feeds back up to the Department of Health and HIQA through a number of mechanisms.
- All those interviewed felt that the increased quality of care, and confidence in the sector, outweighed the cost of bringing in these standards. However, the cost challenges were different for private and public centres; mainly due to older premises and staffing embargos in the public centres.

Nonetheless a number of challenges are faced in implementing these standards, as follows:

- As HIQA wants centre managers to think through what they do to meet the standards, it does not provide guidance on the best ways to meet them. Managers find this frustrating as it means they have to devote a substantial amount of resources to meeting the standards, without being sure if they are doing the right thing to meet them.
- Centre managers find it difficult and time-consuming to fully implement the requirement to collect and analyse data on risks, in order to promote continuous improvement in the services they provide.
- There is no standardised data to allow benchmarking and comparison of the quality of care in different centres.
- Mechanisms to share learning on best practice in different centres are *ad hoc*.
- It can be challenging for staff to change work practices to provide more person-centred care.
- While Fair Deal<sup>3</sup> now allows an older person allocated this funding to choose the residential centre in which they are cared for, budgets do not yet always follow

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<sup>3</sup> A state scheme (officially the ‘Nursing Home Support Scheme’) which provides financial support to those who need long-term residential care.

the service-user, so older people are not able to decide to spend Fair Deal funding on, for example, home care instead of residential care.

- The cost of bringing in the standards can be high, in terms of finance and staff time.
- HSE-run centres are losing staff due to the embargo on public sector recruitment, and find it particularly difficult to access funding to make the infrastructural changes necessary to meet the standards.

Given these strengths and challenges, the following are pointers for future policy development:

- HIQA could provide more guidance on best practice to help centres to meet the standards. This could be particularly beneficial to help ‘average’ centres improve the quality of the services they provide.
- In the United States, data shows that the costs of providing high quality care can be reduced through use of best practice management and care processes. Sharing best practice on these processes could therefore help to reduce the costs of quality improvement.
- HIQA could also provide greater support to centre managers to help them to collect and analyse data on risks within their centre, to promote continuous improvement in services there.
- A standardised data-set in place in all centres would allow national benchmarking of quality of care and methods taken to reach it.
- Person-centred budgeting should be piloted, to allow older people to choose the type of care they wish (for example, home care instead of residential care).
- Trust between managers and inspectors should be encouraged, to help reduce managers’ uncertainty as to whether innovative services will meet the standards.
- A problem-solving group of those influencing provision of long-term care (e.g. providers, the Department of Health, and HIQA) may be useful to examine and address the challenges of providing sufficient quality long-term care in an equitable and sustainable way.



This report examines standards and quality in residential care for older people in Ireland. It is one of a series of reports which make up the NESC<sup>4</sup> project on *Quality and Standards in Human Services in Ireland*. This project assesses how quality processes, standards and regulation contribute to continuously improving human services.

‘Eldercare’ is a range of services for older people who need assistance with basic activities of daily living, such as getting in and out of bed, bathing, dressing, eating, etc. Typically this care is first provided in a person’s home, either informally by friends or family, or formally by professional home care providers. When it is no longer possible to receive this care at home, usually due to increased care needs, then it can be provided in a residential centre. Since 2009, mandatory standards, the *National Quality Standards for Residential Care Settings for Older People in Ireland*, govern the quality of this care.

### **Residential Care Standards**

The *National Quality Standards for Residential Care Settings for Older People in Ireland* contain 32 different standards, covering the rights, protection, health and social care needs, and quality of life of older people; and the staffing, care environment, governance and management of the residential centre.

Since July 2009, HIQA<sup>5</sup> has inspected all residential centres to ensure that they comply with the standards and regulations on care of older people, and centres that do are registered to operate. Inspection reports are compiled based on information from records, observations of care; and meetings with residents, relatives, the person-in-charge<sup>6</sup> and other members of staff. All inspection reports are then published on the HIQA website. The person-in-charge and the owner are also required to adequately understand, and have the capacity to comply with, the standards, and this is assessed through the ‘Fit-person assessment’.

If a residential centre does not meet these requirements, HIQA can close it; or refuse to register it. HIQA can also prosecute for breaches of the regulations.

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<sup>4</sup> NESC, the National Economic and Social Council, is an agency which analyses and reports to the Taoiseach on strategic issues relating to development of the economy, and social justice.

<sup>5</sup> The Health Information and Quality Authority, an independent agency set up by statute in 2007. It inspects and regulates residential settings for older people, in order to register them to operate.

<sup>6</sup> The term used in the Standards for the manager of the residential centre.



Twenty-eight stakeholders<sup>7</sup> interviewed as part of this research welcomed the standards for residential centres, and consider that they have increased confidence in care in this sector. They appreciate the fact that the standards apply to all centres, public, private and voluntary; and are enforced by an independent and powerful inspectorate. Stakeholders also like the focus on the resident, which is much stronger than in previous legislation, and which requires resident involvement in how their care is organised and delivered. The paperwork required under the risk management standard does however draw mixed reactions – some stakeholders feel that it is necessary even though it takes time; while some feel that it takes time away from caring work. Centres are required to collect data on, for example, pressure ulcers, falls, complaints, and the use of physical restraint and psychotropic drugs. This information must be analysed, and systems set up to address any problems, in order to promote continuous improvement of care within the centre.

### **Five Key Themes**

How the *National Quality Standards for Residential Care Settings for Older People in Ireland* and their implementation are relevant to the five key themes addressed in this NESC project are now outlined. These five key themes are – responsive regulation (which is how implementation of quality standards is encouraged by a balance of sanctions and supports); involvement of the service-user; monitoring and learning; devolution and accountability; and balancing quality with costs.

#### **Responsive Regulation**

The regulatory framework of the standards is underpinned by powerful sanctions, which HIQA has used where necessary, closing approximately 10 centres (out of 594) to date. Meanwhile HIQA encourages managers of residential centres to think through how they should apply the standards themselves, to avoid a ‘tick box’ approach to standards implementation; but this means that HIQA does not provide managers with guides to best practice in order to meet the standards. Instead industry organisations, private companies, and the HSE fill this gap, by providing advice and training to support residential centres to meet the standards.

#### **Involvement of the Service-user**

These standards require much greater consultation with, and agreement from, the resident with regard to their care, than the legislation in place prior to 2007. Residents’ committees are mandatory, and persons-in-charge are required to address issues raised by these committees. There is also a strong emphasis on the procedures for residents (and others) to make complaints; and more person-centred care is promoted. Money also now ‘follows the patient’ to a greater extent than in the past, due to the advent of the Fair Deal scheme which pays the majority

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<sup>7</sup> Including HIQA, the Department of Health, the HSE, Nursing Homes Ireland, and a random sample of managers of residential centres.

of the costs of long-term residential care, in a public, private or voluntary sector centre, for those who are assessed as in need of such care. However, older people are not completely free to decide how to use that funding - it must be used for residential care, and cannot be used to pay for care in their home, even if they would prefer to be cared for at home. In addition, it is not clear how the costs of ancillary services, equipment or therapies for older people in residential centres will be covered. Some of these costs are covered under the medical card scheme, but due to a lack of public provision, older people or the residential centre can end up having to pay for these costs - or the older person may have to forgo these services altogether. These problems are to be considered in reviews carried out by the Department of Health and the HSE in 2012.

### **Monitoring and Learning**

The *National Quality Standards for Residential Care Settings for Older People in Ireland* place a strong emphasis on learning and continuous improvement. Each residential centre is required to collect data on risks, and to put in place mechanisms to reduce these risks. All inspection reports are published on the web, which also facilitates learning. A number of centres also meet informally to share learning, but HIQA does not play a strong role in this. This means that the range of practice with which HIQA is familiar, and could share, is not being made available to residential centres. Sharing this learning could, however, allow more centres to improve the quality of their care. At a more strategic level, HIQA meets with the HSE, the Department of Health and Nursing Homes Ireland on a regular basis; and the Department of Health is currently reviewing the regulations which support the standards, to ensure that they operate more effectively.

### **Devolution and Accountability**

The standards are grounded in legislation, which ensures strong accountability for their implementation, and they are also considered to make owners more accountable than the previous legislation. Meanwhile, stakeholders interviewed were of the opinion that these standards provided a baseline for quality care, but that they also encouraged and provided space for innovative practice and continuous improvement. Innovation was considered more likely to occur where the person-in-charge and inspector respected and trusted each other. A number of persons-in-charge disliked the new complaints procedures and wondered about the value of reporting significant incidents in their centre to HIQA; but both of these requirements ensure greater protection of the resident.

### **Addressing Costs While Improving Quality**

Those interviewed for this project, and the results of surveys, all show that there are costs involved in implementing the standards, ranging from the cost of purchasing new equipment/adjusting premises, to the cost of employing extra staff. The challenges of meeting these costs are different for public and private centres, with HSE-run centres facing staff embargos as well as difficulties in procuring funding. Persons-in-charge also reported that ramping up to meet the standards, and revising policies and procedures on an on-going basis, takes a significant

amount of their time. On the other hand, they welcomed the increased confidence that the standards provided for care in the sector; and all felt that the standards are a positive development. It seems that the cost of implementing these standards yields business benefits, and that there are also wider economic and social benefits for older people and their families. In addition, detailed data from the United States indicates that the costs of implementing regulation and quality improvement initiatives in residential centres can be reduced (and indeed can cost less than providing lower quality care), through use of practices such as results-oriented leadership, collaborative management, reduced staff turnover, and implementation of key care processes. This suggests that such practices could also be used in Ireland to help reduce the costs of providing higher quality care.

### **To What Extent do These Standards Prevent Harms and Promote Quality Improvement?**

The *National Quality Standards for Residential Care Settings for Older People in Ireland* were put in place following the scandal around substandard care in the Leas Cross nursing home, and there is a strong emphasis in the standards on preventing the most serious harms and abuses. This is evident in the legislative base for them; the fact that the standards apply to all residential centres, public, private and voluntary; the independence of HIQA, and the strong enforcement powers which it has and uses.

The standards also aim to promote quality improvement. They require centres to install systems of monitoring and self-regulation, which are then inspected by HIQA to ensure that these are operating well (a process known as meta-regulation). A number of requirements also aim to change the culture of care in all residential centres from task-based to person-centred. These processes all aim to promote continuous improvement in services, even though it is taking time for all centres to adopt these processes.

### **Are There Things Which Need to Change to Ensure the Provision of a Quality Service in This Area?**

The various groups involved in design and implementation of the *National Quality Standards for Residential Care Settings for Older People in Ireland* – the Department of Health, HIQA, the HSE, industry associations, NGOs, residential centres, residents and their families - are all connected into one quality improvement framework established by the Health Act 2007. This Act outlines the interlocking elements of a comprehensive quality approach – that standards and regulations on care of older people in residential centres must be met, and that HIQA has the power to inspect and enforce to ensure that this is the case.

To date, HIQA has relied on legal enforcement mechanisms to ensure that the standards are met. It has expressed interest in providing supports to centres to help them meet the standards, but so far efforts to avoid a conflict of interest, and a lack of resources, have meant that HIQA has not concentrated on this area of work. While this may mean that the resources of the regulator are not unduly overstretched, a number of residential centre managers have found this frustrating, and that it has meant that they have had to devote a high amount of resources to meeting the standards. HIQA is also in the unique position of having information on

every residential centre in the country and how it meets the standards. A mid-way point might be that HIQA could provide summaries of learning, data, and best practice from their inspection work, which could be used by managers of residential centres as examples of ways to continuously improve their services. It could also support a network of all centres, to share learning and best practice. Such initiatives might be particularly useful to help 'average' centres to improve standards of care. In addition, sharing best practice on issues such as optimum staff management and care processes may help to reduce the costs of providing high quality care.

The *National Quality Standards for Residential Care Settings for Older People in Ireland* aim to develop more person-centred care, which requires a cultural and power shift in how care has previously been organised, which is a challenging and long-term process. Greater use of person-centred approaches, and the full implementation of the Department of Health's *Review of Practice Development in Nursing and Midwifery in the Republic of Ireland and the Development of a Strategic Framework*, is likely to assist this.

A common minimum data set that assesses the needs and care of older people, whether at home, in a residential setting, or in an acute hospital, has been piloted by the HSE, with a view to rolling it out nationally. This would assist learning and continuous improvement. As well as using a common format to assess the capacities and levels of dependency of older people, it has the potential to generate comparable data to show the outcomes from different types of care, which could help to assess the quality of different services. It could also provide data to help assess the relative costs of different services.

The difficulty of balancing the needs of residents with decisions taken by the service-provider is evident in the decision to close a number of HSE-run homes for a variety of reasons, mostly financial, which can mean residents leaving what is now their home. This is a difficult issue to tackle, and requires a better balance between the needs of older people and of providers. Another area where change is needed is current funding mechanisms which mean that budgets do not always follow the person, and so can lead to unequal access to services for some older people. The HSE and the Department of Health are beginning work to tackle this. These issues underline the importance of actors such as providers, HIQA and the Department of Health co-ordinating the effects of their decisions as much as possible, to ensure services continue to be provided at an optimum level for older people. A problem-solving group of these actors could be brought together to support this.

# Chapter 1

## Introduction

This report examines standards and quality in relation to residential care for older people in Ireland. It is one of a series of reports that makes up the NESC project on *Quality and Standards in Human Services in Ireland*. This project assesses how quality processes, standards and regulation can best contribute to continuously improving human services. An earlier report, *Quality and Standards in Human Services in Ireland: Overview of Concepts and Practice* (NESC, 2011), set out the main approaches to quality, standards and regulation both in Ireland and internationally. Other reports from the project review quality and standards in the service areas of home care for older people, end-of-life care in hospitals, disability, the schools system, and policing. A synthesis report draws together the conclusions of the overview and the individual human services reports, and includes suggestions for the way forward.

Before proceeding, what is meant by residential care for older people is outlined. Eldercare is provided to older people who need assistance with activities of daily living over an extended period of time. Activities of daily living are ‘self-care activities that a person must perform every day, such as bathing, dressing, eating, getting in and out of bed, moving around, using the toilet’ etc. (OECD, 2005:17). Typically, this kind of care is provided informally, either by family or friends, or formally by professional home carers, to the older person in their home. However, when it is no longer possible to provide this care at home (usually due to increased care needs), an older person can receive this care in a residential centre. Mandatory standards, the *National Quality Standards for Residential Care Settings for Older People*, govern the quality of this residential care, and these standards are the subject of this report. This provides an interesting contrast to the area of unregulated home care and voluntary standards for end-of-life care in hospitals outlined in NESC (2012b forthcoming) and (2012c forthcoming). Study of these differing approaches to promote quality in eldercare therefore provides interesting lessons on the successes and challenges of different approaches, and so highlights areas for potential synergies, learning and good practice.

In this report, standards to improve quality of care are focused on, while financial and governance standards such as the Fair Deal<sup>8</sup> are not covered.

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<sup>8</sup> This State scheme (officially the ‘Nursing Home Support Scheme’) provides financial support to those who need long-term nursing care. The resident makes a contribution towards their care and the State pays the rest. Care needs and financial means are assessed and the scheme provides support on that basis. For further information, see [http://www.citizensinformation.ie/en/health/health\\_services\\_for\\_older\\_people/nursing\\_homes\\_support\\_scheme\\_1.html](http://www.citizensinformation.ie/en/health/health_services_for_older_people/nursing_homes_support_scheme_1.html).

Following this introductory chapter, Chapter 2 will outline the demand for residential care services for older people, the level of existing services, and the policy documents that have influenced development and implementation of standards in Irish residential care. Then in Chapter 3, the mandatory *National Quality Standards for Residential Care Settings for Older People in Ireland*, the processes of regulation by which these are implemented, and the various supportive processes put in place to help this, are described.

Chapter 4 outlines how the process of implementing the standards is progressing, while Chapter 5 looks at how these standards and their implementation are relevant to the five key themes of the overall project on *Quality and Standards in Human Services in Ireland*. Chapter 6 then summarises and concludes, and addresses three key questions about the overall efficacy of these standards in improving residential care for older people. These themes and key questions are outlined in Box 1.1 below

## Box 1.1 Quality and Standards in Human Services in Ireland: Key Themes and Questions

### Five key themes:

1. **Responsive Regulation and Standards**  
To what extent is the regulatory, standards and quality improvement regime driven from a command-and-control, self-regulatory, or responsive-regulation perspective?
2. **Involvement of Service Users**  
To what extent, and in what way, are service users involved in the provision and/or regulation of services?
3. **Monitoring and Learning**  
What, if any, are the mechanisms for continuous learning?
4. **Devolution with Accountability**  
Who are the main actors (State, local, private, voluntary providers) driving the regulatory, standards and quality improvement regime, and what are their respective roles?
5. **Addressing costs while improving quality**  
Have attempts been made to improve quality, while reducing costs? If so, how? What impact, if any, has this had on the quality of outcomes? Are there any barriers preventing implementation?

### Three key questions:

1. How convincing is this regulatory, standards and quality assurance regime?
2. To what extent does this regime a) prevent the most serious harms/abuses; and b) promote quality improvement?
3. Are there things in this regime that need to change to ensure the provision of a quality service?

**Source** NESC (2011)

The first five themes outlined in Box 1.1 are key issues considered in this project, and addressed in this report with respect to residential care for older people, so some explanation of them is provided below.

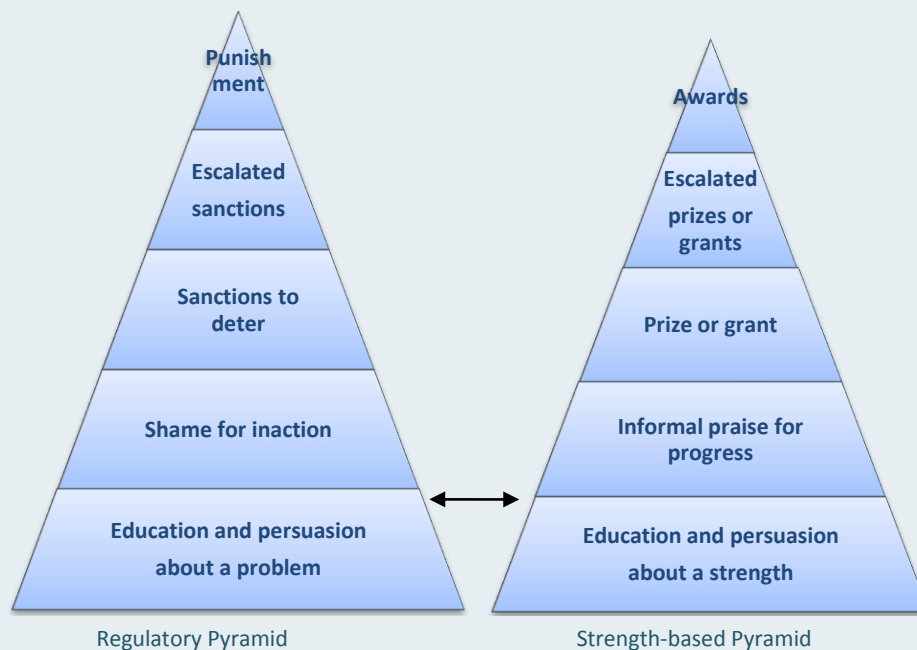


## 1.1 Responsive Regulation

Regulation is one of a number of quality-enhancing mechanisms that can improve the quality of services. The concept of responsive regulation arises from studies indicating that regulation is not effective when it is one of two extremes, which are ‘command and control’ (with rules and regulations implemented through a top-down approach directed by a central regulator), and ‘self-regulation’ (a bottom-up approach where service providers and professionals self-regulate). Responsive regulation instead aims to combine both approaches, and is often depicted as a regulatory pyramid of approaches, with self-regulation and voluntary approaches at the base and sanctions at the top (Braithwaite *et al.*, 2007). To ensure standards are met, the regulator or oversight organisation begins at the bottom of the pyramid with information provision and persuasion, but with the capacity to escalate towards punishment if persuasion fails, sometimes referred to as ‘the gorilla in the closet’. Regulators will seek to persuade, but will act further if matters do not improve.

This pyramid alone, however, does not capture sufficiently the importance of rewards to spur effective regulation. Therefore, Braithwaite has since developed a ‘strengths-based’ pyramid to complement the ‘regulatory’ pyramid, which promotes ‘virtue’ while the regulatory pyramid restrains ‘vice’ (Braithwaite, 2008). Standards as a tool for regulation are used differently and rather than being pushed up through a floor as in the regulatory pyramid, are instead pulled up through a ceiling in the strengths-based model. This is similar to the distinction made by Seddon (2008), who focuses on increasing purpose and *performance* in services rather than on compliance with regulations, and who sees frontline staff heavily involved in driving improvements.

**Figure 1.1 An Example of a Strengths-based Pyramid Complementing a Regulatory Pyramid**



Source Braithwaite (2008:116)

Overall, taking the two pyramids together, the focus is on continuous improvement, by identifying problems and fixing them, but also by identifying opportunities and developing them. The strength of this dual-pyramid approach is at the bottom, where the focus is on education and persuasion. This is where most of the activity takes place within the service delivery organisation, with limited support and/or intervention from external organisations, such as regulators and overseers (NESC, 2011).

A range of approaches can be taken within responsive regulation, two of which are particularly relevant to this study of standards for residential care of older people. One is meta-regulation, where organisations establish systems of self-regulation themselves, and regulators then seek to assure themselves that these systems are adequate and being followed, i.e. it is the regulation of self-regulation (NESC, 2011). This can be carried out within an overall guiding framework to promote quality. The second is 'smart regulation' (Gunningham & Grabosky, 1998), where a range of non-state bodies are involved in supporting regulation, for example, professional organisations, trade unions and NGOs. These groups may be able to act as 'quasi-regulators', for example, NGOs that provide supports to implement standards, although it may be necessary for the State to enforce such standards with organisations who do not respond to the persuasive work of the NGO or other third parties.

## 1.2 Involvement of Service Users

An increasing trend in the provision of human services is a focus on how the *service* user receives the service. This means growing references to ‘person-centred’ services,<sup>9</sup> ‘tailored services’,<sup>10</sup> ‘money following the patient/client’, and so on. There is greater emphasis on taking into account the views of service users through consultation, ongoing engagement and, in some cases, the co-production of services and associated standards, for example, through student councils, patients’ committees, residents’ committees and joint policing committees. Associated with a greater emphasis on service users is an increasing focus on outcomes – for the service user, but also for the service providers, and the service system more widely (NESC, 2011).

## 1.3 Monitoring and Learning

Seeking feedback on the delivery and quality of services is a vital element of all quality assurance systems and is key to continuous improvement. What is needed is a mechanism for practitioners to learn from their practice and monitoring on an ongoing basis to ensure that review and learning, which can be described and demonstrated, are a constant feature of what people do at a local service delivery level (NESC, 2011; Sabel, 1994). According to Kendrick, monitoring and evaluation can point to the need for changes in service models: ‘They [quality and monitoring] are not in themselves capable of assuring quality, unless they are subsequently combined with feasible measures to improve service practice and models’ (Kendrick, 2006:3).

A key message from all the evidence reviewed by NESC in its *Quality and Standards in Human Services in Ireland: Overview of Concepts and Practices* (2011) is the need for a learning culture in the provision of quality human services. Ideally, learning should take place at a number of levels, an approach sometimes referred to as ‘triple-loop learning’. The first loop of learning occurs when practitioners monitor their achievement and make adjustments to gain improved outcomes. The second loop occurs when this kind of practical learning is noted by managers, who subsequently adjust their systems and routines to take note of this. And the third loop occurs when regulators and oversight authorities learn from monitoring the organisation’s improved goals and revise their strategy for the entire field. Meanwhile, diagnostic monitoring<sup>11</sup> and other service review approaches focus on

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<sup>9</sup> Person-centred services focus on the wishes of the service user in relation to the kind of services received and how they are delivered. This is the opposite of more ‘task-focused’ services that are often provided.

<sup>10</sup> This refers to mainstream services that have supports specifically tailored to the needs of the person accessing them, so that the person can overcome obstacles arising from disadvantaged social circumstances. See also NESC’s report, *The Developmental Welfare State* (NESC, 2005).

<sup>11</sup> In this approach, monitoring of services is used to diagnose problems and find solutions.

asking ‘Why?’, in a systematic way with a view to sharing learning, to change systems at the highest level.

## 1.4 Devolution with Accountability

There is some evidence from practice and in the literature, that those who are delivering services directly to the service users know well what is required. Devolving responsibility to service providers to maintain quality but with clear accountability mechanisms to ‘the centre’ can be an effective part of a regulatory system. The evidence suggests that a fruitful approach is to set a broad regulatory framework or a small number of guiding principles ‘at the centre’<sup>12</sup> and then devolve their application to the local context. The centre continues to have an oversight role to ensure compliance but local providers have the opportunity, and, in some cases, the incentive, to improve quality and performance. The over-riding priority is on achieving and improving outcomes for service users (NESC, 2011).

## 1.5 Addressing Costs While Improving Quality

In the current economic climate, cost is to the forefront of any debate on providing public services. In this context, an emphasis on quality may seem like a luxury. Should emphasis instead be put on securing basic services and maintaining access to them? This is an understandable stance but care should be taken about creating a division between ‘basic’ and ‘quality’ human services, as if the latter is somehow superfluous. Quality should be seen as a basic expectation for all users of human services and not something that might supplement the delivery of services, if resources happen to be available. Rather, quality should be seen as intrinsic to the delivery of human services provided by the State, private sector, voluntary sector and communities (NESC, 2012a forthcoming). In this context, a corresponding perspective is that strategies are needed to ensure that quality is not jeopardised, i.e. that services do not deteriorate when there are budget reductions (NESC, 2011).

This raises the question of the costs and savings associated with quality improvement initiatives. A review by Ovretveit (2009), of a range of quality improvement initiatives in the health services, found that few studies actually included all relevant costs, meaning that the evidence available to assess the costs of quality improvement was weak. Nonetheless, savings have been reported in some cases. There is strong evidence that quality improvement changes will improve outcomes for patients, but Ovretveit’s review showed that savings depend

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<sup>12</sup> Depending on the context, ‘the centre’ can be the government, a government department, a regulator, etc. The important point is that power (to varying degrees) is devolved from a central to a local or ‘frontline’ context.

on the type of improvement, on who pays for the cost of poor quality, and the intervention cost of the solution. For example, changes to reduce pressure ulcers can reduce extra treatments and admission rates to hospital. This is beneficial to patients, but will only save the provider money if the cost to the provider of implementing the change is lower than the losses made from the problem before the change. But it is not always the provider who saves through implementation of such initiatives. For example, in some payment systems, longer stays in hospital due to infection are not a cost, but extra income. A hospital can also spend time and money improving, for example, discharge information, but might not gain savings, because the next 'downstream' service will benefit instead from this information.

Another important influence on savings associated with quality improvement initiatives is how well they are implemented, which can vary considerably by location. External support, or previous experience with making changes effectively, will reduce the cost of implementation.

These findings show that addressing costs while improving quality is not a straightforward process. Nonetheless, the limited evidence suggests that some quality approaches can reduce the cost of provision, for example, cutting out waste, changing the way services are provided to make them more efficient and effective (such as more care at home, or changes in staff skill-mix), and taking a person-centred approach. The challenge is to organise work systems and practices in such a way that staff resources can deliver the optimal quality service within the financial resources available, and that associated regulation, standards and quality improvement initiatives support this approach.

## 1.6 Methodology

The methods used to gather the information outlined in this report include documentary research to outline the *National Quality Standards for Residential Care Settings for Older People in Ireland*, and to help assess their effectiveness; and interviews with key stakeholders, representing the public, private, and voluntary sectors. These interviews were carried out to gain greater insight into how the standards are operating in practice, from several viewpoints. A list of those interviewed is outlined in Box 1.2.

## Box 1.2 Stakeholders Interviewed on Standards in Residential Care For Older People

Organisation	Number Interviewed	Comments (see Section 2.3.1 for further detail)
Department of Health	Two managers from the Services for Older People division.	The Department of Health formulates policies for the health service, and so is the key government department influencing strategic development of standards in eldercare.
HSE	Six managers working on implementing aspects of the residential settings standards (but not in charge of a residential setting);  One manager working on monitoring systems.	The HSE (Health Services Executive) runs all public health services in Ireland. This means it is implementing standards in eldercare in the residential centres that it runs.
HIQA	Four managers from the inspection division, in a group meeting;  One ex-employee of HIQA.	HIQA, the Health Information and Quality Authority, is a state agency set up by statute in 2007. One of its functions is to set standards for health and social care, and as part of this it has devised standards for eldercare in residential settings, and inspects and regulates these settings.
NTPF	One manager.	NTPF, the National Treatment Purchase Fund, the state agency that agrees the prices to be paid by the State for care in registered nursing homes.
Nursing Homes Ireland (NHI)	The CEO; The practice development facilitator; and An NHI representative who was a member of a standards development committee.	NHI is the representative organisation for private sector and voluntary nursing homes in Ireland.
Residential Centres (public, private and voluntary)	Six randomly selected persons-in-charge. <sup>13</sup>	A sample of 42 residential centres was randomly selected from HIQA lists, and the person-in-charge of 21 of these was contacted by letter or email to see if they would like to speak to the project researcher about their experience of the development and implementation of these standards. Six agreed to this immediately and were interviewed.
Residential Centres with private sector accreditation (EIQA)	Two owners.	
Accreditation Company	One manager.	
HSE Working Group	One member of a group that drafted a standards framework.	

<sup>13</sup> This term is used in the *National Quality Standards for Residential Care Settings for Older People*, and refers to the manager of the residential centre.

To preserve anonymity, quotes and examples given by those interviewed are presented using the numeric identifiers R1 (respondent) to R28.

A workshop was also held with thirteen key stakeholders (including some of those detailed in Box 1.2), representing those designing and implementing standards, in the areas of home care, residential standards, and end-of-life care.<sup>14</sup> NESC would like to thank all of those interviewed for their interest, and the time they gave to explain the design and implementation of these standards frameworks.

All interviewees were selected due to either a) their key role in this area (e.g. those in NHI and the HSE); b) a recommendation to speak to them, due to their particular experiences in designing or implementing standards; or c) at random, as outlined in Box 1.2. However, as the number of people met is not very large, it is difficult to give weight to some of the issues raised in terms of their representativeness, so caution is advised in their interpretation. Nevertheless, the discussions held do help to begin to reveal key issues arising in the implementation of standards and quality in the area of residential care for older people.

For the residential standards, information has also been gained through reading all the inspection reports of seven per cent of residential settings (42 in total), which were randomly selected from the lists of those inspected by HIQA. These reports provide information on how the HIQA inspection process drives improvement. All quotes given from inspection reports in this report relate to these 42 randomly selected centres, unless otherwise stated.

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<sup>14</sup> Standards in end-of-life care, and in home care for older people, are the subject of two separate NESC reports – see NESC (2012c) and (2012b).





# Chapter 2

## Residential Care for Older People – The Context

## 2.1 Introduction

To provide some context on the number of older people in Ireland, and the demand for care for older people, key statistics on older people and their care are outlined here, drawn from the NESC *Well-being Matters* report (NESC, 2009), unless otherwise stated.

- The 2006 Census showed that there were 467,900 people aged 65 and over in Ireland, accounting for 11 per cent of the population;<sup>15</sup>
- There are more women than men aged over 65, and this over-representation increases with age;
- People aged 80 and over made up 24 per cent of those aged over 65;
- Two-thirds of people aged 65 and over live in private households with others, 27 per cent live alone and 7 per cent live in communal establishments. For people aged 85 and over, less than half live with others, nearly one-third live alone and one-quarter live in communal establishments.

