Draft Regulations for Providers of Home Support Services: An Overview of the Findings of the Department of Health's Public Consultation

A report by the Institute of Public Health in Ireland for the Department of Health

Institute of Public Health

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To be cited as: Sheehan, A. and O'Sullivan R. (2023). Draft Regulations for Providers of Home Support Services: An Overview of the Findings of the Department of Health's Public Consultation.

Published January 2023

ISBN: 978-1-913829-25-4
DOI: 10.14655/11971-1084904

Table of contents

List of Tables

List of Figures

Glossary

ADMA	Assisted Decision Making (Capacity) Act
DOH	Department of Health
FETAC	Further Education and Training Awards Council
GDPR	General Data Protection Regulation
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
IPH	Institute of Public Health
QQI	Quality and Qualifications Ireland
SOP	Statement of Purpose
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNCRC	United Nations Convention of the Rights of the Child

Introduction

Introduction

This commissioned report produced by the Institute of Public Health[1] sets out an analysis of the responses to the Department of Health on a public consultation on new Draft Regulations for Providers of Home Support Services. The consultation was held between 16th June 2022 and 4th August 2022 to inform the draft regulations and to contribute to regulatory impact assessment. The purpose of this report is to reflect and summarise the range of views expressed by respondents on the scope, content and potential impact of the draft regulations.

Background

Publicly funded home support services are currently provided free of charge by the Health Service Executive (HSE) through Services for Older People and Disability Services based on a service users' assessed care-needs. Home support services and home support workers (sometimes called home helps, home carers, healthcare support assistants) primarily provide assistance with personal care as well as help with essential domestic tasks. Personal assistance means a package of support delivered to an adult to optimise his or her functional independence, health and wellbeing, occupational and social engagement which is provided to people under 65 years through HSE Disability Services. The HSE National Service Plan 2022 sets the target activity for Home Support Hours delivered to people with a disability at 3.12m hours (7,326 clients) and the target activity for total home support hours under Older Persons Services is 24.2m (55,910 clients).

Home support hours are provided directly by the HSE or by external providers commissioned by the HSE. Individuals may also obtain services privately from home support providers. A recent report published by the Department of Health has highlighted workforce challenges across the health and social care system and the need for a proactive response[2] . There is currently no statutory regulation of home support services in Ireland, although the HSE as a provider and commissioner of services, has oversight through the tendering and contractual process of publicly funded home support services.

The Department of Health is developing a new statutory scheme for home support services in line with Programme for Government and Sláintecare commitments. In April 2021, the government gave approval to draft a General Scheme and Heads of Bill to establish a licensing framework for home support providers. These draft regulations apply to home support services provided by public, private and not-for-profit companies and organisations and set out the minimum requirements needed to get a licence. The purpose of the licensing system is to ensure that home support services are of consistently high quality and to safeguard service users. As set out in these regulations service users are adults aged 18 or older, who by reason of illness, frailty or disability require a home support service. These draft regulations were prepared following prior discussion with key stakeholders in the sector and submissions to this public consultation will inform further amendments.

[1] The Institute of Public Health is a North South agency which works to inform public policy to support healthier populations in Ireland and Northern Ireland through research and evidence review, policy analysis, partnership working and specialist training.

[2] Department of Health (2022). Report of the Strategic Workforce Advisory Group on Home Carers and Nursing Home Healthcare Assistants. gov.ie - Report of the Strategic Workforce Advisory Group on Home Carers and Nursing Home Health Care Assistants (www.gov.ie)

Aim

The aim of this public consultation was to get the views of organisations and individuals on the scope, content and potential impact of the draft regulations to help inform their development and to contribute to regulatory impact assessment.

Target Group

All those with an interest in the provision of home support including service users, relatives of service users, service providers, home support workers and their representative bodies, health and social care professionals, healthcare organisations, state bodies, advocacy groups, members of the public and others.

Method

Online survey questionnaire (accessed via government public consultation website[3]). Freeform submissions were also accepted.

Results

A total of 210 submissions were received, 198 through a survey questionnaire and 12 via freeform submissions.

This report produced by IPH provides a profile of respondents and an analysis of consultation responses identifying key themes that emerged. It provides an overview of responses, including attitudes to the draft regulations, and views about their impact, followed by a more detailed breakdown of feedback on the overall scope, and individual sections of the regulations. It includes both a statistical breakdown of responses to the 198 survey submissions and a narrative analysis of all 210 submissions (survey and freeform). Submissions are referred to by respondent type. The appendices include a list of organisations that responded, a list of suggested amendments and additions to definitions, the survey questionnaire and a link to the draft regulations and associated consultation documents.

[3] gov.ie - Public Consultation on Draft Regulations for Providers of Home Support Services (www.gov.ie)

Executive Summary

Executive Summary

Profile of respondents

- There were 210 responses, of which 198 were made via the survey and 12 were freeform submissions. The majority of responses were from individuals (118) of which 43 were a combination of service users, their family members and others with support needs. There were 92 responses from organisations including home support providers, healthcare organisations, advocacy, public sector and worker representative bodies.

Overall impact of regulations

- Three-quarters (74%) of survey respondents believed the impact of the proposed regulations would be positive, 4% believed it would be negative and 22% were unsure[4].
- Asked if they had concerns about the introduction of the regulations, 46% of survey respondents said they did, 38% did not and 14% were unsure.

Benefits

Improved service quality and greater protection for service users

- 85% of survey respondents indicated the regulations would result in better quality and consistency of service.
- 82% said they would provide greater protection for service users.
- 88% said they would offer guidance for all involved in home support services.
- Many said that minimum standards were essential to provide a more consistent level of service and ensure a level playing field for all providers.
- A large number of respondents felt regulations were crucial to support people to remain at home safely for longer, particularly in the context of Ireland's ageing population.

More qualified workforce

- 78% of respondents agreed with the requirement for all home support workers to have minimum educational qualifications or to get these within a set timeframe.
- Minimum qualifications were seen as important to delivering more consistent high quality home support services.
- Creating a more qualified workforce with clearer career pathways was also seen as a benefit for home support workers with potential to make the sector more attractive long term.

Concerns

Staffing and recruitment

- Submissions expressed concerns that existing staffing and recruitment problems could be exacerbated by the regulations, and that this could impact on the delivery of home care packages to service users.

[4] Please note that question responses do not always add to 100% because of rounding.

- There was concern that the new requirements for minimum educational qualifications could push some home support workers out of the sector or deter others from joining it. Many respondents broadly supportive of educational requirements also expressed this concern.

Cost of compliance and regulatory requirements

- Some said the costs of complying with these regulations in terms of training, documentation and record keeping could be very high and potentially lead to reduced service provision and smaller providers leaving the market.
- Several queried how the costs of education and training would be funded and called for this to be included in the funding model of home support or provided free by the HSE.
- It was indicated that extending the remit of home support covered by the regulations to housework and social activities, including outside the home, would require extra HSE funding.
- Some respondents said that compliance could be very burdensome for service providers, and increased record keeping could detract from the time home support workers had for engagement with service users.
- A number of submissions suggested a regulatory impact assessment or similar was needed. Some disability service providers said that duplication of compliance activities should be avoided.
- There were calls for an adequate transition period to allow providers prepare for the regulations.

Other

- Concern was expressed that the regulations could lead to a loss of flexibility and shift home support provision to a prescriptive risk-averse model. This was a particular concern in disability sector responses.
- There was a concern that the exclusion of direct employment relationships from regulation could drive a move towards more provision of home support services by unregulated self-employed workers employed directly by service users, creating a two-tier system of regulated and unregulated home support.

Other overarching issues

- Clarification was sought on how the regulations related to the overall framework of home support provision, to new primary legislation and Health Information and Quality Authority (HIQA) standards for the sector, and to the model of statutory home support provision and funding mechanisms being developed.
- Clarity was sought on HIQA's roles as the regulator of home support providers and to the HSE's role as Commissioner of Services.
- Many submissions called for the inclusion of a rights-based approach or specific human rights framework within the regulations.
- Submissions noted the importance of the regulations complying with, and making explicit reference to, the principles and legal obligations under the Assisted Decision Making (Capacity) Act (ADMA), particularly in relation to communication with service users, and assessment and provision of services.
- Many suggested that the regulations should require providers to communicate clearly with service users in appropriate user-friendly formats, such as Plain English and Easy Read.

Scope of regulations

Activities included in home support definition

- At least nine in every ten survey respondents agreed with inclusion of all the types of activity covered by the regulations, namely: physical assistance with mobility, washing etc (97%); reminding or supervising someone to take medication (94%); helping with everyday activities such as shopping and cleaning (93%); exercise and social engagement inside and outside the home (90%); care for emotional welfare such as listening and providing encouragement and personal assistance (94%).
- Although there was very strong support (94%) for including Personal Assistance (PA) services there were also concerns that the regulations would impact on service users' own direction of their service and flexibility to determine what types of support they needed.

Services excluded from regulations

Services for people aged under 18

- Almost half (49%) of survey respondents agreed that services for people under 18 should not be covered by the regulations, 28% did not agree and 20% were unsure.
- There was a concern raised that excluding children from the regulations would contravene their rights under the UN Convention on the Rights of the Child.

Home support by a family member or friend

- 69% agreed that home support by a family member or friend should be excluded, with 17% disagreeing and 12% unsure. Some said that while it was not possible to regulate family care or unpaid care, there should be a mechanism for investigating concerns.

Services that are unpaid

- 64% agreed that unpaid home support services should be excluded with 18% disagreeing and 15% unsure. Some said that home support services provided free by charities or voluntary services should be regulated.

Paid employment relationship between individual home support worker and one service user

- With regard to employment situations where a person using home support employs an individual home support worker directly, 45% of survey respondents agreed these should be excluded from regulation, with 30% disagreeing and 21% unsure.
- Submissions, particularly from service providers, expressed concern about the exclusion of individual employment and the potential it could give for growth in an unregulated sector of home support workers.

Services provided exclusively by registered healthcare professionals (such as nurses or physiotherapists)

- Half (50%) agreed these should be excluded from regulations, 27% disagreed and 20% were unsure.
- Some comments requested regulations to encompass services of registered health professionals (as their role is inextricably linked with home support services), however others expressed the opinion that this was unnecessary as this group are already registered.

Sectional Responses (key issues raised regarding specific sections of the regulations)

Definitions (Section 2)

- Respondents asked for consistency in the language and alignment of definitions with those in other important health service standards and legislation.
- Clarification was sought on a number of definitions with suggested amendments to terms including: 'abuse', 'advocacy', 'personal assistance', 'safeguarding', 'specified person' and 'supporting person'.

Contracts between service user and home support provider (Section 5)

- Submissions queried what the legal implications of individual contracts would be for providers and for the HSE as the main funder and commissioner of home support services.
- Several providers were concerned that the new individual contracts could lead to litigation and cases of breach of contract, including for unavoidable disruption or changes in service.
- Providers stated that the 3 month notice period for cancellation of a service would be impractical although others welcomed it.

Needs assessment and personal support plan (Section 6)

- Clarity was sought on the relationship between the assessment process outlined and current HSE assessments of need.
- Submissions queried if home support providers would have to employ teams of health professionals to carry out needs assessments, also noting issues with getting access to service users' medical records, and potential capacity to consent issues for some service users.

Management of records (Section 7)

- Several respondents felt that it would be impractical to keep large volumes of written records over many years, and record keeping should not become the primary focus of home support workers.
- Some providers wanted the GDPR basis for maintaining and transferring service user records to be specified.
- It was deemed important by some respondents to keep written records in the home, others noted there could be data protection issues with potentially inappropriate access by third party visitors.

Service provision (Section 8)

- Concerns were expressed by both public and private providers that the requirements for specifying service times and staffing arrangements could put providers in breach of contract too easily if they needed to change arrangements at short notice. This was deemed impractical given the complexity of managing teams across geographical areas.

Medication management support (Section 9)

- 70% of respondents agreed with the requirements of this section, 7% disagreed and 14% were unsure.
- Many respondents expressed concern about the substantial risks associated with managing/administering medications and noted that significant training would be required to equip home support workers with the skills and knowledge to do this safely.
- Several said that provisions for handling and storing medications were more like those applicable in a nursing home, which could not be applied to a private dwelling where the provider could not guarantee safe storage.

Qualifications, training and development (Section 12)

- 78% of survey respondents agreed with the requirement that all home support workers have minimum educational requirements or get these within a set timeframe. 12% disagreed and 9% were unsure.
- Many felt minimum qualifications were essential to allow for higher standards of care, protection of service users and professionalisation of the workforce. Some suggested this would lead to clearer career pathways and improved pay and conditions in the sector.
- 57% agreed with the specific requirements set out in Section 12 on qualifications, training and development, 16% disagreed, and 17% were unsure.
- Strong concerns were expressed that the educational requirements would worsen staffing and recruitment shortages and drive some workers out of the sector because of a difficulty in getting formal qualifications.
- Some suggested that apprenticeship-style 'earn as you learn' schemes, or assessments of competency and skills be introduced, with proportionate qualification requirements depending on the type of home support provided. Some said workers must not bear the cost of up-skilling and providers and workers should be supported to achieve the appropriate educational standards.
- A number of respondents felt that induction training requirements (Schedule 3) were excessive and unrealistic in 20 hours, though others called for additional areas to be included.
- Some respondents stated that new home support training/educational modules, including dementia care, should be developed, and that induction training and continuous workforce development should be included in qualifications criteria.
- Many suggested that improved pay, terms and conditions for home support workers should be included in the regulations to help make the sector more attractive and reduce staff shortages. Greater protection for migrant workers in the sector was also called for, as well as safe staffing levels.

Complaints procedure (Section 18)

- 78% of respondents agreed with the requirements of this section, though greater clarity was sought on the complaints mechanism, including whether there would be an independent investigation or appeals mechanism.
- Clarity was requested on whether HIQA was the 'authority' referred to for reporting

complaints, and on the thresholds for reporting.

- Many respondents wanted clear communication requirements with service users about the complaints procedure in accessible formats and in advance of any issue arising.

Health and safety (Section 20)

- Several submissions requested clarity on home environmental risk assessments, when these could be delayed, and what the reasonable expectations for risks were in a person's home.
- Respondents sought clarification on what constituted a health and safety 'incident' that needed to be reported.

Corporate governance (Sections 14-16) and corporate oversight (Sections 17-21)

- A number of submissions called for clearer accountability structures within each provider with minimum qualifications for management and a 'person in charge' or someone in a clinical role to monitor service quality.
- Several wanted clarification of who the regulator was and what their role involved.
- Some requested clarity about the financial procedures outlined (Section 16) and whether these related to HSE-funded homecare packages, or only to privately funded services.
- Many submissions called for greater ongoing consultation with service users through active feedback, surveys and panels/committees of service users and their families (Section 21).