In addition, the proportion of older people in the Irish population is expected to increase significantly over time, to 14 per cent by 2021, and to 20 per cent by 2036 (Department of Health, 2011b:4). Life expectancy is also increasing. In 2009, the life expectancy of an Irish woman aged 65 was 20.7 years, while for a man it was 17.3 years (Department of Health, 2011b:7). This will mean increasing demand for care support for older people. Mercer (2002) estimated that by 2012, 41,700 people aged over 65 would need moderate care supports (10.5 hours of support per week), 18,000 would need high-care support (21 hours per week), and 40,200 would need continuous care (42 hours per week) – a total of 99,900 older people. This figure was estimated to grow to 129,000 by 2022. Due to the increase in the proportion of women (traditionally the informal carers of older people) in the paid labour force and smaller family sizes it is expected that less informal, family care will be available for older people in the future, and that the State will need to provide

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<sup>15</sup> The CSO estimates that the proportion of the population aged over 65 in 2010 had increased slightly, to 11.4 per cent (Department of Health, 2011b:3).

more support in this area (Working Group on Long Term Care, 2008). Formal home-care supports were provided to approximately 66,000 older people in 2010 (see NESCC, 2012b forthcoming, for more detail), while a smaller proportion of older people receive residential care.

## 2.2 How Many Older People Receive Residential Care?

The 2006 Census showed that 5.6 per cent of people aged 65 and over lived in nursing homes and hospitals in Ireland, compared to an EU average of 2.9 per cent. This proportion increases to 22.7 per cent (16.4 per cent for men and 25.5 per cent for women) for 85-year-olds and over, compared to an EU average of 12.4 per cent (CSO, 2007). Research by the National Council on Ageing and Older People (NCAOP) found that the main reasons for admission to long-stay care were chronic illness, mental infirmity, physical disability and social reasons (NCAOP, 2005: 17).

More recent estimates of the number of older people in residential care can be gleaned from the Department of Health's *Long Stay Activity* report (2011b). This gathers information through surveying settings providing long-term care (and so covers long-term care not just, but mainly, for older people). The most recent edition lists the number of beds in the 80 per cent of 594 settings who responded to the survey, for 31 December 2010 (Department of Health, 2011b).<sup>16</sup> At that time:

- There were 22,998 beds in long-term care settings, with 20,784 beds for long-stay care and 2,214 for short-term care (respite, convalescence, etc.).
- Altogether there were 21,048 people in long-stay residential care;
- 69 per cent of residents were aged over 80 at the time;
- Women represented approximately 66 per cent of residents aged 65 and over, and 76 per cent of residents aged 80 and over;
- 63 per cent of all beds were provided by the private sector, 9 per cent by the voluntary sector, and 28 per cent by the State (the increase in the proportion of private sector beds in recent years has been noted by others also, see e.g. Carney *et al.*, 2011).

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<sup>16</sup> One stakeholder (R15) noted that a number of organisations collect data relating to the amount of beds in long-term care settings in Ireland, and that there are some variations between the different data sets. HIQA is likely to have the most definitive statistics on the number of places for older people in residential centres, as it registers each centre to provide a certain number of places, and so does not have to rely on survey data.

## 2.3 Organisations and Policy Documents Relevant To Standards in Residential Care for Older People in Ireland

A large number of organisations – Irish and international, statutory and NGO – and a variety of policy documents have influenced the development of standards for residential care of older people in Ireland. In the following sections, the key organisations are outlined, followed by the main international, and then the main Irish, strategy documents. This is not an exhaustive description of all organisations and strategies influencing standards in Irish eldercare, but a brief overview to give some idea of the range of organisations and policy documents involved (for a list of relevant organisations and documents, see Appendix D).

### 2.3.1 Organisations Involved in Design and Implementation of Standards for Residential Care of Older People in Ireland

First, the key organisations involved in the development and implementation of standards for residential care of older people in Ireland (some of which were referred to in Box 1.3) are outlined in Box 2.1 and Box 2.2.

## 2.4 International Context

The international organisations and policies that influence Irish standards for residential care of older people are now outlined.

In many Irish policies, the EU has a strong regulatory influence, with, for example, an EU directive on environment being transposed into Irish law by the Department of the Environment, and then implemented by local authorities. However, no such clear-cut international context exists in relation to standards on eldercare. The EU has little jurisdiction over health policy, with its work in this area mostly confined to public health, occupational health and safety, and access to health care for EU citizens outside their member states. The UN does have a number of policy documents on older people that the Irish government has signed up to (see NESC, 2009). However, it seems that the main influence of international bodies on Irish policy and practice on standards in eldercare is quite indirect, with these bodies appearing to act as a repository of ideas and best practice, which influences standards development. A number of the particularly influential documents are described here.

## Box 2.1 Key Organisations Involved in Developing Standards in Residential Care for Older People in Ireland

**The Department of Health**, which formulates policies for the health services, and so is the key government department influencing strategic development of standards on eldercare. It contains a number of divisions that have a particular role in this area. These include a) the Office for Older People, which was set up in 2008. This Office has six main responsibilities,<sup>17</sup> including nursing-home regulations, and inspection/accreditation; and b) the Nursing Policy Division, which provides professional advice on nursing, which is relevant to nursing staff working in eldercare.

**HIQA, the Health Information and Quality Authority**, which is a state agency set up by statute in 2007. One of its functions is to set standards for health and social care, and as part of this it has devised standards for eldercare in residential settings. It inspects these centres to ensure they meet the standards, and registers those that do, to operate.

**The HSE, the Health Services Executive**, which runs all public health services in Ireland. This means it is implementing standards in eldercare in the services it provides (such as residential centres etc.). It also provides support to the nursing homes it manages to meet standards, through, e.g. its Nursing and Midwifery Professional Development Units, which provide advice and training to nurses working in eldercare.

**Nursing Homes Ireland (NHI)**, which is the representative organisation for private sector and voluntary nursing homes in Ireland. It was formed in January 2008 following the merger of a number of smaller representative organisations. It has 354 members (see [www.nhi.ie](http://www.nhi.ie)). It was represented on the consultative group drafting standards for quality care in residential centres for older people, and now provides supports to members to implement these standards.

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<sup>17</sup> See [www.dohc.ie/about\\_us/divisions/services\\_older\\_people.html](http://www.dohc.ie/about_us/divisions/services_older_people.html) for further detail (accessed 24 March 2011).

## Box 2.2 Other Organisations Involved in Developing Standards for Residential Care for Older People in Ireland

**The National Council for Professional Development of Nursing and Midwifery**, a statutory agency whose functions are currently being subsumed into the HSE, the Department of Health and An Bord Altranais. In its previous work, it developed the professional roles of nurses and midwives, and supported the delivery of quality nursing and midwifery care to patients/clients. This included support for nurses delivering eldercare.

**An Bord Altranais**, which maintains the register of nurses in Ireland and provides guidance to the nursing profession generally on all matters relating to ethical conduct and behaviour. Its Guidance to Nurses and Midwives on Medication Management is used extensively in residential centres for older people.

**The Federation of Voluntary Catholic Nursing Homes**, a smaller representative group made up of 22 voluntary Catholic nursing homes (see [www.fcvnh.org](http://www.fcvnh.org)).

**Voluntary organisations – Age Action Ireland**, the **Irish Senior Citizens' Parliament** and **Caring for Carers Ireland** are three voluntary organisations that were on the Working Group developing the standards for residential care of older people. The first two are representative organisations for older people, while the latter represents carers.

### 2.4.1 UN Influence

The Second UN World Assembly on Ageing was held in Madrid in April 2002. At this Assembly, a political declaration and the *Madrid International Plan of Action on Ageing* were adopted and signed by the participating governments (including Ireland) (see United Nations, 2002). The Plan of Action was very wide-ranging, and listed 117 recommendations covering three main priority areas:

- Older persons and development;
- Advancing health and well-being into old age; and
- Ensuring enabling and supportive environments.

Two of the Plan's recommendations are relevant to standards in residential care for older people, as follows:

- Develop regulatory mechanisms at appropriate levels to set suitable standards of health care and rehabilitation for older persons; and
- Establish and apply standards and mechanisms to ensure quality care in formal care settings.

However, the Plan of Action falls into the category of ‘soft law’, in that it is not legally binding, and States are under a moral rather than legal obligation to follow its recommendations on the treatment of older people (Law Reform Commission, 2011).

#### 2.4.2 OECD Influence

In 2005, the OECD published *Long-term Care<sup>18</sup> for Older People* (OECD, 2005), a study that looks at long-term care policies in 19 OECD countries, including Ireland. It contains a chapter on monitoring and improving the quality of long-term care, listing initiatives for better regulation and standards in long-term care services, and highlighting that effective monitoring is needed to ensure that such regulation and standards actually lead to improvements in quality of long-term care. This report has influenced day-to-day development and implementation of standards on long-term care in Ireland, as it contains information on how regulations and standards have been introduced in different countries, and it is referenced substantially in the report of the Irish working group on long term care (Working Group on Long Term Care, 2008); see Section 2.5.5 for more detail.

## 2.5 Irish Context

### 2.5.1 Care for the Aged

Calls for standards in the care of older people date back to the first policy document focusing on this issue in Ireland, *Care for the Aged*, which was published in 1968 (Inter-Departmental Committee on Care of the Aged, 1968). This report was written by a working group appointed by the Minister for Health, to report on ‘the general problem of the care of the aged and to make recommendations regarding the improvement and extension of services’ (p. 22). The report did not look at standards in detail, but noted that ‘the standards of services, both domiciliary and institutional ... provided for the aged has improved greatly in many countries in recent years’, and that ‘this country must aim to provide similarly improved standards’ (p. 49). In relation to residential centres, it outlined that they should aid the mobility and safety of older people, provide the atmosphere of a normal home, and not institutionalise their residents.

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<sup>18</sup> This report defines long-term care as services ‘needed by individuals with long-standing physical or mental disability, who become dependent on assistance with basic activities of daily living, many of whom are in the highest age groups of the population’ (OECD, 2005:15).

### 2.5.2 The Years Ahead: A Policy for the Elderly

Twenty years later, *The Years Ahead: A Policy for the Elderly* was drafted by an inter-departmental and inter-agency group appointed by the Minister for Health. Its main overall recommendation was that older people should be supported to remain in their homes as long as possible (a stance reiterated a number of times since in Irish policy on care of older people). It also made two recommendations on standards, as follows:

- An independent inspectorate of extended care facilities for the elderly should be established within the Department of Health comprised of people with first hand experience of providing high standards of care for the elderly (9.48); and
- The Department of Health, in consultation with the health boards and the Irish Private Nursing Homes Association, should draw up and implement a code of good practice for extended care of the elderly suitable to this country's need (9.48). (Working Party on Services for the Elderly, 1988).

A review of implementation of *The Years Ahead* in 1997 (Ruddle *et al.*, 1997) found that such an inspectorate for extended care facilities had not been established, and that there were no plans to establish one, as the Department of Health considered that the health boards had adequate inspection powers already. Meanwhile, the suggested voluntary code of practice for nursing homes had been drawn up in 1995 by a group of stakeholders. It covered the philosophy of care, introductory visits, trial stays, written contracts of care, involvement of residents in decision-making, medication and activities for nursing home residents. Where it was used, it was monitored by the health boards. The majority of nursing homes who responded to a questionnaire circulated by those reviewing *The Years Ahead* stated that they found the Code of Practice good, but others were unaware of its existence.

### 2.5.3 Reports by Other Organisations

A range of other organisations also looked at the issue of standards in residential care, and a number of reports on this were published, in particular by the National Council for Ageing and Older People (NCAOP), and the National Economic and Social Forum (NESF). The Irish Nursing Homes Organisation (INHO, now part of Nursing Homes Ireland) also published a position paper on the issue.

Reports published by the NCAOP since the mid-1980s (when it was known as the National Council for the Elderly<sup>19</sup>) have called for registration of all nursing homes, and stronger inspection and monitoring against existing regulations, and identified particular areas for improvement such as physical environment, fire safety, and

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<sup>19</sup> In fact, the NCAOP has had several names. From 1981 to 1990, it was the National Council for the Aged, which was replaced by the National Council for the Elderly from 1990 to 1997, and then by the NCAOP from 1997 to 2009, when it was dissolved. At all times its terms of reference were to advise the Minister for Health on the welfare and care of older people.



routines (see, e.g. National Council for the Aged; 1985, O'Connor & Thompstone, 1986). A later report in 1991 reiterated many of these points (O'Shea *et al.*, 1991); in fact, the reiteration of the same recommendations over the years is quite striking. The Council's 2000 report, *A Framework for Quality in Long-Term Residential Care for Older People in Ireland* (NCAOP, 2000), recommended an independent inspectorate, inspection of all centres (including those run by the health boards), uniform standards and consultation with residents on services. The Council's final report on residential care, *Improving Quality of Life for Older People in Long-Stay Care Settings in Ireland*, focused on quality of life issues, and recommended greater person-focused care, as well as more home-like environments (Murphy *et al.*, 2006).

During the 2000s, the NESF produced a number of reports looking at care of older people. The most comprehensive, *Care for Older People* (NESF, 2005), recommended that standards of care should be developed for all care services provided to older people, including not only residential and home care, but also services provided in the community. As with more recent NCAOP reports, it emphasised the importance of quality of life of older people. For example, the NESF report noted that service users needed to be consulted about what they consider quality care to be. It called for standards to be developed and renewed in partnership with key stakeholders (older people and their families, service providers etc.); for these standards to be measurable and for the results to be publicly available; and for the standards to be viewed as a mechanism of continuous improvement. The report also emphasised the key role that high-quality staff play in the provision of high-quality care. Finally, it recommended that standards be put on a statutory basis, be inspected by the Social Services Inspectorate, and that there be sanctions for non-compliance.

In 2006, the Irish Nursing Homes Organisation (INHO) published a position paper entitled *Review of Nursing Home Legislation and the Development of National Minimum Standards for Nursing Homes* (INHO, 2006), following on from an invitation from the Minister for Health and Children for the INHO and other stakeholders to become involved in a review of the legislation governing nursing home care at the time. The position paper called for stronger legislation on registration and inspection of nursing homes, as well as greater clarity on the duties and obligations of nursing homes to their residents, and on the rights and entitlements of the residents. More specifically, it outlined the need for standards backed by statute, an independent inspectorate with strong powers, compulsory registration of all nursing homes, and a transparent and effective appeals mechanism where registration is refused. It also outlined minimum care standards, building standards and administration/governance standards.

#### **2.5.4 Quality and Fairness**

The Health Strategy, *Quality and Fairness: A Health System for You* was published in 2001, and outlined an action plan for the development of health services, including services for older people. It has a strong emphasis on standards, with 'high performance' one of the four national goals outlined. Under this goal, it is specified

that ‘this objective is concerned with ensuring that the quality and safety of care in the Irish health system meet agreed standards and are regularly evaluated/benchmarked’ (Department of Health and Children, 2001:25). It committed to prioritising both community and residential care of older people for the drawing up of national standards for quality care. It also had a number of commitments on monitoring, including the establishment of an ‘independent Health Information and Quality Authority’, which would be able to set and monitor standards, putting the Social Services Inspectorate on a statutory footing, and extending its remit to cover residential care for older people.

### 2.5.5 Partnership Agreements

There have been seven social partnership agreements since 1987, and, over time, they tended to include more on services for older people, and more on standards in public services. Often the commitments in the agreements were in line with the recommendations of the relevant strategy documents outlined above.

The first agreement to refer to services for older people was the *Programme for Economic and Social Progress* in 1991 (Government of Ireland, 1991). *Sustaining Progress* in 2003 was the first to look at standards in relation to eldercare. In it, regulatory and standards issues are listed as issues to investigate when implementing a strategic approach to infrastructure of care services for older people and others (Government of Ireland, 2003). Most recently, *Towards 2016*, includes a number of commitments on services for older people, and a commitment to develop standards in long-term residential units, both public and private (Government of Ireland, 2006).

*Sustaining Progress* included a commitment that a Working Group would be established to examine the strategic policy, cost and service delivery issues associated with the care of older people. There was particular concern about the increase in the number of older people needing care, and the decline in the number of informal carers available, given smaller families and the increase in women’s labour force participation. Arising from this, an inter-Departmental Working Group on Long Term Care was established in 2005, chaired by the Department of the Taoiseach, and comprising senior officials from the Departments of Finance, Health and Children, and Social and Family Affairs. Its terms of reference were to identify the policy options for a financially sustainable system of long-term care, and to rationalise the range of benefits, services and grants (both statutory and non-statutory) currently in place, and address associated issues. It focused on the long-term care needs of those aged over 65.

This report (Working Group on Long Term Care, 2008) is the most recent outlining principles for policy on long-term care for older people in Ireland, and reiterates the earlier policy aim that older people should be supported to remain at home, that informal care is key in this, and that professional home care should support this. It

argued that improved home care support would help to minimise requirements for residential care, and in most cases could be provided at lower cost than residential care.<sup>20</sup> It recommended reducing the proportion of older people in residential care, from 4.3 per cent<sup>21</sup> of those over 65, to 4 per cent.

The report did not make many recommendations in relation to standards, apart from stating that home care packages should have clear quality standards, and also noting that legislation was being prepared to establish HIQA, which would monitor standards of care in services for older people.

## **2.5.6 Summary of Key Policy Documents Relevant to Standards on Care of Older People**

This review of policy documents relevant to standards in eldercare shows that since 1988, it has been government policy to support older people to remain at home as long as possible, in line with the wishes of older people.<sup>22</sup> This is seen as a more financially sustainable model for long-term care (although the OECD has cautioned against over-ambitious expectations of cost reductions arising from more use of home care (Working Group on Long Term Care, 2008)). There have also been many calls for standards in relation to residential care for older people, and such standards were introduced under statute in 2009. The following chapter will outline the development and implementation of these residential care standards, the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

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<sup>20</sup> Although it did note that the OECD ‘have warned against overly optimistic assumptions about savings arising from people availing of community rather than residential care’ (Working Group on Long Term Care, 2008:7).

<sup>21</sup> This figure is based on HSE figures for 2004, and comprises only those in residential care. The figure of 5.6 per cent cited in Section 2.2 is from Census 2006, and includes those over 65 in hospital as well as in residential centre care.

<sup>22</sup> The issues of standards in home care for older people is the subject of a separate report. See NESC 2012b.



# Chapter 3

## National Quality Standards for Residential Care Settings for Older People in Ireland

### 3.1 The History of the *National Quality Standards for Residential Care Settings for Older People in Ireland*

Legislation to regulate the care of older people in nursing homes (as they were then called) has existed in Ireland since 1964. The legislation includes both primary legislation (Acts), and secondary legislation (regulations or statutory instruments) under these Acts, which outline in more detail what is required. The key pieces of legislation relating to care given<sup>23</sup> are outlined in Box 3.1.

#### **Box 3.1 Primary and Secondary Legislation Regulating Care of Older People in Residential Centres**

##### **Health (Homes for Incapacitated Persons) Act, 1964**

-SI No. 44/1966 – Homes for Incapacitated Persons Regulations, 1966

-SI No. 317/1985 – Homes for Incapacitated Persons Regulations, 1985

##### **Health (Nursing Homes) Act, 1990**

-SI No. 226/1993 – Nursing Homes (Care and Welfare) Regulations, 1993

##### **Health Act, 2007 (and its 2007 amendment)**

-SI No. 236/2009 – Health Act, 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations, 2009

-SI No. 36/2010 – Health Act, 2007 (Care and Welfare of Residents in Designated Centres For Older People) (Amendment) Regulations 2010

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<sup>23</sup> There are other pieces of legislation that apply to, e.g. financing of care, which are not included here, as it is the type of care given that is the subject of this report.

Legal requirements on care for older people in residential centres were introduced by the 1964 Health (Homes for Incapacitated Persons) Act, which applied to privately run nursing homes only. Under this Act, two sets of regulations on care and welfare were drafted, the first in 1966 and the second in 1985. The 1966 regulations were three pages long, and not very prescriptive, while the 1985 regulation, at twice the length, were more precise and detailed,<sup>24</sup> outlining, for example, specific heating temperatures and space requirements; the requirement for a register of ‘patients’, records of their condition on admission and of drugs administered to them; a sufficient number of competent staff, as well as details on fire safety practice. These regulations also required inspection at least once every six months, which was carried out by health board staff.

In 1990 a new Health (Nursing Homes) Act was introduced. Again, it applied to privately run nursing homes, but this time it also applied to homes run by religious groups, which under the 1964 Act had been exempted from meeting the regulations where they conflicted with their religious ethos. The requirements of the 1990 Act still did not cover homes run by the public sector. Care and welfare regulations under this Act were introduced in 1993, and again were longer and more detailed than the previous regulations. All of the Acts from 1964 on specified that if homes did not meet the legal requirements, those responsible for managing them could be fined and/or could face a prison sentence, and be disqualified from managing a home in future. It was only in the 1990 Act that provisions for the health board to refuse to register a home, remove it from the list of registered homes if it did not meet the regulations, or take over its management if necessary, were included.

Meanwhile, in 2002, the Irish Health Services Accreditation Board (IHSAB), a statutory body, was established. Its mission was to ‘be a key driver for the continuous quality improvement of the Irish health system’, using accreditation and other schemes to improve quality in health services, where deemed appropriate by the Minister (IHSAB, 2004:2). The IHSAB developed an *Acute Care Accreditation Scheme* (IHSAB, 2004: see also NESF, 2005:92–3). The process used to gain accreditation required acute care organisations to self-assess their procedures and practices before this assessment was double-checked by an external team employed by the IHSAB. A system of peer review was also in place. In 2005, IHSAB was developing a residential/non-acute care accreditation scheme, but this was not completed before it was subsumed into HIQA in 2005–6, and the focus on accreditation shifted to the model now in place.

While *Quality and Fairness: A Health System for You* (Department of Health and Children, 2001) clearly indicated in 2001 that the aim was to develop national standards for quality care, establish a Social Services Inspectorate and Health Information and Quality Authority, and prioritise residential care for older people in these, there is little doubt that the scandal around substandard care provided in the Leas Cross nursing home for older people was a catalyst in moving these

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<sup>24</sup> Fitting in well with Braithwaite *et al*’s (2007) observation that regulations and standards tend to increase in length and detail over time.

developments forward. The poor care in Leas Cross was revealed in a current affairs television programme in 2005, with an undercover reporter working in the nursing home for a number of weeks and using hidden cameras and interviews with relatives to reveal serious issues, including untreated pressure ulcers, poor hygiene, poor record-keeping and a lack of activities for residents. This caused significant public concern and discussion, and altogether three official investigative reports<sup>25</sup> were written to look into how such substandard care was given in this nursing home – despite it regularly passing inspections by the HSE (and holding an ISO 9001 quality mark).

### 3.2 Current Legislation and Standards on Care of Older People in Residential Centres

The 2007 Health Act contains the most recent legislation on nursing homes, now called designated centres for older people, and introduced significant changes in the regulation of these. For the first time, all designated centres, whether operated by the public sector, private sector, or voluntary providers, are covered by the legal requirements of this Act. It also set up the independent Health Information and Quality Authority (HIQA), and provided it with a variety of functions. These include: registering residential care centres to operate; inspecting such centres in order to register them; publicising the results of these inspections; and de-registering centres that do not meet the legal requirements, through application to the District Court. HIQA is also empowered to draft standards on care. Two key sets of regulations on care in designated centres for older people have been made by the Minister for Health under this Act – the *Care and Welfare of Residents in Designated Centres for Older People Regulations, 2009*, and the *Registration of Designated Centres for Older People Regulations, 2009*.

Compared to the earlier regulations, the 2009 Care and Welfare Regulations have a greater focus on the older person, including, for example, provision on the rights and dignity of older people, and on consultation with them; communication to them; a complaints procedure in designated centres; and reviews of quality of life as well as safety of care. These inclusions address the recommendations of several NCAOP and NESF reports outlined in Chapter 2. Meanwhile, management requirements now include risk management procedures, a four-page list of the records to be maintained in the centre, and the requirement to have written policies and procedures on various issues, e.g. abuse, communication, end-of-life care, etc.

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<sup>25</sup> These three are the Hynes report which investigated the care of Peter McKenna, who died 13 days after being transferred from St Michael's House to Leas Cross (HSE, 2005); the O'Neill report which reviewed deaths in the home between 2002 and 2005 (O'Neill, 2006); and the Commission of Investigation (Leas Cross Nursing Home) report (2009).



For the first time, there are now also standards in relation to care of older people in designated centres, the *National Quality Standards for Residential Care Settings for Older People in Ireland* (HIQA, 2009b), as the Health Act 2007 empowered HIQA to draft such standards.

To draw up these standards, HIQA consulted with a wide variety of stakeholders, including the general public. The working group set up to advise on these standards included the Department of Health and Children; HIQA (the CEO of HIQA was chair of the group); the HSE; industry groups (e.g. Nursing Homes Ireland); professional groups (An Bord Altranais; associations representing occupational therapists, social workers, physiotherapists, geriatricians, etc.); and groups representing older people (Age Action, Alzheimer Society, the Irish Senior Citizen's Parliament, etc.). International best practice also fed into development of the standards. They were mandated by the Minister for Health and Children in March 2009.

There are 32 standards, which are grouped into seven sections, as outlined in Box 3.2. (on page 30).

Each standard has an outcomes statement that sets out in broad terms what is expected in terms of the service provided to the resident. Under each standard, criteria are also set out, which explain how a service can be judged to see whether or not the standard is being met. The example of Standard 2: *Consultation and Participation*, is given in Box 3.3.(on page 32).

A key goal behind the standards is that they promote person-centred care, in a home-like environment (HIQA, 2009b). This can be seen in the move away from the vocabulary used in earlier legislation and regulations, from terms such as 'nursing home', to 'residential care setting', and from 'patient' to 'resident'.

There is a legal difference between the regulations under the Act, and these standards. Regulations are based on primary legislation and are designed to give effect to the legislation. They spell out the detail of what the legislation intends, and can be legally enforced. On the other hand, HIQA (2009b:8) states that the standards are 'designed to encourage continuous improvement', and while the vast majority of the standards relate to a requirement under the regulations, some do not. Only the standards that link directly to the regulations are legally enforceable.

To be registered to operate, all residential care settings must comply with the regulations. If the setting is not in compliance with the regulations it will fail to achieve registration status or lose this status. To be registered, a centre must also meet each of the outcomes statements that describe a standard. It is not, however, necessary to meet all the criteria under a standard in order to meet the standard outcomes. However, confusingly, some but not all of the criteria under the standards are required by the regulations, and so these particular criteria must be met as they are a legal requirement. There is some ambiguity on the legal position if a centre does not comply with an aspect of a standard that is not linked to a regulation. In that case, will it fail to be registered or lose its registration? This has not been tested yet in the courts, as currently the centres that have failed to be registered have breached both standards and regulations. A review of the

## Box 3.2 National Quality Standards for Residential Care Settings for Older People in Ireland

### Section 1: Rights

- Standard 1: Information
- Standard 2: Consultation and Participation
- Standard 3: Consent
- Standard 4: Privacy and Dignity
- Standard 5: Civil, Political and Religious Rights
- Standard 6: Complaints
- Standard 7: Contract/Statement of Terms and Conditions

### Section 2: Protection

- Standard 8: Protection
- Standard 9: The Resident's Finances

### Section 3: Health and Social Care Needs

- Standard 10: Assessment
- Standard 11: The Resident's Care Plan
- Standard 12: Health Promotion
- Standard 13: Health Care
- Standard 14: Medication Management
- Standard 15: Medication Monitoring and Review
- Standard 16: End of Life Care

### Section 4: Quality of Life

- Standard 17: Autonomy and Independence
- Standard 18: Routines and Expectation
- Standard 19: Meals and Mealtimes
- Standard 20: Social Contacts
- Standard 21: Responding to Behaviour that is Challenging

### Section 5: Staffing

- Standard 22: Recruitment
- Standard 23: Staffing Levels and Qualifications
- Standard 24: Training and Supervision

### Section 6: The Care Environment

- Standard 25: Physical Environment
- Standard 26: Health and Safety

### Section 7: Governance and Management

- Standard 27: Operational Management
- Standard 28: Purpose and Function
- Standard 29: Management Systems
- Standard 30: Quality Assurance and Continuous Improvement<sup>26</sup>
- Standard 31: Financial Procedures
- Standard 33: Register and Residents' Records

**Source** HIQA (2009b)

<sup>26</sup> Many of the other standards also incorporate requirements on continuous improvement. See Section 5.3.1

regulations, which is currently underway, is looking at the links between the regulations and the standards (see Section 5.3.4 for more).

## 3.3 The Process of Regulation

To be registered to operate, a residential setting must apply for either first-time registration, or to renew its registration. The centre is then inspected by HIQA to ensure that it meets the regulations under the Health Act 2007, meets the *National Quality Standards for Residential Settings for Older People in Ireland* and also is run by a 'fit person'. A centre that meets these requirements is then registered to operate; one that does not can have enforcement proceedings taken against it. How these processes operate are outlined in this section.

### 3.3.1 Inspection

The degree to which residential centres meet the regulations and standards is assessed through inspections and monitoring by HIQA. The inspection process began in July 2009, and a number of different types of inspection are carried out. In general, the most thorough is the 'registration inspection', and once a residential centre has passed this, it is registered to provide a specified type of care to a specified number of people, for the next three years. After the three-year period is up, centres apply for re-registration.

Other types of inspections include:

- **Scheduled inspections**, which take place at intervals over the three-year registration cycle, depending on the centre's level of compliance with regulations;
- **Follow-up inspections** to check on specific matters arising from a previous inspection;
- **Triggered inspections**, following notification of a significant event or concern; and
- **Inspection on notification of a change in circumstances** (e.g. person-in-charge changes).

### Box 3.3 Standard 2: Consultation and Participation

#### Standard 2: Consultation and Participation

Each resident's rights to consultation and participation in the organisation of the residential care setting, and his/her life within it, are reflected in all policies and practices.

#### *Criteria*

- 2.1 Where the resident has been admitted to the residential care setting in an emergency, he/she is given time, information and, if necessary, access to an advocate, in order to decide whether or not to remain in the residential care setting on a long term basis (See standard 3: Consent).
- 2.2 The resident is consulted on what information is provided to his/her relatives or representative in relation to his/her care and to whom this is provided.
- 2.3 The resident contributes ideas to and participates in the day-to-day activities of the residential care setting.
- 2.4 The person-in-charge facilitates the establishment of an in-house residents' representative group for feedback, consultation and improvement on all matters affecting the residents. At least one nominated person acts as an advocate for people with dementia/cognitive impairment. Issues raised by the residents' representative group are acknowledged, responded to and recorded, including the actions taken in response to issues raised.
- 2.5 Feedback is actively sought from the resident on an on-going basis on the services provided. The residential care setting clearly demonstrates how the impact of the resident's feedback informs reviews and future planning.

Source HIAQ (2009b)

A review of inspections carried out by HIQA between July 2009 and October 2010 showed that 33 per cent of inspections were for registration; 36 per cent were scheduled; 22 per cent follow-up; and 9 per cent triggered (HIQA, 2012).

Inspections can take place at any time – day, evening, week, weekend, and be announced or unannounced. When carrying out the inspection, inspectors meet with residents, relatives, the person-in-charge and other members of staff. They examine records, including care plans, medical records, accident and incident logs. They sit and observe care. They also eat meals with residents. This allows them to build up evidence to assess the extent to which the centre complies with the regulations and standards.

An inspection report is compiled from the evidence gathered, and an overall assessment on the safety and quality of care provided to residents is given. An assessment is given for each of the 32 standards.

In Box 3.4 quotes from inspection reports of the 42 residential centres randomly reviewed for this project are provided, to show contrasting examples of the quality of life and environment in different settings.

For each standard, the assessment gauges whether there is:

- Evidence of good practice;
- Some improvements required; or
- Significant improvements required.<sup>27</sup>

Where improvements are needed, the inspection report lists the requirements and recommendations for change.<sup>28</sup>

A draft inspection report is drawn up and sent to the provider of the residential centre within 28 days. The provider can correct any factual inaccuracies, and also must draw up an action plan detailing how they will address the requirements for change and the recommendations, and within what timeframe. The action plan is then added to the inspection report drawn up by HIQA, and both are published together as one document on the HIQA website.