1 Consultation Process and Profile of Respondents

1. Consultation Process and Profile of Respondents

1.1 Consultation Method

The primary method of consultation on the draft regulations was by survey. The survey questionnaire was developed by the Institute of Public Health (IPH) in collaboration with the Department of Health. There was a combination of closed and open questions to allow respondents to indicate their attitude to the proposed regulations and to identify areas where they had views or concerns. Most respondents made their submissions directly online via EU Survey, but there was an option to email or post survey responses which were then added to the survey dataset for analysis. A number of organisations and individuals also submitted freeform responses, and these were analysed alongside the survey responses, as were supplemental submissions made by organisations in addition to their survey responses.

The public consultation took place for a six-week period from 16th June 2022, and this was extended for a further week upon request, until 4th August 2022. It was disseminated by press release, on the Department of Health's website and on the government public consultation hub. It was also promoted on social media channels and by email to stakeholder organisations. Plain English and Easy Read summaries of the draft regulations were developed by IPH with feedback obtained from disability organisations to improve clarity and readability. These were made available along with the consultation documents to explain the proposals to a wider audience.

The Department of Health held a number of online meetings with stakeholder groups to discuss the draft regulations and consultation process. The Disability Participation and Consultation Network[5] held two online information sessions to inform members about this public consultation and made available sign language interpreters to facilitate participation. Department of Health representatives provided briefings at these sessions and participants were encouraged to make submissions and raise awareness about the consultation with relevant organisations and individuals.

IPH analysed the consultation responses to produce this report combining quantitative and qualitative (narrative) analysis. Quantitative breakdowns of responses to closed questions are provided in the relevant section - such breakdowns only relate to the 198 survey responses submitted, and not to the 12 freeform submissions. For the qualitative analysis, all 210 submissions including survey and freeform responses, were analysed to identify common issues, themes and attitudes. These are set out broadly in line with the regulation sections and consultation questions. Important themes and concerns are also highlighted in the Executive Summary and Key Themes sections. Chapter 1 describes the consultation process and gives a profile of respondents. Chapter 2 provides an analysis of submissions relating to the overall impact and scope of the draft regulations. Chapter 3 provides an analysis of submissions related to specific sections of the draft regulations. The report concludes with a recap of key themes.

5 The Disability Participation and Consultation Network is a network of civil society organisations and individuals concerned with the rights of disabled people under the United Nations Convention for the Rights of People with Disabilities.

1.2. Profile of Submissions

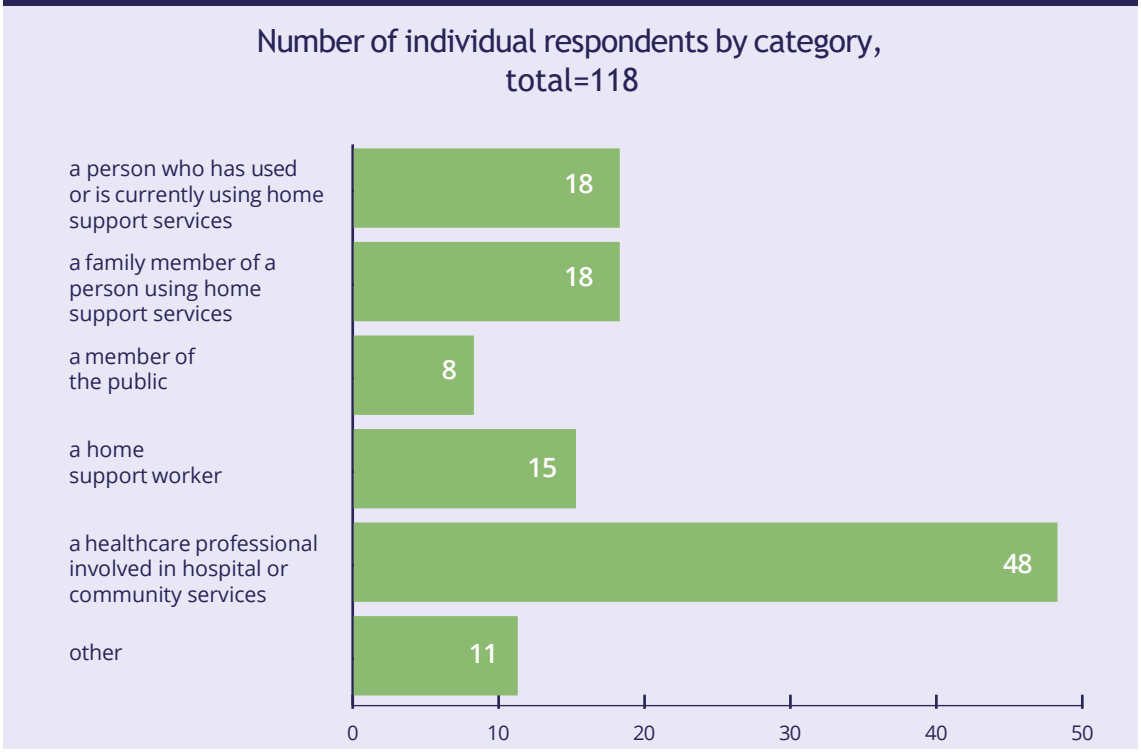
Of the 210 submissions to the public consultation. 198 were submitted through the survey with a further 12 freeform submissions. Eight organisations submitted additional comments as well as making a survey response.

Of the 198 survey submissions, 82 were on behalf of an organisation and 116 were by individuals. A few larger organisations submitted separate responses from different sections or units. Of the 12 freeform submissions, 10 were from organisations and 2 were from individuals. Overall, of the 210 responses, 118 (56%) were from individuals and 92 (44%) were from organisations.

Individual Respondents

A breakdown of the 118 individual responses (both survey and freeform submissions combined) shows there were 18 people who were using or had used home support services (15% of the 118 individual responses), and another 18 were family members of people using home support services (15%). There were also 11 respondents in the 'other' category. Of this 'other' category a total of seven had either used services, were family members of service users, family carers or people who said they required home support services but did not have any. A total of 43 responses (36%) therefore were from people with home support needs or their family members. The largest category of individual respondent was healthcare professional involved in hospital or community services at 48 (41% of the total). There were 15 submissions from home support workers (13%) and 8 from members of the public (7%).

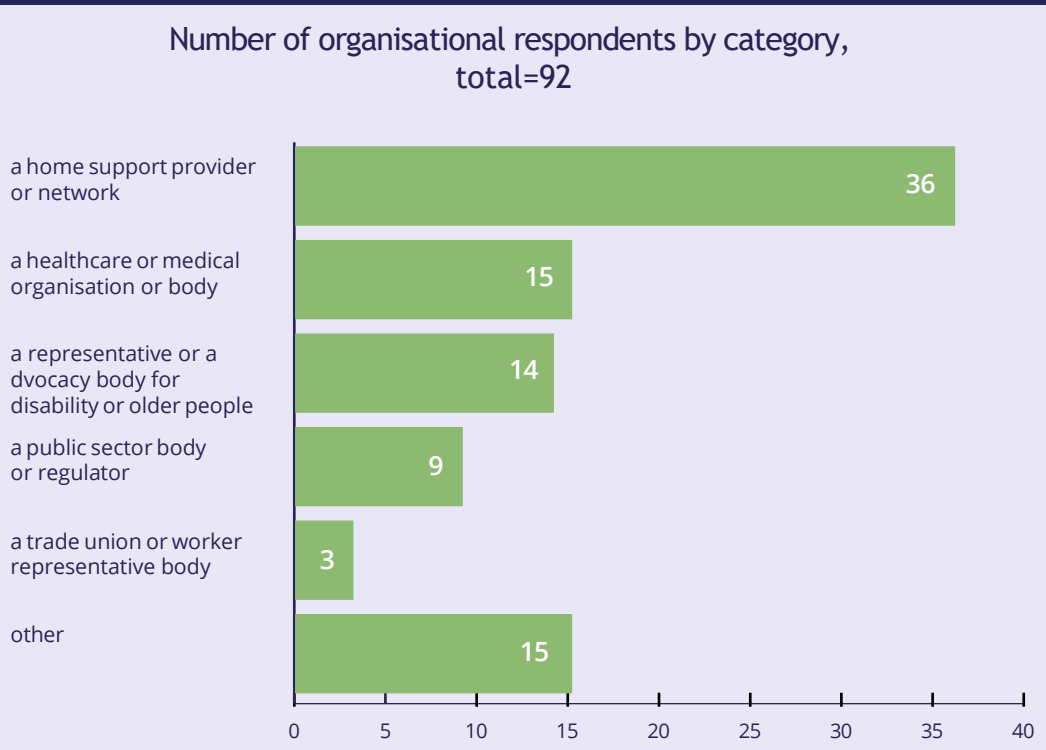
Figure 1. Individual response breakdown



Organisational respondents

A breakdown of the 92 organisational responses (survey and freeform) shows that there were 36 from home support providers or networks (39%), with 15 from healthcare or medical organisations (16%), 14 from a representative or advocacy body for disability or older people (15%), nine from a public sector body or regulator (10%), three from a trade union or worker representative body (3%) and 15 in the 'other' category (16%).

Figure 2. Organisational response breakdown



A full listing of respondents is contained in Appendix 1. Where percentage breakdowns are given of response rates to questions, these are based on the 198 survey responses (or a subset of these if indicated), and do not include the 12 freeform responses (as these did not explicitly address the specific questions on which breakdowns are based).

2 Analysis of Submissions: Impact and Scope of Regulations

2. Analysis of Submissions: Impact and Scope of Regulations

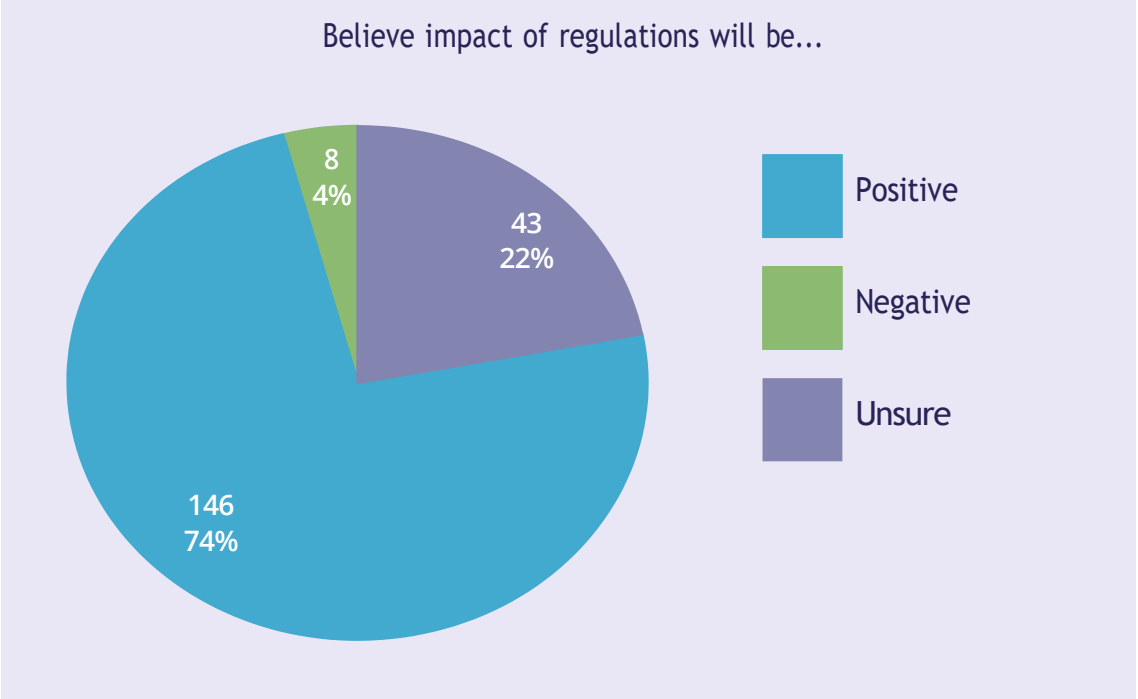
2.1. Overall attitude to regulations

In this section there is a breakdown of survey responses to specific multiple-choice questions on the impact of regulations, perceived benefits, and concerns about them, and a narrative summary of the main issues raised about the overall impact of the regulations[6].

Impact of regulations – survey findings

Survey respondents were asked if they believed the impact of the proposed regulations would be positive, negative or if they were unsure. Almost three quarters said it would be positive (74%), 4% said negative, and 22% were unsure about the impact.

Figure 3. Impact of regulations



A breakdown of responses to this question by different groups in Table 1 below shows that a large majority of all groups felt the impact would be positive, ranging between 63% and 86%. A small proportion, between 0% and 13%, felt the impact would be negative. A more sizeable minority, ranging from 11% to 33% (22% overall), said they were unsure about the impact. Home support providers were the most positive overall with 86% saying the impact would be positive. In the combined category of those with support needs and family members (43 in total), there was a higher level of concern or uncertainty, with 5% believing there would be a negative impact, and 33% unsure.

[6] Please note that question responses do not always add to 100% because of rounding.

Table 1: Impact of regulations by respondent type*

Group	Positive	Negative	Unsure	Number
Overall	74%	4%	22%	198
Individual	70%	6%	23%	116
Organisation	79%	1%	20%	82
Home Support Provider	86%	3%	11%	35
Advocacy Body	75%	0%	25%	8
Trade union/ worker representative body	67%	0%	33%	3
Public sector body/ regulator	78%	0%	22%	9
Healthcare or medical organisation	75%	0%	25%	12
Service user	72%	11%	17%	18
Family of service user	67%	0%	33%	18
Member of public	71%	0%	29%	7
Home Support Worker	73%	13%	13%	15
Healthcare worker in hospital or community	77%	6%	17%	47
COMBINED: Person with support needs/ family member	63%	5%	33%	43

**The small numbers in some respondent categories should be considered when comparing differences in attitudes between groups*

Benefits of regulations – survey findings

Asked what they thought would be the benefits of introducing these regulations, Table 2 below shows that 85% of respondents selected better quality and consistency of service, 82% felt there would be greater protection for service users and 88% said there would be guidance for all involved in home support services. A large majority of respondents of all groupings identified these as benefits; support was at its strongest amongst organisations such as home support providers and advocacy groups. 18% said there would be other benefits, and these included improved conditions and education for workers, clearer career pathways in the home support sector, and more support for service users to meet their social and personal needs.