HIQA subsequently returns to the centre for follow-up inspections to assess how the action plan is being implemented, and the extent to which the requirements and recommendations for registration are being addressed.

HIQA data shows that by the end of September 2010, 1,213 inspections had been carried out – 986 (81 per cent) of private or voluntary centres and 227 (19 per cent) of public centres (HIQA, 2012). This is in line with the proportion of centres in each type of ownership, as 21 per cent of centres are run by the HSE and 79 per cent by private or voluntary providers (HIQA, 2012).

It is interesting to consider how the inspection process can help drive improvement. An example of one residential centre is given in Box 3.5, (on page 36), looking at how provision of activities for residents has been addressed through the inspection process.

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<sup>27</sup> The format of the inspection reports has changed somewhat since this review was carried out in late 2011.

<sup>28</sup> There are requirements for change when a regulation is breached, and recommendations for change when a standard not covered by a regulation is breached.

### Box 3.4 Excerpts from Inspection Reports for Randomly Reviewed Residential Centres<sup>29</sup>

#### Bedtimes

*Centre 37 (inspection of 17-18 Sept 2009)*<sup>30</sup>

Inspectors saw that residents were restricted in the choices they were offered and their daily routines seemed to meet the needs of staff, rather than support the residents in living their lives. Inspectors saw staff putting residents to bed immediately after tea at 5pm, with the majority of residents in bed by the time the night staff came on duty.

*Centre 375 (inspection of 3-4 June 2010)*

Residents told inspectors that they exercised choice around how they spend their day, getting up and going to bed when they wished, having breakfast in bed or in the dining room at times convenient to them.

#### Residents' committees

*Centre 37 (17-18 Sept 2009)*

There were no formal structures or processes in place which allowed residents' or relatives' views to inform future planning or service development. Inspectors failed to find any residents who attended the residents' meetings alluded to in the pre-inspection questionnaire. Residents who spoke with inspectors claimed that they were never asked for their views.

*Centre 150 (15 Dec 2009)*

Inspectors were informed that a residents' meeting was held once a month. At this meeting matters of interest to residents were discussed. Minutes of these meetings were read and they indicated that management **responded in a timely manner to residents' requests.**

#### Finance

*Centre 37 (17-18 Sept 2009)*

When inspectors reviewed the petty cash accounts of the residents, they found discrepancies in the financial affairs of 11 residents; the amounts missing varied between €10 and €130.

*Centre 325 (9-10 June 2010)*

Inspectors reviewed the systems in place to manage residents' finances. The sample of records reviewed indicated that there was a good standard of documentation and receipting. Finances were accountably managed and explained to the resident or their representative.

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<sup>29</sup> All of these reports can be found, listed by residential centre, at <http://www.higa.ie/social-care/find-a-centre/nursing-homes%20> (accessed autumn 2011 and spring 2012).

<sup>30</sup> Subsequent reports for this centre show many actions to improve these problems

### **Challenging behaviour**

*Centre 450 (12 Jan 2011)*

Inspectors reviewed the care plan for managing one resident's behaviour that challenged and found that information recorded was not sufficient to ensure the consistency of interventions... while the person-in-charge considered this resident's behaviour unpredictable, other staff were more familiar with the triggers and could describe and explain when incidents of challenging behaviour would most likely happen. This information was not recorded as part of the resident's plan of care to inform staff practice.

*Centre 375 (3–4 June 2010)*

A comprehensive policy on managing behaviour that challenges was implemented and guided staff practice. Behaviour management charts were in place, should a resident's behaviour become challenging. The policy included guidance and procedures for managing different types of behaviour including absconding, aggressive and intrusive behaviour. Detailed strategies and interventions were documented to manage the different types of behaviour in order to achieve positive outcomes for the resident.

### **Space**

*Centre 537 (27 Aug 2009)*

There was a lack of personal storage space for residents, particularly in one resident's room. Essential furniture, such as a wardrobe and a locker, were not available for all residents.

*Centre 325 (9 June 2010)*

Inspectors visited residents' bedrooms and noted that residents' had suitable space for storing their clothes to include hanging space in their wardrobes. Each resident had been provided with a locker with a lockable drawer to allow them secure personal items ensuring their privacy.

### **Equipment**

*Centre 37 (17 Aug 2009)*

Equipment service records did not contain any information about the routine servicing of kitchen equipment or hoists... There were no plans for the routine maintenance and replacement of equipment.

*Centre 187 (29 Sept 2009)*

There was appropriate assistive equipment available to meet the needs of the residents, such as electric beds, hoists, pressure relieving mattresses, wheelchairs and walking aids. There was evidence that hoists and other equipment were maintained, while service records were up to date.

### **Staff training**

*Centre 37 (17 Aug 2009)*

Care assistants, who formed the largest part of the workforce and provided direct care to residents, did not have formal FETAC (Further Education and Training Awards Council) qualifications.

*Centre 100 (27 April 2010)*

The staff told inspectors that ten out of twelve care assistants were facilitated to complete Further Education Training Awards Council (FETAC) Level 5 training which allowed them to have the skills and knowledge to provide high quality evidence based care to residents

### Box 3.5 Assessment of Continuous Improvement through Standards Inspection Process, in Residential Centre 187<sup>31</sup>

This residential centre has been inspected four times since the HIQA standards inspection began to be implemented in July 2009. The first inspection was a standard registration inspection on 29-30 September 2009, and the second was a shorter one-day follow-up inspection on 14 January 2010, to check if the changes required were being put in place. A one-day inspection was carried out on 24 June 2010, partly as a new provider and person-in-charge had been appointed, and partly as there had been notifications of concerns about wound care and management in the home. Finally, as centres must re-register if a new person-in-charge or provider is appointed, a second full registration inspection was carried out on 10–11 November 2010. All inspections but the last were unannounced.

Each registration inspection found that the centre provided a good standard of care in a homely and well-maintained environment. Each one also found that some improvements were required to comply with the regulations. How these were addressed by the residential centre is outlined here.

#### *Issue: Activities*

Inspection one found that:

‘activities provided for residents were limited and ... some residents [were] sitting without any meaningful engagement for periods of time’ (p. 10).

The inspection report therefore stated that:

‘the provider is failing to comply with a regulatory requirement in the following respect: “Activities provided for residents on the day were limited” and stated that the “action required” was ‘provide opportunities for residents to participate in meaningful and purposeful activity, and occupation and leisure activities that suit their needs, preferences and capacities with particular consideration given to residents with dementia and other cognitive impairment.’

By the time the residential centre submitted their action plan to address these requirements on 30 November 2009, the person-in-charge was able to state that:

‘Attached activities timetable currently established. Some Alzheimer residents partake in some of these activities, e.g. music, art, fit for life. However, we are currently looking at other specific activities for Alzheimer and dementia residents. Nurse attending activity co-ordinators meetings for this purpose.’ (p. 23)

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<sup>31</sup> These quotes are from reports of one of the 42 centres that were randomly chosen for further study. See <http://www.higa.ie/social-care/find-a-centre/nursing-homes&20> for the full reports (accessed autumn 2011 and spring 2012).



By inspection two, which inspected the extent to which the action plan was being implemented, the inspector was able to state that:

‘Opportunity for residents to participate in meaningful and purposeful activities that suit their needs has been upgraded and is ongoing ... The person-in-charge informed the inspector that the care assistants have commenced documenting activities of daily living on each resident which has led to a greater understanding of the needs of each individual ... a number of new activities have been extended since last inspection, for example, Sonas therapy, fit for life programme, a cinema night with old films, and karaoke evening with the involvement of relatives.’ (p. 7).

Inspection three did not look at this issue in detail (it only focused on a small number of issues, particularly those relating to the complaint on wound care and management), but did find when reviewing resident care plans that:

‘There was a separate folder called “hobbies and interests”. This contained invaluable information regarding the social histories of residents but was not included in their care plans or nursing notes’ (p. 7).

By the time of the more comprehensive registration inspection carried out on the fourth inspector’s visit, it was found that:

‘Care plans had ... good narrative detailing all aspects of residents including social, health and personal needs. The activities coordinator was involved in this process to ensure comprehensive information was obtained to inform the activities programme.’ (p. 12) and

‘There was a full-time activities coordinator present. Many residents commented positively on the range of activities provided as well as the kindness of the activities person. Activities included gardening, baking, card playing, cinema nights, music sessions, fit-for-life and walking in the enclosed garden as well as outside.’ (p. 11)

These inspection reports suggest that activities were limited at the time of the first inspection, but that a larger and well-planned activities programme was put in place following on from that. By the time of the second inspection, care assistants were asking residents their preferences, which were then documented in their care plans, and by the time of the fourth inspection this care plan information was being used by the activities co-ordinator to inform the activities programme.

HIQA (2012) has also outlined the extent to which recommendations for change identified in the first inspection reports of 574 centres were implemented within the next 15 months.<sup>32</sup> This study of first and follow-up inspection reports found that

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<sup>32</sup> This was done by reviewing 705 inspection reports compiled between the beginning of July 2009 and the end of September 2010. These were the reports from the initial inspection visit to 574 centres, and the reports from the 133 follow-up inspections undertaken in that time period.

over three-quarters of recommendations for change identified in first inspections were fully or partially implemented by the time the follow-up inspection occurred. However, implementation was higher when the work required to implement the recommendation was relatively straightforward (such as changes to administrative procedures), while regulations that required new systems, or a large number of documents to be drafted and put in place, had lower implementation rates. Breaches of regulations were most common in relation to premises (found in 80 per cent of centres); risk management procedures (75 per cent of centres); staff recruitment (68 per cent); general welfare and protection (63 per cent); and assessment and care plans (62 per cent).<sup>33</sup> In follow-up inspections that took place within a 15 month period, the proportion of actions implemented on these regulations was as follows:

**Table 3.1 Percentage of Breached Regulations that were Addressed by the Time a Follow-up Inspection was Carried Out, 2009–2010**

Regulation breached	Percentage of Recommendations fully implemented	Percentage of Recommendations partially implemented	Total Percentage of Recommendations fully or partially implemented
Premises	40	26	66
Risk management	53	24	77
Staff recruitment	36	45	81
General welfare and protection	53	24	77
Assessment and care plan	46	36	82

Source HIQA (2012, Tables 6 and 7)

### 3.3.2 Written Notifications

In addition to inspections, HIQA also monitors residential centres through return of forms recording certain events or incidents. Notification must be received within three days of: death of any resident under 70, outbreak of infectious disease, serious injury to a resident, unexplained absence of a resident, any allegation of

<sup>33</sup> It should be noted that there are a number of requirements under each of these regulations, and if a centre breached one of these, it is recorded as a breach of regulations.

abuse, or of misconduct by staff. Quarterly returns are also provided to HIQA on any accident, fire, loss of power/heating or water, evacuation of the centre, or change to the trading name of the centre. Other events, such as change in ownership or change in management, also need to be notified to HIQA. Failure to notify these events contravenes the regulatory requirements.

These notifications are used by HIQA to prioritise and decide the order in which to visit centres. This is an example of what Gunningham (2010) has called ‘risk-based regulation’, i.e. identifying organisations at highest risk of not complying with standards, and focusing resources on them.

### 3.3.3 Fit-Person Self-Assessment

A second element of the registration process assesses the ‘fitness’ of the ‘person-in-charge’ (usually the manager) and the ‘provider’ (usually the owner) to provide the service. The person-in-charge and the provider read a ‘Fit-person’ self-assessment manual (HIQA, 2009a) and complete a self-assessment evaluation form, and the HIQA inspectors then carry out Fit-person interviews with them. This information is used to assess their understanding of, and capacity to comply with, the requirements of the regulations and the standards. Providers and persons-in-charge must be judged as ‘fit’ in order for the centre to be registered.

The Fit-person self-assessment process allows the person-in-charge and provider to identify gaps in their services or areas of learning, and challenges them to think about how they will be addressed. For most of the standards, the fit-person Entry Programme document describes the key aim of the standard, gives an example of good practice and bad practice, and asks the person-in-charge and provider to fill in examples of how this standard is currently implemented in the residential centre.

For example, in the section that focuses on residents’ rights, the person-in-charge and provider are asked to answer the following questions:

- What do you and your staff do to enable residents to have a say in the running of the centre, if they are deaf, blind or suffering from dementia?
- If you are an existing provider can you think of examples where the views of the residents were sought and a change was brought about in a policy or process? Describe the most significant change in your centre (HIQA, 2009a:15).

References to useful documentation are provided. After reading this document, the person-in-charge and provider fill in the fit-person self-assessment evaluation form, and return it to HIQA.

HIQA stresses that the fitness of the provider and person-in-charge are key. Gunningham (2010) and Deming (1982) have also noted the importance of competency, with the former arguing that regulation can fail when the management of the organisation required to meet standards is incompetent. Parker (2007) has argued that it is possible to incorporate legal provisions into

regulatory approaches to counter this problem, and the Fit-person requirement is an example of this.

HIQA staff interviewed for this report underlined the importance of the provider's willingness to engage with requirements for change outlined in the inspection report, when deciding on enforcement procedures (see Section 3.3.4 below). Where the provider worked on implementing the recommendations, HIQA was happy to work with them on this. However where this was not the case, HIQA would move more rapidly to close such centres.<sup>34</sup>

### 3.3.4 Enforcement

A centre that does not meet the requirements on regulations, standards and/or 'Fit-person assessment' can be subject to a number of forms of enforcement under the Health Act 2007. The strongest form of enforcement allows HIQA to end the operation of the centre. It can also refuse to register a centre, or to limit its operation, to, for example, a certain number of residents, or residents of a certain dependency (e.g. limiting its operation to residents without dementia). Thirdly, HIQA can prosecute for breaches of the regulations. HIQA has strong enforcement powers, for example, the ability to enter a premises at any time, and to seize any data storage mechanism, such as documents, records and computers, without a warrant.

## 3.4 Supportive Processes

A range of programmes are in place that support implementation of the standards (and a number are quality improvement initiatives whose adoption pre-dates the introduction of the standards). These programmes will be outlined here, with more detailed discussion in later sections. The supports provided by the HSE are listed first, followed by those provided by private sector organisations. HIQA currently does not provide such supports to residential centres, although indicated in interviews for this project that it would like to develop this aspect of its work.

The HSE has put in place a number of programmes to support the transition to person-centred care. These are the 'practice development' and Teaghlach models of care, and the advocacy programme. The first two are relatively small-scale in nature, and have been located mainly in HSE-run centres, but there are plans for the learning from the practice development programme to be rolled out more

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<sup>34</sup> One example is Upton House, Co. Offaly, which was closed after HIQA applied for a court order to do this in 2010. The inspection report of 8 September 2009 was published by HIQA without an action plan from the provider as 'no completed Action Plan was received by the Authority despite a number of formal requests for the Action Plan to be submitted. The Authority regards this as unacceptable ... If further regulatory action is required, this will be taken' (see <http://www.hiqa.ie/inspection-reports/upton-house-nursing-home-111-nursing-home-inspection-report-8-and-9-september-200> – p .21).

widely. In contrast, the advocacy programme is being implemented in a wide range of both public and private centres. It has also moved from being solely HSE-funded to being jointly operated by the HSE and Nursing Homes Ireland. There are also some general supports available through policies and procedures drafted by the HSE for all services that it manages and/or funds.

### 3.4.1 HSE – Practice Development

The Office of Nursing and Midwifery in the HSE has carried out a two-year practice development project<sup>35</sup> to develop a person-centred culture in residential services for older people. ‘Practice development’ is ‘an organised approach to changing and improving practice through the systematic transformation of care practices and culture’ (HSE *et al.*, 2010:13). Using facilitation, participating staff are encouraged to observe and question the detail of day-to-day work practices, and change these in order to develop more person-centred care. As it is the staff themselves who question and adapt the work practices, the interventions adopted to achieve a person-centred culture of care become deeply embedded in the organisation.

Initially, a pilot exercise was carried out in two residential centres between 2004 and 2006, and to build on that, a larger national project involving 17 residential centres from the four HSE regions was carried out between 2007 and 2009<sup>36</sup> (16 centres were run by the public sector, and one by a voluntary body). A facilitation team was established consisting of two practice development researchers from the University of Ulster and six nurses from the HSE Nursing and Midwifery Planning and Development Units (NMPDU), who worked as external facilitators with each of the residential units in their geographical areas. They worked with a nursing staff member who was trained as an ‘internal facilitator’ in each of the 18<sup>37</sup> participating centres in the programme. Each of the participating centres then established a multidisciplinary practice development group, made up of a wide variety of staff – nurse managers, staff nurses, therapists, health care assistants, and, in some cases, catering and housekeeping staff. The involvement of all staff was found to greatly enhance the work as it provided a greater pool of observations and ideas, as well as ensuring that all staff were involved in changing the organisational culture (HSE *et al.*, 2010).

Facilitated workshop days then took place every four to six weeks, attended by the external facilitator from the local NMPDU and the internal facilitator from each residential centre. Between these workshop days, a variety of facilitation tools were used in each workplace to generate change. For example, environmental observation was carried out by staff so that they could explore how person-centred the environment is for residents. In this exercise, staff were prompted to look at,

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<sup>35</sup> This was funded by the National Council for the Professional Development of Nursing and Midwifery, an agency whose functions are now subsumed into the HSE, the Department of Health and An Bord Altranais.

<sup>36</sup> So the practice development process pre-dates the introduction of the HIQA standards.

<sup>37</sup> Seventeen of these centres were HSE-run centres, and one was run by a voluntary body.

e.g. decoration (colours, styles); lighting (natural, artificial); noise levels (radio, television, equipment); odours; signage (how clear, how welcoming); access to gardens; space in bedrooms (personalised or not), etc. Person-centred language exercises were also carried out – for example, are residents called feeders, heavies? Are there any references to nappies, cot sides, beakers, etc? All such language would be considered demeaning, and should be changed to ensure that the older person is seen as an individual, rather than a child or a medical issue. For more information on the range of activities, and evaluation of the effectiveness of the interventions, see HSE *et al.* (2010).

### 3.4.2 HSE – Teaghlach Model

The HSE has also developed the Teaghlach model, which again aims to change the culture of care away from the task-oriented medical model of care to one that supports older people to direct their own lives in the residential centres that are their homes. This approach, which like the practice development programme is person-centred, looks at how the residential centre building is designed to promote life as it is at home. It recommends dividing the home into domestic-style units or households, with single ensuite rooms, and a dining room/kitchen for everyone, which allows older people to be involved in preparing meals. Staff are dedicated to each household unit, to develop good relationships with residents and their families, and the household team is non-hierarchical and responsible for all outcomes within the household. Care plans also reflect this person-centred approach, as the example given below from one centre shows:

Lough View [residential centre] operated from a ‘Teaghlach model’ which meant that they took considerable care to ensure that Padraig [a resident, who had been a farmer all his life] had a plan of care that reflected his usual life pattern ... This meant that Padraig was able to get his breakfast when he woke at 4am, listen to the radio for a few hours before getting up. During the spring and summer months he would tend to the vegetable garden and in the winter he swept the paths (with assistance). Each night he had a bottle of Guinness after his tea and he would sit in the kitchen chatting with John-Joe and Eamonn (2 residents who came from the same Parish as him). On a Friday night the home had an arrangement with the owner of the local pub who sent a taxi to take the men there where they drank Guinness and played poker.<sup>38</sup>

Financial support from an innovation fund was used to pilot the Teaghlach approach in two public centres, while one privately run residential centre piloted it using their own funds. It had been planned to use this model for all new residential centres built by the HSE, but with cutbacks in government spending such building has not happened (see Sections 5.2.6 and 5.5.3). At the moment, private and voluntary

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<sup>38</sup> From [http://www.placestoflourish.org/pdf/Death\\_dying\\_and\\_after\\_care.pdf](http://www.placestoflourish.org/pdf/Death_dying_and_after_care.pdf). (accessed 30 January 2012).

sector individuals who inquire about building new residential centres are provided with information on the model.

### 3.4.3 Advocacy Programme

Another project that has been set up to encourage learning, but drawing on external pressure for change, is the advocacy programme for older people in residential care. It encompasses three main strands – an independent volunteer advocacy programme, training, and information.

The first phase of the volunteer advocacy programme was HSE-funded, and recruited 150 volunteer advocates, who spent over a year visiting 67 residential care settings on a weekly basis. The volunteers see the following as the main elements of their advocacy roles:

- Empowering and enabling people to make choices, and helping them to make decisions;
- Being able to speak up on behalf of an individual, which may be at odds with the institutional or care regime; and
- Listening to people and taking them seriously, and observing the dynamics of relationships.

Communications and feedback are provided from volunteers to Directors of Nursing and managers. An evaluation of the programme recommended that the programme continue to be resourced, but moved out of the HSE to a more independent body, such as the Citizens Information Board (see Pillinger, 2011). In line with this, the HSE, in partnership with Nursing Homes Ireland, tendered for a voluntary organisation to assume responsibility for the advocacy programme. The HSE provides the time and expertise of staff (1.25 whole-time equivalents) previously involved in managing and rolling out the service, while NHI provides financial and in-kind support. The Third Age Foundation was awarded the contract to continue the service in May 2011. By early 2012, 250 volunteers had been trained, and the programme had expanded nationally to over 120 residential centres [R28].

The advocacy programme has also provided funding to train staff to enable them to put a value on compassion in their care roles and in their personal lives. This was defined as ‘Personal Excellence’ and developed into a programme of training for 118 staff in seven residential units/homes across the country. The training is designed to improve self-awareness of the value of compassion and to empower staff to enable them to gain a sense of purpose from their care roles. The evaluation of the training has been positive, and also suggested a number of ways in which the training could be cascaded through a ‘training the trainers’ approach, with networks of Personal Excellence Champions across all residential units/homes, and good-quality leadership in the individual residential centres (Pillinger, 2011).

Meanwhile information on residential centres, the third part of the advocacy programme, is provided on [www.myhomefromhome.ie](http://www.myhomefromhome.ie) where over 300 residential centres have filled in details on their service (just over half of all centres – use of the site by residential centres is voluntary). This information is useful for an individual or family trying to decide on a residential centre, as it lists the same information for each centre, for example, room types, transport links, types of care offered, the quality programmes offered, a quality provider checklist (existence of advocacy services, a residents’ group, activity programmes), privacy policy (call buttons, lockable doors, staff knock on residents’ doors before entering, private space for residents to store belongings), care provision, etc. The website also includes detailed information on what to look for, and what questions to ask, when choosing a residential centre, as well as a link to the HIQA inspection reports for each centre. However, Pillinger (2011) noted that verification of the information posted on the site was difficult to achieve, and that HIQA needed to play a more direct role in linking its inspection role to the publication and verification of information provided on the site.

#### **3.4.4 Other Support Provided by Public Sector Bodies**

The HSE provides mandatory training on elder abuse to all residential centres, public, private and voluntary. It also provides training on use of restraint to all residential centres. Meanwhile An Bord Altranais organises training (including e-training) on medication management. In addition, a wide range of on-line training and resources are available for health care staff on the HSElandD webpage.<sup>39</sup>

The HSE has also had a Code of Governance in place since 2006, which applies to services managed or funded by the HSE, including its residential centres for older people. The Code provides guidelines on the systems and procedures that should be in place to manage the work of the HSE in an effective, accountable and transparent way. Although the main focus is on the board and financial issues, one section focuses on non-financial risk management, including quality and safety issues. There is also reference to HSE policies, procedures and codes on risk, advocacy and customer care, and quality and patient safety (see HSE, 2011b). These provide guidelines that HSE staff can use to develop relevant policies, procedures and practice.

#### **3.4.5 Private Sector and Other Supports**

In the private sector, a range of quality improvement approaches have been adopted, which help centres to meet the requirements of the standards. These supports are training, the establishment of peer group networks, accreditation, and licensing to use an approach that incorporates person-centred care. Use of the latter three approaches pre-dates the introduction of the HIQA standards, but, as

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<sup>39</sup> See [www.hseland.ie](http://www.hseland.ie).



will be outlined in Chapter 5, these processes have helped centres to put in place mechanisms that help meet the requirements of the standards.

### ***Training***

On training, NHI (Nursing Homes Ireland) employs a practice development co-ordinator, and runs education days for members to help them meet the various standards. The training provided is based on demand from members, and is related to what HIQA requires residential centres to do to comply with the standards. Many residential centres have had to develop new policies and procedures in order to meet the HIQA standards, and NHI has assisted them to devise and implement such policies. It provides templates and guidance documents on issues such as the contract of care, and the resident's guide. The most popular training courses that NHI runs are on risk management, audit, governance, clinical governance, infection control and medication management. Often an informal 'train the trainer' model is adopted, whereby one person from a residential centre is trained at an external training course, and then returns to the residential centre to teach other staff there what they have learnt.

Residential centres also source training from a variety of private companies to help them meet the new standards requirements. A number of voluntary bodies also provide training, for example, the Irish Hospice Foundation, which provides training on end-of-life care to residential centres that seek this.

### ***Peer-group Networks***

Prior to the development of the HIQA standards, a standardised set of policies and procedures was developed by the Nursing Homes Nursing Projects, and was for sale at a cost of €2,500 (PA Consulting Group, 2009). Eighty residential centres were originally involved in this group project, and there are currently forty. The members of this group act as a support group to each other.

### ***Accreditation***

A number of Irish residential centres have received the Q Mark for Nursing Homes accreditation. This Q Mark was developed in 2006, through the Irish Nursing Homes Organisation (INHO<sup>40</sup>) and the Irish Society for Quality and Safety in Health care (ISQSH) working in collaboration with Excellence Ireland Quality Assurance (EIQA). This accreditation programme assesses four key components of residential centre management:

- Organisational Commitment (including compliance, continuous improvement and business planning);

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<sup>40</sup> Now part of Nursing Homes Ireland.

- Employee Engagement (all aspects of employment including recruitment and training);
- Support Systems and Processes (encompassing all internal day to day processes within the Nursing Home); and
- Quality of Life (addressing all issues that affect the day to day care of residents and their day to day activities).

Organisations seeking this Q Mark accreditation receive information on the Q Mark for Nursing Home standards, and then implement changes to their organisation to bring its practices up to these standards. Organisations can then carry out an internal practice assessment, before being assessed by a team of external assessors, who write up a report that identifies and scores areas of best practice, areas of positive performance and areas for improvement, including critical areas (see <http://www.eiga.com/certification/nursinghomes>).

ISO accreditation involves a similar process, and can be gained for general quality management, and for occupational health and safety, although it does not have a specific accreditation for nursing homes. However, a number of residential centres in Ireland have gained ISO management and health care accreditation. Recently, Joint Commission International (JCI), one of the largest international health care accreditation companies, has set up a joint venture with an Irish firm, Health Care Informed (HCI), and offers accreditation specific to long-term care centres.<sup>41</sup>

### ***Licensing and Training to Use a Person-Centred Approach to Residential Care***

Approaches similar to the HSE's Teaghlach model have also been adopted by a number of private residential centres in Ireland. These models, such as the Eden Alternative,<sup>42</sup> the Greenhouse Model,<sup>43</sup> or the Dementia Care Matters<sup>44</sup> approach, also advocate small centres structured like a home; clutter rather than a bare and sterile environment; resident involvement in day-to-day activities such as preparing food, cleaning, gardening and house maintenance; and a move from task-based to person-based care. These approaches are argued to eliminate the loneliness, boredom and helplessness that older people can feel in residential care. Training is available from private sector organisations on the process of putting such care practices in place, and licenses can be gained to show that a centre operates under, e.g. the Eden Alternative or Greenhouse Model.

Next, in Chapter 4, the reaction to the new standards and their implementation will be outlined.

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<sup>41</sup> One person-in-charge interviewed, whose centre had been accredited with the Q Mark for Nursing Homes, stated that she was not going to continue seeking this accreditation, as she felt that the HIQA standards provided a stronger framework, with more focus on residents, to assure quality in her centre.

<sup>42</sup> See <http://www.edenalt.org/>, (accessed 12 March 2012).

<sup>43</sup> See <http://thegreenhouseproject.org/about-us/mission-vision/>, (accessed 12 March 2012).

<sup>44</sup> See <http://www.dementiacarematters.com/a3.html>, (accessed 12 March 2012).

## Chapter 4

# *The National Quality Standards for Residential Care Settings for Older People in Ireland in Practice*

In this chapter, the reaction to the *National Quality Standards for Residential Care Settings for Older People in Ireland*, and general information on their implementation, is outlined, before moving on to discuss the five key themes of this project on quality and standards in Chapter 5. For ease of reference, from now on the popular term, ‘the HIQA standards’, will be used, but this refers not only to the *National Quality Standards for Residential Care Settings for Older People in Ireland*, but to the entire framework of standards, regulations, inspection and enforcement for care in residential centres for older people, which are underpinned by the provisions of the Health Act 2007.

## 4.1 Reaction to Introduction of the Standards

Although a number of those interviewed had concerns about the workload generated by implementation of the standards, the value of some particular standards, and some aspects of the broader inspection framework (which will be outlined below), none of the twenty-eight persons interviewed on these thought the introduction of these standards was negative. In fact, all saw them as a positive step for the residential centre sector.

Going back 20 years to working in a nursing home first – I’ve seen that some of the care in it was absolutely appalling, so there’s always been a need for it [standards] and there will always be a need for it, simply because humans are humans, and I suppose also the fact that nursing homes are run as businesses. [R9]

From the point of view of those who owned and/or managed residential centres, the scandal around substandard care provided in the Leas Cross nursing home (see Section 3.1) diminished confidence in the sector. The new regulations, standards and inspection framework brought in under the Health Act 2007 are seen as transforming residential centre care, and as helping to restore public belief in this care – although the journey along this road to full public belief was not considered over.

A number of factors in the HIQA standards framework were considered particularly positive, as follows:

- The fact that the inspectorate (HIQA) is independent – previously the HSE inspected all residential centres, but the HSE also needed beds in these residential centres, giving rise to a conflict of interest, which no longer exists (Commission of Investigation [Leas Cross Nursing Home], 2009);
- There are now stronger penalties, more easily implemented, in cases where regulations are not met. One person-in-charge who had worked as a HSE inspector under the previous framework said that:

This means that the residential centres are prepared to take all the inspector's recommendations on board ... it's very different now, people get things done. When the HSE inspected you, they would find things wrong, which were not fixed. Now they are. [R14]

Another said that the mandatory nature of the new regulations provided persons-in-charge with focus, 'as you know you have to meet them' [R12];

- Publication of the detailed inspection reports on-line, with the name of the person-in-charge, has been positive. As the person-in-charge who was previously a HSE inspector said: 'I remember one home I used to inspect, and when HIQA inspected it their report was nearly identical to mine, but HIQA had the power to put the report on their website – and that changes a lot' [R14];
- It was also noted that the 2007 Health Act allows HIQA to close a residential centre if the person-in-charge or the provider is not a 'fit person' to run such a centre, a provision that which was not in the 1990 Act. A number of those interviewed referred to 'cowboys', and felt that the new regulations would dissuade these groups from setting up residential centres, as one person-in-charge explained:

There are some [owners] whose attitude is – a pound is a pound and the bottom line for them is, you know, did they gain any profit ... I remember working in a place where it was bought as a tax break and the owner walked around and he kept referring to the patients as the inmates! ... He wasn't part of the caring profession, it was a tax break, it's as short and simple as that. [R9];

- The current standards cover many more areas than were covered under the 1993 regulations, with a greater focus on the residents in particular. Other new elements that persons-in-charge welcome include the focus on quality of life and resident activities; the move from a medical model of care to a more social model; and the focus on governance, risk management, environment, care plan reviews and staff training.

Other aspects of the new inspection framework that private residential centre managers, in particular, liked were that all residential centres now have to meet the same standards, and all are inspected, whereas previously HSE-owned residential centres were not inspected or subject to the regulations that applied to private and

voluntary residential centres. The new situation is perceived as much fairer. The standards are seen by one private sector person-in-charge as a greater driver for improvement in the public sector, as pressures of competition are already providing a motivation for private sector residential centres to have good standards of care [R13].