Table 2: Benefits of introducing these regulations

Benefits of introducing these regulations	Number	Percentage	Total
Better quality and consistency of service	168	85%	198
Greater protection for service users	162	82%	198
Guidance for all involved in home support services	174	88%	198
Other	35	18%	198

Positive impacts – narrative analysis of submission views

The major benefits seen in these regulations included better quality and consistency of service, more guidance for all involved in home support, greater protection for service users and a more qualified workforce.

Better quality, consistency and guidance

Many submissions said that establishing minimum standards was essential to providing a more consistent level of service.

Respondents noted that regulation should ensure that all providers were regulated equally and independently, ensuring HSE, voluntary, non-profit and private providers were treated in the same way. It was hoped this would create a level playing field for all providers with clear concise guidelines and standards to ensure more consistent service standards.

> *"Currently, the standard of Home Support can vary widely. This is particularly evident in dementia care meaning these regulations have the potential to have significant positive impact on people living with dementia and their families."* **Home support provider**

> *"The introduction of the regulations will ensure that there is a minimum regulatory requirement for all providers, currently this is not the case. Providers who deliver services in line with best practice can be disadvantaged when competing with providers who are not delivering services to any recognised standards and therefore are able to deliver their services at a lower cost."* **Home support provider**

Some hoped that the regulations would result in more equal access to home support services in all parts of Ireland. Many also noted the importance of developing standards for the sector and working to ensure more people could stay at home as they aged.

> *"The need for developing standards in this sector is clear and the focus on an alternative to residential care, particularly in the wake of the pandemic and its impact in residential settings, is welcome."* **Professional representative body**

> *"I live alone without family support. I couldn't remain at home without home support services. Sometimes I feel rushed but understand that Home Support Workers are very busy and do not have much time to get to the next house. I value this service and those who provide it. Think that the regulations will improve services for me and home support workers."* **Service user**

Some also noted that clear guidelines could enable service providers and home support workers to have more clarity about what was permitted, and that this could help prevent breaches of health and safety in areas such as hoist use or medication management.

Greater protection for service users

Many submissions said that the regulations should provide greater protection for service users, and this was particularly important given many were vulnerable due to ill health or reduced cognitive ability. The inclusion of the will, preference and autonomy of the person to lead the service was welcomed by some, as was the inclusion of support for the emotional and social wellbeing of service users.

> *"Home support is generally provided to vulnerable people who, in many instances, will not complain if the standard is poor. Regulation will contribute to protecting the elderly and vulnerable population in our society and keep them safe."*
> **Family member of home support service user**

More qualified workforce and clearer career pathways

Having a better qualified workforce was seen as a major potential benefit for service users. Some said that current training was often minimal or varied enormously between providers and the regulations would ensure much more consistent and higher standards.

Some submissions expressed the hope that a more qualified workforce would lead to more professionalisation, clearer career pathways and better working conditions in the sector. A public sector body said urgent action was needed to address the crisis in the homecare workforce and provide high-quality homecare.

> *"Establishing a minimum standard of qualification for homecare workers would go some way to obtaining a competent workforce. This minimum standard will also help safeguard people in receipt of homecare, and will contribute to the professionalisation of the workforce, thus enhancing job satisfaction and the status of the role in broader society."* **Public sector body**

Some felt that by improving standards and oversight, the regulations would also be beneficial for working conditions and service quality which a worker representative body said was essential.

> *"The poor treatment of staff, especially carers from a migrant background, the lack of training and induction, the poor communication between staff and management are contributing to the poor outcomes for service users. Regulatory measures to improve standards and establish good practice standards are essential. The regulation will be positive if it is enforced, resourced properly and if providers are held accountable."* **Worker representative/advocacy body**

Others noted the benefit of the regulations would only apply if the system was independently monitored and evaluated and the findings were used for ongoing development to ensure better outcomes for all.

Concerns about the regulations – survey findings

Asked if they had any concerns about the introduction of these regulations, 46% of respondents said yes, and 38% said no, while 14% said they were unsure, as shown in Figure 4.

The breakdown by respondent type in Table 3 below shows that there was a particularly high level of concern about the introduction of these regulations in the advocacy body group at 88% and in the public sector body/regulator group at 78%. Amongst those with support needs and family members combined, 40% had concerns, and 40% did not.

It should be noted that a majority of all respondents who had concerns (60 out of 91, or 66%) believed their overall impact would be positive but expressed uncertainty or requested clarification about certain aspects of the regulations.

Figure 4. Concerns about introduction of regulations

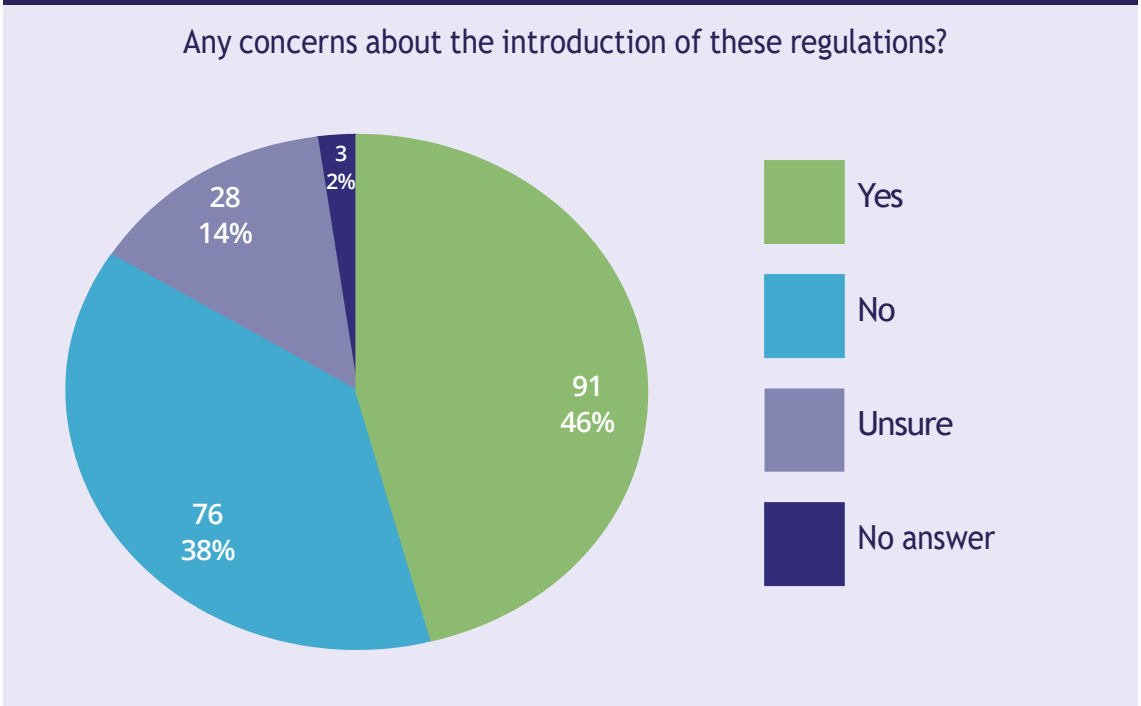


Table 3: Concerns about regulations by respondent type

Do you have any concerns about the introduction of these regulations?*	Yes	No	Unsure	Number
Overall	46%	38%	14%	198
Individual	35%	47%	17%	116
Organisation	61%	27%	10%	82
Home Support Provider	51%	31%	14%	35
Advocacy Body	88%	0%	0%	8
Trade union/ worker representative body	67%	0%	33%	3
Public Sector Body/regulator	78%	22%	0%	9
Healthcare or medical organisation	58%	42%	0%	12
Service user	33%	50%	17%	18
Family member	50%	28%	22%	18
Member of public	29%	57%	14%	7
Home Support Worker	33%	53%	13%	15
Healthcare Worker in hospital or community	34%	51%	15%	47
COMBINED: Person with support needs/ family member	40%	40%	21%	43

**The small numbers in some respondent categories should be considered when comparing differences in attitudes between groups as small differences can lead to wide fluctuations*

Concerns – narrative analysis

Many respondents across all sectors, including some who were very supportive of the regulations, expressed some concerns about their potential impact. The most widespread concerns were related to the impact on staffing and recruitment, followed by concerns about the cost of compliance and the regulatory compliance which some felt could divert care time to compliance activities.

> *"Notwithstanding the welcome and likely positive impact of the regulation of home care, there are diverse risks associated with its introduction, for example, driving up the cost of services; a decrease in the pool of home care professionals initially; home care becoming over-regulated, technocratic and a related diminution of the important person-centred focus; people (care recipients and families) not wanting to report regulation issues to avoid conflict or because of fear of having the home support service withdrawn."* **Public sector body**

Recruitment

Respondents said that existing difficulties with recruitment could be exacerbated by the regulations, in particular by the requirements for formal educational qualifications. There was a concern that some long-time experienced home support workers who were unable to achieve the minimum requirements would be forced to leave the sector while potential new recruits could also be deterred. It was notable that some respondents who supported minimum qualifications also expressed this concern and the impact it could have on meeting service users' needs.

> *"It is essential that the effect of the implementation of the regulations is not to reduce the number of staff currently working in services or to have a chilling effect on the numbers of staff considering working in this sector."*
> **Home support provider network**

> *"I do beg you to consider the ordinary person, already traumatised by an acquired brain injury, stroke or other personal disaster, and to implement any standards so that it does not make finding a home support worker even harder."*
> **Healthcare professional**

Concerns about the potential impact on recruitment are outlined further in Section 3.3. Staffing.

Cost

A number of submissions from providers and the public sector said that the cost of compliance with these regulations in terms of training, documentation and record keeping, could be very high and could lead to smaller providers exiting the market and potentially to reduced service levels.

> *"The implementation of the Standards should not lead to a situation where the cost of provision becomes prohibitive and only the select few get a valuable resource."* **Public sector body**

Concerns about the costs of education and training, supervision and insurance are outlined further in Sections 3.3 (Staffing), 3.4 (Corporate Governance), and 3.5 (Corporate Oversight).

Regulatory requirements and time lost to compliance

Many respondents across different sectors were concerned that compliance could detract from the amount of time home support workers had for their direct engagement with service users because of increased record keeping and documentation demands. They feared it would also place a heavy burden on service management that would be particularly onerous for small providers.

> *"We often see where regulations, no matter how well intentioned they may be, having unforeseen consequences. Also I am concerned that regulations shift resources toward compliance activities, leaving a smaller share of the home support budget for frontline services and workers' wages."* **Service user**

Several submissions, including statutory bodies and providers, suggested a regulatory impact assessment or similar was needed to assess the impact on providers and the sector, and to avoid duplication of compliance activities, particularly in the disability sector. It was felt it was essential to do this before regulation of the sector began, and to give an adequate transition period.

> *"There is a significant risk that without a transition period that a number of providers may choose to leave the market resulting in significant service deficits and capacity issues for the healthcare system."* **Public service body**

Loss of flexibility

There was also a concern that the regulations could lead to a loss of flexibility and shift home support provision to a highly prescriptive and risk-averse model with increased consistency leading to a 'one size fits all' approach. This was a particular issue in the disability sector and amongst those using personal assistance services (see also Section 2.2 on Scope).

> *"I want to self-manage my own care and too much regulation will not allow me to do so. A one size fits all approach does not work for clients with differing needs and preferences."* **Service user**

Several submissions from different groupings including home support workers and service users, felt that home support should be provided in any way the service user wanted as people's priorities varied.

There needs to be a more flexible approach to home support:

> *"Some weeks I do not need help when my daughter is around. Other weeks, I need more hours especially when I have medical appointments myself and there is no one available to care for my wife. I want to keep my wife out of a nursing home."* **Family member**

Two-tier system

As the regulations relate to home support providers and not to individual employment relationships (i.e. where a service user employs an individual home support worker directly), some providers feared this could push more home support workers into a self-employment model that would not be regulated, leading to lower protection for service users. They said there had already been a move towards a number of companies acting as employment intermediaries for home support workers and families, but with no further involvement in how that service is provided and felt the new regulations could intensify that trend. See also Section 2.2 on Scope: Proposed Exclusions.

Workers' rights and conditions

Many submissions from all groupings said there should be measures to improve the pay and conditions of home support workers in the regulations, and without such measures it would be impossible to improve working conditions and address staff shortages.

> *"[We are] concerned that the proposed regulations do not give sufficient mention or weight to the development of a secure, sustainable and professionalised workforce, with due emphasis in the regulations on appropriate terms and conditions of employment, including tenure; elimination of zero-hour contracts; sick pay, annual leave and pension provision; and pay for time and travel expenses when travelling between service users, as well as ongoing annual continuous professional development."* **Medical organisation**

2.2. Scope

This section covers issues raised about what or who is covered and what is not covered by the draft regulations.

What is covered by the regulations

The survey had a number of questions about what activities are covered by the home support regulations. Table 4 below shows that there was strong support for all the types of activity covered by the regulations with at least nine in every 10 respondents agreeing they should cover assistance with mobility, washing, mealtimes etc; reminding or supervising someone to take medicine; help with everyday activities such as shopping, cleaning and cooking; exercise and social engagement inside and outside the home; care for the emotional welfare of the service user such as listening and providing encouragement; and personal assistance (i.e. measures to support independence, health and social engagement). Support for including these activities was generally consistent across all respondent types, although some expressed concerns that regulation would be proportionate to the type of supports provided and would allow for some flexibility in how they were applied, rather than imposing a more medicalised risk-averse model on all.

Table 4: Agreement with activities covered by home support regulations

Do you agree that the home support regulations should cover the following types of activity for those who need assistance due to illness, frailty or disability?	Yes	No	Unsure	Number
Physical assistance with mobility, washing, mealtimes and using the bathroom, or reminders/ supervision of these activities where necessary	97%	1%	1%	198
Reminding or supervising someone to take medication	94%	1%	4%	198
Helping someone to do everyday activities such as shopping, cooking and cleaning	93%	3%	3%	198
Exercise and social engagement inside and outside the home	90%	4%	4%	198
Care for the emotional welfare of the service user, such as listening and providing encouragement	90%	3%	4%	198
Personal assistance (that is a package of assistance provided to support independence, health and social engagement)	94%	3%	1%	198

Physical assistance with mobility, washing, mealtimes and using the bathroom, or reminders/ supervision of these activities where necessary

There was near universal agreement that these types of activities should be covered with 97% agreeing, 1% disagreeing and 1% unsure, as shown in Table 4. One healthcare professional noted that hands on personal care wasn't always needed and sometimes service users just wanted the reassurance of someone there while they performed tasks like personal hygiene, to alleviate the fear of falling.

Reminding or supervising someone to take medication

94% agreed that reminding or supervising someone to take medication should be covered, 1% disagreed and 4% were unsure. A few home support providers who disagreed emphasised they provided social care and/or spiritual support rather than medicalised care. It was notable however that despite the broad support for the inclusion of medication support, many concerns were expressed about the details of how this would be carried out in practice. These are discussed further in Section 9 on Medication Management Support.