The HSE managers interviewed also liked the new framework. As one HSE person-in-charge memorably remarked, ‘the standards have gotten some of my lazier colleagues up off their backsides’! [R12] He also noted that the standards had helped to develop standardised policies and procedures in residential centres around the country. Previously they had varied in quality, and in existence. He saw the standard approach as better.

#### **4.1.1 Unpopular Elements of the New Standards and Regulations**

There are a number of aspects of the standards and regulations that are not viewed so favourably. One mentioned several times as time-wasting is the requirement on paperwork for existing employees. While seeing this requirement as relevant for new staff, one person-in-charge noted that even though he had been recruited through a rigorous public recruitment process, he still had to gather medical certificates, proof of nursing registration, three references, etc., even though all of these documents had been supplied to the HSE when he was first recruited 15 years previously [R12].

Review of inspection reports showed that Garda vetting of staff was slow when residential centres were first being inspected for registration, with follow-up reports frequently noting that Garda vetting still had not been completed.<sup>45</sup> However, by now (almost three years later, with the first round of registration inspection nearly finished) it seems that Garda vetting has been obtained for staff in most centres.

A second aspect of the standards and regulations that persons-in-charge disliked is the complaints process. As one person-in-charge noted, ‘I don’t like the way they don’t tell you the type of complaint they are investigating or where it came from – is it disenchanted staff? A fussy relative?’ [R13] When a complaint is received, ‘inspectors arrive unannounced, and say – I’m here on foot of a complaint – it’s very off-putting’ [R13]. As complaints can be given anonymously, another person-in-charge said that ‘if something is anonymous, we can all make up complaints, we could keep ... [the inspectors] busy for the year’. [R9]

Thirdly, two providers remarked that HIQA can be slow to process registration [R10], including registration for an extension to an existing centre [R13], although one noted that this process seemed to move faster now.

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<sup>45</sup> This is confirmed by HIQA (2012), which notes that some documents required to be held for staff were difficult to obtain, such as Garda vetting.

#### 4.1.2 A New Standard and Regulation that has Mixed Reaction

##### *Negative Views*

The paperwork required under the standards and regulations drew mixed reactions. One owner viewed it negatively, feeling that staff, particularly nurses, were being taken from frontline delivery to fill in paperwork [R10]. And another stakeholder commented that:

I suppose the thing that's been the hardest has been the whole administrative burden ... The carers in nursing homes, they're into caring. When you say to them, 'document it' - that's been a big change for these people. [R15]

But other persons-in-charge felt that they were getting used to the paperwork requirements over time:

Initially there was a lot to get yourself HIQA compliant, but not now that it's been put in place and is on-going. [R12]

A provider who had previously gained Q Mark accreditation reported that there was a lot of paperwork when first being accredited by Q Mark, also, but that the experience of this process helped her to adapt to the type of bureaucratic overhead required to meet the HIQA standards later (although she found the process of meeting the HIQA standards considerably more complex than that required to meet the Q Mark standards) [R19].

Meanwhile, even though another person-in-charge felt that the worst was at the beginning, she thought that the paperwork requirements were still high:

Initially there's volumes [of paperwork]. The most difficult part is at the beginning. But you are never finished as you never have all the policies and procedures done, as services change. Services are forever evolving and you need to revise the policies and procedures. [R2]

In line with this, HIQA (2012:20) reported that where regulations on policies and procedures were breached, only 38 per cent of recommendations to rectify this were fully implemented by the time of follow-up inspection, which they attribute to 'the difficulty providers had in complying with the numerous new requirements in relation to this regulation'.

##### *Positive Views*

On the other hand, several persons-in-charge felt that the paperwork associated with the standards and regulations was 'necessary' [R16], and didn't 'add a lot of paperwork to existing requirements' [R12].

Other persons-in-charge said that:

Too much paperwork is an excuse used – it is hard to find time to do it, but you need it written to show something is done. For example, the care plan needs to be written, and then followed through on. [R16]

People are complaining about paperwork as they are not used to it – but they should be doing it! [R14]

One of the requirements of the HIQA standards is that data is collected by the centre on a variety of health issues, including, for example, pressure ulcers, use of physical restraint in the last week, use of psychotropic drugs, number of falls in the past month, those losing significant weight in the last month, and complaints. These data are then to be analysed to identify any patterns of risk, and to find ways to minimise these (a form of meta-regulation, whereby regulators encourage organisations to adopt internal systems to manage risk – see also Section 5.3.2). One owner [R10] wondered what the benefit was of reporting falls, injuries, wounds?, feeling that the Director of Nursing would know if there was a problem, without such paperwork. He felt that the span of responsibility and communication lines are more important than these regular reviews. But others did not think so. One specifically stated that the ‘risk management data collection is good’ [R2], while another said that it ‘makes you question everything’ [R16]. An interviewee from HIQA outlined that some of the paperwork is required as part of good practice, but because it is required under the HIQA standards, some view it as ‘HIQA jumping on people and requiring paperwork’ [R18]. But, she wondered, how can persons-in-charge be certain that they are improving on, for example, rates of falls, sedation, etc., all the time, if data is not collected to check it? Older people can also be at risk if records are not maintained of these occurrences. Her view is that the data is collected for the benefit of residents. This issue will be considered more in later sections.

#### **4.1.3 The Standards and Culture Change**

One provider stated that the HIQA standards are ‘a new paradigm in how residential care should be provided, and tie in with person-centred care’ [R19]. Considering this comment, it seems that the standards represent culture change on two key levels – first, as the person-in-charge commented, the standards are more person-centred and draw more on the ‘social model’ of care than previously, and second, the new management regime to be adopted, which involves more policies, procedures, data collection and review than previously.

Another person-in-charge noted that ‘this kind of change doesn’t happen overnight. You need to change minds and bring in new practices’ [R16].

The interviews suggest there is a continuum of views on the standards, and that the views of persons-in-charge and owners on the standards depend on where they are on this continuum. Those who were inspectors before, or had previously been



accredited under a private sector system such as Q Mark, seem to generally be supportive of standards and find the paperwork required under the new framework less burdensome.<sup>46</sup> Those who are putting these requirements in place for the first time vary between those who see it as (at least initially) lots of work but useful, and those who see it as a lot of work but not always useful. Interestingly, this chimes with the categorisation by an ex-HIQA employee [R7] of residential centres as very good (and so don't really need the standards), very bad (and so need to be closed), and mediocre (who need to be nudged to improve).

#### 4.1.4 Getting Ready for Inspection, and the Inspection Itself

Getting ready for inspection is a very time-consuming process. Persons-in-charge and providers reported:

Three months of preparation ... a very large amount of time. [R13]

It's a huge amount of work to look at all components of the 32 standards ... [it's] about lots of small details, for example the GP, staff, environment, equipment – so many little things need to be focused on to make sure it works properly ... and all the employees have to follow the policies and procedures and standards, all the time, and it has to be consistent. [R19]

The actual registration inspection and Fit-person interview were also hard. One person-in-charge reported that the 'Fit-person interview was a nightmare, the most difficult thing I've ever done in my life' [R2], (an interesting observation from someone who was noted in the inspection report to have strong leadership, competence, commitment, and good knowledge of the standards and regulations). Another found it to be 'gruelling and long' [R16]. Several were unsure exactly what HIQA was looking for in these interviews. However, one person-in-charge summed it up well:

[HIQA] didn't ask me 'What's section three [of the standards]? Don't look', – they didn't ask me that. They wanted to see that I had a broad understanding of what standards are about and I think what they wanted really was to find out is... 'Is your heart in the right place? Is what you're here for what you should be here for? Are you here for the patient or are you here for yourself? Do you care about your job?' [R9]

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<sup>46</sup> Three persons-in-charge had experience of other standards before: two of Q Mark, and one of a HSE pilot project. All felt that the experience of preparing for these standards processes had made the process of preparing for HIQA inspections easier. Such a view was also identified in an earlier study of hospital accreditation in Ireland (see Doyle & Grampp, 2008).

In terms of inspection, a HIQA interviewee said that ‘some providers have gotten a big shock’, a feeling confirmed by some of the persons-in-charge, who described the inspections as ‘a shock’ [R2], ‘nerve-wracking’ [R2], and ‘like an exam’ [R13].

Two persons-in-charge also said that staff felt intimidated [R14], and that some staff were very nervous [R13]. However, persons-in-charge also found the inspectors to be very polite, ‘nice’, [R2] and ‘mannerly’ [R13].

The inspections were reported by several persons-in-charge to be very thorough [R13, R2] – they ‘went through everything with a fine toothcomb’ [R13]. However, one person-in-charge felt that ‘inspectors can have hobby horses, things they harp on about’ [R13], while one owner felt that ‘inspectors are allowed to impose prejudices on local areas’ [R10]. Although he was unable to cite an example of this when asked for one, concern about the objectivity of inspectors when assessing compliance with some standards was also noted by Prospectus (2010) in their NHI-commissioned report reviewing the inspection process.<sup>47</sup>

There has also been a change in the background of inspectors. Under the previous regulatory framework, HSE inspection teams typically comprised people with nursing, medical and environmental health expertise, whereas HIQA inspection teams now have a broader base of skills, representing both health and social care. This is in line with the more person-centred approach of the new standards, but not all persons-in-charge and owners found this good. One owner commented that:

Before it was a doctor and he did a lot of very good medical inspection, for twenty years, looking at the physical care of the most dependent patients – from my point of view I find the new social care inspectors less good. [R10]

One person-in-charge [R9] and two providers [R2, R19] found that inspectors without a nursing background ‘didn’t appreciate the needs of some residents’.

Overall, comments from a number of persons-in-charge and providers suggest that the inspection process is now ‘bedding down’ [R10]. Some felt that HIQA had ‘settled in a bit’ [R13] and was ‘fine-tuning’ it now [R12]. One said that ‘the first visit was daunting, but I’m getting to know it a bit now’ [R12], while one person-in-charge [R13] and one provider [R19] commented on the good relationship developing with inspectors to their centres. So the ‘bedding down’ being noted could be due to either persons-in-charge becoming more familiar with the HIQA processes of inspection, or to a change in the HIQA approach – or both.

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<sup>47</sup> Following each inspection, inspectors leave the residential centre manager with a quality improvement questionnaire, to be returned to HIQA with feedback on how the inspection was experienced. The completed questionnaires are reviewed by a range of staff in HIQA to identify any issues arising. See also Section 5.3.4. HIQA also has a code of conduct to define how staff conduct inspections. See <http://www.hiqa.ie/system/files/Code-of-Conduct-inspection-investigations-reviews.pdf> for more information (accessed 11 April 2012).

# Chapter 5

## How the HIQA Standards are Relevant to the Five Key Themes of this NESC Project

In this chapter, how the HIQA standards framework and its implementation are relevant to the five key themes of this project – responsive regulation; the role of the service user; learning; devolution and accountability; and sustaining quality with reduced resources – are explored.

## 5.1 Responsive Regulation

The first theme considered is that of responsive regulation (described earlier in Section 1.1). To what extent does the HIQA standards framework display elements of this? What is the balance between ‘command and control’, self-regulation and supports?

First, the issue of sanctions and ‘letting the regulated know that more onerous action will be undertaken if matters do not improve’ (NESC, 2011) will be considered. The HIQA standards are underpinned by the Health Act 2007 and associated regulations, and so there are a variety of ‘more onerous actions’ that can be undertaken if matters do not improve, ranging from refusing to register a centre, to sanctions and fines, and criminal and/or civil prosecution (see Section 3.3.4). And as outlined in Section 4.1 above, persons-in-charge and owners, and other stakeholders, see this as a considerable improvement on the previous framework. As one person-in-charge commented:

With the new standards and regulations] everything is a lot more professional ... it's a lot stricter and regulated, as it should be, and there are loads and loads of improvements. [R9]

Between July 2009 and April 2010, HIQA had closed seven residential centres, and by July 2010 (one year into registration inspection), five had informed HIQA that they were closing (Ryan, 2010), presumably as they decided that they were not going to carry out the changes required for registration.<sup>48</sup>

In its *Compliance with relevant legislation* guide (HIQA, 2009c), HIQA outlines the different types of enforcement action it can use, which are outlined in Figure 5.1 below. These are similar to the approach in the ‘regulatory pyramid’ outlined

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<sup>48</sup> In a discussion with the Oireachtas Committee on Health and Children in January 2012, the CEO of HIQA stated that HIQA had taken procedures against 20 centres that had not met the standards. See <http://debates.oireachtas.ie/HEJ/2012/01/19/printall.asp>, (accessed 23 April 2012).

earlier in Figure 1.2, showing a move from more minor, non-statutory, actions, ultimately up to ‘emergency’ statutory actions, to ensure that the standards are met.

**Figure 5.1: Social Service Inspectorate Escalating Scale of Enforcement Actions**



Source HIQA (2009c)

In addition to these, there are also a number of ‘lighter’ ‘onerous actions’ that prompt those owning and managing residential centres to comply with the requirements of HIQA reports. As pointed out in Section 3.3.1, the detailed inspection reports are published on the web, with the name of the owner and manager on the front cover. Owners and managers would obviously not be happy to see a poor report associated with them in the public domain, so this is a motivation to comply with the regulations and standards. Another person-in-charge noted that complying with the requirements of the inspectors meant that they stopped returning for follow-up inspections, and so ‘it’s in your best interests to implement what they want!’ [R12]

However, as the CEO of NHI noted in an interview, ‘The inspection regime is robust, which it should be ... but some members would say to me that they feel guilty until

proven innocent,' (quoted in Jordan, 2011). This was echoed by some persons-in-charge. One remarked, 'it's good to be able to say that as a business we are robustly regulated. But you don't want people to be beaten either.' [R13].

Another commented that:

You need to root out these people but don't come heavy on everyone ... I really think that HIQA should have a little bit more respect for people that work day in, day out, with patients. And we can all put our hands up and recognise that we're not perfect and we make mistakes, and there are some right so-and-sos working in the industry, the same as any industry, [but] ... I think they're ... strict enough policies. [R9]

An ex-employee of HIQA commented that 'at the moment inspection is a bit like airport security – you have to check everyone, even though it isn't necessary for everyone' [R7]. On the other hand, the centres have to be registered only once every three years,<sup>49</sup> and HIQA also uses the notification of events to identify the centres that it feels it needs to visit more often. Analysis of the 42 centres randomly selected for review in this report shows that by July 2011, one had received six visits, and one had received five. 48 per cent of the centres had received one visit, and 43 per cent two. The centre that had received six visits had breached many regulations. This indicates use of the 'risk-based regulation' approach, whereby HIQA visits the centres it is most concerned about most often. In terms of responsive regulation, centres with very good practice can also show HIQA the ways in which very good care can be delivered, which could provide best-practice ideas for centres that do not perform as well.

### 5.1.1 HIQA Does Not Provide Supports

Responsive regulation is argued to work best when sanctions are balanced with provision of supports to the regulated. However, persons-in-charge and providers reported that:

HIQA won't tell you how to do it ... They don't tell you how to do the things in the action plan ... They want you to do something else – but they won't tell you how! [R16].

A provider described how:

Right now, if there is a problem with something you are doing, HIQA say – how are you going to fix it? And they also say – it's not our job to tell you how to fix it' [R19].

This lack of guidance was described as 'negative' by another person-in-charge [R16].

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<sup>49</sup> Barring a change in circumstances, such as change of owner, or change of person-in-charge, in which case registration under these new conditions must be sought.

In meetings with HIQA, it was very clear that HIQA does not want the standards to become something where a 'tick box' approach would help people to meet them. HIQA staff thought that a 'how to pass a HIQA inspection'–type training course would be very negative, as they felt that improving standards of care in the residential centres was not something that could be learned, but instead was related to the capacity of the provider and person-in-charge. This is consistent with a meta-regulation approach, where the regulator specifies the goals to be achieved, and leaves it to those operating on the frontline to work out how best this can be done (NESC, 2011).

However, in discussions with a larger group in HIQA, staff members noted that enforcement and inspection is taking a lot of HIQA staff time, and so it is difficult to find time to work as guides with the residential centres to help them to develop best practice. Another inspector pointed out that the UK Quality Care Commission has a lot of material available on-line to help persons-in-charge assess if they are meeting standards. Recent contact with HIQA indicated that guidance on a number of further issues is being developed for providers at the moment. It is possible for guidance on best practice to be given without HIQA being prescriptive, as persons-in-charge could use such guidance to develop their own best practice.

HIQA does have a section on its website (one of five key sections), entitled 'Resource centre – tools, guides, forms'<sup>50</sup> that contains a section for Nursing Home<sup>51</sup> Providers. This includes a guide to the inspection process, covering how it operates, and the different stages of registration; a guide on how enforcement procedures work; the code of conduct on how HIQA staff conduct themselves and inspections; and a link to the Fit-person Entry Programme.

An ex-employee of HIQA who was interviewed considered that the 'Fit-person assessment' was an aid to best practice, as this process prompts persons-in-charge and providers to think through an issue, by asking themselves – what fits my service under this standard? Again, this approach is consistent with meta-regulation. The questions asked and references in the assessment do give some guidance [R7]. A number of persons-in-charge thought so, also, saying that:

The Fit-person tool helps you learn – I've used the Fit-person guide a lot, after going through it I brought in training for nurses and health care assistants ... and appraisals with staff' [R14].

And another commented that it asks:

'What are your current practices?' and ... [then] ... 'What would you like to have? What sort of a timeframe?' [It asked us] what we should be doing. Which was very good. [R9]

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<sup>50</sup> See <http://www.hiqa.ie/resource-centre>, (accessed 6 April 2012).

<sup>51</sup> Even though the standards apply to 'residential care settings', the term 'nursing home' is used here by HIQA.

However, considering that some persons-in-charge found it difficult to complete, not all might consider it a support.

Under the previous inspection framework, the HSE was in a difficult position, given that it carried out inspection, regulation, and purchaser and provider roles in relation to residential centres. It is possibly as a result of this that HIQA takes such pains to be independent. For example, one respondent reported asking HIQA if they would join a group developing a care-planning tool [R17], but HIQA responded that they needed to be outside this work.

However, changing practice in residential centres to comply with the new regulations and standards is so much work – as one person-in-charge said, ‘the expectation is that you can implement all local and national policies with no assistance’ [R2] – that other means of support are being sought out by persons-in-charge, and are being provided through ‘self-service’, or a range of other private and statutory sector organisations.

### 5.1.2 So Where Do Persons-In-Charge Gain Supports From?

One route is the ‘self-service’ one – as one person-in-charge noted, ‘you can go on the internet and grab policies from somewhere if you needed them that badly’ [R9]. Particular sources included the UK Care Commission website, with one person-in-charge describing how she ‘downloaded all their material on what to do to prepare for inspection’ [R13], as she felt that a senior HIQA staff member had drawn heavily on this material, and so it might be useful in preparing for the new Irish inspection regime.

Private sector companies also provide some supports, and one person-in-charge described buying a set of policies and procedures from such a company.<sup>52</sup> A number of companies provide supports to centres to help them meet the HIQA standards. In a conversation with a member of staff from one of these companies [R29], it was outlined how in some cases a centre had invited the company in after they had been told by HIQA that their centre could not be registered without significant changes. The company then works with the residential centre and its staff to put in place new systems and ways of working so that the centre can pass its follow-up inspections. Some centres ask these companies to carry out an audit before a registration inspection, to see which areas they need to improve. Others ask for assistance in meeting specific aspects of the standards, such as risk management. A number of companies also provide support for centres to put in place a computerised record system, for example, which can help them gather data on falls, use of medication, etc., and see if these can be reduced.

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<sup>52</sup> This person-in-charge did note that HIQA ‘saw through them right away’, as they were not centre-specific, and so he used the generic policies and procedures as a basis for developing ones that were centre-specific.



As outlined in Section 3.4.5 above, other organisations also provide supports, particularly NHI and the HSE. One provider [R19] noted that NHI had released ten bulletins with common findings from inspections reports on, e.g. governance, fire safety, risk management, and care planning and assessment (the latter three are regulations that were noted to be particularly likely to be breached, by HIQA [2012]). These bulletins contain a list of ‘evidence of good practice’, and persons-in-charge can put such good practice in place to help meet the requirements of the standards. NHI also engaged the Irish Quality Centre to prepare an NHI inspection protocol, *Enhancing and Managing the Process of Inspection*. This is a tool to assist NHI members prepare for and manage inspections with all inspectorates, and was launched nationally in March 2012.

Centres accredited with a Q Mark noted that EIQA do provide best practice examples as part of their Q Mark for Nursing Homes, but as they only inspect approximately 60 residential centres, the range of best practice they can draw on is much less than HIQA could, considering that they inspect all 574 residential centres in the State [R19]. A comprehensive list of best practice examples might also provide useful models to help what one stakeholder [R7] called the ‘mediocre’ residential centres improve the services they provide.

Meanwhile, the HSE is looking at best practice supports for the residential centres it runs, but it also shares these supports with non-HSE centres. NHI is represented on a number of working groups in the HSE that are relevant to meeting the HIQA standards and regulations, including groups on advocacy, stroke and dementia care. In line with its independent role, HIQA has not been represented on these HSE groups. The Nursing and Midwifery Planning and Development Unit (NMPDU) of the HSE West region is also currently reviewing published HIQA reports for a sample of publicly funded residential care centres for older people nationally. The purpose of the review is to establish how best the Office of the Nursing and Midwifery Services Director of the HSE can support staff and influence health care outcomes in residential care settings for older people, while meeting the requirements of HIQA.

The Department of Health meanwhile set up a group to develop a national policy on a restraint-free environment in residential centres, with representation from the HSE, HIQA and other stakeholders [R19]. The outcome of this group’s work was published as *Towards a Restraint Free Environment in Nursing Homes* in late 2011 (Department of Health, 2011a). This document outlines general principles for residential centres to follow, to achieve a restraint-free environment.

So, an important driver of adherence to the HIQA standards and regulations is the threat of sanctions, with residential centres encouraged to develop or find their own solutions, often with the help of third parties (consistent with meta-regulation and smart regulation approaches). Meanwhile, HIQA can be considered weak on the ‘support pyramid’ aspect of responsive regulation.

## 5.2 Involvement of the Service User

This section looks at how the standards framework takes into account the needs and voice of service users. As throughout this chapter, the information presented is gained from speaking to stakeholder groups, persons-in-charge and owners, and from documentary evidence. Therefore the views of residents, the service users themselves, were not gained directly.

### 5.2.1 HIQA Approach to Involvement of Service Users and the Wider Public

There are a number of ways in which the service user is involved. HIQA is concerned with this issue in all of its work, with one of the five key headings on its website entitled 'Getting involved'.<sup>53</sup> This part of the website outlines how HIQA involves service users, and the public more generally, in a number of ways:

- Through consultation with a wide range of stakeholders;
- Through the requirements of the HIQA standards themselves;
- Through the inspection and monitoring processes that elicit the opinions of service users;
- Through providing information (such as inspection reports) that assists the public in decision-making in the health and social-care needs;
- Through investigations that HIQA is statutorily empowered to carry out; and
- Through workshop events.<sup>54</sup>

The use of the first four of these procedures is evident in the development and implementation of the *National Quality Standards for Residential Care Settings for Older People in Ireland*, and how this occurs will be outlined below.

### 5.2.2 Consultation in the Design of the Standards

First, a number of groups representing older people – although not any residents of centres – were on the Working Group that HIQA set up to advise on the draft standards. Consultation sessions were also held with key stakeholder groups (including groups representing older people), by both the Department of Health and Children, and HIQA. Comments were sought from the public through

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<sup>53</sup> See <http://www.hiqa.ie/getting-involved>, (accessed 14 January 2012).

<sup>54</sup> See <http://www.hiqa.ie/getting-involved/how-we-involve-people>, (accessed 3 November 2011).

advertisements in the national media and on HIQA's website (103 were received). Finally, HIQA undertook ten focus groups with residents, relatives/carers and prospective residents, together with a further ten workshops, around the country (Department of Health and Children, 2009).

It is clear when comparing the four drafts of the standards that the final draft has much stronger emphasis on residents' rights than the first draft.<sup>55</sup> The final draft contains much stronger provisions than the first on resident consent; resident rights; resident consultation and participation; resident privacy and dignity; resident independence; how the complaints procedure involves the resident; conditions in which restraint can be used; and the requirement for staff to be competent to communicate with residents, particularly those with communication difficulties. For example, the criteria in standard 2 in the second draft of the standards outline that:

The resident is offered the opportunity to contribute ideas to and participate in the day-to-day activities of the ... centre, (HIQA, 2007)

but in the final draft this is much stronger, stating that:

The resident contributes ideas to and participates in the day-to-day activities of the residential care setting. (HIQA, 2009b)

Similarly, the medication management standard in the final draft includes the criteria that:

Residents are advised as appropriate about the side effects of prescribed medicines and are given access if they request it, to the patient information leaflet provided with medicines. The residents should be afforded the opportunity to consult the pharmacist or other appropriate independent health care professional about medicines prescribed as appropriate. The resident should be advised about these rights.

This criterion was not in the earlier drafts (see Department of Health and Children, 2007; HIQA, 2009).

### 5.2.3 Focus on the Resident in the Standards

Overall, the standards aim to be person-centred, and this is specifically stated in the final version in several places. For example, the introduction to the standards outlines that:

The National Quality Standards ... provide an important road map for both service providers and users, for the development of person-

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<sup>55</sup> The process of developing the standards is the subject of a PhD thesis by Ciara O'Dwyer, Social Policy and Ageing Research Centre, Trinity College Dublin.

centred models of care which are driven by a respect for the rights of older people and are focused on quality of life measures meaningful to individual residents (HIQA, 2009b:9).

Many of the standards in Section 1, on Rights; in Section 3, on Health and Social-Care Needs, and in Section 4, on Quality of Life, specifically focus on involving the service user and gaining their perspective on accessing and receiving care in the centre.<sup>56</sup> Some of the key standards that focus on service users involvement are outlined here.

### ***Residents' Committees***

Under the 'Consultation and participation' (Standard 2), one criterion outlines that:

The person-in-charge facilitates the establishment of an in-house residents' representative group for feedback, consultation and improvement on all matters affecting the residents ... Issues raised by the residents' representative group are acknowledged, responded to and recorded, including the actions taken in response to issues raised. (HIQA, 2009b:15)

Persons-in-charge interviewed reported that establishing a residents' committee was useful, as follows:

We've found out a lot through that ... Mary, the receptionist/admin person here has trained in advocacy, and chairs the committee ... and myself and [the owners] go through the minutes of the residents' committee meeting to see how we can take the requests on board. [R13]

Here's an area I suppose where HIQA were right and we would have been wrong, because [I didn't think there was much point in setting up a residents' committee] ... but there are things that they say that you've never listened to before. [Small things like] the care assistants, [the residents say they] knock on my door and then they come in. When they knock at the door they should wait for me to tell them to come in ... We changed our butchers because they said 'sorry, the meat here is very, very tough' and we passed that message on to the cook and she passed it on to the butcher and things didn't change, so I got something from another butcher ... and they said that was much better. [R9]

### ***Complaints***

There is also a strong emphasis in these standards on the procedure for residents (and others) to make complaints. To ensure learning from this, criteria under

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<sup>56</sup> A list of all references in the standards to resident choice, consent and consultation is included in Appendix A.

Standard 6 ask that ‘the person-in-charge ensures that complaints and comments are raised at team meetings for feedback and future learning. Measures required for improvement are put in place’. (HIQA, 2009b:19). This helps ensure that the voices of residents are better heard and acted on. Inspection reports focus frequently on the process for making complaints, and follow up on these to ensure that this happens.<sup>57</sup> This requirement also helps address one of the problems identified at Leas Cross. Following the Prime Time television programme, which showed poor quality care in that home, the HSE set up a complaints review group to investigate this, and one of the findings of this group was that:

If complaints received by the nursing home had been systematically recorded and available for inspection, it would have been much easier for both the nursing home management and the relevant health authorities to identify and deal with emerging patterns of inadequate care. (Commission of Investigation (Leas Cross Nursing Home), 2009:122)

### ***Consent and Consultation***

The criteria of several standards specifically require the input of residents to various activities. For example, criterion 7.2 outlines that a resident cannot be moved from their allocated room without their consent. Criterion 16.2 outlines that the residents’ wishes regarding end-of-life care are to be discussed, documented and implemented as far as possible. A particularly important issue is set out in criteria 21.20 and 21.21, that the resident is not to be restrained without their informed consent. As outlined earlier, the Department of Health (2011a) has developed a policy to promote a restraint-free environment in residential centres, with HIQA, the HSE and NHI, to ensure that this is promoted as much as possible.

### ***Person-centred Care***

Criterion 18.3 states that ‘the resident is to be enabled to live in a manner akin to his/her own home and the daily routines of the residential care setting, including meal times and bed times, are not solely dictated by staffing rotas’ (HIQA, 2009b:33). This is an important goal of the standards, and indeed of the regulations,<sup>58</sup> but at first inspection not all centres were meeting this criterion. The quote given in Box 3.4 from an inspection report of Centre 37 outlined that residents were put to bed after tea at 5pm. In the inspection report it was noted that:

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<sup>57</sup> As the inspection report of Centre 187 on 24 June 2010 (p. 6) shows: ‘[There were] very few recordings [of complaints] and those complaints that were recorded had totally inadequate documentation. There was no follow up recorded and no learning outcomes documented’ (see <http://www.hiqa.ie/social-care/find-a-centre/nursing-homes/abbeylands-nursing-home-alzheimer-unit>). This was followed up in later inspections of the centre.

<sup>58</sup> Where centres do not give residents choice in e.g. bedtimes, they breach the regulation on residents’ rights, dignity and consultation (as in Centre 37, 17–18 Sept 2009 report, p. 33) (see <http://www.hiqa.ie/social-care/find-a-centre/nursing-homes/gallen-priory-nursing-home>).

Staff claimed that they put residents to bed only when they (the residents) expressed a wish to retire.

However, the views of residents were different:

One lady explained that she went [to bed] early, as she may have had to stay up very late if she waited for the night staff 'to get around to her'... Another lady who spoke with inspectors was clearly upset that her wishes, in regard to what time she went to bed at, were not taken into consideration.<sup>59</sup>

Practice development, as outlined in Section 3.4.1, is one mechanism that aims to tackle such practices and move them towards person-centred care. This can be challenging for staff, as this quote from the evaluation of the practice development initiative in 17 Irish residential centres in 2009 indicates (HSE *et al.*, 2010:88):

Changes were more successful and sustaining when residents/guests were invited to participate and where there was real engagement. This ... necessitated shifting the power-base and many participants [i.e. staff] found this very challenging. There was a lot of over caretaking where staff felt that residents/guests were not capable of making decisions about their environment or that they didn't like to be asked. The first 'real conversations' exercise with residents/guests was a steep learning curve where the feedback received was not necessarily the feedback anticipated. The realisation that all wasn't right in their service and that residents were not necessarily happy with everything was a shock for most participants [i.e. staff].

In addition, several standards criteria aim to maintain the independence of residents, through maintaining their activities and social contacts, by keeping up their existing lifestyles, and also by encouraging them to physically do things for themselves. As one provider put it, 'in these standards, there is less emphasis on "doing for" the resident' [R19]. This is evident in a number of criteria under Standard 25, which require the environment of the home to allow residents to move independently, through the use of, e.g. ramps, visual aids, lifts, etc. Another way in which this is promoted is by encouraging residents to eat independently and to help themselves to food – practices that are praised in inspection reports. However, this is queried by some persons-in-charge, with one wondering why not facilitating residents to serve themselves vegetables, sauces and tea was considered an area for improvement in a number of inspection reports. He felt that 'you're really not depriving or abusing somebody by putting their vegetables on a plate' [R9]. Encouraging residents to help themselves does, however, help maintain their physical agility, and provides them with choice. But as another person-in-charge

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<sup>59</sup> Inspection of Centre 37 on 17–18 September 2009. Subsequent reports show a lot of change in this, with a later inspection report from 10 March 2010 saying that 'residents were complimentary about the flexible arrangements for going to bed' (see <http://www.hiqa.ie/social-care/find-a-centre/nursing-homes/gallen-priory-nursing-home>, p. 8).

noted, it can be easier for staff to do everything for an older person. In one case, a provider reported that the residents would prefer staff to carry out most tasks for them [R19]. And as outlined in Section 4.1.1, the new ability for people to make anonymous complaints to HIQA is an issue that can be challenging for staff, due to the manner of unannounced inspections to investigate complaints. However, both changes aim to provide a more person-centred service for older people in residential centres.