Helping someone to do everyday activities such as shopping, cooking and cleaning

Again, there was strong support with 93% agreeing with their inclusion, 3% disagreeing and 3% unsure about helping someone to do everyday activities such as shopping, cooking and cleaning. A number of submissions noted the importance of these activities to some service users, including those who did not have family support. A few said that it would be impossible for some people to remain at home without additional supports such as shopping and home management, so the current system in some areas of only providing personal care was unsustainable.

However some home support workers or representative groups felt that household chores should not be part of the remit of home support workers, and that their inclusion would lead to increased demands on workers to do these types of activities. Others noted the lack of time and the need to prioritise core activities of personal care.

Exercise and social engagement inside and outside the home

Some 90% agreed this should be covered, 4% disagreed and 4% were unsure. Most submissions welcomed the inclusion of exercise and social engagement, noting their importance for service users' health and wellbeing. However there was a request for clarification about what was meant by 'exercise', and it was noted that there might be risks attached to these types of activities, including some that insurers may not wish to cover.

Some suggested that rather than stating 'exercise', 'support for physical activity' or 'movement' should be referenced. More formal exercise might need to be provided by healthcare professionals and home support workers would need to liaise with them about appropriate programmes depending on the person's health condition.

> ***"Exercise would need to be clarified because it could have different interpretations and different requirements and impact as a result. Does this refer to assisting to mobilise, to engage in physical activity or to carry out an exercise programme. To provide this assistance would require direction from a physiotherapist, some aspects would require training."***
> **Professional representative body**

A number of submissions said regulations should be proportionate to the types of activities provided (a view also expressed in relation to personal assistance services).

> ***"A home support service which is mainly 'exercise and social engagement' or provides minimal home support (i.e. facilitating banking, appointments, etc.) should have the regulations applied in a proportionate way and only as applicable to the individual being supported."*** **Home support provider network**

Some felt it was unclear how regulations could cover social engagements outside the home, or how independence could be supported in 30 minute slots. They felt it was unfair to put these types of support in the regulations unless there were budgetary increases in home support funding to cover them. A few submissions from providers and service users said that there might be issues with getting insurance for these types of activities, including the use of personal vehicles to transport service users and these should be clarified to allow them to happen.

Care for the emotional welfare of the service user, such as listening and providing encouragement

There was strong support for the inclusion of care for emotional welfare, with 90% agreeing, 3% disagreeing and 4% unsure. Some noted the importance of psychological wellbeing to physical health and wellbeing. A small number of submissions said however that care for emotional welfare should be provided by family members or a multidisciplinary team, rather than by home support workers. While it was highlighted that most staff were caring and empathetic, it was also noted that they needed more training and support to deal with the needs of service users with cognitive impairment, while time was also an issue providing emotional support.

Personal assistance (a package of assistance provided to support independence, health and social engagement)

There was strong support for including Personal Assistance (PA) in the regulations with 94% agreeing, 3% disagreeing and 1% unsure. However, despite the broad support there were also very significant concerns about how that could be done and a concern that PA service users would be forced into a risk-averse medicalised model of support.

Several submissions, including some from service users and Independent Living groups said it was important the regulations did not restrict service user's own direction of their service and flexibility to determine what type of supports they needed.

> *"Individuals who use a personal assistant service require a service that allows for greater independence, options, choice and empowerment and this is not home care which is mainly home help for the elderly or home care for people with intellectual disabilities. PA services require a greater degree of flexibility as the PA service user is capable and can supervise the day to day activities their PA assists them with little or no need to contact the service provider regularly."*
> **Service user**

> *"Regulation is badly needed, please emphasise the PA and independent living model in addition to those who need support and guidance to manage their lives, many of us do not need a 'care' model, I need a person to do what my body cannot so I can live my life, risks and all, as I choose."* **Service user**

Some PA service providers and service users welcomed elements of the proposed regulations but noted concerns about a generic approach. A public sector body said there should be an emphasis on choice, control and self-direction in the definition of personal assistance (see also Appendix 2). It also said it was crucial to have further consultation and engagement with home support service users, including those using PA services, because the regulations would have a very significant impact on how services were delivered. A number of submissions from service users, providers and public bodies said that the regulations should be proportionate to different types of needs.

> *"The home care regulatory system needs to distinguish between people who require care and support because of frailty or reduced decision making capacity and people who require the support of a Personal Assistant (PA) to carry out the normal activities of daily living, attendance at and participation in work."*
> **Public sector body**

> *"We have concerns about the impact of the generic approach being proposed within these draft regulations and therefore their capacity to guide the diverse models of PA Assisted Living Services included within the regulations for completely different home support services."* **Home support provider network**

An advocacy body said the regulations should align with measures in the Personalised Budget Pilot (a pilot scheme giving people with disabilities greater choice and control of their supports) as people might transition between both systems.

Other observations in relation to what is covered

A number wanted the regulations to explicitly state that they applied to older persons' home support, disability services home support, and personal assistance. Some wanted respite care to be explicitly referenced to support family carers in getting a break from caring duties. Other areas of support suggested for inclusion were accessing education; attending medical appointments; completing application forms and managing bills; use of assistive technology to promote independent living; end of life care planning; support for non-medical religious care and spiritual care; and use of assistance dogs.

Proposed exclusions from regulations

Respondents were asked if they agreed with the exclusion of certain types of home support service from the regulations. As outlined in Table 5 below, there were varying views. Some 69% agreed that home support by a family member or friend should be excluded, and 64% agreed that unpaid home support services should be excluded. However substantial numbers disagreed or were unsure about the exclusion of certain other categories of home support services from regulatory cover. These were children's services, individual employment relationships and services provided only by registered healthcare professionals, where approximately half agreed, and half either disagreed or were unsure about the exclusion (between 1% and 4% did not answer each of these questions).

Table 5: Agreement with services not covered by the draft regulations

Do you agree that the following types of service are NOT covered by these home support regulations?	Yes	No	Unsure	Number
Services for people aged less than 18	49%	28%	20%	198
Home support by a family member or friend	69%	17%	12%	198
Home support services that are unpaid	64%	18%	15%	198
A paid employment relationship between an individual home support worker and one service user	45%	30%	21%	198
Services provided only by registered healthcare professionals (such as nurses or physiotherapists)	50%	27%	20%	198

A public sector body said all care in the home should be covered to ensure equity and avoid confusion to users and the public. It said legislation should set out the government's intention to include all homecare services at a later date, i.e. staged commencement, as otherwise the framework in place might not be suitable for under-18s or those receiving complex care if the scope expanded in the future.

Responses in relation to each exclusion category are presented below.

Services for people aged less than 18

With regard to services for people aged under 18, almost half (49%) agreed they should not be covered by these regulations, 28% did not agree and 20% were unsure.

A public sector body felt the regulations should extend to all in receipt of care in the home including children. Many other submissions also called for their inclusion and said that to avoid gaps in service, under-18s should either be covered or explicit reference made to other equivalent regulations governing those services.

A large provider network noted that while most of its members agreed the regulations should only apply to those aged 18 or over, several members providing services to children and adults said they would welcome the introduction of regulations for those under 18. A provider/advocacy group asked what regulations would cover under-18s if these did not.

Another public sector body said it had concerns about excluding children from the regulations and the impact this would have on upholding their rights, as children's services would not benefit from the same level of independent oversight as services for adults. It stated that this went against Ireland's obligations under the United Nations Convention on the Rights of the Child (UNCRC) and the obligation for state players to ensure private service providers operated in accordance with the UNCRC.

> ***"The [public sector body] therefore encourages the Department to give serious consideration to the inclusion of services provided to children within the remit of the regulations for home support services, with explicit reference made to children and their rights. We believe the failure to do so, or to legislate for their inclusion on a phased basis, could be considered discriminatory."***
> **Public sector body**

It also noted 651 paediatric home support packages had been provided in 2022, and that medical care formed a primary element of these, so services from healthcare professionals should be included in the scope of the regulations.

Home support by a family member or friend

Regarding home support by a family member or friend, there was stronger support for excluding this from the regulations with 69% agreeing, 17% disagreeing and 12% unsure as seen in Table 5.

Of those that disagreed, some advocacy groups said there would be safeguarding concerns if family or voluntary care was not included, and it should be subject to the same safeguards and protections as other forms of care.

A public sector body indicated that the definition of what constituted a 'personal relationship' between a service user and a worker (point (b) in the exemptions listed on page 3 of the Draft Regulations) might need further consideration as it could give rise to abuse where persons avoid being subject to the regulations by virtue of having a certain type of relationship with the service user.

Some service user submissions noted that while it was not possible to regulate family care or unpaid care, there should be a mechanism for investigating concerns, and a new safeguarding policy might be appropriate for that. Another said that for family care where a carer's allowance was received, some evidence of care received was appropriate.

Home support services that are unpaid

For unpaid home support services, 64% agreed these should be excluded, with 18% disagreeing and 15% unsure as seen in Table 5. A number of submissions called for unpaid voluntary services to be regulated to protect vulnerable service users from abuse. One service user submission felt that it was not possible or appropriate to regulate unpaid care (as well as family care), but there should be a mechanism for investigating concerns.

An advocacy group said that voluntary or charitable services did not give special protection from abuse or harm to service users, so if something was deemed a home support service, it should be regulated to ensure appropriate safeguarding and governance standards.

A paid employment relationship between an individual home support worker and one service user

With regard to direct employment relationships where a person using home support employs an individual home support worker, 45% of respondents agreed that these should be excluded from regulation, with 30% disagreeing and 21% unsure, as seen in Table 5.

Many submissions, including from some providers, advocacy groups and state bodies, expressed concern about the exclusion of individual employment relationships between a service user and a home support worker, and the potential for an unregulated sector of home support workers to grow.

Some service providers raised concerns about the potential of creating a two-tier system whereby those employed directly by service users were not regulated, which could result in a drive towards a 'grey market' of unregulated home support. One provider said this could leave service users vulnerable to abuse or exploitation, and they would also have no cover for worker holiday or illness.

Some providers noted there had already been a move towards some companies acting as employment intermediaries for home support workers and families, with no further involvement in how that service is provided; and felt the new regulations might intensify that trend and cause a proliferation of this model of home support provision that would be unregulated.

> ***"While regulation must be proportionate, to leave these types of paid arrangements entirely outside regulation risks encouraging a grey market" which may serve to undercut the very purpose of regulation. Potential "uberisation of care should be considered/addressed in proportionate regulation."***
> **Home Support Provider**

Some service users said that any paid employment relationship should be regulated as it was a professional relationship. A service provider said the regulations should apply to any agency that placed an individual home support worker with a service user.

Services provided only by registered healthcare professionals (such as nurses or physiotherapists)

Similarly, with regard to services provided only by registered healthcare professionals such as nurses or physiotherapists, half agreed these should be excluded from these regulations, but 27% disagreed and 20% were unsure, as seen in Table 5.

A public sector body/regulator said the regulations should include all services provided in the home by a licenced home support provider including professional and clinical care such as nursing, physiotherapy and occupational therapy. It did not advocate regulating these professionals, rather the care and support provided.

Some submissions queried why health professionals such as public health nurses or physiotherapists providing home support were not covered by the regulations and said any paid services should be regulated. Several said there should be oversight and quality control of their work through monitoring and evaluation.

A professional representative body identified the need for communication with primary care physiotherapists to be enshrined in the regulations to ensure safe delivery of home exercise and mobilisation.

Clarity on relationship of regulations to overall framework of home support

A number of submissions called for greater clarity in the regulations on the overall framework of home support provision, and how these regulations related to this, and to the future model of service provision being developed. This includes the primary legislation requiring home support providers to get a licence to operate, forthcoming HIQA standards on home support provision, and the statutory scheme for home support provision being developed by the Department of Health. One submission noted it was difficult to consult on regulations in the absence of primary legislation.

Others also wanted clarity on how the regulations relate to the existing home support system including the HSE Tender systems for home care provision and associated features of these such as Service Level Agreements between providers and the HSE, and whether these would exist under the new model. Clarity on the HSE's role in relation to homecare packages was sought.

> ***"There is no mention of the HSE or HSE homecare packages in the draft regulations. If the intention is for the current system of HSE funded, private sector provided care services to continue, obligations and responsibilities of HIQA, the HSE and providers need to be very clear."*** **Family member**

Greater clarity was also sought on HIQA's role as the regulator of home support providers. A public sector body stated that regulation could not be introduced without an overarching legislative framework, and the regulator of homecare must be equipped with adequate powers to respond in an agile and proportionate manner to non-compliance with the regulations.

Another public sector body said it needed clarity on the underpinning principles, parameters, scope and financing model and/or co-payment model to apply in a Statutory Scheme and associated regulations, and a timeline for the introduction of these, as this information was crucial to the successful implementation of regulation. It also called for clarity on the HSE's role as Commissioner of Services, a home support provider and (potentially) as a provider of last resort in the event of a provider's license being removed.

3 Analysis of Submissions: Sectional Issues

3. Analysis of Submissions: Sectional Issues

This chapter identifies key issues raised in relation to Section 2 (Definitions), to Sections 3-21 and Schedules 1-6 of the draft regulations. It includes responses to questions 9-13 of the public consultation survey which focus on those particular sections, as well as responses to other questions and in freeform submissions which are relevant to these matters. A breakdown of survey responses by section is provided first, followed by key findings from the narrative submissions.

3.1. Definitions: Section 2

Several submissions called for consistency in the use of language and definitions across the regulations and to align with other important health service and HIQA standards and legislation such as the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People).

Particular examples noted where the language should be consistent were the use of the terms Regulator/Authority/HIQA; licenced/registered; service provider/home support provider; and supporting person and specified person. It was also suggested that 'must' or 'will' should replace the word 'should' in the regulations.

Appendix 2 contains details of suggested amendments to definitions outlined in Section 2 of the Draft Regulations, and additional definitions or clarifications sought by consultation respondents.

Rights-based approach

A large number of submissions called for the inclusion of a rights-based approach or specific human rights framework within the regulations. This was particularly important to stakeholders in the disability sector, who were concerned that the regulations reflected a care model for frail or sick older persons rather than for supporting independent living in the community. Some noted that this could result in a risk-averse medicalised model of home support rather than one that could support and empower those using it to live full lives. Others noted that many measures outlined were more appropriate to a nursing home or institutional setting than to an individual's home, and that the ethos of disability services should be reflected more in terms of a rights-based approach.