#### 5.2.4 Conflicts within the Standards on a Person-centred Approach

While the emphasis on residents in these standards is welcome, some persons-in-charge did report that conflicts can arise between the person-centred and other standards. For example, two stakeholders [R15, R19] commented on how it could be difficult to balance the focus in the standards on reducing use of psychotropic medication, with the needs of a resident who could not sleep or was distressed. On the other hand, psychotropic drugs can be used as a form of restraint, which aids the service provider rather than the resident (Law Reform Commission, 2009; Department of Health, 2011a). One example of this is in Centre 37, where at the time of the first inspection, residents were being put to bed at 5pm, and medication records showed that over half the residents were prescribed night-time sedation.<sup>60</sup>

Another conflict mentioned was that between risk and the person-centred element of the standards. For example, is it safe to have a kitchenette for residents to use, even though this helps them to maintain their independence? This issue will be discussed in more detail in Section 5.4.3.

#### 5.2.5 Focus on the Resident in Inspection and Monitoring

The views of residents are also incorporated into this standards framework through the inspection reports. As outlined in Section 3.3.1, HIQA compiles these reports through a number of sources of data, and this includes the views of residents and relatives.

When a centre receives notification of an inspection from HIQA, it is sent the following:

- A poster to be prominently displayed in the centre, which informs all residents, relatives, visitors and staff of the date the inspection will take place and invites relatives and residents to meet with HIQA during the inspection visit, if they wish; and

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<sup>60</sup> See report of 17 August 2009 at <http://www.hiqa.ie/social-care/find-a-centre/nursing-homes/gallen-priority-nursing-home> More flexible bedtimes were introduced following this inspection visit.

- Questionnaires to be distributed by the person-in-charge to residents and relatives seeking their views on different aspects of day-to-day life in the centre.<sup>61</sup>

However, although the consultation of residents and relatives is welcome, some stakeholders felt that some are reluctant to raise concerns. Such concerns are evident in the inspection report for one centre (Centre 37), where it was noted that ‘a lack of trust between relatives and managers was evident when two relatives chose to give over questionnaires personally. They said they were worried that the provider would not forward questionnaires with unfavourable comments to the inspectors.’ (p. 21, report of 17–18 August 2009).<sup>62</sup> A number of those interviewed felt that expectations around care in residential centres are often low, and many older [and younger] people are loath to complain, in case this would damage their relationship with the staff (see also Law Reform Commission, 2009). In addition, one provider said that while the HIQA process for the input of residents and relatives worked well for those who are good communicators, she had heard anecdotally that it was not as good for those who are not good communicators, who can sometimes become upset [R19].

The publication of the inspection reports themselves can also help prospective service users choose a residential centre (although a number of those interviewed felt that the reports might be too long and detailed for this purpose. The format has been changed somewhat since this research was carried out).

Finally, HIQA has established a relatives’ panel, which consists of groups of relatives of residential centre residents (past and present), who meet to provide feedback to HIQA on how the safety and quality of services provided in residential centres can be improved. Any person who is interested can contact HIQA to become involved in this panel.<sup>63</sup> HIQA does not have any residents’ panels providing feedback to them, which they explained was due to the difficulties that frail older people would face travelling to a central location, and as the views of residents are ascertained during inspections.

### 5.2.6 Ways in Which the Service User is not Focused on

Although these standards were praised by several persons-in-charge for their greater focus on the service user, it was also felt that there is room for improvement, some of which falls outside the scope of the regulations and standards.

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<sup>61</sup> HIQA guide entitled *Are you ready for your inspection?*, (accessed at <http://www.hiqa.ie/resource-centre/care-providers/forms-guidance>, on 16 April 2012).

<sup>62</sup> This was the centre visited most often by HIQA of the 42 randomly reviewed for this study. This suggests that there are unlikely to be many centres where relatives have such a high level of concern about the provider passing on such information from them to HIQA inspectors. Subsequent inspection visits also show improvements in the care of residents in this centre.

<sup>63</sup> See <http://www.hiqa.ie/getting-involved/volunteer-panels> for more detail (accessed 16 April 2012).



One way in which this came up was through discussion on the extent to which ‘money follows the patient’. Since 2009, the Fair Deal provides funding (under certain conditions) for an older person to receive care for assessed needs in a residential centre of their choice (for further information see Law Reform Commission, 2009:100–101). This increases choice as their care can be funded in any residential centre, while previously this only applied for those in a public sector residential centre (although it still depends on availability of spaces in the desired homes). Nevertheless, an older person who is allocated Fair Deal funding cannot use it to organise their own home care if this is what they would prefer – although the vast majority of older people would prefer to be cared for at home. However, the Programme for Government committed to reviewing the scheme, with a view to developing a secure and equitable system of financing for community and long-term care (Government of Ireland, 2011). One of the issues that will be looked at in this review, which is due to begin in 2012, is the balance of funding between residential and community care, and the extension of the Fair Deal scheme to other sectors.

In addition, an older person in hospital who is not able to return home without supports may remain there until funding is released from a separate budget line for home care or residential centre care. This makes little sense from a cost point of view, as a hospital bed is significantly more expensive than the other options, and also as hospital is not a suitable place for an older person who is not acutely ill to spend an extended period of time. Routines are rigidly set, and there are few (or none) of the activities and choices that are increasingly provided in a residential centre, for example. However, the HSE Service Plan for 2012 outlines that ‘the HSE is committed to working with the DoH [Department of Health] in allocating funding from long-term residential care and other potential sources, such as acute hospitals, to increase intermediate care capacity, i.e. step-up/step-down beds, and to provide additional community services such as home care packages’ (HSE, 2012:44).

Another way in which money currently does not follow the patient is that older people are reported to be more likely to receive services such as chiropody, physiotherapy and occupational therapy, free, if they are in a centre run by the HSE (see also HIQA, 2012). Although older people are entitled to these services free of charge whether they are in a public, private or voluntary sector home, in reality it is easier for these services to be accessed in public residential centres or community hospitals, which are often the location for provision of these services to the wider community. Some sense of the difficulties faced in accessing such services in private and voluntary centres is shown through a survey of these residential centres, where centre managers were questioned about the extent to which a number of HSE therapies (physiotherapy, occupational therapy, speech and language therapy, dietician, and wound care support) were available to the centre in a timely manner (i.e. with days to weeks), when a referral was made. 23 per cent

of managers responded,<sup>64</sup> and showed that speech and language therapy was most often available in a timely manner (but only in 24 per cent of the centres), and physiotherapy least often (in 11 per cent of the centres). In addition to this, 43 per cent of managers reported that wound care support was not available to them at all from the HSE in their area, while 32 per cent reported that speech and language, and occupational therapies were not available to them from the HSE in their area (INECMA, 2012, forthcoming).

Fair Deal also does not pay for the costs of social programmes (even those that are required under the regulations), incontinence wear, chiropody, ophthalmic and dental services, transport and specialised equipment. The Department of Health explains that medication and aids that are already prescribed for individuals under an existing scheme are not included in the services paid for by Fair Deal, as this could involve the taxpayer paying twice for the same services.<sup>65</sup> However, there are concerns about how these services and aids are being provided to older people, and so the HSE Service Plan for 2012 outlines that a national ancillary group has been set up to put standardised processes in place to ensure equitable delivery of ancillary care, aids and appliances to all older persons, in both residential and community care. This should be completed by the end of the third quarter of 2012 (HSE, 2012).

Under the Fair Deal, the National Treatment Purchase Fund (NTPF) currently pays the same rate per bed in each residential centre, and does not vary this rate by the dependency of the older person.<sup>66</sup> There was some suggestion that this meant that private sector residential centres were less likely to accept an older person with very high care needs, as it would cost them more to provide this care than the NTPF would pay [R10]. (The *Long Stay Activity Statistics 2010* (Department of Health, 2011b) show that 47–51 per cent of those in HSE residential centres were of maximum dependency compared to 27 per cent in private centres. Private centres also had a higher proportion of low- and medium-dependency residents than public centres). This could reduce choices for older people.

An unanticipated consequence of the recession is that a number of HSE residential centres are closing as the State faces problems funding the costs of upgrading these

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<sup>64</sup> So the survey data refers to 102 out of 447 private and voluntary centres. The authors note that 'given the low response rate, caution should be used when extrapolating the results to the general population' (INECMA, 2012, forthcoming:3).

<sup>65</sup> As outlined in the Information Sheet on the scheme on the Department of Health website – see [http://www.dohc.ie/issues/fair\\_deal/informatinsheet\\_per\\_cent20\\_fees.pdf?direct=1,p.2](http://www.dohc.ie/issues/fair_deal/informatinsheet_per_cent20_fees.pdf?direct=1,p.2), (accessed on 28 May 2012).

<sup>66</sup> The Comptroller and Auditor General noted that levels of dependency were not generally taken into account when the NTPF negotiated bed prices with residential centres (see Comptroller and Auditor General, 2010:652). The NTPF [R26] explained that the key reason for this is that there is currently no nationally consistent measure of dependency levels to use as a basis for negotiating the price of care by dependency level. The new Minimum Data Set being piloted by the HSE (see Section 5.3.5) may provide a solution to this in the longer term. The review of Fair Deal, which will be carried out by the Department of Health later this year, will also consider the effectiveness of current methods of negotiating and setting prices in private and public centres.

homes to meet the physical environment standards,<sup>67</sup> and is not able to replace staff who leave due to the embargo on public sector recruitment (HSE, 2012). This can mean that centres that provide good care but that cannot meet the physical environment standards, or replace staff, are being closed. Clearly, this can have very negative impacts on residents. Although the HSE's Service Plan for 2012 outlines that 'any decision to close a unit will only be taken following an extensive consultation process with clients' (HSE, 2012:45), it is not clear exactly how this will operate. One centre that was due to be closed had these plans reversed by court order, to facilitate a three-month consultation period, but some felt that this merely 'reset the clock' by three months (Wall, 2011). In some countries, other mechanisms are used to ensure greater security of tenure for groups needing long-term care, such as shared ownership of accommodation by the service user and a State body (see, e.g. The Health and Social Care Change Agent Team, 2005), although these schemes seem to be more often used by people with disabilities. Another possibility is ownership of residential centres by local community trusts. However, both types of schemes are rare.

Several of those met also were of the view that the focus on the resident could go much further. One person suggested that older people should be on interview panels when residential centres are recruiting new staff. In one centre, such a process was being put in place:

The person-in-charge had recently completed a survey ... to ascertain residents' interest in becoming involved in the recruitment process for new staff. Seven residents had expressed an interest in being involved at various levels, from sitting on the interview panel to being an observer of the process. The human resource manager told inspectors the recruitment policy was currently being amended to reflect the new role of residents in the future filling of vacant posts when they arise<sup>68</sup>

To date, however, such involvement is rare.

Another stakeholder felt that older people should have stronger rights, comparable to those for people with disabilities [R1]. The rights of the latter group are covered by the United Nations *Convention on the Rights of Persons with Disabilities* (UN, 2008), which has been signed and is due to be ratified by the Irish Government; while the UN's *Madrid Plan of Action on Ageing* (UN, 2002) is not legally binding. Another noted that older people who move into a residential centre are still very much forced into living an institutional way of life – for example, few are able to

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<sup>67</sup> HIQA (2012) shows that while the Premises regulation was the one most often breached, HSE-run centres recorded the highest level of breaches (94 per cent) compared to private centres (76 per cent) and voluntary centres (70 per cent). This is related to the age of the premises (HSE-run centres often occupy older buildings), with 88 per cent of premises built before 1949 recording a breach of this regulation, compared to 65 per cent built from 2000. There are many requirements to be met under this regulation, which may explain why so many centres breached it.

<sup>68</sup> Inspection report for Centre 325, 9 June 2010, p. 12 (see <http://www.hiqa.ie/social-care/find-a-centre/nursing-homes/brookvale-manor-private-nursing-home>).

carry out normal activities such as cooking or gardening, even to a limited degree. This person felt that providing activities for older people does not compensate for their loss of independence, and that despite the changes the standards bring, the culture of residential centre care is still very much a 'we do for you' culture.

## 5.3 Learning and Monitoring

### 5.3.1 How Do the Standards Themselves Encourage Learning, Monitoring and Continuous Improvement?

As stated in the *Overview of Concepts and Practice* (NESC, 2011), it is important to consider the extent to which the standards themselves encourage learning, monitoring and continuous improvement. Skok (2000) has outlined that the notion of standards implies clear-cut criteria and fixed definitions of quality, whereas the notion of continuous quality improvement implies a continual process of self-examination and a never-ending search for improvement without a fixed destination, (see Commonwealth of Australia, 2005:29). This tension is being addressed by the development of more flexible and less prescriptive standards, and the development of standards specifically requiring organisations to demonstrate continuous improvement systems. Review of the HIQA standards indicates that both minimum fixed and continuous improvement standards need to be met for a residential centre to be registered. The 2009 regulations on *Care and Welfare of Residents in Designated Centres*, and on *Registration of Designated Centres for Older People*, outline many specific tasks that persons-in-charge are legally obliged to undertake (e.g. that each resident must have a care plan, agreed with them, and reviewed every three months); see Appendix B for a list of minimum fixed requirements in the Standards.

However, the emphasis on continuous improvement in the HIQA standards was stated by a number of those interviewed:

I think that [the HIQA] standards and the whole inspection regime are about continuous improvement and they are not a kind of a baseline ... [The] standards are ... saying to people – you need to be constantly evaluating yourself, looking at what you're doing, critically evaluating your systems. [R15]

In a meeting with HIQA, inspectors there stated that the standards are not there to 'service a monitoring system', but to shape day-to-day practice.

So there is a definite emphasis on continuous improvement in the standards. The Introduction states that:

For service providers, these Standards provide a road map of continuous improvement to support the continued development of person-centred care ... in the case of those standards which are not regulatory standards, or standards linked to regulations, failure to

comply will not in themselves lead to failure to be registered or loss of registration, but they are designed to encourage continuous improvement (HIQA, 2009b:6,8).

There are a number of requirements throughout the standards that aim to promote continuous improvement. These include an annual review of systems and practices, with a corrective action plan developed and implemented to address areas requiring improvement (criterion 30.1); regular review of policies, procedures and practices in line with monitoring and residents' views (criterion 29.8); and research, quality assurance and audit (criterion 30.4) (HIQA, 2009b).

These requirements are in line with the concept of meta-regulation, whereby regulators encourage organisations to install systems of monitoring and self-regulation. Some of these requirements are quite specific, such as collection of data for ongoing monitoring and continuous improvement, on: vaccines, pain, pressure ulcers, use of physical restraint in last week, use of psychotropic drugs, use of catheters, falls in the last month, those spending most of the time in bed, those losing significant weight in last month, complaints, significant events, and the unexplained absence of residents. Criterion 14.4 also requires that 'medication errors, suspected adverse reactions and incidents are recorded, reported and analysed within an open culture of reporting. Learning is fed back [to staff] to improve patient safety and prevent reoccurrence' (HIQA, 2009b:26).

Attention to how such requirements are being implemented is evident in inspection reports. For example, an inspection on 29–30 September 2009 in Centre 187 found, on medication management that:

There was also no evidence of monitoring, review or ongoing audit, and the procedure for recording, reporting and analysing medication errors had not been implemented. (p. 13)

In the Action Plan sent to HIQA on 20 November 2009, the provider of Centre 187 responded that the existing policy, procedures and guidelines had been updated in line with current legislation and regulations. These changes were reflected in the second inspection report, which found that:

There was evidence that monitoring, review and audit of medication management had commenced. Systems were put in place to record, report and analyse medication errors. (p. 5–6)

Again, this is in line with the meta-regulation approach, whereby regulators assure themselves that the monitoring and self-regulation systems installed by service-providers are adequate and being followed.

As outlined in Section 4.1.2, persons-in-charge interviewed as part of this research had a range of views on this practice of data collection for monitoring and learning purposes, with one saying that it 'makes you question everything' [R16], and another noting that:

You have the reviews every three months, and now you bring in the doctors, residents, families ... and we have less complaints now, as people are involved and problems get thrashed out in the care planning meeting. [R16]

However, another provider of a small residential centre considered that a good person-in-charge would 'know anyhow' [R10] if a concern was arising, and that the data reviews were time-consuming.

Another person-in-charge who also found the review time-consuming had more mixed feelings, thinking it had some value:

Gathering information [takes] me an hour every Monday morning ... I log the figures here and I do three-monthly reviews on them ... It's good from the sense that we can review our falls and the guy coming here for our physio ... does his falls review and he can gather the information for it and we can show information. But ... at times, the pressure of paperwork tends to defeat the whole thing, that you're more focused on doing the paperwork than actually delivering the care. [R9]

These findings are confirmed by the HIQA (2012) review of the results of 15 months of inspection reports. They found that the second-most-often breached regulations were these risk management procedures, with three-quarters of all centres not meeting all the regulations on this when first inspected. As HIQA notes, 'this [is] a very detailed regulation and centres found it difficult to comply with all the requirements' (p. 21). HIQA found that 48 per cent of the centres which breached this regulation on the first inspection had completed all the work required to meet the regulation within 15 months; and a further 26 per cent had partially implemented these recommendations. However, HIQA would like to see a higher rate of implementation, as 'the benefit of having such policies in place to inform learning reduces the level of risk to residents and, in turn, increases the level of safety in the centre' (p. 22). These findings underline the suggestion by one stakeholder that the standards are a 'culture change' (see Section 4.1.3); some centres seem to be further ahead in this culture change, as they are implementing the new requirements more fully. The fact that some centres are not fully implementing these requirements means that the success of the meta-regulation approach is reduced. This raises the question of what other supports might be needed to ensure that all centres are implementing this, and other new requirements, in the standards.

As well as the written records to be kept to assess risk, the standards also require verbal feedback on services. This should be gained in staff meetings, from residents,

committees, and from residents more informally. This feedback is to be used to review services and inform future planning (see, e.g. criterion 2.5<sup>69</sup>).

The standards also require considerable review and learning to ensure that the care of the older person is relevant to their needs. Their wishes and choices are to be documented, and implemented as far as possible, and their health and medication is to be reviewed regularly. (Further detail on such requirements in the standards are included in Appendix A.) These requirements aim to promote greater learning about the residents' needs, and what processes need to be put in place for these to be met.

As well as the focus on recording data and gaining verbal feedback, the standards also require 'continuous learning' for staff – for example, Standards 24, 27 and 29 require regular training and professional development for both staff and the person-in-charge (HIQA, 2009b). Similarly, the Fit-person self-assessment process can prompt learning. As outlined in Section 3.3.3, this process requires the person-in-charge and the provider to consider how they currently meet the standards, and to explore what processes they could put in place in future to meet them. And as outlined in Section 5.1, at least some persons-in-charge did find it useful for learning.

This overview shows that the standards provide a potential example of meta-regulation, through the processes for continual learning to be put in place within the residential centre, although as HIQA (2012) shows, not all centres had mastered this. Some of these processes, such as the residents' committees, are seen as very successful. Views are more mixed on whether the paperwork required for regular review is worth the time that it takes, but most persons-in-charge interviewed did feel that there was learning from these processes. Whether or not the continuous learning processes in the standards and inspection framework are the optimum ones to promote learning could be debated, but it is clear that they do *aim* to promote learning. This raises the question of what other supports might be needed to ensure that all centres are implementing the standards requirements, an issue that will be returned to in Chapter 6.

### 5.3.2 Learning in the Residential Centres

#### *Involvement of Staff in Meeting the Standards*

The process of preparing for the new standards and inspection framework meant a lot of learning involving staff took place in the residential centres. One person-in-charge described the process adopted in her centre:

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<sup>69</sup> 'Feedback is actively sought from the resident on an ongoing basis on the services provided. The residential care setting clearly demonstrates how the impact of the resident's feedback informs reviews and future planning.'



To bring in the standards, work started in 2009. I set up a series of meetings with all staff, and we discussed one standard at each meeting. I asked staff how we would implement it. And I developed local policies based on that. So all the staff did it. I put up signs about the standards everywhere too! Staff now understand it and question everything. [R16]

### ***Staff Learning and Culture Change***

Another person-in-charge commented that a lot of the work for the standards is ‘developing staff and bringing them on board’ [R14]. It was also stressed how important it is to ensure that staff feel valued as this new approach is integrated into existing work. The importance of developing staff and bringing them on board can be seen in the practice development work carried out by the HSE, referenced in Section 3.4.1 earlier. This approach encourages staff to change how they work and adapt their working practices to listen to residents. The following example shows this well – when staff spoke to residents they learnt that the residents’ view of a homely environment was different to that of staff:

A residents’ sitting room was redecorated after staff talked to residents about what they considered a homely environment to be. As a result all lounge areas were transformed from minimalist design with contemporary furniture and décor that did not represent the residents’ experiences of a homely room, to rooms with focal points such as a fireplace, a pendulum clock on the wall, flowers on the mantelpiece, and a cabinet with ornaments (HSE *et al.*, 2010:78).

The HIQA standards introduction states that the ‘National Quality Standards for Residential Care Settings for Older People will not, by themselves, bring about a transformation from institutional to more person-centred models of care. This will require a significant cultural shift in our society. [They] do, however, provide an important road map for both service providers and users, for the development of person-centred models of care’ (HIQA, 2009b:7). The practice development approach aims to make that cultural shift. Two people interviewed during this research were of the view that the practice development process is the core of what it means to improve standards, because it helps to change the culture of care. One person [R21] explained how there is too often a focus on reaching a ‘technical’ end goal, without looking at patterns of work, or the ‘people side’. The ‘people side’ looks at how people work together, how they share power, how they manage conflict, etc. These issues must be grappled with to achieve good-quality services, but they are usually left out. New standards that are established without corresponding work on people and patterns of work will not be implemented.

As outlined in Section 3.4.2, models such as the Eden Alternative, Teaghlach, or the Dementia Care Matters approach, advocate a change from task-centred care to a more person-centred approach. However, it takes time to move from the older, task-based institutional model of care to a person-centred one. A culture that is task-based needs to first become aware of person-centred approaches, and then put in place mechanisms to allow staff to move from detached, science- and task-



based care where emotions are suppressed to one where the philosophy of care is based on feelings and emotions, and values and beliefs, and services are run for individuals. Box 5.1 outlines four stages to such a culture change, as outlined for the Dementia Care Matters model, by David Sheard.<sup>70</sup>

In November 2011, the HSE (in collaboration with NHI, the Atlantic Philanthropies, the University of Ulster and Dundalk Institute of Technology) published *Places to Flourish*, which provides centre managers with guidance on how to move towards more person-centred models of care (see [www.placestoflourish.org](http://www.placestoflourish.org)). It draws on learning from the practice development and Teaghlach models of care (see Section 3.4.2), as well as other person-centred pilot projects and international evidence. Guidance is provided on how to make changes in workplace organisational patterns, and on putting more person-centred care in place, for example, in relation to dining, going to bed, and keeping up social contacts.

In relation to dining, the guide outlines what has been put in place in a unit in one centre to provide a better dining experience. Advice is provided on how to, e.g. reduce noise levels in dining rooms; to provide extra light, which older people need; to provide choice of food to older people; and to provide adapted cutlery, plates, etc. which will help residents eat independently. Residents can take part in preparing food through, e.g. growing herbs and vegetables, or through giving family recipes to the kitchen. Options to eat alone, with others, or with preferred others can also be given to residents. The guide also outlines challenges for staff in providing this type of care, and helpful tips on how to deal with these challenges (HSE, 2011a). These provide practical advice to help centres start on the process of culture change, although the Sheard model suggests that the move to fully person-centred care takes considerable time and work. Encouragingly, senior HIQA staff outlined their support for these models at conferences in 2011,<sup>71</sup> and stressed that they saw no contradiction between these person-centred approaches and the HIQA standards.

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<sup>70</sup> Source: Presentation by David Sheard at the My Home Life Wales seminar, November 2010, [http://www.ageuk.org.uk/Global/Age-Cymru/My\\_Home\\_Life\\_Wales/Events\\_per\\_cent20Details/National\\_per\\_cent20Sem-Nov10/David\\_per\\_cent20Sheard.pdf](http://www.ageuk.org.uk/Global/Age-Cymru/My_Home_Life_Wales/Events_per_cent20Details/National_per_cent20Sem-Nov10/David_per_cent20Sheard.pdf). (accessed 14 November 2011).

<sup>71</sup> For example, at the Nursing Homes Ireland conference on 10 November 2011, and at the launch of *Places to Flourish* (see <http://www.placestoflourish.org/>) on 15 November 2011.

### Box 5.1 Sheard Model of the Move from the ‘Clinical’ to the ‘Congruent’ Service

<b>Model 1: The clinical service – a traditional old culture organisation</b>	Philosophy of care based on science, function, rationality and bodies	Detached professionalism	Lack of person-centred beliefs	No qualitative observation of service	Task-based care	Suppression of emotions at work	Clinical training – causes, signs and symptoms	
<b>Model 2: The confused service – an adapted old culture organisation</b>	Philosophy based on hierarchy of needs from physical to spiritual	Detached professionalism	Person-centred beliefs	No qualitative observation of service	Task-based care	Suppression of emotions at work	Awareness training	
<b>Model 3: The creative service – a muddled new culture organisation</b>	Philosophy of care based on feelings and emotions	Attached professionalism	Person-centred beliefs	Qualitative observation of service	Confused task-based care	Expression of emotions at work, but no strategy	Awareness training	
<b>Model 4: The congruent service – a new emotion-led organisation</b>	Philosophy of care based on feelings and emotions	Attached professionalism	Person-centred beliefs	Qualitative observation of service	Service run by individuals for individuals – free flowing	Evidence of an emotions at work framework	Training is focused on self-awareness and action	Implementation of staff well-being tool

Source See Footnote 69

In 2010, the Department of Health and Children published *A review of Practice Development in Nursing and Midwifery in the Republic of Ireland and the Development of a Strategic Framework* (Department of Health and Children, 2010). The first part of this document reviews practice development work to date in nursing and midwifery in Ireland, and the second part lists eight strategic objectives to be carried out to promote practice development. The HSE is now working on one of the objectives, to develop a national practice development framework, by bringing together the different practice development initiatives and similar ‘essence of care’ initiatives, within a national framework. For example, the Nursing and Midwifery Planning and Development Unit of HSE North West has, over the past year, developed a practice development framework and piloted this with a view to wider implementation. It is also facilitating bi-annual practice development schools to build capacity in this across all services in the HSE North West, and influencing the practice development agenda in Ireland through programmes of practice development research and evaluation. All of these initiatives will provide more learning for those working in residential centres to enable them develop this model of care. However, a number of stakeholders interviewed [R21, R22, R23] were of the opinion that practice development as a strategy to promote person-centred care had low visibility.

### ***Learning from the Inspection and Monitoring Process***

The inspection, the action plan and the follow-up inspections also promote learning. Where the inspection identifies an issue that needs to be changed in order for a centre to be registered, the provider and person-in-charge then need to think how to address it and outline their plans in the action plan, and a follow-up inspection later takes place to ensure that the necessary changes have been made. (Examples of this have been given in earlier sections.)

However, it was suggested that learning could be improved if HIQA provided feedback to centres on how they were performing against other centres, e.g. by comparing the statistics gained from notification forms [R17].

### **5.3.3 Learning Across Residential Centres**

Learning is shared between residential centres in several ways. As outlined earlier, training and guidance is provided by the HSE, the NHI and other organisations including EIQA and companies helping centres meet the requirements of the standards. The Nursing Homes Nursing Project, which was set up in 2005 (following the Leas Cross scandal), originally brought together over 100 centres, and now has 40 members, who meet to share learning, sometimes through conferences open to a wider audience. Within the HSE, the managers of some centres meet, although this practice varies by HSE area. Events run by the HSE and NHI, such as training seminars, also allow networking and exchange of ideas. The NHI Care Awards for excellence in residential centre care also showcase centres with good practices and management. These are some of the elements of ‘smart regulation’, whereby third parties such as professional organisations, trade unions and NGOs, become involved in some aspects of regulatory practice. A downside is, however, that not all residential centres are involved in these groups.

Prior to the introduction of the standards, HIQA also ran a nationwide series of seminars for providers, to introduce the relevant legislation, regulations and standards, and to outline the respective roles and mutual expectations of regulator and provider.

In 2009, the NHI commissioned a review of how the initial inspections of NHI residential centres were progressing, identifying a number of key issues for persons-in-charge and providers (specifically the costs of meeting the HIQA standards requirements, and inconsistencies between inspectors) (Prospectus, 2010). The HSE West, as noted previously, is also reviewing a sample of all inspection reports for its centres, which will identify means to support staff and influence health care outcomes whilst meeting the requirements of HIQA, and this review is due to be available in 2012. As these reports are, or will be, in the public domain, they provide some learning for other centres, and indeed for HIQA and the Department of Health. A number of those met from the private sector also noted that the HSE share their training courses with private sector centres, again promoting learning.

Similarly, the methodology and evaluation of the practice development project carried out by the HSE is available on-line as a source of learning. Informal meetings of the national network who worked on this project also occur.

In addition, centre managers can learn from reading each other's inspection reports on the HIQA website, although persons-in-charge reported that trawling through inspection reports is an inefficient way of identifying good practice, particularly as HIQA inspectors already see this good practice and could let them know which centres have a best practice solution to their problems.

### **5.3.4 Learning at National Level**

#### ***Learning Feeding up to HIQA***

Learning feeds up to HIQA in a variety of ways. As outlined in Section 3.3.2 above, notifications of serious incidents are completed by residential centres and then forwarded onto HIQA within a short timescale. This allows HIQA to monitor the extent to which serious incidents arise in a centre.

There are also a number of mechanisms in place to help HIQA to learn more about implementation of the standards. First, at the end of an inspection, inspectors are required to leave the residential centre manager with a quality improvement questionnaire, to be returned to HIQA, to provide feedback on how the inspection was experienced. However, one person-in-charge, while noting that it is possible to complain about an inspection, also mused that, 'given that centres "need" the inspectors, does anyone complain?' [R13].

Second, HIQA has a number of panels of providers and persons-in-charge, which they meet with regularly, to identify issues arising in implementation of the standards. This is considered helpful by both HIQA and the providers. One person-in-charge [R13] also felt that recently HIQA had started to listen more carefully to

feedback from these groups. HIQA also formally meets Nursing Homes Ireland every two months.

The inspection reports are another source of learning for HIQA, and, to draw this together, in 2012 HIQA published a composite report collating the findings of all inspections and follow-up inspections carried out between 1 July 2009 and 30 September 2010 (HIQA, 2012). This report outlines the main regulations breached, and the proportion of recommendations that were fully or partially implemented following the first inspection report. Similarly, the review of the inspection process by NHI (Prospectus, 2010), and the practice development work published by the HSE (HSE *et al.*, 2010), can provide learning to HIQA.

HIQA also has an internal quality assurance process. This focuses on reports, inspections and inspectors. During the summer of 2011, HIQA was developing quality assurance on the consistency of reports, as the report is the main output for the public and the centre.

A number of those met during the course of this research noted that there is no regulation of HIQA – for example, it is not accountable to the Ombudsman (see Jordan, 2011). On the other hand, the Law Reform Commission (2009) notes that the Health Act 2007 protects registered residential centres by ensuring that they have a right to respond to a decision of HIQA, and by ensuring that there is recourse to the courts.