> ***"There is a significant concern expressed by our members that older persons' regulations have been transposed onto disability regulations rather than the development of a model that is more suited to the rights-based approach under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and which responds to the specific needs of people with Disabilities."***
> **Home support provider network**

The relationship with other acts and conventions including the Disability Act, the ADMA and the UNCRPD was noted and the need to focus on outcomes for service users.

"The current recommendations need to be re-written from a social model of disability and a human rights perspective and in accordance with HIQA's Guidance on a Human Rights-based Approach in Health and Social Care Services. It is vital that the disabled person, as the expert in their own needs and requirements, is involved in this process from the outset." **Disability advocacy group**

Assisted Decision Making (Capacity) Act (ADMA)

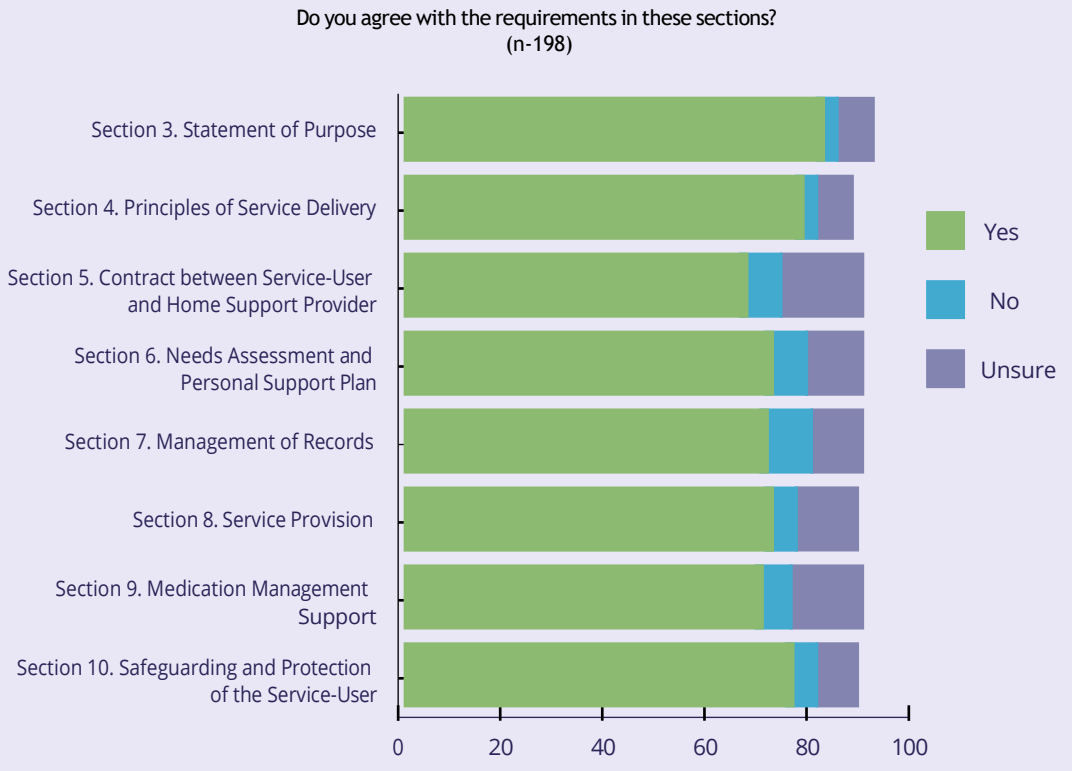
Many submissions noted the importance of the regulations complying with the principles and legal obligations under the ADMA in relation to assessment and provision of home support needs and services and called for more explicit reference to this throughout the regulations. This included the need to communicate clearly with service users in relation to service provision, assessments and contracts, and to reference a clear legal basis for the transfer of information or sharing of health data with the 'supporting person'.

3.2. Service Delivery. Sections 3-10

Sections 3-10 of the regulations set out key aspects of service delivery: Statement of Purpose; Principles of Service Delivery; Contract; Needs Assessment and Personal Support Plan; Management of Records; Service Provision; Medication Management Support; and Safeguarding.

As indicated in Figure 5 below, between 67% and 82% of respondents agreed with the requirements in these sections, while between 4% and 10% disagreed, and between 7% and 16% were unsure. Full breakdowns are given in Tables 6-13. The sections with the highest levels of disagreement or uncertainty were contracts, needs assessment, management of records, service provision and medication management support. The sections dealing with statement of purpose; principles of service delivery; and safeguarding and protection of the service user had the highest level of agreement.

Figure 5. Agreement with requirements of different sections



A full breakdown and summary of key points is provided with each individual section below.

Statement of Purpose (Section 3)

This is a document prepared by the service provider outlining the services it offers and the intended service users needs. As seen in Table 6 below, 82% agreed with the measures outlined, 4% disagreed and 7% were unsure.

Table 6: Agreement with requirements of Section 3: Service Delivery

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 3: Statement of Purpose	82%	4%	7%	8%	198

The main issues raised included the format and dissemination of this – some stressed it should be provided to service users in hard copy as a matter of course as many older people did not use the internet. Others felt a provider website was the best place for it, particularly to allow for regular updates.

A few said the Statement of Purpose (SOP) was too long (particularly in relation to the Schedule 1 requirements) and one suggested that the level of detail required might break GDPR or confidentiality rules. A public sector body said that some details in the Statement of Purpose listed in Schedule 1 in the draft regulations were unnecessary as they were contained in other policies. One advocacy body said there should be a SOP in the regulations themselves stating what home support was and who was entitled to it, and this should align with the Sláintecare implementation plan. Another called for it to state that the service provider would make every reasonable effort to address the will and preference of users.

Several submissions, particularly from advocacy groups, called for Plain English and Easy Read versions of the SOP and other user-relevant documentation, outlining the person-centred behaviours expected of home support workers. Another said it should be provided in a person's native language if they didn't comprehend English, and oral (audio) version and other accessible formats should be available as needed. A public sector body suggested that Section 3(2) should be amended to read that the SOP should "contain the information as set out in Schedule 1" as Schedule 1 did not contain a list of services. Two submissions from providers said that private companies were entitled to change their focus or develop into a different type of service – it should be enough to notify the regulator of changes rather than seek approval for this as required in Section 3(7).

Principles of Service Delivery (Section 4)

This requires service providers to publish a charter of service delivery outlining the quality of service and types of behaviour a service user can expect in interactions with the service provider's employees. As seen in Table 7 below, 78% of respondents agreed with these requirements, 4% disagreed and 7% were unsure.

Table 7: Agreement with requirements of Section 4: Principles of Service Delivery

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 4: Principles of Service Delivery	78%	4%	7%	11%	198

Similar to the SOP, there were calls for this charter to be accessible, available in different user-friendly formats and provided as standard to service users (rather than purely on request). Some wanted the values and behaviours expected of both parties to be included, e.g. respect, compassion and dignity, while one called for an additional point to ensure principles were applied in practice. Another said it should include service quality indicators that the provider aimed to achieve, and for home support users to be involved in this document. Providers had varied views – some welcomed it, but some felt that a separate charter was not needed as the same could be captured in the contract or statement of purpose and one noted that individualised charters (and statements of purpose) would be completely inoperable as many cases were emergency or palliative discharges, while there were also continuous changes in service user needs.

Contract between Service user and Home Support Provider (Section 5)

This section outlining the details of what must be in a written contract about the service which providers will supply to the service user was one of the most commented on sections, raising many concerns. As seen in Table 8 below, 67% of respondent agreed with the requirements, 8% disagreed and 16% were unsure.

Table 8: Agreement with requirements of Section 5: Contract between Service-user and Home Support Provider

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 5: Contract between Service User and Home Support Provider	67%	8%	16%	9%	198

One of the major concerns raised was the introduction of individual contracts between service users and service providers, and what the legal implications of this would be for providers, and for the HSE as the main funder and commissioner of home support services. The relationship to Service Level Agreements (SLAs) which are currently the main mechanism governing the relationship between the HSE and service providers was also queried. Several noted that more clarity was needed on the contractual relationship between the provider and Commissioner (HSE) on the one hand, and the provider and service user on the other, as this was crucial for governance, and it was not clear how the former would affect the latter.

One submission said that in the case of publicly funded home support, the service provider would be the HSE and private providers were subcontractors to them – any change to this would have significant impact on all aspects of home support provision. A public sector body said it had concerns about the legal implications for contract provisions as it was both a service commissioner and service provider.

Breaches of contract and legal cases

Several providers expressed concern that the new individual contracts could lead to litigation and cases for breach of contract, and some felt they would cause anxiety and confusion for service users. It was noted that there was a wide range of reasons why services might be disrupted, and it needed to be clear what constituted a breach of agreement.

> *"This is the first time we have been notified of contracts between clients and providers and will lead into a legal contractual relationship that has not existed in previous homecare tenders. Contracts between providers and service users [are] likely to cause confusion and increased legal issues."* **Home support provider**

Another submission said that individual contracts were currently discouraged by the HSE. One provider suggested that an alternative approach might be to require service providers to enter a contract with the service user unless the services were provided pursuant to a contract with the HSE. State funded clients could be referred to a provider after an initial HSE determination of the level of need and service, with the provider then doing a needs/risk assessment and agreeing a care plan.

A public sector body noted the importance of providing for minimum required terms in a contract for care with service users and said it was important these were consistent and mirrored the provision in designated centres unless there was evidence-based need to make specific provisions for home-based settings. It noted that some service users could have capacity issues and there could be a question over whether an enforceable 'contract' was in place – so the use of that term might need consideration. Some submissions suggested the term contract be changed to agreement or written agreement to reduce legal risks.

It was also requested that a template contract be provided to help clarify what was needed, as individual contracts for state funded client services were a new departure and providers would need to get legal and insurance advice on the implications.

There was also a view that the terms required in contracts were too specific and might reduce flexibility. There were calls to clarify the relationship between the care plan and the contract, and to specify what should happen if shifts could not be covered as not all providers could guarantee this.

Notice of cancellation

Some providers were concerned about the 3 month notice period for cancellation of a service, saying this would be impractical, and that more criteria for cancelling a service at short notice should be included. This could include a staffing crisis, pandemic or unsafe environments/abusive persons which could put staff at risk. However, others felt it should not be possible for a service provider to cancel a service at short notice, or only if very specific criteria were met, or with a clearly outlined process guiding cancellation.

A small number of submissions from providers said that if services could be cancelled by the service user at short notice, there could be financial implications for service providers, particularly small community organisations. They said the 3 month cancellation notice period should work both ways as a lack of security for the home support worker was a disincentive to recruitment.

Needs assessment and personal support plan (Section 6)

Section 6 of the draft regulations outlines the requirements for a needs assessment and personal support plan to be carried out by the service provider before providing home support. 72% of submissions agreed with the proposals, 8% disagreed and 11% were unsure as outlined in Table 9 below. The major issues raised were how these related to HSE assessments (if any), and who would carry them out.

Table 9: Agreement with requirements of Section 6: Needs Assessment and Personal Support Plan

Do you agree with the requirements set out in...	Yes	No	Unsure	No answer	Number
Section 6: Needs Assessment and Personal Support Plan	72%	8%	11%	9%	198

Clarity was sought about the needs assessment, who would carry this out, and how it related to current practice where this is carried out by HSE professionals. Many submissions asked for clarification of this in relation to publicly and privately funded services, and on the role of the provider, funder and commissioner of services in this.

> *"There are significant financial, governance and clinical risk issues should the care needs assessment or clinical review be undertaken by a private or voluntary home support provider."* **Public sector body**

> *"Is the expectation that the needs assessment be completed by the provider or by the referrer/funder. The regulations do not acknowledge that is usually not [the] provider who decides the number of allocated hours this is the responsibility of the funder."* **Advocacy body**

A number of submissions, particularly from providers, questioned how this needs assessment would be carried out in practice, as if the responsibility of providers, it would require them to employ relevant healthcare professionals which would be unrealistic for many providers. Some noted that the HSE clinical assessments required to fund home care package effectively covered client assessments. A number also noted there could be issues about service user capacity when carrying out assessments and the fact medical information was not supplied to private providers from health services. One service user said they would be very unhappy to have a service provider carry out a needs assessment as they stated that none they had ever engaged with would have the expertise to carry this out.

Some suggested a more holistic assessment was needed to include social and psychological needs, though noting a budget would be needed for this. Several submissions from medical organisations and advocacy groups wanted provision for social care professionals as well as health professionals to be able to carry out needs assessments. They noted that as the definition of home support services was very wide, some service users' needs would be more social than medical.

A professional body called for assessments to be carried out using the InterRAI tool (a standardised assessment tool used by the HSE) and by the public health nurse or community registered nurse to ensure continuity of care and clinical governance. Others noted that at the very least standardised assessment tools would be needed to avoid inconsistency. It was noted that there was no comprehensive standardised assessment in disability services, and clarity was needed about whether a specific tool or assessment should be used.

One professional body submission called for consultation between the healthcare professional who carried out the needs assessment and the home support worker to transfer knowledge. Another professional body said that home support workers should link in with healthcare professionals prior to discharge from hospital to learn how to assist service users in a way that would facilitate increased function and independence. Some felt that needs assessments and support plans should be reviewed more regularly than once a year.

Personal support plan

Some organisations and individuals welcomed the personal support plan requirements as a positive move in allowing for more person-centred care, although the allocation of additional staff for this and clarification of who was responsible would be essential, particularly around the role of the public health nurse. A home support worker representative body said that the goals of the service user should be the most important factor when drawing up the support plan. A member of the public said that enablement should be at its centre unless there were good reasons not to. A medical body stated that the personal support plan should include provision of an end of life care plan while a provider said more consideration should be given into how telecare could be incorporated into the plan.

Management of records (Section 7)

This section outlines what records should be kept in relation to the service user and their home support service, and how these records should be maintained and transferred if necessary. As seen in Table 10 below, 71% agreed with the requirements, 10% disagreed and 10% were unsure. The major issues raised with these requirements were the volume of records to be kept, the format, and GDPR issues around sensitive data.

Table 10: Agreement with requirements of Section 7: Management of Records

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 7: Management of Records	71%	10%	10%	10%	198

Volume and format of records

Submissions from providers said that there could be large volumes of records over many years, and it would be impractical to provide copies of all of them such as daily logs. They called for clarification of what records needed to be maintained and transferred if switching service provider.

A number of submissions from different groupings said that record keeping should not become the primary focus of the home support worker. Others suggested that time could be allocated and funded to home support workers for record keeping, or that minimum records should be kept. One suggested a standard template be developed for all records, care plans, referrals and assessment forms to ensure consistency.

Some noted the importance of recording times of home support visits to monitor attendance. Another called for safeguarding complaints to be included in records, and one called for information about ethnic and social background to be recorded to facilitate better service planning.

There were different views about the format of record keeping. Several submissions from medical organisations, providers and advocacy groups, said the proposals put too much emphasis on hard copy records, and electronic records should be acceptable and encouraged for all records including the home support file, with suitable devices provided to workers to do this securely. It was argued that electronic logs and records would be easier to monitor and manage, as well as complying with government policy on greater use of Information Technology (IT).

However, some felt it was important to maintain written records in the home unless specific circumstances made it inappropriate. A public sector body felt that there could be data protection issues about storing records in the home of someone who was vulnerable due to frailty or reduced capacity, as they might be inappropriately seen by relatives or visitors. One provider network said that there should be arrangements to store records off site for those who did not want or have room to store them in their home, while another called for records to be stored digitally but made available in hard copy upon request.

GDPR legal basis

Several submissions called for an explicit legal basis to be included for keeping and transferring documents to ensure providers could be GDPR compliant (General Data Protection Regulation). They also noted the regulations should be compliant with national policies and guidelines, with strengthened GDPR provisions including time limits for retaining records. One said there needed to be clear service user authorisation for certain records to be kept or for transferring information from a person's house to the custody of a service provider, while another called for regular copying and transfer of records from the home to the service provider with measures to prevent loss or damage. Another called for clarity around who was responsible for the collection of records during care and after its termination.

Some submissions said that there could be information noted about third parties that might be relevant for carers, but this should not be handed over when transferring service. Some submissions including one by a home support worker noted that record keeping rules were important as there were currently some poor practices such as sending client care plans via WhatsApp on unlocked phones.

Service Provision (Section 8)

This section outlines the broad requirements for home support arrangements such as specification of time and staff allocation, and when these can be altered. As seen in Table 11 below, 72% agreed with the requirements, 6% disagreed and 12% were unsure.

Table 11: Agreement with requirements of Section 8: Service Provision

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 8: Service Provision	72%	6%	12%	11%	198

The main concerns raised about these measures were about time and staff allocations and the potential that providers would be in breach of contract too easily if they needed to change arrangements at short notice. Providers noted the complexity of managing home support teams across geographical areas and said the regulations should reflect the practical realities (see also contracts). One provider said it was not feasible to record changes in times in the support plan, but this could be recorded by the supervisor and noted in the service user's file.

Some service users and advocacy bodies also noted that times of service and tasks completed should be recorded and periodically reviewed to ensure compliance with the care plan. Another suggested including requirements for reasonable accommodation to ensure good communication with the service user, for example; assistive technology, interpreters or translation apps.

One advocacy group suggested that a notice board with home support schedules and photo IDs of home support workers should be in clear view in service user homes to reduce anxiety, with reminders by text or phone call. Several called for systematic advance notice of changes of home support worker and of holiday leave, illness retirement etc. Many submissions agreed with the requirement to try to assign the same support worker to an individual service user, though one stated this was not always a good idea.

A public sector body felt that the requirements on specifying details of service provision (also referenced in the contract section 5 item 5c) were not practical as any change in the time of service delivery or change of staff without service user agreement might be considered a breach of contract.

> *"Home support staff, whether HSE directly employed or those employed by providers, work in teams covering a number of clients in a geographical patch. It is not practical to guarantee assignment of the same staff member to an individual client. This section needs to be reviewed and amended to reflect the practicalities of delivering a service in the community."* **Public sector body**

Medication Management Support (Section 9)

This section details the policy providers must have in place on how medications management support is provided in the home. As outlined in Table 12, some 70% of respondents agreed with the requirements, 7% disagreed and 14% were unsure. This area

generated much discussion. Although some welcomed the greater responsibilities given to home support providers in medication management support, others said there were risks associated with this, and significant training and resources would be needed to implement it. It should be noted that in the separate question on overall scope (Table 4 in Section 2.2), 94% agreed that "reminding or supervising someone to take medication" should be covered by the regulations, 1% disagreed and 4% were unsure.

Table 12: Agreement with requirements of Section 9: Medication Management Support

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 9: Medication Management Support	70%	7%	14%	9%	198

A number of submissions including one from a professional body said that medication management support was fundamental to keeping people at home and should be a key aspect of home support. A service provider said that medication management was a grey area with a fine line between opening a blister pack and administering medications – however not providing support was counterproductive to the future of homecare. It suggested expanding the scope of home support workers in line with social care roles might be needed to allow for safe administration, with significant training needed. Some welcomed the new focus on policies and training in this area.

Some submissions that welcomed the measures said clear procedures were needed in areas such as prescription medication, eye drops, pain patches and topical creams, and around dementia in clients living alone who need full assistance with medication management. One advocacy body said there should be a specific reference to supporting a person to follow best practice inhaler technique and to monitor inhaler expiry dates and dosages. One provider said that provision for administering rescue medication was also essential where service users had conditions like epilepsy – as otherwise services might not be able to provide respite care to families.

Risks and training

Concerns about the risks associated with managing/administering medications were expressed by some providers, service users and advocacy groups. They stated significant training would be required to equip home support workers with the skills and knowledge to do this safely. Some said medication management should only be undertaken by trained professionals and home support workers should only be allowed to prompt, but not administer medications.

Several submissions from the disability sector and home support workers expressed that medication management support should not be an expectation for all service users as it would require a significant increase in staffing and funding to implement. They felt that medication management was too big of a responsibility for home support workers given the high risk of medication errors and potential adverse impacts, as well as the high level of training and clinical supervision necessary for it.

An advocacy body said that medication management was an area of concern as most Personal Assistants were lone workers with no means of double-checking medication and would not have access to the type of clinical oversight needed. Some providers felt that medication supervision implied the home support provider was accountable for it and would require extensive training beyond the remit of non-medical home support workers, while insurers might also raise concerns. Some felt that it was fine for home support workers to collect prescriptions, but they were not qualified or skilled in administering medicines. Community health professionals said policies on medication management should involve their input.

Some submissions noted that the current HSE Tender only allowed for medication prompting, not administration or management. The training and assessment of competency required to administer medicines would not be feasible for home support providers to achieve for all staff, so each provider should determine its own medication policy.

It was also noted that some of the measures around handling and storage medications were more like those applicable in a nursing home where there was direct clinical oversight. Some felt that this model was not transferrable to home support as a service provider could not 'ensure' safe storage of medications in a person's private home. Suggestions for this section included setting out details of specific medication support needs in a person's care plan, and that the service provider should monitor adherence to the policy.

Consent

Some submissions noted concerns relating to service user consent for medication management and the legal authority of the support person to give consent. An advocacy group felt that the consent clause in this section did not align with the HSE Consent Policy or the ADMA requiring the consent of the person before starting any treatment or investigation. Another said that the legal authority of the supporting person needed to be explicitly stated if they were giving consent to medication management on behalf of the service user.

One service user stressed that while they wanted home support workers to be aware of regulations around medication, they did not want that worker coming in telling them when or if they could take their medication. Another said they had an issue with carers not being able to assist with medications currently, even if clearly instructed by the service user. Another submission suggested a clear reporting pathway for medication errors and near misses, and for both the supporting person and relevant health professional (not either/or) to be informed of these.

Safeguarding and Protection of Service user (Section 10)

This section details requirements to ensure the security, safety and protection of the service user and their home. As outlined in Table 13, 76% of respondents agreed with the requirements, 6% disagreed and 8% were unsure. The main concerns were about the scope of the section, with some suggestions about practical changes to strengthen safeguarding.

Table 13: Agreement with requirements of Section 10: Safeguarding and Protection of the Service User

Do you agree with the requirements set out in ,,,	Yes	No	Unsure	No answer	Number
Section 10: Safeguarding and Protection of the Service User	76%	6%	8%	10%	198

A number of submissions expressed concerns about how service users whose home support mechanism was not covered by these regulations would be protected from abuse, e.g. those directly employing a home support worker, those receiving unpaid or voluntary home care provision.

Calls were made to broaden the approach by implementing the HSE safeguarding framework within home support services, or by following the national policy on safeguarding vulnerable persons (forthcoming for the health and social care sector), or the measures proposed in the Adult Safeguarding Bill 2017 (not enacted).

Broader definitions of abuse were requested to include coercive control, discriminatory abuse and organisational abuse, and one suggested using definitions aligned with ADMA legislation (see also Appendix 2). An advocacy group suggested using similar language on advocacy as detailed in the Health Act 2007. Stronger measures for case managers or key workers to support advocacy were suggested.

There was concern about older or ill people, and those with dementia not having the opportunity to report abusive treatment to supervisors, and a suggestion to hold regular private meetings where they could do so. It was also suggested that the section on communicating with those with additional communication needs (Sec 10(2)(b)) be strengthened. A service user said that this section did not adequately reflect safeguarding issues affecting service users aged 18-65 who could recognise abuse themselves

A trade union submission called for the inclusion of the right of representation by a trade union official for any staff member who had a safeguarding allegation made against them. There was also a request for any employees or former employees of a home support service to be excluded as financial beneficiaries of a service user (as well as the service provider itself being excluded). It was also noted that there were no details of provisions to review or investigate allegations of abuse by staff as outlined in a previous version of the draft regulations.

3.3. Staffing. Sections 11-13

Sections 11-13 cover staffing requirements including how staff are recruited, trained and supervised in providing care, as well as minimum qualifications and the timeframes for getting these. As indicated in Tables 14-17, between 57% and 78% of respondents agreed with these measures and between 9% and 16% disagreed. Between 11% and 17% were unsure about the requirements. Section 12 on qualifications, training and development generated the most concerns.

Staffing (Section 11)

This section deals with staffing requirements for services including staffing levels, Garda vetting, communication ability and the need to have robust identification documents. As seen in Table 14, below, 70% agreed with the requirements, 9% disagreed and 11% were unsure.

Table 14: Agreement with the requirements of Section 11: Staffing

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 11: Staffing	70%	9%	11%	10%	198

Some providers stated that the recruitment crisis for home support workers meant it might be difficult to always maintain staffing levels at the level specified.

Some submissions from healthcare bodies, a family member and a home support worker called for a minimum level of English to be specified or for the communication requirement to specify an ability to communicate with the service user a worker was assigned to. It was also queried if effective communication related to written and oral competency in English and how this was to be achieved.

Some noted that international police clearance was causing issues currently with recruitment of staff, especially for those coming from Ukraine. Some submissions suggested alternatives such as legal affidavits or annual self-declarations should be considered for these exceptional situations.

One trade union submission requested the inclusion of staffing protection measures and of disciplinary procedures including rights of representation for home support workers.

Qualifications, Training and Development (Section 12)

This section deals with minimum educational requirements for home support workers and the timeframes for getting these. As seen in Table 15 below, 57 % agreed with the requirements set out in this section, 16% disagreed and 17% were unsure

Table 15: Agreement with requirements of Section 12: Qualifications, Training and Development

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 12: Qualifications, Training and Development	57%	16%	17%	10%	198

A separate question was asked about the overall requirement for all home support workers to get minimum educational qualifications within a set timeframe (whereas the previous question related to the specific requirements outlined in Section 12). As shown in Table 16 below, 78% agreed, 12% disagreed and 9% were unsure. This indicates that while almost eight out of 10 respondents (78%) agreed with the broad concept of minimum educational requirements, a smaller proportion (57%) agreed with the specific requirements outlined (though still a majority).

Table 16: Agreement with requirement for all home support workers to have or get minimum educational requirements

	Yes	No	Unsure	No answer	Number
These regulations will require all home support workers to have minimum educational qualifications, or to get these within a set timeframe. Do you agree with this?	78%	12%	9%	1%	198

Many submissions across all sectors supported the minimum qualifications and said that they were essential to allow for higher standards of care, greater protection of service users, and more professionalisation of the workforce. Some said proper training was crucial to protect vulnerable service users and ensure taxpayers' money was spent properly. Several submissions expressed the hope that mandatory qualifications would also lead to clearer career pathways and improved pay and conditions in the sector – and suggested pay should reflect higher qualifications to reward and retain staff.

> *"It is essential for both the individual service user and the home support worker that the role of the worker is seen as a professional, valued role. As well as a high standard of education, continuing professional development will be necessary as part of an overall staff retention policy."* **Advocacy body**

Some said that regulations and qualifications were essential to ensure quality care and protection of service users.

> *"From my experience carers often have very little training if any and induction comprises of observing another carer for a very short period. In many instances the carers are kind and caring and try to do their best but with lack of knowledge and training can unknowingly cause harm."* **Family member**

A few submissions also felt that the five year timeframe specified for achieving QQI[8] Level 5 qualification was too long and should be reduced to between one and three years. One suggested 12 months to pass the mandatory modules and a further 12 months to complete the full qualification, with financial incentives to complete these.

Some service users and advocacy groups felt that personal qualities or interests of workers should be recognised as these might be more important to some service users or that qualifications should be proportionate to what was needed, with sufficient time allowed to let workers achieve them.

> *"The timeframes for these qualifications should be mindful of the nature of this work, physically demanding, low pay. Please do not put the qualifications beyond the reach/barrier of good workers who may not be able to achieve this if hours require the person to not work without pay/ impact on family life (vast majority of workers are female). Please be mindful of the barriers that might drive very essential workers away."* **Family member of service user**

[8] QQI (Quality and Qualifications Ireland) is the state agency that provides quality assurance on educational qualifications.

Recruitment and loss of workers

Many submissions - including some that were broadly supportive of minimum educational requirements - expressed concerns that the educational requirements would worsen the recruitment shortage, particularly as the typical worker profile included many people who were returning to the workforce or were a long time out of the education system and might be put off by minimum entry standards or the need to get qualifications. Several provider submissions said that some excellent workers might not have the literacy or IT skills, or the confidence to undertake formal educational courses and might be lost to the sector as a result.

> *"A new employee will seven times out of ten be a lady in her 40s or 50s returning to work after child rearing or caring for a loved one of her own. To have 2 QQI modules an essential component of her recruitment is a barrier to her progressing as she may be daunted by doing the course."* **Home support provider**

One advocacy body warned that while minimum educational standards were highly desirable, providers must be supported to achieve this or else they might be unable to recruit and retain enough staff to deliver services, which would be detrimental to those in need of supports. See also Section 2.1 on Concerns.

Types of qualifications

Many respondents, particularly providers, suggested apprenticeship-style 'earn as you learn' schemes or supported qualifications within the workplace, or easily accessible training modules within the HSE land system (a HSE online learning portal).

Some providers suggested that certificates of competency be used to recognise past experience – one suggested the HSE Carer Competency Assessment form could be used annually to review worker skills and others called for affordable training and recognition of skills and experience, including essential personal skills such as empathy.