### ***Learning Across Regulators and Across ‘The Centre’***

As well as learning from residential centres, HIQA also works with a number of regulators to co-ordinate their approaches and their work in residential centres.

First, until recently HIQA had an external reference group on the standards, meeting four times a year. Representatives on this group included HIQA, the HSE, the Department of Health and Children, Nursing Homes Ireland, An Bord Altranais, and other regulatory bodies (on food, environment, pharmacy, etc.). This group assessed policy implications arising from the standards process, and also helped to co-ordinate the different types of regulations that residential centres have to meet. However, as the work of the group was not proving useful, HIQA has suspended its operation. There is, however, a memorandum of understanding between HIQA and the Food Safety Authority, to clarify what each body regulates in relation to food in residential centres, and another between HIQA and The Pharmaceutical Society of Ireland. Discussions on a memorandum of understanding are also underway between HIQA and An Bord Altranais, between HIQA and the Gardaí, and between HIQA and other bodies. Unexpectedly, nearly all the persons-in-charge, and HIQA, did not see the work of the different regulators as overlapping. All saw the work of the different regulators as separate, and persons-in-charge did not object to having different regulators checking different requirements in their centres, and indeed many saw it as appropriate as they did not expect one regulator to have knowledge of such a broad range of requirements.

Second, HIQA has regular meetings with the Assistant National Director of Services for Older People in the HSE on similar issues. There is a document agreed by the

two organisations, outlining where and how their functions intersect. One particular issue on which HIQA and the HSE co-operate is the closure of a centre that does not meet registration requirements, as in these cases the HSE is required under law to make arrangements to meet the needs of residents. The HSE can put its own staff in to manage the centre, or close it (the latter is usually the option taken. The issue of closure of HSE residential centres will be considered in more detail in Section 5.5.2 ).

HIQA also regularly meets the Office for Ageing and Older People in the Department of Health in relation to what they are learning, and how this can be progressed.

Another source of learning and monitoring is the review of the Care and Welfare Regulations under the Health Act 2009, which is being finalised by the Department of Health. This review has been undertaken by the Department to examine issues that have arisen since the introduction of the new regulatory framework in July 2009, and to utilise the experiences and knowledge gained since then. The Department consulted with HIQA, and requested other relevant organisations such as Age Action to make a submission on the regulations, and also set up a group comprised of NHI, the HSE and the Federation of Voluntary Catholic Nursing Homes. Key issues looked at include some of those listed in Section 4.1 above as problematic, and are as follows:

- The system for handling complaints, including the independent appeals process;
- Requirements on maintaining records, including medical records, information set out in schedules, and ways of avoiding duplication;
- The requirement for 24-hour nursing cover and how that applies to community care homes (which would have less dependent residents than other centres);
- Interaction with other statutory agencies with a view to ensuring consistency with regulations and other legal requirements;
- Contracts with residents; and
- Underpinning the policy on a restraint free environment.

Drafting of amended regulations is being carried out and they are expected to be introduced in 2012 (Fitzpatrick, 2011).

The Department of Health is also made aware of key issues arising in implementation of the standards through representations and parliamentary questions to the Minister, and issues raised in politicians' clinics. This allows the Department to identify any trends arising in implementation, and to discuss with HIQA any which concern them.

### 5.3.5 A Minimum Data Set

The HSE recently completed a project on the pilot of a single assessment tool, to assess an older person and their need for care, whether that be in a hospital, a long-term care setting, or at home. Implementation of such a national assessment tool would allow commitments in *Towards 2016* to design and deliver care to older people, in an integrated manner based around the needs of the care recipient, to be met. However, this data could also be used for monitoring and learning about services.

To progress this work, a Single Assessment Tool (SAT) Working Group was set up in the HSE in 2010, co-chaired by the HSE Assistant National Director for Older Persons, and an independent expert on eldercare. This group has piloted use of the interRAI suite of assessment tools with a view to rolling them out nationally. These tools are the result of international collaboration and application over the past two decades, and they are currently used in 30 countries.<sup>72</sup>

Two pilot projects have been carried out on use of this system, one in Dublin and one in a rural location in Tipperary. In each location, six public health nurses have used the assessment in the community, as well as six health professionals in a hospital, and approximately eighteen more in a long-term care setting. Each of the staff has been trained on entering the data onto a computer system, and the usability of the system has been assessed through survey and focus groups with staff, and clients/carers. The working group will report shortly on the findings.

The assessment process collects a minimum data set, which can be used first for care planning, but also to measure outcomes for older people from different services, and so to monitor the quality of services. This would help assessment of care needs and outcomes in different care settings and HSE local health offices around the country, and so would provide good monitoring and learning data.

## 5.4 Devolution and Accountability

This section looks briefly at the main actors driving this standards framework, their respective roles, and the crossovers between them.

### 5.4.1 Who Are the Key Actors in the Standards Framework?

It is useful to consider first who the main actors are. At a basic level, there are three key actors – the service user, service provider, and ‘the centre’. The key body at ‘the centre’ is the Department of Health which formulates and evaluates policy on health services, and has a complicated role, as it acts as a representative for a

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<sup>72</sup> See <http://www.interrai.org>. (accessed 15 March 2012).

balance of several interests. One interest is that of citizens, who in themselves are not a homogenous group, as they are both older people who need services, and tax payers, who may have varying views on how services to older people should be delivered and paid for (and obviously these two groups overlap, as well). The Department also needs to balance the interests of citizens with the interests of those providing care for older people, be they State, voluntary or private providers, to ensure that such care is provided effectively. Another important ‘central’ body is HIQA, which inspects against the standards, as required by the Health Act 2007 and its associated regulations and standards.

Each of these actors has different needs and responsibilities in the standards framework. The older person, who at this stage of their life can be very vulnerable, needs to be provided with high-quality, safe services that meet their needs. The Department of Health, under its remit to formulate and evaluate policy on health services, has several roles and responsibilities on behalf of government and the citizen – for example, to ensure services are provided (currently by a balance of HSE, private and voluntary providers); to ensure that they are paid for out of existing resources (currently through a balance between the individual older person and the tax payer); and to ensure that they are safe, responsive and of high quality (the requirements are set out by regulations and standards under the Health Act, 2007, with inspections to ensure the requirements are being met carried out by HIQA). As part of meeting these responsibilities, the Department of Health needs information on who needs what services and who can and does provide them; on the Department’s behalf, HIQA needs information on the quality and safety of the services provided.<sup>73</sup> The service provider, meanwhile, plays an important role not just in providing the service, but also in interpreting and meeting the requirements of both the service user and the Department of Health and HIQA.

Given the needs and responsibilities of these diverse groups, a number of complex questions arise. For example, who should be making decisions for whom, to what extent, and why? Negotiation on these issues takes place on a day-to-day basis in the implementation of the standards as well as over a longer timeframe, as the roles and responsibilities of various groups change in wider society. The optimum balance between all of these needs, responsibilities and roles is not easy to strike.

#### **5.4.2 How Are the Key Actors Involved in Standards Design and Implementation?**

To start with the development of the standards, at that time all of the actors were brought together into an advisory group. As outlined in Section 3.2, they debated drafts of the standards that had been produced originally by the Department of Health, and then were amended by HIQA. HIQA subsequently further revised the

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<sup>73</sup> The Department of Health obviously also needs information on how the services can be paid for, but this issue is not explored in depth in this report.



draft standards based on the inputs from this group and the public, and finally the Minister for Health mandated them.

In relation to implementation of the standards on a day-to-day basis, the *Quality and Standards in Human Services in Ireland: Overview of Concepts and Practice* report in this series (NESC, 2011) pointed out that in the most fruitful regulatory frameworks, local providers have the opportunity, and in some cases, the incentive, to improve quality and performance. The HIQA standards have adopted a meta-regulation approach, whereby providers are not only given the incentive, but actually required, to collect and review data to allow them put in place their own systems to manage risk. HIQA then checks these systems to ensure that they are adequate and are being followed. As the requirement to collect data for review is prescriptive, does this requirement reduce the autonomy of some centres? Some residential centres were already using these approaches, others were not. This requirement may reduce the autonomy of centres not previously operating in this way, but the approach was agreed in partnership with service providers and groups representing older people. In addition, it deals with some of the problems identified in the Leas Cross case. Some of the recommendations made by the group reviewing care in that centre, ‘to prevent similar situations emerging in other nursing homes’ (Commission of Investigation Leas Cross Nursing Home, 2009:201), were that:

- All nursing homes should undergo a structured multidisciplinary review every three months, including a medication review, a nursing assessment and paramedical evaluation ...
- There should be in place a process to audit and monitor practice to achieve and sustain best practice. (*Ibid.*: 202).

So it appears that the approach taken by the HIQA standards is that the system of requiring centres to audit themselves is a mechanism which should be used as part of a regulatory system to ensure quality, even if it reduces the autonomy of providers in some ways.

Meanwhile, the mechanisms that persons-in-charge use to address any problems identified in their internal audit are not prescriptive. It is clear that HIQA expects persons-in-charge and providers to come up with their own solutions to manage risks such as falls and medication errors, and thereby improve quality and performance, as the following quotes show:

The standards are an interpretation, not a prescription. So each nursing home has to look at every standard and how to meet each one. There’s no bible on how to be compliant! [R19]

What you provide for residents with dementia will be very different to what you provide in a home for less dependent people, even under the same standards. [R7]

Reading the inspection reports of the random sample of centres selected for this study certainly shows very varied practices. Overall, the standards outline the goals

to be achieved and some procedures to be carried out, while the persons-in-charge work out how best this can be done within their centres.

### 5.4.3 How Much Scope and Innovation is Possible Under the HIQA Standards?

One person who had previously worked for HIQA was of the view that this meta-regulation approach means the standards allow innovation, as the person-in-charge is able to decide themselves how to meet a standards outcome, as suits their residents [R7]. Certainly there are examples of centres that meet standards in innovative ways. One person-in-charge [R13] outlined how they were meeting the standard on end-of-life care, which is that ‘each resident continues to receive care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy to meet the residents’ needs’. This person-in-charge has been working with a consultant in a local hospital to produce an ‘end-of-life care passport’ for residents who are seriously ill or dying. The residents’ wishes are discussed with them, and then are noted in the passport – for example, it could outline that the resident does not wish to have aggressive treatment if they become more seriously ill, or that they want to die in the residential centre rather than in hospital. This passport is brought with an older person if they are being admitted to hospital. This means that A&E staff can read their wishes in the passport, and treat them or discharge them as appropriate in line with these. This end-of-life passport is not something prescribed by the standards, but instead is an innovative solution to the requirement to provide end-of-life care to meet the resident’s needs. An interesting question here, however, is how such innovative practice can be shared.

Another provider [R19] said that the standards ‘do let you be innovative, but some people are afraid to be so – there’s a “reds under the beds” element!’ An ex-employee of HIQA also felt that when a provider is anxious, they want rules to be sure they are meeting the standards correctly [R7]. This was echoed by a person-in-charge who felt that ‘people are afraid to do things which are not in the policy’ [R2]. But another person-in-charge felt that people use regulations as an excuse not to innovate, and asked, ‘what’s the worst that could happen if you innovate? You’ll be asked to stop – that’s it!’ [R12].

Given that there is ‘no bible on how to be compliant’, as one person-in-charge put it, a number of persons-in-charge said that they challenged HIQA inspectors and discussed interpretations of the standards that they did not agree with in relation to their centre. One [R2] outlined how an inspector had queried the use of a digital lock on the dining-room door, as the inspector felt it was not good practice to lock residents out of the dining room. However, the person-in-charge explained that one resident with behavioural difficulties would eat the sugar and other food in the dining room, and so it needed to be locked. She wondered would the locked door be criticised in the inspection report, but it was not.

Providers who challenged the inspectors felt that a good relationship with the inspector was necessary to do this. One remarked that her inspector was tough, but also very practical and helpful, and so very beneficial to work with. This led to a

good relationship of trust between the provider and the inspector, and so a good atmosphere in which to be innovative. The provider was of the view that where there was not a good trusting relationship, that individuals could be defensive, which does not lend itself to innovation [R19]. This is consistent with the arguments of responsive regulation that a productive relationship between regulator and regulatee is necessary.

Discussing innovation leads to discussion of the issue of risk, evocatively described by one person-in-charge [R13] as ‘a four letter word’. Eldercare providers have traditionally often tried to reduce risks to the older person (see, e.g. Taylor, 2006). However, as one stakeholder remarked, and as the standards underline, it is up to an older person to decide what they want to do. The next-of-kin cannot decide, and one standards criteria specifically states that an older person can decide to take part in risky behaviour. But sometimes innovations are seen as risky. For example, one person-in-charge [R12] described how he had a turf fire burning in his centre, something that most of the residents would have had in their houses all their lives, and liked. However, he was forced to stop this by a fire-safety officer (this occurred before HIQA was established). In contrast, one HIQA inspector [R18] said that she had no problem with a fireplace, and that it depended on how its use was managed. Were there fire guards, for example, or were staff in the room when a fire was lighting? She also felt that it was positive to have kitchens where residents in a centre can cook or bake, with any risks well managed. Some of those whom the researcher met were of the opinion that the standards did not allow kitchens or kitchenettes that residents could use. But a review of the inspection reports of the 42 centres randomly selected for this study shows that some had kitchens that residents used (e.g. Centre 87). In one centre, the following was noted in the inspection report:

One resident was assisting the chef in the kitchen with the washing up and preparing vegetables. Inspectors noted that this resident wore adequate protective clothing and was supervised by the chef. The resident told an inspector that he enjoyed working in the kitchen and that he also helped outside with painting. He reported that he liked to keep busy and was pleased with the responsibility he was given. However, there was no risk assessment undertaken to identify and control hazards associated with working in the kitchen to ensure the resident’s safety while working in the kitchen. (Centre 375, report of 3–4 June 2010: 16)

Despite the comment on risk assessment, no action was required on this in the list of issues to be addressed at the end of the inspection report, perhaps indicating concern about, but acceptance of, any risks that might be involved. Meanwhile, in a number of centres residents took part in gardening and grew food and flowers for the centre, and this was not seen as problematic by inspectors (e.g. centres 662, 325, 375). Such practices are not widespread but they do exist, and while they may have some risks for frail older people, they also have many benefits. Literature on risk outlines how the focus on preventing physical risk to frail people can prevent them from taking part in activities that provide opportunities for development and learning (Godin, 2004), or indeed enjoyment. As outlined earlier, some of those met

were of the view that there was a lot of scope for more such resident-centred activities in centres.

Nonetheless, although many of the standards do allow innovation as to how they are implemented, there are also a large number where what is required is prescriptive. This is particularly evident in infrastructure requirements, with, for example, the temperature of bedrooms and day rooms set, as well as specific criteria on cleaning rooms, sluice rooms, laundry rooms, size of bedrooms, and communal space (see Appendix B for a list of all standards with fixed minimum criteria).

#### **5.4.4 Interpretation and Consistency**

Although several stakeholders referred to the importance of context in how the standards are interpreted, a number also remarked on inconsistencies in interpretation. Some of those interviewed noted that the inspection reports can make slight differences in how something is done in different residential centres look very big, which should not happen [R13].

There have been a number of reports of inconsistencies in inspection, when comparing different centres across the country and when comparing different inspectors inspecting the same centre (see, Jordan, 2011; Prospectus, 2010), a view that was supported by some stakeholders interviewed for this report [R15, R24]. HIQA also notes that consistency is a big challenge for a regulator – as it is in every country. The fact that the HIQA standards do not provide an exact outline of how they should be met compounds this challenge. But one stakeholder interviewed stressed how important it is for standards ‘not to be arguable with’ (i.e. to be clear what is expected), and for fairness of process to apply. Otherwise buy-in to the standards process risks being lost [R7].

#### **5.4.5 Accountability – The Role of the Person-In-Charge and the Provider**

Meeting with stakeholders as part of this research underlines the key role that persons-in-charge play in interpreting the standards. Persons-in-charge lead on how to implement the standards in their centre, motivating and tapping the knowledge of their staff, and drawing on expertise from a variety of sources in order to interpret the standards correctly and meet them. Their competency must be proven through the Fit-person process in order for the centre to be registered to operate. Their importance is confirmed in an interview with the CEO of HIQA, in 2011:

The person-in-charge is critical. An average provider with an excellent qualified person-in-charge is likely to succeed. An average provider with a poor person-in-charge is not. (Reach, 2011:2)

Effective persons-in-charge can be what Sibley (2011) described as ‘sociological citizens’ – those who work beyond compliance and the formal responsibilities for

their role, having a strong commitment to practical rather than perfect outcomes, to experimenting with what might work now, and dealing with different situations as they might arise (see NESC, 2011).

An inspector interviewed as part of this research project [R18] also pointed out the important role of the provider. It is the provider who decides whether or not to spend the money to put in place what is needed to meet the HIQA standards. Although the 1993 regulations outlined that the provider and person-in-charge were both responsible for operation and management of a centre, one person-in-charge outlined how the new HIQA standards had helped to ensure greater provider accountability in this area:

The [previous] owner ... would [only] talk to me for five minutes in the morning or five minutes in the evening but we didn't actually sit down and discuss 'well, this needs to be addressed, this needs to be ...' Whereas at the moment I could go out to the owner and say, 'Well look, the standards say we need to have so many showers in this area, we need so many toilets in this area, we're kind of infringing on their rights if you don't provide this or provide that.' So it's all very straightforward. ... As part of the inspection and the registration process, the owner is brought into it, whereas before the owner just had to be a business man or a builder or something like that. Whereas now he's made aware of a certain amount of his responsibilities. [R9]

The standards strengthen the link between the provider and person-in-charge in private sector homes, but it was felt that in HSE homes the link between the two is quite distant and more fragmented. The person-in-charge of one HSE home compared the direct link between a person-in-charge and provider in a private centre to her own, where she said she had to 'go through so many people to solve a problem' [R2]. A person-in-charge in a private home can talk to the owner to look for funding for, e.g. maintenance, whereas a person-in-charge of a HSE centre may have to wait while such a request goes through several layers of decision-making in the HSE. Another described how, for issues that he could not address himself, he had to 'escalate it up to the LHO [HSE Local Health Office]' [R12].

#### **5.4.6 Balancing Monitoring by 'The Centre' with the Needs of Residents and Providers**

It is interesting to consider how HIQA receives information to help them ensure the quality and safety of care in residential centres. This information is gained through the inspection process, and also through the notification forms (NFs) on significant events, which centres complete and return to HIQA. As noted in Section 3.3.2, residential centres have to notify a number of organisations of such events. For example, for a death, they must inform HIQA, as well as the coroner and the HSE among others (in fact, the duplication of such reporting is one of the issues being addressed in the current review of the *Care and Welfare of Residents in Designated Centres for Older People Regulations*, 2009). One person-in-charge wondered how useful returning these forms was:

If [we] had five 68-year-olds after dying in the last three months, I'd be getting suspicious, I wouldn't need HIQA to tell me ... [R9].

However, return of the NFs allows HIQA to monitor quality of care in residential centres in a timely way, and the requirement for this data to be sent to HIQA answers a need identified in a review of complaints about care in the Leas Cross nursing home. One of the recommendations that the group reviewing this case made, 'to prevent similar situations emerging in other nursing homes', was that 'A central registry should be developed to collate data from the nursing home inspectorate and to identify poorly functioning nursing homes' (Commission of Investigation Leas Cross Nursing Home, 2009:201–202). The return of NFs to HIQA allows this.

Similarly, in Section 4.1 above, the person's-in-charge dislike of anonymous complaints about care in their centre was outlined. However, the ability of anyone to make an anonymous complaint to HIQA also addresses a need identified in the Leas Cross report. That report shows that prior to the Health Act 2007 and its accompanying regulations and standards, it was HSE practice to only investigate complaints when they were made by a resident or their relative. As a result, a complaint by the principal social worker of Beaumont Hospital about the care of a patient who had since died in Leas Cross was not investigated by the HSE. Therefore, the Leas Cross Commission stated that:

the Commission considers that it should be understood that the purpose of investigating a complaint is ... to ensure that all residents receive adequate care and that problems do not recur. Accordingly, the source of a complaint is largely irrelevant and the H.S.E. has a duty to investigate any credible allegation regarding the care of nursing home residents. ... The Commission considers that it would be preferable to provide more clearly that a complaint may be made by any interested person. (Commission of Investigation [Leas Cross Nursing Home], 2009:182).

A complaint that can be made anonymously addresses this problem identified in the Leas Cross report.<sup>74</sup> It, like other changes made to the regulation of residential centres following the Leas Cross report, is an element of triple-loop learning, whereby 'regulators and oversight authorities learn from monitoring ... and [subsequently] revise their strategy for the entire field' (NESC, 2011:37).

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<sup>74</sup> However, HIQA does not have the power to investigate individual complaints. Instead it considers whether the information given to it indicates that a centre does not comply with the regulations, and so could put all residents at risk, and takes action based on this (see <http://www.hiqa.ie/legal/concerns> [accessed 10 April 2012] for further information). One respondent [R28] noted that this leaves a gap, as the HSE can investigate complaints about care of an individual in an HSE-run centre (and the issue can be referred further to the Ombudsman, if necessary), but no State organisation has jurisdiction to investigate complaints about the care of an individual in a privately run centre, where, for example, use of the centre's complaints procedure has not resolved the issue.

These examples illustrate the complexities of balancing the needs and responsibilities of different actors in this standards framework. While some of the requirements under the new standards framework can be difficult for persons-in-charge, nonetheless they do provide HIQA with information that helps it identify centres where care is not good, so that it can focus its resources there, and so improve quality of care for these older people.

## 5.5 Addressing Costs While Improving Quality

### 5.5.1 What Are the Key Costs Associated with Implementing the Standards?

#### *Costs Reported by Residential Centres*

Stakeholders interviewed for this research outlined a number of costs associated with implementing the HIQA standards. A survey commissioned by NHI showed that by early 2010, the cost to date of meeting the changes required following HIQA inspections had been on average €77,872 per NHI member centre (NHI, 2010; and presumably other costs have been incurred in the following two years). The main costs reported by persons-in-charge and providers were meeting the physical environment and staffing standards, and the amount of time it takes to implement new systems and come up with solutions to meet the standards requirements.

For example:

[What would be the main cost for you in meeting the HIQA standards?] Staffing... out and out staffing, no doubt about it... it's absolutely a huge cost.... eight years ago we had a lot more patients and we had fewer staff. [R9]

Staff training requirements, and associated costs, have also increased:

There's more emphasis nowadays too, on training, whereas [in the old days] one or two might get a study day once a year, whereas now there's a lot of stuff on say, challenging behaviour and infection control and FETAC level courses. [R9]

Another provider in a privately run centre noted how she had paid €120,000 'and that's just set-up costs – just "stuff" I bought, the costs of meeting some environmental and physical standards – I had to buy radiator covers and thermostatic valves on taps; and there were some additional training costs'. She noted that as HIQA did not provide specific guidance, but required providers and persons-in-charge to think it through themselves, that she had three managers working on this, which was 'a huge overhead'. [R19]

This provider also noted that the €120,000 she had spent did not include management or staff time; and all persons-in-charge spoke about the extra time



which they had worked, and often their staff also, to prepare for registration inspections, and to address requirements arising from these.

The costs of meeting the physical environment standards can be large also. HIQA (2012) shows that the regulations on premises were those most often breached, with 80 per cent of centres breaching at least one of these regulations. Lack of visitor space, and inappropriate arrangements for smoking were common breaches (40 per cent of centres); followed by inadequate sluicing facilities (26 per cent of centres); inadequate storage space for residents' property and possessions (18 per cent of centres); inadequate physical design and layout (20 per cent); and inadequate private and communal space for residents (10 per cent). A report commissioned by the Department of Health as part of a regulatory impact assessment of the standards estimated that it would cost €3bn for all centres to meet the standards (PA Consulting Group, 2009).

Some estimate of the overall actual costs of implementing the standards, and inspecting to ensure they are met, can be gauged by considering the compliance costs incurred by residential centres, and the expenditure incurred by HIQA in inspecting these. These can be estimated at approximately €54.5 million in 2010<sup>75</sup>. In that year the State spent €1.027 billion on the provision of residential care to older people (HSE, 2011, Comptroller and Auditor General, 2010), and so the estimated initial cost of implementing the standards is 5.3% of that State spend. More accurate data is available on the costs for private residential centres. These show that the average cost for these centres to meet the initial changes required to comply with the standards equated to 4.5% of average annual turnover in 2009-2010<sup>76</sup>.

### ***How Do These Costs Compare Internationally?***

It is difficult to find similar international data with which to compare this. One United States study found that federal and state funding on the agencies that implement regulations for residential centres for older people was equivalent to 0.4% of all spending on these centres (Walshe, 2001). However there was variation – while on average a state spent \$24,247 to survey a centre, this ranged from \$8,577 in West Virginia to \$80,440 in Delaware (Walshe & Harrington, 2002). In addition it has been argued that the average state and federal spend on this is too low (Wiener, 2003, Walshe & Harrington, 2002). Irish data shows that the

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<sup>75</sup> If the average figure of €77,872 spent by the NHI member residential centres to meet the standards in their first eight months of operation (July 2009 to February 2010) (see NHI, 2010) is extrapolated to all 594 residential centres in operation at the time, then a cost of €46.3 million was incurred by the centres. Meanwhile in 2010, the expenditure of HIQA was €16.3 million (HIQA, 2011), and given that HIQA have a variety of functions, it is estimated that approximately half of HIQA's budget for that year was spent on inspection of residential centres for older people, so approximately €8.2 million. These two figures add up to a cost of €54.5 million.

<sup>76</sup> Data from the NHI Annual Private Nursing Home Survey 2009/2010 (NHI, 2010) shows that total average annual turnover of registered beds in the 447 NHI member centres for 2009-2010 was €768,218,912. This is compared to the total average cost for centres to meet the changes required by the standards in their first eight months of operation, which at €77,872 per centre for the 447 centres, is €34,808,784. This represents approximately 4.5% of total average annual turnover.



inspection costs of HIQA amount to approximately 0.8% of State spending on residential care for older people<sup>77</sup>, a figure not as low as the mean incurred in the US, but a very small proportion of the overall spend on residential care for older people; and also possibly more adequate, given that the average US costs were considered too low. The Walshe (2001) study also noted that no data was available on the costs borne by centres to meet the standards, but Zhang & Grabowski (2004) suggest that the indirect costs borne by residential centres as part of the inspection (such as interacting with the regulator, preparing for inspections, gathering and providing data) were likely to be greater than the direct costs to the State; and the comments of stakeholders interviewed for this NESC research indicate that this is likely to be the case in Ireland also.

It is interesting to consider here the relationship between regulation, quality improvement and costs. Most of the research on this issue has been carried out in the US, where comprehensive data exists to link costs, level of regulation and quality in residential centres<sup>78</sup>. Such data does not yet exist in Ireland, so it is not possible to know to what extent these aspects of the Irish residential care sector are similar to that in the US. Nonetheless, there are likely to be some parallels.

The US research on the relationship between regulation, costs and quality tends to look only at the relationship between two of these factors (e.g. between regulation and costs, or between costs and quality), but nonetheless it points to a number of trends overall, as follows:

- First, it seems that more stringent regulation costs more;
- Second, regulatory requirements can be associated with an increase in quality; and
- Third, higher quality care does not necessarily cost more.

More detail on each of these three trends is outlined in the following sections.

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<sup>77</sup> As noted above, in 2010, the HSE spent €1.027 billion on residential care for older people, and it is estimated that approximately €8.2 million was spent by HIQA that year on inspection of residential centres for older people, which is 0.8% of the HSE spend.

<sup>78</sup> This is due to the existence of the OSCAR (Online Survey Certification and Reporting) system, which includes over 700 items of data on nursing homes which receive funding from Medicaid (96% of all nursing homes in the US). This information covers the health status of residents, the operation of the centre, and its regulatory compliance, and is updated annually (see Park & Stearns, 2009).

### 1. *The costs of regulation*

On the first point, the costs of regulation, Mukamel *et al.* (2011)<sup>79</sup> found that in US states with more stringent regulation<sup>80</sup> of residential centres for older people, the total annual expenditure incurred by these centres was higher than in states with less stringent regulation. However, another study noted that the majority of costs incurred in a residential centre exist regardless of the quality of care provided there, given the large amount of basic care and services that must be provided in any case (Hicks *et al.*, 2004)<sup>81</sup>.

### 2. *Regulatory requirements can be associated with an increase in quality*

On the second point, a number of researchers have shown that some requirements of regulation are associated with an increase in quality (with quality usually judged as the quality of health of residents<sup>82</sup>). Particularly strong associations have been found between the health of residents and staffing levels, with higher staffing leading to higher quality of care (Castle, 2008; Bostick *et al.*, 2006)<sup>83</sup>. This association also shows why more stringent regulation can be linked to higher costs – not surprisingly Mukamel *et al.* (2011) and Knox *et al.* (2003)<sup>84</sup> found that costs increase with staff wages. Long term care in residential centres is very labour intensive, and so the inputs of staff are an important component of quality. For example, pressure ulcers can often be prevented or resolved by frequently repositioning bedbound residents, but this is labour-intensive. Centres which have continence training programmes and practices also have less incontinent residents, but these practices can be labour-intensive also (see e.g. Zhang & Grabowski, 2004). It is particularly nurse staffing which has been found to lead to higher quality care (see e.g. Rantz *et al.*, 2004); with registered nurses and nurse assistants more likely to be associated with better quality care (Spilsbury *et al.*, 2011)<sup>85</sup>.

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<sup>79</sup> This study looked at the costs for 11,168 residential centres for older people in all US states.

<sup>80</sup> In the US, federal law requires certain minimum standards in residential care centres, but individual states can also require higher standards than this, and many do, although these requirements vary. For example, a minimum number of staff hours per resident per day is set in 39 states, ranging from 1.76 staff hours per resident per day in Oregon, to 3.6 hours in Florida (Castle, 2008).

<sup>81</sup> This study assessed cost and quality of care in 446 residential centres for older people in Missouri.

<sup>82</sup> This is because the key databases on care in US nursing homes contain little data on quality of life issues.

<sup>83</sup> The Castle (2008) study reviewed 70 studies that looked at the relationship between staffing levels and quality in residential centres; while Bostick *et al.* (2006) reviewed 87 research articles and government documents on the same topic.

<sup>84</sup> This study looked at costs in the 1002 residential centres in Texas.

<sup>85</sup> This article reviewed 50 studies assessing the relationship between nurse staffing levels and quality of care for residents in residential centres for older people.

More specifically, Zhang & Grabowski (2004) found that the quality of residents' physical health in 22 states<sup>86</sup> in the US increased in the three years following introduction of stronger regulation and specific requirements on staffing in 1990<sup>87</sup>. They found that the improved quality of health was associated with increases in staffing, many of which were required by the regulations. A direct link between increase in staffing and improved quality was however only evident in centres which had had substandard staffing levels prior to the introduction of the stronger regulations. Park & Stearns (2009)<sup>88</sup> also found that regulations on staffing levels most strongly affected centres which had previously had low staffing levels.

### **3. Higher quality does not necessarily cost more**

On the third point, studies on the link between quality and costs show that the relationship between quality of health care and costs in residential centres varies – at first, as quality increases, costs rise; but then both plateau off, and then costs begin to fall while quality stays high (Mukamel & Spector, 2000)<sup>89</sup>. This has been noted by a number of authors, for example Zhang & Grabowski (2004), Hicks *et al.* (2004), and Knox *et al.* (2003). Spilsbury *et al.* (2011) summarise Donabedian's (2003) arguments on reasons for this. Donabedian outlines that a certain threshold (such as staffing) has to be passed for improvements (such as quality) to be observed. However there is also an upper threshold so that even though more resources are available, improvements will become relatively smaller and eventually reach a point where no further improvements are evident despite increased resources.