> *"All home support workers need to have a pathway to having qualifications recognised (including non-EU qualifications) and to turn competences into qualifications (e.g. someone with low academic qualifications but long experience of care work should not be excluded by these provisions) … . In support of the regulations, it is important that the state ensures there is access to training and that it is affordable to low income workers, including migrant workers."*
> **Advocacy body**

It was felt that appropriate qualifications should be tailored to the homecare environment as existing QQI qualifications were often more tailored to nursing home care. Some suggested the training modules needed for home support should be specified with an emphasis on assessment of practical skills, and it was better to specify these requirements in standards rather than regulations. The importance of recognising international and other qualifications was also noted given the multinational workforce profile.

Qualifications proportionate to role

Some submissions, including by family members of service users, suggested that home support workers could be permitted work in certain lower-risk areas while they got qualifications – but should require qualifications before working in certain areas such as intimate care or dementia care.

A number of submissions from service users and others felt that qualifications should be proportionate to the type of care provided – for example light housework, shopping or social interaction might not require minimum standards. One service user noted they had a personal assistant to help with shopping and household tasks, while other home support workers helped them with personal care, transfers to a wheelchair and catheter bag management. They felt the latter should have education and training, but the former would not need qualifications.

Further training

Many submissions suggested additional or ongoing training/continuous professional development was required to allow workers to increase their skills and provide more complex care. Specific additional training elements suggested included: patient moving and handling; assisted decision-making; effective communication; end-of-life care; disability module for those working with disabled service user; mental health training for those working with service users with mental health issues; safeguarding; medication management; epilepsy treatment (buccal midazolam); asthma care and inhaler use; peg feeding and bowel care.

Clarification of timeframes

Some submissions asked for clarification as to when the 3 year/ 5 year period for achieving a Level 5 QQI qualification started, and if it began again if the worker switched jobs, which some felt could encourage provider-hopping. Clarification on the starting point of the window for qualification was also sought, i.e. January 2022 or the year of commencement of the regulations.

Cost

Submissions from home support workers, representative groups and providers noted the costs associated with minimum qualifications and stated that low-paid workers must not bear the brunt of these. Some questioned whether there would be state support for these, or if the HSE or employers would meet the costs. Respondents warned that providers must be resourced to help staff meet the qualification requirements to avoid deepening the recruitment crisis.

> *"I feel that the amount of qualifications required and cost will push people away from the industry."* **Home support worker**

Some further observations relating to training are set out in the section Schedule 4: Induction Training.

Supervision of Staff (Section 13)

This section deals with supervision, mentoring and shadowing requirements for home support workers. As seen in Table 17 below, 67 % agreed with the requirements, 10% disagreed and 12 % were unsure.

Table 17: Agreement with the requirements of Section 13: Supervision of Staff

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 13: Supervision of Staff	67%	10%	12%	12%	198

A public sector regulator said that providers would need support to understand what was meant by supervision, the difference between mentoring and supervision, and the skills, knowledge and experience required of a supervisor.

Submissions from family members welcomed additional worker supervision. However, some providers expressed concern at the requirement that inexperienced workers be supervised or shadowed for the first 20 hours of direct service user contact, saying this could put an excessive strain on smaller companies. Some providers also queried who would pay for it, noting there would be significant costs and resources needed.

> *"The one size fits all approach to a limited selection of educational qualifications combined with an onerous 20 hrs induction and 20 hrs supervision/shadowing is too prescriptive and lacks flexibility or recognition of employee prior qualifications, experience, or level. It has a chilling effect on recruitment of workers and is not recognised in the HSE costings."* **Home support provider**

Some submissions said managers should be available out of hours to support staff, and that guidance should be given on the supervisor role and minimum qualifications required for it.

3.4. Corporate Governance. Sections 14-16

Sections 14-16 of the regulations sets out key aspects of corporate governance: management of the service; reporting data to the regulator; and financial procedures. Around seven in every 10 respondents broadly agreed with these measures while around one in five either disagreed or was unsure as outlined in Tables 18-20 below.

Management of the Service (Section 14)

This section deals with requirements for clear management of the service including monitoring the quality of home support provided, management structures, maintaining records and providing contact details to service users. As seen in Table 18 below, 71% agreed with the requirements, 7% disagreed and 12% were unsure.

Table 18: Agreement with the requirements set out in Section 14: Management of the Service

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 14: Management of the Service	71%	7%	12%	11%	198

Accountability structures

Several submissions called for clearer accountability and management structures within each provider to be specified with more detail on who was responsible for different aspects of service provision. One called for these structures to be applied to self-employed personnel recruited through an organisation also.

Submissions from public sector bodies and providers said it was important that those managing a home support service were qualified to do so – some suggested that requirements similar to those applicable in nursing homes be applied, e.g. that the person in charge should be a Director of Nursing or Nurse Manager, while others suggested a minimum FETAC Level 7 award in health or social care be required (potentially with a time window to achieve this), and a minimum of three years' experience in a management or supervisory role.

A public sector body felt that the wording of this section should be reviewed to avoid repetition with Section 7 on the Management of Record. A public sector regulator said it had concerns about the enforceability of some measures which may be more appropriate to set out in primary legislation. Further clarification was also requested in relation to records required, management structures and required certificates and licences.

The requirement for service providers to give service users contact details for managers was welcomed as important.

> *"It seems so basic, but we are constantly getting calls from family members of service users who are under the care of other companies. They do not know who to call as they need to cancel or because a carer has not arrived. When you ask them do they have a contact number for the provider, they reply no, that they are just ringing around until they get the right one."* **Home support provider**

Oversight and service user input

Several submissions felt that providers should have to prove their compliance with quality standards and should not be allowed 'mark their own homework'. One suggested annual HSE audits be included.

More service user input was also called for, with some suggesting service providers should be required to have panels of service users/family carers or similar within their structures to inform service planning and implementation. Some wanted feedback from home support workers to be actively included in quality assessment.

> *"Much more emphasis needs to be placed on the Client being a part of the governance and quality assurance process and they need to be able to hold services to account, this requires rigorous, criterion based policy check lists."* *Service user*

There were also calls for this section to specify reportable incidents and the thresholds for these, including, for example, alleged or confirmed incidents of abuse and unexpected deaths, similar to nursing home requirements.

Insurance

A number of submissions from providers noted issues with specifications around necessary insurance cover, such as business interruption costs and loss of earnings. They said there had been 50% increases in insurance costs in the last three years and raised a concern that additional liability cover might not be recoverable from the market or available from insurers – one suggested that the State Claims Agency should be responsible for cover where a provider was licensed and had entered a Service Level Agreement with the HSE. Another suggested the insurance level for self-employed personnel should be considered within the regulations.

Reporting Data to the Regulator (Section 15)

This section outlines the details of what should be included in an annual report to the regulator or other government agency. As can be seen in Table 19 below, 72% agreed with the requirements, 6% disagreed and 12% were unsure.

Table 19: Agreement with the requirements set out in Section 15: Reporting Data to the Regulator

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 15: Reporting Data to Regulator	72%	6%	12%	11%	198

Clarification was requested on who the regulator was, HIQA or the Department of Health. There was also a call for the regulator to have an audit and verification function to validate data with consequences for inaccurate information and for aggregate data to be published to inform research and review of the sector.

Regulatory Compliance

Some disability sector providers noted concerns about introducing a new regulator and called for a regulatory impact assessment given they already had to report to the HSE Disability Services with statistics, financial and compliance reports.

Some submissions from providers said that reporting should be kept to a minimum to avoid too much form-filling and to protect service users, and that there should be realistic timeframes. One suggested making it quarterly rather than annual would reduce administrative burden and resolve any problems quickly with the funder. Another said state agents should be responsive to feedback on regulatory burden.

Some providers said the level of information required was very onerous as staff and service user numbers fluctuated so numbers would only be correct at a specific date.

Additional reporting suggestions

However, others wanted more data to be reported, e.g. on care needs, disability type, age and gender, staff qualifications and user feedback. A number of submissions suggested that notifiable/serious events should also be reported, potentially similar to what was

required in designated centres. Some suggested safeguarding issues and high-risk events such as falls or pressure sores be reported, with a schedule of these to allow continuous monitoring of safety and quality of service.

Some advocacy group submissions called for the number of home support hours provided, and approved but not provided, to be included in reporting, and for this to be checked with service users; and for the ratio of managers and staff to service users to be declared and available to service users.

Some felt that data protection and data sharing requirements should be considered in this section, or that not all incidents should be reported.

Financial Procedures (Section 16)

This section deals with requirements in relation to fees, payments and fee increases. As shown in Table 20 below, 68% agreed with the requirements, 6% disagreed and 14% were unsure.

Table 20: Agreement with the requirements of Section 16: Financial Procedures

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 16: Financial Procedures	68%	6%	14%	12%	198

While some submissions welcomed the introduction of financial controls saying it would bring greater transparency and protection for service users, others queried how regulations could be put in place governing fees and fee increases for private provision of home support (i.e. hours not funded by HSE home support packages).

Relationship of financial procedures to HSE home care packages

Several submissions expressed confusion about this section given the vast majority of home support by private providers was HSE funded so all financial transactions were conducted via the HSE. Some were concerned that this section of regulations might suggest that home support package hours would have to be paid for by service users or that means testing of home support provision would be introduced. Greater clarity was requested on this and on how these measures related to the HSE commissioned and funded model of home support.

It was also felt that financial procedures appeared to relate to private arrangements, but the financing model for the future Home Support Scheme should also be reflected. Further consideration was also needed as to whether there was a sufficiently robust legal basis for service providers engaged on behalf of the HSE to raise charges.

Fee increases

Several submissions said providers should be required to give a reason for price increases, e.g. whether based on consumer price index, increased wages for recruitment or higher regulatory costs, with a mechanism to prevent arbitrary increases.

One advocacy group called for state control over fees because of concern over increases and suggested that a similar approach to that taken by the Department of Children, Equality, Disability, Integration and Youth for childcare providers, involving a high level of cost transparency to enable the Department to make decisions in relation to fee levels in that sector. Another submission called for the Department of Health to get the Competition and Consumer Protection Commission to review the financial regulations given their experience in the care sector.

A submission by a member of the public called for more than three months notice of fee increases to be given, and advocacy groups called for service providers to communicate fee increases in a way that could be understood by the service-user. Other called for measures to address contractual arrangements and pay scales of home support workers. One noted there should be an explicit exemption for the service provider/worker from acting as a pension agent for the service user.

One provider queried what the threshold would be for a service to cease, e.g. if the service user did not pay their bill. Another submission noted that prearranged budget of a service provider should not be affected if a service user cancelled a service as this could impact other service users due to shared service elements. However others said a service should not be paid for if not delivered.

3.5. Corporate Oversight. Sections 17-21

Sections 17-21 of the regulations sets out key aspects of corporate oversight: policies and procedures; complaints procedure; infection prevention and control; health and safety; and governance, management and quality assurance. Close to eight in every 10 respondents broadly agreed with these requirements, while around one in ten either disagreed or was unsure, as outlined in Tables 21-25.

Policies and Procedures (Section 17)

This section deals with how required written policies and procedures should be set out and reviewed. As shown in Table 21 below, 78% agreed with the requirements, 5% disagreed and 7% were unsure.

Table 21: Agreement with the requirements of Section 17: Policies and Procedures

Do you agree with the requirements set out in...	Yes	No	Unsure	No answer	Number
be Section 17: Policies and Procedures	78%	5%	7%	11%	198

Some providers noted that some policies were not relevant to every individual so only the required and applicable policies should apply in each case. It was also queried if policies on liquids, needs assessment, contingency and incidents were in line with current policies. A public sector body said there should be a provision placing an onus on service providers to make the policies and procedures available to home support workers, similar to 2013 Regulations for designated centres.

There was also a call for policies and procedures to be drawn up by appropriately qualified healthcare professionals; and for access to independent advocacy to be added. A service user noted the staff handbook and policies should reference existing legislation such as the Convention on the Rights of Persons with Disabilities and ADMA(C) Act.

Submissions called for inclusion of additional policies relating to dementia, management of actual or potential aggression (MAPA), first aid and medication. One service provider submission noted that as home support workers were not clinically trained, fluids and hydration, and medication management were not recommended nor was handling service user's money or property.

Some submissions also called for this section to include protection for home support workers including references to employment laws and mechanisms, and vaccination policies (see also Section 19).

A provider network queried if a review every three years would be external at additional cost.

Complaints Procedure (Section 18)

This section deals with the procedures for facilitating service users to make complaints, and for handling and keeping a record of complaints. As seen in Table 22 below, 78% agreed with the requirements, 5% disagreed and 6% were unsure.

Table 22: Agreement with the requirements of Section 18: Complaints Procedures

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 18: Complaints Procedures	78%	5%	6%	11%	198

This section generated a lot of comments centring around complaints mechanisms, communication with and protection of service users, definitions of complaint and the thresholds for reporting to the regulator.

Mechanisms

Several submissions across different sectors called for more detail on how complaints would be handled, and particularly if there would be an independent investigation or appeals mechanism. An advocacy body said more clarity was needed on sanctions for not adhering to regulations and queried whether the regulator would investigate complaints. In long term care it noted the regulator does not investigate individual complaints but will receive concerns – however a strong investigation function for home support was essential given those using it were sometimes very vulnerable and isolated.

Several submissions suggested service users would be better served by having an independent authority to investigate unresolved complaints, as well as ensuring standards. One queried if HIQA would deal with complaints against home support workers as the regulations did not include an overseeing authority for hearing complaints other than the service provider.

It was queried if HIQA was the 'authority' referred to in 18 (5) for reporting complaints and also in 18 (4) which required that complaint records should specify the outcome be recorded.

A trade union submission felt the complaints section should confirm the right of representation by a trade union official for any staff member with an allegation against them, while another submission called for the right of a home support worker to formalise a complaint.

A social worker submission said that as well as managing complaints from service users, there should be clear procedure for dealing with complaints from third parties - such as hospitals and Public Health Nurses.

One family member of a service user said the complaints procedure should be open, transparent and based on restorative justice rather than adversarial and costly.

Communication with service users

There were a number of calls for clear communication with service users about the complaints procedure to include Plain English, Easy Read and other accessible forms of information. Advocacy bodies and individuals said the procedure should be well publicised and not just made available when a complaint arose.

One ageing advocacy group called for explicit reference in the procedure, to the Assisted Decision Making (Capacity) Act, the Decision Support Service and the three levels of decision support available under it. It should also state that if a service user had appointed someone to assist them with decisions, that person should be able to use the complaints procedure on their behalf, while there should also be a procedure for dealing with the concerns of a family member or other interested person.

It was considered that the wording of the complaints procedure section 18(2)(a) needed attention and the whole section could be expanded to include service user feedback in line with the parameters of the HSE's 'Your Service Your Say' policy and procedures to provide the service with opportunities to incorporate quality improvement initiatives.