What are the reasons for this? They are related to some of the findings on the link between staffing and quality. Zhang & Grabowski (2004:20) note that 'staffing may be a necessary, but not sufficient, input toward achieving greater quality. Many desirable outcomes may require not only additional staff but better care practices in general'. In fact quite a number of management and care practices are likely to influence costs and quality. For example, the management of staff can be very important, with staff turnover, use of agency staff, workforce morale and education level all influencing the quality of care given by nursing staff (see e.g. Hicks *et al.*, 2004). High staff turnover reduces continuity of care, which decreases quality of care for residents (Bostick *et al.*, 2006). And from a management point of view, replacing and training new staff increases costs. Several studies have also shown how other management practices are associated with higher quality. For example,

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<sup>86</sup> Twenty-two states were looked at, as the researchers were only able to access data allowing comparison of quality and staffing, both pre- and post- regulatory change, for 22 states.

<sup>87</sup> The US Nursing Home Reform Act, which began to be implemented in 1990, requires that a registered nurse be on duty at least 8 hours a day; that auxiliary nurses be on duty 24 hours a day; and that there be a registered nurse as director of nursing. Nurses' aides are also required to receive a minimum of 75 hours of training. 'Sufficient' staff must also be employed, although 'sufficient' is not defined.

<sup>88</sup> This study compared the 16 US states with staffing standards in excess of the federal requirements to other states, using data for 15,217 residential centres.

<sup>89</sup> This study looked at data from 525 private and public nursing homes in New York state (84% of all centres there).

Rantz *et al.* (2004) compared the costs and quality of care processes in a range of centres which rated highly, average, and poorly on resident outcomes<sup>90</sup>. They found no statistically significant difference in costs between the three different groups of centres; and in fact the centres with the best resident outcomes had lower costs than the centres with the poorest resident outcomes. They also found no significant differences in staff hours, staff wages, or staff mix. Instead leadership and basics of care were key variables explaining the differences in quality. The directors of nursing, and the administrators, in the centres with the best outcomes were much more likely to have been in their jobs for at least five years than those in the centres with the poorest outcomes. Most of the centres with the best outcomes had active quality improvement programmes in place, and they also used collaborative decision-making more. In terms of care processes, Rantz *et al.* found a number of significant differences, which are worth outlining in detail here, as they contribute to higher quality for lower cost.

First, the 'good' centres often used risk assessment procedures to identify risk and to help make decisions about care. Assessment processes that involved follow-up by a registered nurse (results-oriented leadership) were also common. The researchers also observed staff in the facilities with good outcomes carrying out key care delivery processes to promote good movement, nutrition, hydration, continence and skin care for residents. For example, to ensure that residents ate well and so did not lose weight, staff in these centres were using the following practices: serving appealing food, providing choice of food and using attractive presentation, using tables and chairs of the correct height so that residents could easily reach their food and drinks, and using more adaptive devices to help residents eat and drink independently. Staff also helped residents to eat and drink, and those who needed to be fed were helped with a ratio of one or two residents per staff member. In centres with poor outcomes, staff fed more than two residents at a time, and in many cases, more than five or six residents at a time. It appears that staff in good centres organised their work so that more staff would be available to assist residents at meal times. Not surprisingly, in these centres, there were fewer residents being tube-fed, or suffering problems due to de-hydration, than in the centres with poor quality outcomes.

The researchers also found that in the good centres they were able to discuss with staff what the care processes were supposed to be, and then see them carrying out these processes. In centres with poor care outcomes, staff described what care processes they were supposed to be implementing, but they were *not* observed actually carrying these out. It was also common in these centres to see a disconnect between the care processes which the administrator and director of nursing described nurses' aides carrying out, and the care processes which the nurses' aides actually carried out.

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<sup>90</sup> They used Missouri state databases to identify resident outcomes and costs in residential centres, and from this divided the centres into three groups - those that performed well, average, and poorly, on resident outcomes. They then assessed the quality of care processes through participant observation in a random sample of centres from the three different groups.

Rantz *et al.* argue that the key differences here are nursing and administrative leadership. Good nursing leadership ensures that the right processes of care are actually being carried out for residents. Team and group processes are important in ensuring that this happens. If these factors are in place, along with a quality improvement programme, then they found that the essential basics of care are more likely to be implemented, providing better outcomes for residents.

Other studies have also found a link between higher quality care and collaborative work practices. An evaluation of the Wellspring model of quality improvement adopted in a number of Wisconsin residential centres found that cross-disciplinary training and team working were again associated with higher quality and reduced staff turnover, compared to other centres (Stone *et al.*, 2002)<sup>91</sup>. This study found that implementing these practices was cost-neutral. And Anderson *et al.* (2003)<sup>92</sup> also found that higher quality care was associated with collaborative leadership, good communication skills of managers, results-oriented leadership, and longer tenure of directors of nursing and other managers.

There are also some interesting findings on the link between ownership status and quality of care in the US, where approximately 68 per cent of residential centres are for-profit, 26 per cent non-profit<sup>93</sup>, and 6 per cent publicly-owned (Amirkhanyan *et al.*, 2008:334). It has been found by several authors that non-profit residential centres there have higher quality care than for-profit centres (see e.g. Grabowski & Hirth, 2003, Knox *et al.*, 2003, Amirkhanyan *et al.*, 2008)<sup>94</sup>. On the other hand, non-profit centres have higher costs (Knox *et al.*, 2003). These findings can be related to the fact that for-profit centres have lower nurse staffing levels than non-profit centres (Harrington *et al.*, 2001)<sup>95</sup>. A possible reason for the lower quality and staffing in the for-profit centres is that there are more residents whose fees are paid by Medicaid<sup>96</sup> in these centres, and Medicaid payments are generally low. Another reason proposed is that resources are diverted away from clinical care and towards profits (Harrington *et al.*, 2001). On the other hand, a study of residential centres in Texas found that as quality of care increases, centre profitability increases (Knox *et al.*, 2003). The authors argued that this is because centres with high quality of care have higher occupancy rates, and as occupancy rates rise, the centre's actual costs drop, which boosts its profitability. So again, the literature suggests that while higher quality can be related to higher costs, that this is not necessarily the case, and that a range of other variables (in this case, the level of Medicaid payments, and occupancy rates) also influence the relationship between costs and quality.

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<sup>91</sup> This evaluation compared outcomes in the 11 centres using the Wellspring model with the outcomes in all Wisconsin centres, both pre- and post-implementation of that model.

<sup>92</sup> This study looked at management practices and resident outcomes in 164 Texas residential centres for older people.

<sup>93</sup> These centres are often affiliated to a religious or charitable organisation.

<sup>94</sup> Grabowski & Hirth studied data for 16,978 US residential centres for older people; while Amirkhanyan *et al.* analysed data on 14,123 centres.

<sup>95</sup> This study analysed data for 13,693 US centres.

<sup>96</sup> A federal system of health insurance for those requiring financial assistance.

A final interesting point on the relationship between quality and ownership status is that an increase in the market-share held by non-profit centres has been found to result in an increase in quality of care in all centres. This is argued to be because the consumer is educated to know that higher quality care is available from non-profit centres, which incentivises for-profit centres to increase quality (Grabowski & Hirth, 2003).

There are also suggestions on how other management practices can reduce costs while maintaining quality. For example, Knox *et al.* (2003) suggest that increases in quality may reduce the costs of correcting 'poor care' problems (for example, the costs of treating pressure ulcers are high (Bennett *et al.*, 2004)), while also reducing litigation and insurance costs, and fines.

### **Summary**

This literature therefore suggests that where regulation requires certain factors which improve quality to be put in place, this can increase costs, although the majority of costs incurred in a residential centre still exist regardless of the quality of care provided there. In addition, higher quality care does not necessarily cost more than lower quality care, and here a range of factors come into play. Leaders who are experienced and results-oriented, and who communicate well and use collaborative management styles are important; as are good care processes, low staff turnover, non-profit ownership, a good reputation for quality, high occupancy levels, and a higher proportion of non-profit centres in the local market. These factors have all been found to promote good quality care, without necessarily incurring higher costs. These findings suggest that sharing learning on how to implement good practice is important, as not only can it help to increase the quality of care in all centres, but it can also help to reduce the costs of increasing this quality. Sharing learning is something which HIQA could support. Specifically, learning could be shared on the following – communicative and collaborative management, results-oriented leadership, design and implementation of good care processes, and information on how to reduce staff turnover. The findings from the literature also support the requirements in the Irish standards for experienced clinical leadership and for the fit-person process to assess the competency of managers, as well as HIQA's focus in inspections on assessing the follow-through from policies on care processes to actual practice, as all of these have been shown to increase quality while reducing costs, in US studies. The findings also suggest a role for the Department of Health in ensuring a balance of providers, as a higher proportion of non-profit centres in local areas in the US has been shown to promote higher quality care in neighbouring for-profit centres. Meanwhile, the HSE can play a role in ensuring that the InterRAI single assessment tool pilot (see Section 5.3.5) be rolled out nationally. This assessment tool uses a common format to assess the dependency levels of older people and would be able to generate comparable data to show the outcomes from different types of care. The collection of such data may be useful in assessing the costs and quality of different types of care in Ireland, as the OSCAR data in the US currently does.

While Ireland does not yet have data available to carry out the type of analyses done in the US on the costs and quality improvement linked to regulation, the

finding that implementing the Irish standards has economic costs is balanced by the unanimous view of those interviewed for this research that the standards are a positive development. The standards are seen to have restored confidence and improved care in this sector. This links to international findings on costs and quality of regulation in this sector. A number of international reports argue that at a broad level, introduction of regulation has increased the quality of care in residential centres (see for example, on the US and Australia, OECD, 2005, Wunderlich & Kohler, 2001), and it can be seen that in many countries, not just Ireland, regulations on residential care have become more comprehensive in recent times (OECD, 2005), suggesting that they are seen as effective. In addition, authors such as Leatherman *et al.* (2003) outline that there are different ways in which implementing quality improvements can yield a return on investment. The ‘business case’ for improvement is that there is a financial return on investment, for the investor, within a reasonable time frame. The ‘economic case’ is that the financial benefits exceed the costs, but the benefits may accrue to patients, providers or some other segment of society. In addition, the benefits may occur several years after the initial investment. There is also the ‘social case’ for quality improvement, which is the benefit to the patient or to society of improved health, regardless of cost. Applying these ‘cases’ to the costs of implementing the HIQA standards indicates that they yield business benefits (a better, more attractive service), as well as economic and social benefits (greater quality of life for older people), particularly over the longer term.

### 5.5.2 Different Cost Challenges for the Public and Private Sector

When the HIQA standards were being drafted, the Department of Health commissioned a report which estimated that the costs of upgrading the physical infrastructure of the HSE-run centres would be up to €1.8bn (PA Consulting Group, 2009). In line with this, the National Development Plan 2007-2013 outlined that €5bn would be invested in residential care for older people over the period of the plan (Government of Ireland, 2007). However the recent economic downturn is causing difficulties in sourcing this funding, and many of the public centres also face difficulties in staffing, due to the embargo on recruitment of public sector staff. One HSE person-in-charge said that she had only one clerical officer to deal with the paperwork required under the standards, and that she would like more [R2]. Another outlined how he used to be able to send a staff member into town with a resident to do their Christmas shopping, but this was not possible any longer due to non-replacement of staff who had left. A number of HSE persons-in-charge (and inspection reports for their centres) outline that the ‘solution’ to the embargo on staff recruitment is to reduce the number of residents in the centre. However the US experience (outlined in Knox *et al.*, 2003) suggests that this reduced occupancy may actually lead to higher costs.

As noted in Section 5.2, stakeholders interviewed as part of this research were concerned that HSE-run centres might be closed as the economic downturn left the State less able to afford the costs of upgrading these centres to meet the HIQA standards, particularly the environmental standards, which had to be met within six years. These concerns have been confirmed by announcements of closures of HSE-



run homes in late 2011 (Mac Connell, 2011a). Reasons given by the HSE include reduced financial allocations, reduced staff numbers due to the public sector staff moratorium, and difficulties in meeting the HIQA standards (Breaking News, 2011). However, at least one of the centres due to be closed does meet all the HIQA standards (Mac Connell, 2011b). It has since been clarified by the Minister for Health and the HSE that while it would cost €600-900 million to bring the 30 per cent of public sector beds which do not meet the required standards up to those standards, that centres with less than 50 beds are difficult to maintain from a financial point of view<sup>97</sup>. The cost per patient per day in private centres (at €850) is also less than in the public system (at €1,350-1,400) (Mac Connell & Carolan, 2011). So, there seems to be a range of reasons why the HSE is deciding to close these centres. Meanwhile, the Minister for Health has requested the HSE to draw up a viability plan for its residential centres for older people. The aim is to identify the maximum number of beds and public residential centres which could be retained within existing available financial and staffing resources. The HSE has identified a small number of homes that may have to close in 2012. The CEO of HIQA, in a discussion with the Oireachtas Committee on Health and Children in January 2012, outlined how it is entirely up to a provider, be they private, public or voluntary, to close a centre<sup>98</sup>.

Those interviewed were not of the view that all residential centre care should be provided by the private and voluntary sector [R1, R10, R20]. A mix of both public and private care was seen as best (by those from both the public and private sectors). This view is backed up by US research (Grabowski & Hirth, 2003) showing that a higher proportion of non-profit residential centres in an area is associated with increased quality of care in all centres in that area. It was also suggested that the HSE could provide more step-down facilities, with more medical care, which is higher-risk, and which some private sector providers are reported to be less interested in providing. Certainly, the *Long Stay Activity* figures published by the Department of Health (2011) show that private centres had a higher proportion of low and medium dependency residents than public centres. Others felt that all care should not be based in centres which have to make a profit. In this regard, the HSE operates a number of centres in isolated rural areas with low population numbers, where it might be difficult for a private-sector provider to run a financially-viable business. Another reason given for the HSE continuing to run residential centres was that under the Health Act, 2007, they are required to take over the running of residential centres which are refused registration by HIQA. This means that the HSE needs to maintain its expertise in this area. It was noted that there is no articulated vision of what mix of public and private centres should exist. This makes it difficult for all sectors to plan for future provision. Certainly, the recent announcements of closures of HSE-run centres mean that in the long-term an increasing proportion of centres which meet the standards will be located in the private sector. But the US

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<sup>97</sup> In this case, it is worrying to note from HIQA (2012) that 73 per cent of centres in 2009-10 had less than 50 residents.

<sup>98</sup> See <http://debates.oireachtas.ie/HEJ/2012/01/19/printall.asp>, accessed 23 April 2012.



experience indicates that public and non-profit centres incentivise for-profit centres to compete more on the basis of higher-quality care (Amirkhanyan *et al*, 2008), and while no data currently exists to show if this is the case in Ireland also, it does suggest that there is value in having a range of models of care provided by centres run by both for-profit and non-profit organisations. Amirkhanyan *et al* (2008) also show that public centres had a significantly higher proportion of those receiving Medicaid financial support, which suggests that a range of ownership models may be important to ensure access for all groups to residential care.

In the meantime, the lack of funding for public sector centres means that some are finding innovative ways to raise money, such as fundraising through charities set up for them by a local voluntary group. For example, in centre 525, a charity for the centre had raised money which has been used to build a secure sensory garden for residents, and to install a video link to local church services (Centre 525, Inspection report for 1-2 December 2009).

### 5.5.3 Cost Contradictions

So, despite significant improvements in the funding arrangements for residential care (through Fair Deal), and in the framework to support quality in this care (under the Health Act 2007), there are several contradictions in how the care infrastructure for older people is organised and funded. These have implications for the quality of care provided. Some of these contradictions have been outlined in Section 5.2 earlier, for example:

- Fair Deal funding does not cover the costs of all requirements under the HIQA standards; and
- The NTPF pays the same rate per older person cared for under Fair Deal, even though their care needs differ.

Some of these issues will be considered in the review of Fair Deal which will be carried out by the Department of Health later in 2012.

Other contradictions, for example, provision of ancillary services to older people in residential centres, and difficulties in moving older people from hospital to more suitable care due to budget rigidities, are being addressed under the HSE's 2102 Service Plan.

Added to this is the issue noted in this section, that some HSE centres providing good quality care could be closed due to costs and lack of financial viability.

HIQA inspectors have noted that these contradictions are arising, and point out that it is the role of the HSE and the Department of Health to look at these strategic issues. The Department is considering some of these issues, for example, it is examining the overall issue of access to community services, their sustainability, and charging for them. Its review of the Fair Deal scheme will also consider the balance of funding between residential and community care.

These problems raise the important issue of the combined effect of the decisions of the main actors in the standards framework, particularly the providers, HIQA and the Department of Health. Regularly sharing key information is likely to support a type of 'fourth loop learning', whereby strategic issues beyond the remit of only the regulator are identified and planned for (see Section 1.3 for a definition of triple loop learning). It could therefore be useful to establish a problem-solving group of those influencing the provision of long-term care (e.g. providers, the Department of Health, and HIQA) to examine and address the challenges of providing sufficient quality long-term care in an equitable and sustainable way.

# Chapter 6

## Summary and Conclusions

This final chapter summarises how the *National Quality Standards for Residential Care Settings for Older People in Ireland* are relevant to the five key themes of this NESC project, which are – responsive regulation (which is how implementation of quality standards is encouraged by a balance of sanctions and supports); the role of the service user; learning; devolution and accountability; and addressing costs while improving quality. The three over-riding questions posed in the Overview report (NESC, 2011) are then addressed in relation to the HIQA standards framework. These are – how convincing is this regulatory and standards framework? To what extent does it a) prevent the most serious harms, and b) promote quality? And – are there things in this standards regime which need to change to ensure the provision of quality services?

## 6.1 Responsive Regulation

In terms of responsive regulation, the regulatory framework of the standards for residential centres is underpinned by powerful sanctions, which HIQA has used where necessary, closing approximately 10 centres (out of 594) to date. Meanwhile, HIQA encourages managers of residential centres to think through how they should apply the standards themselves, to avoid a ‘tick box’ approach to standards implementation; but this means that HIQA does not prescribe ways to meet the standards, or provide supports to managers on this. However, other organisations do provide such supports, including private companies, Nursing Homes Ireland (a representative group for private and voluntary sector centres), and the HSE (in particular for the centres which it runs and manages). These supports include training and information days, as well as longer term intensive work with residential centres to change their management and day-to-day work practices in order to meet the new standards.

## 6.2 Involvement of the Service User

These standards require much greater consultation with, and agreement from, the resident with regard to many aspects of their care. Residents’ committees are mandatory, and persons-in-charge are required to address issues raised by the committees. There is also a strong emphasis on the procedures for residents (and others) to make complaints; and a more person-centred approach to care is promoted. Money now ‘follows the patient’ to a greater extent than in the past, due to the advent of the Fair Deal scheme which pays the majority of the costs of

long-term residential care, in a public, private or voluntary sector centre, for those who are assessed as in need of such care. However, older people are not free to decide how to use that funding - for example, it must be used for residential care, and cannot be used to pay for care in their home, even if they would prefer to be cared for at home. The balance of funding between residential and community care, and the extension of Fair Deal to other sectors, are however issues which will be considered in the Department of Health's review of Fair Deal in late 2012. Another important issue is that it is not clear how the costs of ancillary services, equipment or therapies for older people in residential centres will be covered. Technically, some of these costs are covered under the medical card, but due to limited public provision, older people can end up having to pay for these services themselves. The HSE has set up a group to address this problem.

### 6.3 Monitoring and Learning

In terms of learning, there is an emphasis on continuous improvement within each individual centre in the standards and regulations. Using a meta-regulation approach (i.e. the regulation of self-regulation), each centre is required to collect data on risks (such as falls, pain, pressure ulcers, use of restraint, etc), and to put in place mechanisms to reduce these risks. A number of residential centres also meet informally to share learning, but as noted earlier, HIQA does not play a strong role in this. Instead the HSE, private companies and industry associations provide opportunities to share learning. This means that the range of practices with which HIQA is familiar, and could share, is not being made available to residential centres. At a more strategic level, a review of the operation of the regulations for the residential centres has been carried out by the Department of Health, and the regulations will be updated on the basis of this review. HIQA does meet with the HSE, the Department of Health, and Nursing Homes Ireland on a regular basis.

### 6.4 Devolution with Accountability

With regard to devolution and accountability, there can be a tension between setting standards at a central level, and encouraging service providers to be innovative at local level. However, stakeholders interviewed were of the opinion that while the standards provided a baseline, that they also encouraged and provided space for innovative practice and continuous improvement. Innovation was considered more likely to occur where the person-in-charge and inspector respected and trusted each other. The standards were also considered to make owners more accountable; and while a number of persons-in-charge disliked the new complaints procedures, and wondered about the value of reporting significant incidents in their centre to HIQA, both of these requirements ensure greater focus on, and protection of, the resident.

## 6.5 Addressing Costs While Improving Quality

Those interviewed for this project, and the results of surveys, all show that there are costs involved in implementing the standards, ranging from the cost of purchasing new equipment/adjusting premises, to the cost of employing extra staff. For HSE-run residential centres, staff embargos and reductions in funding pose particular challenges, and are leading to some HSE-run residential centres being closed, which clearly can have negative impacts on residents. Persons-in-charge also reported that ramping up to meet the standards, and revising policies and procedures on an on-going basis, takes a significant amount of their time. On the other hand, they welcomed the increased confidence that the standards provided for care in the sector; and all stated that overall the standards are a positive development. It seems that the cost of implementing the HIQA standards yields business benefits, and that there are also wider social benefits for older people and their families. Meanwhile, review of comprehensive data from the United States shows that the costs of regulation and quality improvement in residential centres can be reduced, and indeed can cost less than provision of lower quality care, through use of practices such as results-oriented leadership, collaborative management, reductions in staff turnover, and implementation of key care processes.

## 6.6 How Convincing is this Regulatory, Standards and Quality Assurance Regime?

This review of the development and implementation of the HIQA standards framework shows that this new framework is considered much more convincing than the previous one in assuring good standards of care for older people. The focus in the standards and regulations on the quality of life of the resident is particularly welcomed; and the audit and review processes put in place, while not always popular, are often seen as good practice. The existence of the independent inspectorate, HIQA, and the range of enforcement powers that it has under the Health Act 2007, and which it uses, are believed to have increased the quality of care in residential centres for older people.

## 6.7 To What Extent Does This Regime Prevent the Most Serious Harms/Abuses?

This standards framework was put in place following the scandal around substandard care in the Leas Cross nursing home, and there is a strong emphasis in the framework on preventing the most serious harms and abuses. This is evident in the legislation and standards, in the independence of HIQA, and in the strong enforcement powers which it has and uses.

## 6.8 To What Extent Does This Regime Promote Quality Improvement?

As well as aiming to prevent serious harms, the new framework also aims to promote quality improvement. It provides a good example of meta-regulation, with the standards requiring residential centres to install systems of monitoring and self-regulation, which are then inspected by HIQA to ensure that these are operating well. These internal monitoring systems are put in place to identify risk and so prevent serious harms. Service-users also must be consulted, and the standards and the inspection process aim to change the culture of care in all residential centres from task-based to person-centred. Processes such as user consultation, residents' committees, advocacy, and person-centred approaches to care such as the Teaghlach model and others, all aim for co-production of services by resident and provider, to a much greater extent than previously. These processes all aim to promote continuous improvement in services.

Some of the learning and continuous improvement processes, such as the residents' committees, are seen as very successful. Views are more mixed on whether the paperwork required for regular review and internal monitoring of risk is worth the time that it takes, but most persons-in-charge interviewed did feel that there was learning from these processes. Whether or not the continuous learning processes in the standards and inspection regime are the optimum ones to promote learning could be debated, but it is clear that they do aim to promote learning and continuous improvement. However, it was suggested that learning could be improved if HIQA provided guidance on best practice, which could help more centres to attain higher standards of care.

The promotion of learning within residential centres also underlines the key role of the person-in-charge as an interpreter of the standards. Persons-in-charge are required to come up with their own solutions in order to meet the standards' requirements as they apply to the residents in their centres. In an example of smart regulation, persons-in-charge draw on the resources of a range of bodies, with a variety of private companies, trade organisations and others, providing supports to residential centres to assist them to meet the standards. Good persons-in-charge are 'sociological citizens', who work beyond compliance and the formal responsibilities of their role, having a strong commitment to practical rather than perfect outcomes, to experimenting with what might work, and dealing with different situations as they arise. The key role of the person-in-charge is recognised by HIQA, who requires them and the provider to be assessed as fit to run the residential centre, before it can be registered.

## 6.9 Are There Things in This Regime that Need to Change to Ensure the Provision of a Quality Service?

A number of changes that could ensure greater provision of a quality service in this area have been identified throughout this report, and the key changes suggested are as follows:

- Sharing learning on best practice;
- Supporting culture change to promote more person-centred care;
- Collecting standardised data to assess the quality and costs of different services; and
- Co-ordinating the decisions of providers, the Department of Health, and HIQA, to ensure that services for older people are provided at an optimum level.

These are outlined in more detail in the following paragraphs.

### 6.9.1 The Need to Share Learning on Best Practice

HIQA relies on the legal enforcement mechanisms which it has at its disposal to ensure that the standards are met. It has expressed interest in providing supports to centres to help them meet the standards, but to date efforts to avoid a conflict of interest, the priority accorded to registration and inspection, and a lack of resources, have meant that HIQA has not concentrated on this area of work. While this means that the resources of the regulator are not unduly over-stretched, a number of residential centre managers have found this frustrating, as it has meant that they have had to devote a high amount of resources to meeting the standards. At the moment, centres learn from private companies which provide such information; and from networks and trade associations. HIQA, however, is in the unique position of having information on every residential centre in the country and how it meets the standards. A mid-way point might be that HIQA could provide summaries of learning, data, and best practice from their inspection work, which could be used by managers of residential centres as examples of ways to continuously improve their services<sup>99</sup>. This would overcome the disadvantages of the current mechanisms of sharing learning – that they are voluntary, and diffuse, rather than applying to all centres. Sabel and Zeitlin (2011) have argued that an effective method of ensuring quality improvement throughout a sector is to have shared agreement on what quality goals are, while allowing local discretion on the ways to meet them. Ideally information about the multiple methods used at local

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<sup>99</sup> The recently published analysis of findings from the inspection reports (HIQA, 2012) provides a base for this.



level to meet the quality goals would then be shared, with co-ordinated learning gained from comparison of different mechanisms. This would involve central and local actors together setting metrics to assess achievement, with local actors reporting performance, and taking part in peer review. Were HIQA to facilitate such a process, and share information on the best methods to provide high quality care, this could lead to greater levels of knowledge of best practice in the sector, which would optimise learning on continuous improvement, and so promote better quality care in all centres. The review of US experience meanwhile indicates that sharing best practice on results-oriented leadership, collaborative management, reducing staff turnover, and implementing key care processes, could also have the benefit of sharing best practice which helps to reduce costs.

The experience of the schools system (outlined in NESC, 2012a forthcoming), provides some ideas for HIQA for sharing learning from inspections. For example, the Department of Education Inspectorate has published *Effective literacy and numeracy practices in DEIS<sup>100</sup> schools* (Department of Education and Science, 2009), a publication which describes, in detail, effective literacy and numeracy strategies used in DEIS schools. How these strategies were devised and implemented is outlined, covering e.g. the time taken to train staff, the new practices carried out by teachers and pupils; and the importance of issues such as leadership, managing change, effective communication, and good training, in driving improvement. Many persons-in-charge of residential centres would welcome such compilations of good practice, to know how they might improve care and meet the requirements of the HIQA standards.

Another option is support for a network to share best practice, involving all residential centres, which could also be useful in ensuring learning is widely disseminated. The Hospice Friendly Hospitals Network, outlined in NESC (2012c forthcoming), could provide a model for such a network. It was set up to share learning and good practice on end-of-life care in acute hospitals. Its membership includes senior managers from all hospitals implementing the *Quality Standards for End-of-Life Care in Hospitals*, and it meets at least three times a year, over two days, to share learning both formally and informally.

Were HIQA to share learning on best practice, this would promote triple loop learning. The first loop of learning occurs when local actors make adjustments to their practices to gain improved outcomes. The second loop occurs when this kind of practical learning is noticed by managers, who alter their systems to include this. Finally the third loop occurs when regulators learn from monitoring the organisation's improved goals and revise their strategy for the entire sector. This could involve disseminating information on best practice to all residential centres. Such practice could help improve standards of care in all centres; and in particular might be helpful in raising the performance of 'mediocre' centres, who may need more support to improve.

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<sup>100</sup> A programme to improve educational outcomes in schools in disadvantaged areas.

### **6.9.2 Supporting Culture Change to Promote More Person-Centred Care**

The standards aim to develop more person-centred care, and this research has shown that this requires a cultural and power shift in how care has previously been organised, which is a challenging and long-term process. Greater use of person-centred approaches, and the full implementation of the Department of Health's (2010) *Review of Practice Development in Nursing and Midwifery in the Republic of Ireland and the Development of a Strategic Framework*, is likely to assist this. It will also require some institutional change, and change in skills sets and how these are applied.

It is also interesting to consider here how the standards, which focus on fine-grained, gradual improvement of existing services in residential centres, relate to more radical change in the nature or conception of care for older people. The Teaghlach model (see Section 3.4.2) or the Dementia Care Matters model (see Sections 3.4.5 and 5.3.2) are such re-conceptions of the care of older people, being more radical models to support older people to direct their own lives in the residential centre which is their home. Such models advocate changes in the physical environment of residential centres (to small centres structured like a home); and resident involvement in day-to-day activities (such as preparing food, cleaning, gardening, and house maintenance); and so overall promote a significant re-orientation from the task-based medical model of care to a person-based model of care. Often the drivers for such new models of care come from beyond national standards and regulation bodies - while being welcomed by HIQA (as outlined in Section 5.3.2). This suggests that for continuous improvement, it may be necessary to have a combination of a) standards and inspection; b) a range of other drivers; and c) an appropriate connection between these two.

### **6.9.3 The Collection of Standardised Data to Assess the Quality and Costs of Different Services**

A common minimum data set that assesses the needs and care of older people, whether at home, in a residential setting, or in an acute hospital, has been piloted by the HSE, with a view to rolling it out nationally. This would assist learning and continuous improvement. As well as using a common format to assess the capacities and levels of dependency of older people, it could generate comparable data to show the outcomes from different types of care, which would help to assess the quality of different services, as well as their cost-effectiveness. The data set could also assist decisions on the most appropriate setting in which the care needs of an older person can be met.

### **6.9.4 The Importance of Co-ordinating the Decisions of Providers, the Department of Health, and HIQA**

The difficulty of balancing the needs of residents with decisions taken by the provider is evident in the decision to close a number of HSE-run homes for a variety of reasons. Any provider may make the decision to close their centre, but there is

no doubt that this can have a negative effect on residents and their ability to stay in what is now their home. This is a difficult issue to tackle, and requires a better balance between the needs of older people and of providers. It is also not clear what the balance of private and public providers will be in Ireland in future, although US research indicates that a balance of different types of providers can help to promote competition on the basis of quality in for-profit centres.

Another area which needs further work in Ireland is review of current funding mechanisms which mean that budgets do not always follow the person<sup>101</sup>, and so can lead to unequal care outcomes for some residents. The HSE and the Department of Health are beginning work to tackle these issues. This underlines the importance of a ‘fourth loop’ of learning, as it is important for actors such as providers, HIQA and the Department of Health to co-ordinate the effects of their decisions as much as possible, to ensure services continue to be provided at an optimum level for older people. A problem-solving group of those influencing provision of long-term care<sup>102</sup> may be useful to begin to address these issues.

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<sup>101</sup> Fair Deal funding is allocated specifically to meet the care needs of an individual person, while budgets for therapy, equipment and home care currently are not.

<sup>102</sup> The network to share best practice, suggested in section 6.10.1, could also feed into this.

the  $\mathbb{R}^n$  is a linear space over  $\mathbb{R}$  with the usual addition and scalar multiplication. The inner product is defined by

$$(x, y) = \sum_{i=1}^n x_i y_i \quad (1)$$

where  $x = (x_1, \dots, x_n)$  and  $y = (y_1, \dots, y_n)$  are vectors in  $\mathbb{R}^n$ .

The norm of a vector  $x$  is defined by

$$\|x\| = \sqrt{(x, x)} = \sqrt{\sum_{i=1}^n x_i^2} \quad (2)$$

The distance between two vectors  $x$  and  $y$  is defined by

$$d(x, y) = \|x - y\| = \sqrt{\sum_{i=1}^n (x_i - y_i)^2} \quad (3)$$

The angle between two vectors  $x$  and  $y$  is defined by

$$\cos \theta = \frac{(x, y)}{\|x\| \|y\|} \quad (4)$$

The orthogonal projection of a vector  $x$  onto a vector  $y$  is defined by

$$p_y(x) = \frac{(x, y)}{(y, y)} y \quad (5)$$

The orthogonal complement of a subspace  $W$  is defined by

$$W^\perp = \{x \in \mathbb{R}^n \mid (x, y) = 0 \text{ for all } y \in W\} \quad (6)$$

The orthogonal decomposition of a vector  $x$  into a vector in  $W$  and a vector in  $W^\perp$  is defined by

$$x = p_W(x) + (x - p_W(x)) \quad (7)$$

The orthogonal distance from a vector  $x$  to a subspace  $W$  is defined by

$$d(x, W) = \|x - p_W(x)\| \quad (8)$$

The orthogonal distance from a vector  $x$  to a vector  $y$  is defined by

$$d(x, y) = \|x - p_y(x)\| \quad (9)$$

The orthogonal distance from a vector  $x$  to a line  $L$  is defined by

$$d(x, L) = \|x - p_L(x)\| \quad (10)$$

The orthogonal distance from a vector  $x$  to a plane  $P$  is defined by

$$d(x, P) = \|x - p_P(x)\| \quad (11)$$

Appendix A  
References to Resident Consultation,  
Consent, Preferences etc. in the  
Criteria of the *National Quality  
Standards for Residential Care  
Settings for  
Older People in Ireland*<sup>103</sup>

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<sup>103</sup> This is not an exhaustive list.

## In the Introduction:

Standards provide a road map of continuous improvement to support the continued development and provision of person-centred, accountable care.

International best practice in residential care settings for older people is moving away from institutional “hospital” type care to more intimate home-style settings, which enable residents to live full lives that reflect, as far as possible the lives they led prior to their admission. The National Quality Standards for Residential Care Settings for Older People will not, by themselves, bring about a transformation from institutional to more person-centred models of care. This will require a significant cultural shift in our society.

The National Quality Standards do, however, provide an important road map for both service providers and users, for the development of person-centred models of care which are driven by a respect for the rights of older people and are focused on quality of life measures meaningful to individual residents.

## In the standards criteria:

- 3.1 The resident is presumed to be capable of making informed decisions in the absence of evidence to the contrary.
- 3.2 The residential care setting has a policy that outlines the procedure for seeking consent from the resident prior to any treatment or care-giving or, in the case of emergency, in accordance with best practice. The policy addresses when the resident does not wish to consent and when the resident lacks the capacity to consent.
- 3.3 The information provided to the resident or his/her representative, for the purpose of informing choices, is given at the earliest opportunity and in a manner that he/she can understand in order to ensure, as far as possible, that he/she has sufficient time to consider the information given and his/her options.
- 3.4 Clear explanations in a format and language suitable for the resident, and/or appropriate communication and visual aids are used to assist the resident, where necessary, in decision making, and in keeping with the principle of maximising autonomy.

- 3.5 The resident is facilitated to access an advocate/advocacy services when making decisions relating to consent to treatment or care, if necessary and in accordance with his/her wishes.
- 3.6 The resident's wishes and choices relating to treatment and care are discussed and documented, and as far as possible, implemented and reviewed regularly with him/her.
- 3.7 The resident or his/her representative is provided with the information required to make an informed choice about any proposed medical intervention or treatment. The information outlines the advantages and disadvantages of the proposed action, including any likely side effects.
- 3.8 The resident's lack of capacity to give informed consent on one occasion is not assumed to be the case on another occasion. Where there is any doubt as to the resident's capacity to decide on any medical treatment or intervention, his/her capacity to make the decision in question is assessed by a suitably qualified professional using evidence-based best practice.
- 4.1 Care practices are personalised to respond to the resident's individual needs and preferences.
- 5.1 The residential care setting has a policy that acknowledges the rights of the resident. The policy sets out the manner in which the resident is informed of and facilitated in the exercise of his/her rights.
- 5.2 The resident has access to citizen's information and advocacy services.
- 5.3 The resident has equitable and timely access to health care services. Where medical care is not provided by the residential care setting team, the resident has access to a general practitioner of his/her choice. (See Standard 13: Health care.)
- 5.5 The resident is facilitated to access legal advice.
- 5.7 The resident's decision to participate in activities involving personal risk is respected, and when necessary is documented.
- 5.8 The resident is facilitated to observe or abstain from religious practice in accordance with his/her wishes.
- 6.1 The residential care setting provides an environment that is conducive to residents, staff, family, advocates or representatives, and visitors being able to raise issues and make suggestions and complaints (verbally or in writing) in a spirit of openness and partnership and without fear of adverse consequences.
- 7.2 Once a room is allocated (single or multiple occupancy) the resident is not moved from the room, unless at his/her request or for medical reasons or an identified assessed risk in the case of a resident with dementia/cognitive impairment, without his/her consent or the agreement of his/her

representative. This also applies to residents who are absent from the residential care setting for acute hospital admission. The reason for moving a resident to another room is documented.

- 11.5 The care plan is discussed, agreed and drawn up with the involvement of the resident and/or his/her representative. If the resident is unable or unwilling to participate, this is documented.
- 16.2 The resident's wishes and choices regarding end of life care are discussed and documented, and, in as far as possible, implemented and reviewed regularly with the resident. This includes his/her preferred religious, spiritual and cultural practices and the extent to which his/her family are involved in the decision making process. Where the resident can no longer make decisions on such matters, due to an absence of capacity, his/her representative is consulted.
- 16.5 The residential care setting has facilities in place to support end of life care so that the resident is not unnecessarily transferred to an acute setting except for specific medical reasons, and in accordance with his/her wishes.
- 16.6 Every effort is made to ensure that the resident's choice as to the place of death, including the option of a single room or returning home, is identified and respected.
- 17.1 Care practices reflect a person-centred approach to care. They encourage individuality and self-sufficiency, and promote the resident as an equal partner in his/her own care.
- 17.3 The person-in-charge manages the residential care setting in a manner that maximises the resident's capacity to exercise personal autonomy and choice. Where the resident's choice is restricted, the reason for this is explained and documented and appropriate support is provided. (See Standard 3: Consent.)
- 17.4 There are clear communication and information processes in place to facilitate the resident exercising choice.
- 17.5 The resident is given a choice to participate in individual and/or communal recreational activities.
- 17.6 The resident's individual choices relating to his/her preferred term of address are respected.
- 17.7 (part of) Staff engagement with residents actively promotes opportunities for self-expression.
- 17.8 The resident handles his/her own financial affairs for as long as he/she wishes and has the capacity to do so.
- 17.10 The culture, practice and procedures of the dementia-specific residential care unit reflect a person-centred approach that provides the additional



time needed to enable independence and functioning to the resident's highest possible level.

- 18.1 The routines of daily life and activities are flexible and vary to suit the resident's expectations, preferences, previous interests and capacities, as outlined in his/her care plan. They are reviewed at three-monthly intervals in consultation with the resident as part of his/her care plan review.
- 18.2 (part of) The resident is given opportunities for participation in meaningful and purposeful activity, occupation or leisure activities, both inside and outside the residential care setting, that suit his/her needs, preferences and capacities.
- 18.3 The resident is enabled to live in a manner akin to his/her own home and the daily routines of the residential care setting, including meal times and bed times, are not solely dictated by staffing rotas.
- 18.4 The resident's social, religious and cultural beliefs and values are respected and accommodated within the routines of daily living.
- 18.9 Staff are trained in and understand the communication difficulties that residents experience and are trained in and make every effort to support and facilitate residents' communication (verbal and non-verbal) needs in an individualised manner. Person-centred communication is encouraged in all interactions, in consultation with relevant health care professionals.
- 19.2 The menu offers the resident a choice of meal at each mealtime. A choice is also available to residents on specific diets.
- 20.2 Links with and involvement of local community groups and/or volunteers in the residential care setting are encouraged and maintained in accordance with residents' preferences and with appropriate protective measures.
- 20.3 The resident can receive visitors in private. The resident chooses who he/she sees and does not see and his/her wishes are respected and recorded.
- 20.4 The person-in-charge ensures that there are no restrictions on visits except when requested to do so by the resident or when the visit or the timing of the visit is deemed to pose a risk.
- 21.20 The resident is not restrained without his/her informed consent. The resident is informed of the potential negative outcomes and hazards of physical restraint use. Where the resident is judged to lack the capacity to consent, physical restraint is not used if he/she expresses a clear and consistent preference not to be restrained. The single exception is the physical restraint of the resident as an emergency measure when his/her unanticipated behaviour places him/her in imminent danger of serious physical harm. In such circumstances the use of the physical restraint does not exceed beyond an immediate episode.

- 21.21 Except in rare, time-limited emergencies, or for brief provision of essential care, no physical restraint is used that causes the resident distress, discomfort, anger, agitation, pleas for release, calls for help or constant attempts to untie or release him/ herself.
- 25.8 The residential care setting is creatively designed in a manner that safely accommodates residents' mobility, audio and visual needs. The design and layout encourages and aids independence including appropriate signage and use of colours.
- 25.19 (part of) The resident is encouraged to personalise his/her own room and may choose to provide his/her own furnishings.
- 25.26 The resident, including those with a physical, sensory, mental health, dementia or other cognitive impairment, has access to relevant communal areas, through the provision of, where required:
- ramps and passenger lifts;
  - stair/chair lifts;
  - grab rails, hoists and other aids;
  - appropriate signage and colour; and
  - schemes to assist safe mobility.
- 25.28 Call systems with an accessible alarm facility are provided in every room normally used by residents and for every bed with due regard to the resident's safety.
- 28.6 Service delivery plans are resident-focused and promote continuity in service delivery. Where progress is less than expected, or where difficulties or risks are encountered, the service responds to this and initiates changes to the service delivery plan.
- 29.8 Policies, procedures and practices are regularly reviewed in light of changing legislation, alert directions, quality monitoring, residents' views and best practice. They are subsequently amended and implemented as required. There is clear evidence in this regard.
- 32.3 (part of) The resident's record includes... the resident's personal preferences including their preferred communication method.

## Appendix B

### References to Fixed Minimum Criteria in the *National Quality Standards for Residential Care Settings for Older People in Ireland*<sup>104</sup>

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<sup>104</sup>This is not an exhaustive list.

Each requirement is listed with the number of the relevant standard criterion.

What is to be included in the guide for residents is specified (12 items.)

Resident must be told of fees to be charged, including activities etc that may incur additional costs.

- 1.6 Resident must be informed about key aspects of service within 24 hours of emergency admission.
- 2.4 Person-in-charge must facilitate establishment of an in-house residents' representative group. At least one nominated person is to be an advocate for those with dementia.
- 3.10 Where written consent is required, forms are to be maintained in individual case records.
- 4.2 Residents' privacy and dignity to be respected with regard to 12 particular issues.
- 4.4 Staff to demonstrate respect for resident with regard to five particular issues.
- 4.5 Resident has to have access to a phone for use in private.
- 4.8 Resident's permission is sought before anyone enters his/her room.
- 5.1 Policy on residents' rights has to set out how resident is informed and facilitated in exercise of his/her rights.
- 6.3 Required elements of the complaints procedure are outlined (six elements).
- 6.5 Register of complaints must include details of investigation and any action taken.
- 6.6 Complaints must be raised at team meetings.
- 7.1 Resident must get a contract specifying terms and conditions within one month of admission.
- 7.2 Required (where applicable) elements of contract are outlined (seven elements).

- 8.1 Required elements of elder abuse policy outlined (three elements).
- 8.4 Training required for staff on abuse (six elements).
- 9.4 Conditions under which provider handles residents' money outlined (three elements).
- 9.6 Centre must keep signed records and receipts of items in safekeeping.
- 10.1 Information on resident's health and other needs must be obtained prior to admission, and within 72 hours where admission is emergency.
- 10.4 Risk assessment must be carried out and recorded on admission and reviewed every three months.
- 10.5 Comprehensive assessment of need using a Minimum Data Set must be completed within seven days of admission and reviewed every three months.
- 11.1 Care plan must be commenced within 48 hours of admission.
- 11.6 Care plan must be updated every three months.
- 13.2 Records to be maintained and followed up re referrals to health care services.
- 14.3 Medication management policy must cover at least four specified issues.
- 14.4 Staff adhere to nine procedures on the administration of medication. Only in date and properly stored medications to be administered.
- 14.6 Records to account for medicines to be kept, with a medicine administration chart including six specified issues.
- 14.7 Medications to be administered by a registered nurse only.
- 14.8/9 Controlled drugs to be handled in line with An Bord Altranais guidelines and legislation.
- 15.2 Condition of resident on medication is monitored and reviewed every three months at least.
- 15.3 Where resident is in hospital, any changes to medication must be communicated to centre within six hours of discharge.
- 15.4 Adverse reactions must be reported to the Irish Medicines Board.
- 15.6 All residents on long-term medication must be reviewed by a medical practitioner at least on a three monthly basis. Ten items are to be given special consideration.

- 16.1 Palliative care needs of resident are assessed, documented and regularly reviewed.
- 16.2 Palliative wishes and choices of resident are assessed, documented and regularly reviewed.
- 16.4 Staff are provided with training on end-of-life care as appropriate.
- 16.7 Resident's family facilitated to stay with the dying and there are overnight facilities for their use.
- 16.10 Resident's relatives are provided with practical information, verbal and in writing, on what to do following death, including access to bereavement care services and how to register the death.
- 16.11 Return of personal effects is formally documented and signed.
- 16.13 Deaths are to be notified to coroner's office and HSE.
- 17.2 There is a policy on independence of residents.
- 18.1 Activities of resident reviewed in care plan at three monthly intervals.
- 18.6 Up-to-date information on activities is circulated to each resident .
- 19.2 Resident is offered a choice at each mealtime.
- 19.3 Resident is offered three full meals a day; hot & cold drinks and nutritious snacks are available at all times.
- 19.7 Daily menu is displayed.
- 19.12 Staff receive training in safe food handling.
- 20.4 Person-in-charge to ensure no restrictions on visitors unless risky, or resident requests such restrictions.
- 21.2 Policy on responding to challenging behaviours must include six specified issues.
- 21.3 Care plan to be reviewed regularly in relation to challenging behaviour. Case reviews to be recorded.
- 21.5 All interventions in relation to challenging behaviour are to be reviewed regularly.
- 21.7 Standardised assessment tool to be used, and evidence documented.
- 21.12 PRN drugs (to be given as required) – indication for use to be documented.
- 21.17 Physical restraint not to be used for three specified types of behaviour.

- 21.18 Assessment must be documented prior to use of restraint – seven specific issues to be documented.
- 21.19 Short-term use of restraint must be recorded in a register.
- 21.22 Routine ‘as needed’ orders for restraint cannot be used.
- 21.23 Physically restrained residents must be regularly checked for three issues, and this documented.
- 22.2 New staff can only be confirmed in post following six steps.
- 22.3 Contracts with temping agencies must cover five issues.
- 22.4 Staff must have written job descriptions and a copy of terms and conditions before starting.
- 22.6 Volunteers’ roles and responsibilities to be set out in written agreement between the centre and volunteer.
- 23.2 Staff file must contain nine specified issues.
- 23.3 Number and skill mix of staff on duty must be determined by a nationally validated assessment tool.
- 23.5 Must be a planned and actual staff rota at all times.
- 23.6 Care must be supervised by a registered nurse on duty.
- 24.2 Newly recruited staff to start FETAC Level 5 training within two years of taking up employment.
- 24.3 Staff and development programme to exist and cover four specified issues.
- 24.4 Staff to receive induction training.
- 24.6 Record of all completed staff training and development to be kept.
- 24.7 Staff development and appraisal policy to be established.
- 24.8 Staff to be supervised regularly.
- 25.2 Building to meet fire safety and other relevant building regulations.
- 25.4 There is to be a programme of, and records on, maintenance.
- 25.5 Buildings and contents are to be insured and there must be a valid insurance certificate.
- 25.12 Heating to be 18 degrees in bedrooms and 21 degrees in rooms used during the day.

- 25.13 Rooms to be naturally ventilated and windows to allow one to see out when seated.
- 25.15 Rooms to be centrally heated, radiators to be no hotter than 43 degrees. Heating can be controlled in resident's own room.
- 25.16 Hot water to be stored at 50–60 degrees, valves to supply water at no more than 43 degrees.
- 25.20 Residents' rooms to be lockable.
- 25.21 Each resident to have a lockable storage space.
- 25.22 Screening to be in rooms with more than one resident.
- 25.25 Policy on medical devices and equipment (provision, repair, etc.).
- 25.28 Call systems in every room and bed.
- 25.31 Minimum space per resident defined, and type of rooms.
- 25.33 Kitchens required, must comply with food safety legislation.
- 25.35 Specific criteria (six) on cleaning rooms.
- 25.36 Specific criteria (eight) on sluicing facilities.
- 25.37 Specific criteria (seven) on laundry rooms.
- 25.38 Specific criteria (four) on offices.
- 25.39/  
40 Specific criteria on size of bedrooms .
- 25.42 Ratio of toilets to residents set, as well as four other specifications.
- 25.43 Ratio of assisted baths to residents set, as well as time scale for this.
- 25.45 4–6 specifications on communal space (size, type of rooms that must be available).
- 25.46 Specifications on size of treatment room, if it is required.
- 25.47 Newly built centres must have kitchens.
- 25.48 Newly built centres must have lifts and must be certain size.
- 25.49 Newly built centres must have cleaning rooms, which meet certain specifications.
- 25.50 Newly built centres must have sluice room, which meets six specifications.
- 25.51 Newly built centres must have laundry, which meets seven specifications.



- 25.52 Newly built centres must have office, which meets four specifications.
- 25.53 Newly built centres must have single rooms of 12.5m<sup>2</sup> minimum size.
- 25.54 Newly built centres must have 80 per cent of residents in single rooms; shared rooms must be at least 20m<sup>2</sup> with no more than two residents; can be a room for up to six residents who need 24-hour high-support nursing care.
- 25.55 Newly built centres must have at least one assisted toilet per floor.
- 25.56 Newly built centres must have an *en suite* bathroom in all bedrooms. Additional toilets are to be wheelchair-accessible.
- 25.57 Newly built centres must have at least one assisted bath to eight residents.
- 25.58 Specifies size of bathrooms, toilet, shower rooms in newly built centres.
- 26.3 Information, training, supervision and monitoring of staff in relation to health and safety is required, under ten broad headings.
- 26.4 There must be a safety statement for each centre.
- 26.7 Findings of risk assessments to be recorded; also reviewed and updated regularly.
- 26.9 Significant events must be recorded. Next of kin must be informed.
- 26.11 Requirements in relation to vehicles – must be roadworthy, insured and only staff with full driving licences can drive them, maintenance checks have to be done, incidents have to be reported as per incident report policy.
- 26.12 Lifts must be inspected and certified.
- 26.13 Must be an emergency plan.
- 26.15 Must be a fire safety policy and procedure communicated to all staff commencing employment and annually thereafter.
- 26.16 Up-to-date fire management plan required, revised and actioned as necessary.
- 26.17 Must be staff training on fire safety and evacuation.
- 26.18 Must be fire drills at least twice a year.
- 26.19 Emergency lighting and fire retardant materials required.
- 26.20 Must be written proof that all statutory requirements on fire safety are met.

- 26.21 Clear lines of accountability for infection prevention and control required.
- 26.22 Policies and procedures on infection prevention and control must be used by staff on daily basis, covering ten specifications.
- 26.33 Must be staff training and yearly updates on risks of infection.
- 26.24 Requirements on alcohol rub and hand-washing sinks.
- 26.25 Must be clearly documented systems to respond to outbreak of infection.
- 26.26 Separate changing facilities required for catering and non-catering staff.
- 26.27  
/28 Specifications on laundry rooms.
- 26.28 Staff must receive training on food safety legislation.
- 27.1 Specifications on the person-in-charge – five are listed.
- 27.2 Qualifications and experience of person-in-charge specified (to apply from 2014).
- 27.5 Must be a named manager to whom each person-in-charge reports (for companies/organisations with multiple residential centres).
- 27.7 Chief inspector must be notified in writing of any changes to person-in-charge or registered provider.
- 28.1 Statement of purpose and function must include six specifications.
- 28.3 Chief inspector must be notified of any proposed changes to purpose and function (before it happens).
- 28.4 Statement of purpose must be reviewed and updated where necessary, and be in a format that is accessible to residents.
- 28.5 Must be Service Level Agreements with purchasers of beds, which are implemented and monitored.
- 29.3 Professional development plans must be put in place.
- 29.4 Staff must receive training in, and implement, all policies and procedures. There must be evidence of this.
- 29.6 Must be a designated person to contact in an emergency.
- 29.7 Legally required certificates must be up to date.
- 29.8 Policies and procedures must be regularly reviewed.
- 30.1 Must be an annual review of systems etc.

- 30.2 Data must be collected on 13 specifics (falls, vaccines, etc. and more if necessary).
- 30.3 Care plans must be reviewed every three months.
- 31.1 Must be letter from the centre's accountant to show necessary financial procedures are implemented.
- 31.2 Must be insurance cover.
- 32.1 Residents' records must be secure, up to date, meet legal requirements etc.
- 32.2 Specifies information on residents that must be in register – 13 specifications and 8 optionals.
- 32.3 Specifies information on residents that must be recorded – 13 specifications (with subspecifications).
- 32.5 Policy on data retention and destruction required.

There are also supplementary criteria for dementia specific centres.



Appendix C  
Requirements in the *National Quality  
Standards for Residential Care  
Settings for Older People in Ireland* for  
Review of Residents' Care<sup>105</sup>

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<sup>105</sup>This is not an exhaustive list.

Each requirement is listed with the number of the relevant standard criterion. Italics are the author's.

- 3.6 *The resident's wishes and choices* relating to treatment and care are discussed and *documented*, and as far as possible, implemented and *reviewed regularly* with him/her.
- 8.1 There is a *policy on the prevention, detection and response to abuse* within the residential care setting... The implementation of the policy *is reviewed annually*.
- 10.5 A comprehensive *assessment of the resident's health, personal and social care needs, ... is reviewed* as indicated by the resident's changing needs or circumstances and no less frequently than at three-monthly intervals.
- 12.3 *The resident's general physical and mental health is* promoted through the provision of social contact and appropriate health promoting interventions, devised and *reviewed* by allied health professionals.

Standard 13 – Health care: *Each resident's assessed health needs are reviewed and met on an ongoing basis* in consultation with the resident.

- 14.9 *....arrangements for self-administering medicines are kept under review.*

Standard 15: *Medication Monitoring and Review*

- 15.2 *The condition of the resident on medication is monitored and subject to review* at three-monthly intervals or more frequently where there is a significant change in the resident's care or condition.
- 15.5 *Each resident on long-term medication is reviewed by his/her medical practitioner on a three-monthly basis*, in conjunction with nursing staff and the pharmacist.
- 16.1 *The resident's palliative care needs are* assessed, documented and *regularly reviewed*.
- 16.2 *The resident's wishes and choices regarding end of life care are* discussed and documented, and, in as far as possible, implemented and *reviewed regularly* with the resident.
- 18.1 *The routines of daily life and activities* are flexible and vary to suit the resident's expectations, preferences, previous interests and capacities, as

outlined in his/her care plan. They *are reviewed at three-monthly intervals.*

- 21.3 Where a resident's behaviour presents a risk to him/herself or others, his/her care plan sets out a plan of care that meets his/her individual assessed needs. The *plan is reviewed regularly to assess its effectiveness and reflect the resident's changing needs.*
- 24.9 There is an *active practice development policy in place that incorporates evidenced-based principles on dementia care, best practice findings and new learning.*
- 30.3 The *person-in-charge ..., for the purposes of monitoring, reviews care plans at at least three monthly intervals* to ensure that the care planning process is conducted in accordance with guidelines and procedures.
- 23.3 *The number and skill mix of staff on duty is determined and provided according to a transparently applied, nationally validated, assessment tool, to plan for and meet the needs of the residents. This is subject to regular review.*

Appendix D  
Institutions, Agencies and Frameworks  
Relevant to Quality and Standards in  
Eldercare, May 2011



This list outlines all of the national organisations and documents relevant to eldercare in Ireland, and is modelled on a framework to list such groups and documents developed by Carney *et al.* (2011).

While reading it, bear in mind that some organisations and documents serve a number of purposes, so it can, for example, be difficult to decide whether a document should be categorised as a strategy or a framework, or a piece of research.

### **Organisations**

#### *Government departments*

Department of Health

#### *Executive offices in Government departments*

Office for Older People (in Department of Health), est. 2008

Nursing Policy Division (in Department of Health)

#### *State agencies*

HIQA (Health Information and Quality Authority), est. 2007

HSE (Health Services Executive), est. 2005, due to be closed by current Government  
Irish Health Services Accreditation Board (IHSAB), est. 2002, merged into HIQA in 2007

National Council for Ageing and Older People, est. 1997, dissolved in 2009

National Council for Professional Development of Nursing and Midwifery, est. 2001, dissolved in 2011

An Bord Altranais, est. 1950

Office of the Ombudsman

#### *Offices in state agencies*

Office of the Nursing and Midwifery Services Director (in HSE)

Nursing and Midwifery Professional Development Units (in HSE)

Office of Advocacy Services (in HSE)

#### *Advisory groups (set up to advise on policy development)*

Expert Advisory Group on Services for Older People (in HSE), est. circa 2005, closed circa 2008

Interagency group developing draft standards for home care services (under HSE, 2008)

Task Group on home help and home care standards (in HSE), est. 2010

Commission on Patient Safety and Quality Assurance

Law Reform Commission

Working Group on Long-Term Care  
 Hospice Friendly Hospitals national steering committee  
 Hospice Friendly Hospitals advisory team

*Multi-stakeholder alliances (set up to implement a policy)*

National Advocacy Programme Alliance (NAPA)  
 Health and Social Care Regulatory Forum

*Social partnership institutions/forums*

N/A

*Participatory forums – citizens*

Forum on Services for Older People (HSE's Office of Advocacy Services)  
 Volunteer Panels (HIQA)

*Participatory forums – service providers*

Social Services Inspectorate's Providers of Older Person's Residential Care Services  
 Panel (Regional Providers Panel) (HIQA)

*NGOs*

Age Action  
 Alzheimer Society  
 Irish Senior Citizens' Parliament  
 Age & Opportunity  
 Irish Hospice Foundation/Hospice Friendly Hospitals programme  
 Older Women's Network  
 Third Age  
 Older & Bolder

*Industry associations/lobby groups*

Nursing Homes Ireland  
 Home Care Association

**Documents**

*International agreements*

Madrid International Plan of Action on Ageing, 2002

*EU strategies*

N/A

*Legislation*

Health Act 2004 (which established the HSE)  
 Health Act 2007 (which established HIQA), and its amendment  
 Health (Homes for Incapacitated Persons) Act, 1964  
 Health (Nursing Homes) Act, 1990

*Regulations*

SI No. 44/1966 – Homes for Incapacitated Persons Regulations, 1966  
 SI No. 317/1985 – Homes for Incapacitated Persons Regulations, 1985  
 SI No. 226/1993 – Nursing Homes (Care and Welfare) Regulations, 1993

SI No. 236/2009 – Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations, 2009, and amendments

SI No. 245/2009 – Health Act 2007 (Registration of Designated Centres for Older People) Regulations, 2009, and amendments

#### *Standards*

National Quality Standards for residential care settings for older people in Ireland, published 2009 (HIQA)

Draft National Quality Guidelines for Home Care Support Services (drafted in 2008) (HSE)

National Guidelines and procedures for standardised implementation of the home care packages scheme (2010) (HSE)

National Standards for the provision of home care support services (2010) (HSE)

Invitation to tender for the provision of high quality, enhanced home support and personal care services for older people, to complement existing community services (2011) (HSE)

Service level agreements between HSE and funded organisations (HSE)

Tender document between HSE and providers of home care packages (HSE)

Quality standards for End-of-Life care in Acute Hospitals (no date) (Hospice Friendly Hospitals programme)

Acute Care Accreditation Scheme: a framework for the continuous improvement of the quality and safety of patient/client centred care

#### *Governmental Strategies, Policies & Plans (plans of action that determine decisions, actions)*

The Care of the Aged (1968)

The Years Ahead: A Policy for the Elderly (1988)

Quality and Fairness: A Health System for You (2001)

Report of the Working Group on Long Term Care (2008)

National Development Plan, 2000–2006

National Development Plan, 2007–2013

National Anti-Poverty Strategy

A review of practice development in nursing and midwifery in the Republic of Ireland and the development of a strategic framework (DoHC, 2010)

Health Information Strategy, 2004

#### *Partnership agreements*

Sustaining Progress, 2003

Towards 2016, 2006

#### *Non-governmental strategies and plans*

Voluntary code of practice for nursing homes, 1995

#### *Frameworks (conceptual frameworks that can be used to develop Strategies)*

Building a Culture of Patient Safety (Report of the Commission on Patient Safety and Quality Assurance)

Report of the Interdepartmental Working Group on Long-Term Care, 2005

Framework for Public and Service User Involvement in Health and Social Care Regulation in Ireland (by the Health and Social Care Regulatory Forum)

*Reports/research/data*

OECD – Long-term care for Older People (2005)  
 NESF –Care for Older People (2005)  
 NESF – Implementation of the Home Care Package Scheme (2009)  
 Annual Output Statement, Health Group of Votes (annual)  
 Long Stay Activity reports (annual)  
 Report of the Commission of Investigation (Leas Cross Nursing Home)  
 Assessment of costs of national draft quality standards for residential care settings for older people in Ireland, 2009 (commissioned by Dept of Health and Children as part of a Regulatory Impact Assessment, from PA Consulting)  
 Assessment of costs of national draft quality standards for residential care settings for older people in Ireland: International benchmarking, 2008 (commissioned by Dept of Health and Children as part of a Regulatory Impact Assessment, from PA Consulting)  
 Nursing Home Standards Regulatory Impact Assessment (Dept of Health and Children, 2009)  
 Legal aspects of carers (consultation paper published by Law Reform Commission, 2009)  
 Legal aspects of professional home care (final report published by Law Reform Commission, 2011)  
 National Audit of End-of-Life Care in Hospitals in Ireland, 2008/9 (Hospice-Friendly Hospitals)  
 Who Cares? An investigation into the right to nursing home care in Ireland (2010) (Office of the Ombudsman)  
 The Implementation of a model of person-centred practice in older person settings: Final report (2010)  
 Enhancing care for older people: A guide to practice development processes to support and enhance care in residential settings (2010)  
 National Advocacy Programme for older people in residential care evaluation (2011)  
 High level review of the HIQA inspection process for residential care settings for older people (report commissioned by Nursing Homes Ireland)

**Actions**

*Programmes/projects/initiatives/funding schemes*

Fair Deal (Dept of Health and Children)  
 Practice development (HSE/National Council for Professional Development of Nursing and Midwifery)  
 Volunteer advocacy programme  
 Myhomefromhome.ie  
 Teaghlach (HSE)  
 Nursing Homes Nursing Projects (private sector)  
 Hospital Friendly Hospitals supports to acute and community hospitals  
 National Treatment Purchase Fund

*Monitoring mechanisms*

HIQA inspection reports



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