Protection of service user

A number of submissions called for protection of the service user following a complaint. For example, where a complaint was about a specific home support worker, the service provider should assign a different worker to the complainant until an investigation was complete. In addition this procedure should specify how the service user would be protected if they make a complaint, while regular supervision of individual home support workers would be helpful. Other submissions noted that the complaints procedure should include the right of a service user to be supported by an advocate and the provider should have a dedicated complaints officer and review/appeals pathway. There was a request for the Office of the Ombudsman to have a role.

Definitions and Thresholds

A number of submissions said there should be clarity on what constituted a complaint, particularly in relation to the threshold for reporting complaints further. Some noted that easily resolved complaints or issues do not need a formal investigation. One family

member noted it would be useful to have a definition of complaints to include informal verbal and written complaints. Some requested clarification on who the Regulator and Authority were, and on what needed to be reported to them.

Several submissions noted that reporting all events to HIQA would swamp them and result in administration overload – they also queried if the HIQA notification/reporting portal would be used for this and how much detail would have to be submitted. Some submissions noted that the use of the term 'reasonable person' in 18 (5) was quite vague in determining what might pose a risk to health or safety and should be reported immediately. It was felt that the difference between safeguarding concerns and other complaints must be clear and reported appropriately.

Infection Prevention and Control (IPC) (Section 19)

This section deals with the requirements to have an infection prevention and control policy, training for staff, appropriate PPE stocks and outbreak management plans. As seen in Table 23 below, 81% agreed with the requirements, 4% disagreed and 5% were unsure.

Table 23: Agreement with the requirements of Section 19: Infection Prevention and Control

Do you agree with the requirements set out in ,,,	Yes	No	Unsure	No answer	Number
Section 19: Infection Prevention and Control	81%	4%	5%	11%	198

Many submissions noted that this policy must be in line with national guidelines and standards and should be regularly reviewed and updated. A public sector body suggested adding reference to standards at the end of 19(1).

A submission by a home support worker representative body said the IPC policy should be drawn up by a healthcare professional or suitably qualified person to ensure a quality service. It should also include a list of notifiable diseases and training in IPC measures must have been completed prior to the worker entering a home. It should also be available in Plain English and Easy Read formats.

A number of submissions from healthcare and worker representative bodies said that worker vaccination policy and other occupational health issues should also be addressed, including a policy on staff illness to protect service users. Some said that risk assessment should be carried out regarding unvaccinated workers, and they should have access to vaccinations including for Hepatitis B. It noted however that many home support workers were not registered with a GP which could make vaccination schemes difficult.

Some submissions suggested specifying other areas of importance to infection control, including respiratory hygiene, body fluids, needle safety etc. It was also noted that making PPE supplies the responsibility of providers would add significantly to costs and would need to be funded.

Health and Safety (Section 20)

This section deals with requirements for staff training in health and safety, recording of incidents, home risk assessments and safety alerts. As seen in Table 24 below, 77% of respondents agreed with these requirements, 5% disagreed and 6% were unsure.

Table 24: Agreement with requirements of Section 20: Health and Safety

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 20: Health and Safety	77%	5%	6%	12%	198

Many of the submissions in this section related to home risk assessments, and to reporting of incidents including the timeframe for this.

Home environmental risk assessments

Regarding home environmental risk assessments, a public sector body suggested including a definition of this in the definitions section.

A provider network noted that health and safety responsibility for a property generally lies with the leaseholder, landlord or owner, and that health and safety responsibilities were outside the scope of the home support provider, as individuals had a right to maintain their home as they wished. Several submissions from providers said it should be specified who carries out the assessment and also details reasonable expectations about someone's home and risks.

Some submissions from workers or representative bodies queried if it was good practice to start a service without this assessment, one said it was not acceptable to allow seven days for assessment (permitted in urgent cases) as workers were being sent into a potentially dangerous environment. One home support worker noted very serious safety concerns in some homes (e.g. drinking, drugs, violence, rats).

One public sector submission said that a risk assessment requirement could impact on short notice cover to HSE service users which was regularly requested, so timely turnaround of risk assessments must be ensured.

Worker health and safety and training

A number of submissions called for measures to support the health and safety of home support workers and to protect them from physical and biological hazards and workplace violence. Measures suggested included a dedicated staff health and safety representative, a working alone policy and specification of worker terms and conditions that didn't discriminate between HSE and private home support workers.

Some providers noted higher costs for training in fall prevention, first aid, life support, food safety and fire safety as these were not currently mandatory and should be funded – particularly the case for personal assistants. One provider noted that current practice on first aid and life support would be to alert emergency services rather than intervening with potential to make things worse. Some queried if there was a minimum standard to be achieved in these (e.g. HSEland).

Others called for more areas to be specified for training in 20(1) including continence promotion, pressure ulcer prevention, dementia and palliative care principles. An advocacy group said that moving and handling training should specify use of a hoist, as this was a key area of concern across service users.

Another submission by a healthcare professional said staff needed to be made aware of the need for dietary modifications due to reduced swallow function, to dementia and communication needs, to pressure sore issues and to the importance of encouraging safe movement rather than to discouraging movement.

Some felt that measures on health and safety should be proportionate and applicable to the individual service user, for example, the stipulation for staff falls prevention training was a medicalised approach to home support that was unlikely to be needed for a young, fit service user.

Reporting

Regarding recording of health and safety incidents within 24 hours and reporting to a regulator within 3 days, (20(2)), one provider felt this timeframe was more onerous than the system in designated centres. On the other hand, a family member of a service user noted that the timeframes might be too short for someone at risk. A worker representative group said the severity of the incident should determine the timeframe.

A number of submissions queried what constituted an 'incident' that needed to be reported as numerous issues were handled and resolved daily, so further specification needed. The amount of detail needed was also queried and what system would be used for this. A public sector body asked for section 20 (2) on reporting to be moved to Section 15 (Reporting Data to Regulator).

It was suggested that references to handling and moving and food safety should be removed as it was the remit of the Health and Safety Authority and the Food Safety Authority of Ireland to assess compliance in these respectively, and these areas were outside HIQA's scope.

Governance, Management and Quality Assurance (Section 21)

This section deals with the procedures for quality assurance and improvement, consultation with service users and risk management policies. As seen in Table 25 below, 74% agreed with the requirements, 5% disagreed and 9% were unsure.

Table 25: Agreement with requirements of Section 21: Governance, Management and Quality Assurance

Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Section 21: Governance, Management and Quality Assurance	74%	5%	9%	13%	198

Overall structure

Two public sector body submissions suggested Sections 20 and 21 be reviewed together for greater clarity as they contained related elements.

A public sector body recommended inclusion of appropriate oversight and governance arrangements for incident management including serious incident management and associated policies and procedures in place to report, manage and learn from incidents.

It was also suggested that there be a separate section on Quality Patient Safety encompassing risk management, incident reporting and management, compliance, best practice, audit etc. A public sector response outlined a number of areas that could be included here: quality assurance systems; risk management systems including risk escalation; training in incident reporting and how to recognise and report incident; Incident reporting, management and review; health and safety of staff; home safety and other risk assessments; and evaluation of service users feedback to inform quality assurance.

Governance structures

Several submissions from healthcare bodies, advocacy groups and providers said that governance structures needed to be strengthened, and should, for example, include a 'person in charge' with suitable skills to ensure workers were equipped to meet service users' needs and monitor service quality. One large home support provider felt the clinical governance standard proposed was weaker than in the existing HSE tender.

> ***"Clinical structures within home care are required to meet the diverse needs of service users through development of care plans, to ensure competence and development of home support workers and supervisors, to ensure home care organisations play a proactive role within the wider healthcare ecosystem and to ensure quality and relevance of internal training and support programmes for workers. Regulations should set out clearly the clinical governance structure required of a home care company, including the role and responsibilities of a 'Person in charge'. Supervisors must have suitable skills, knowledge and experience, to ensure workers introduced to a new service user with a different set of needs is trained and coached to meet that service user's needs."***
> **Home support provider**

One submission said this whole section (Corporate Oversight) was negatively impacted by failure to provide accountability structures within each service provider.

Several submissions said the regulations did not outline the role of the regulator for audits, oversight and inspections. An advocacy group noted that the regulations did not outline the precise reporting duties of providers to HIQA, nor how often inspections or reviews could be carried out.

A public sector body/regulator submission said that healthcare professionals such as public health nurses were central to the operation of home support services and therefore clinical governance arrangements for home support including the required interplay with healthcare professionals should be included to ensure high quality safe person-centred support. Another submission said that to support integrated care, there should be a mechanism for ensuring governance and accountability in community and primary care settings.

Several submissions noted that administrative and governance requirements should be efficient and streamlined and state agencies should be responsive to feedback.

Consultation with service users

A number of submissions from advocacy groups felt this section was weighted towards corporate governance, rather than to hearing the voice of service users, who should be given regular opportunities to voice concerns and engage in co-design, co-production and co-evaluation. Some suggested committees or representative groups of service users or family carers to provide input on governance structures.

Some service users said there should be quarterly feedback through a survey and full consultation annually with feedback to service users on changes and evidence learning. It was suggested that consultations should be biannual rather than annual. The role of clients should be included as part of the accountability process for co-design, co-production and co-evaluation. Another felt there should be objective benchmarks or measurements to assess standards with external reviews and monitoring – poor examples in the past included client surveys being done in presence of home support worker.

3.6. Schedules

This section contains Schedules 1 to 6 which outline further details about the policies, documents, records and training home support providers must have, and about the roles of a 'supporting person' and a 'specified person' in interactions between the service provider and the service user. In general, nearly eight in 10 submissions supported the requirements, and around one in 10 disagreed or were unsure.

Overall

Some providers said that the schedules highlighted the extra time and resources that would be needed to comply with the regulations and the need for a resource impact assessment to prepare for them and appropriate resources to implement them. It was felt that the large amount of information and documentation required of providers might be confusing for service users and result in the most important information being missed. A few submissions said it would be preferable to make this documentation available online and to signpost service users towards it, rather than publishing it all in paper form.

Schedule 1. Statement of Purpose

This outlines up-to-date information on the service provider which must be contained in its Statement of Purpose. As outlined in Table 26 below, 78% agreed with the requirements in Schedule 1, 2% disagreed and 9% were unsure.

Table 26: Agreement with requirements of Schedule 1: Statement of Purpose

Question 13: Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Schedule 1. Statement of Purpose	78%	2%	9%	11%	198

Regarding 1 e) detailing operational policies, a public sector body/regulator submission said that as the provider was required to have these policies in place (in main body of regulations), these details were unnecessary here.

Another submission suggested that for transparency, the Statement of Purpose should contain details of the ownership of the service provider, the type of company etc. Another wanted the inclusion of staff retention, support and supervision structures, as well as risk mitigation measures for both the service user and the home support worker.

Schedule 2. Policies and Procedures

This lists key policies and procedures which a provider must have in place, though it is not exhaustive. As outlined in Table 27 below, 76% agreed with the requirements in Schedule 2, 3% disagreed and 10% were unsure.

Table 27: Agreement with requirements of Schedule 2: Policies and Procedures

Question 13: Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Schedule 2. Policies and Procedures	76%	3%	10%	12%	198

Some submissions said it should be stipulated that qualified personnel draw up all policies and procedures, and that these be aligned with national policies and guidelines. There was also a call for home support workers to be required to periodically sign and confirm that they had read and agreed with the policies.

A number of submissions queried some of the terms used, particularly "person-centred enablement' and falls prevention. One provider network noted that while policies and procedures were necessary, adults had the right to will and preference in their own home – and a blanket application of the regulations and schedules could see a move from a person-first rights-based model to a compliance-based approach.

Many submissions from different groupings called for the inclusion of additional policies. These included: independent advocacy; incident management; open disclosure; whistleblowing; gifts and wills; driving policy (on worker driving client's car or driving client in own car); and money handling/property policy (one service user noted they did not want to put money in a provider's account but might want support worker to go to bank for them).

Other areas suggested to include in the listed policies:

- Response to emergencies. It was noted that it is important to specify the procedure for responding to emergencies, as sometimes carers left service user to go to next call before an ambulance or support person arrived.
- Dementia care and Pressure sore care. One religious group submission said that not all service users would choose medically orientated care.
- Recruitment. A submission called for minimum standards for references to be required, another called for a staff retention strategy, a framework for safe staffing and healthcare worker health and safety policy.

- Risk management. Policy around risk management should include safety and risk assessments prior to commencement of service including risk travelling to a rural setting and to areas with poor mobile coverage, night-time precautions, lone worker issues, and risks around property and data protection.
- Food and nutrition policy. A provider network said this should be limited to heat and serve.

Schedule 3. Induction Training

This schedule lists 23 areas which should be included in induction training for home support workers, while stating this is not exhaustive and training and education should be tailored to needs of the individual service user. As outlined in Table 28 below, 75% agreed with the requirements in Schedule 3, 6% disagreed and 8% were unsure.

Table 28: Agreement with requirements of Schedule 3: Induction Training

Question 13: Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Schedule 3: Induction Training	75%	6%	8%	11%	198

A public sector body/regulator said this list was extensive and relevant, but providers might need support in carrying it out as workers would be employed and paid while doing it but not technically working. Further training should be required periodically.

Another submission felt that induction training should be consistent across all providers to ensure that all workers could meet the needs of all service users, rather than individualised for particular clients. A home support provider unit said that a detailed formalised induction training plan was needed.

The length of time taken for proposed training was a concern, some provider submissions said the training outlined was excessive and could not be done in 20 hours or it would result in a box-ticking exercise. Some felt the training might not be relevant to the particular service provided and did not take account of prior educational qualifications. Tailored induction relevant to level of care required would be better with a competency framework for progression during career. It was suggested that some modules could be hosted on HSEland to standardise learning and standards

Many submissions called for inclusion of training around capacity and supported decision-making in line with the principles of the Assisted Decision Making (Capacity) Act 2015 (ADMA) to be included given this would be a fundamental aspect of delivery of service that was not currently addressed.

One large provider network called for training on a rights-based approach including the ADMA principles and the United National Convention on the Rights of People with Disabilities (UNCRPD) for services providing supports to people with disabilities, also including areas such as advocacy, self-directed living, community inclusion etc.

A provider submission said that some policies might not be appropriate for all services including personal assistant services or would need further clarification to ensure they did

not clash with individual choice, e.g. fluids and hydration, food and nutrition, medication administration, pressure sore management. A religious home support provider submission said that their training for home support workers did not take a biomedical approach or base care on clinical diagnosis as that was incompatible with their service users' choice of care.

Other areas

Other areas suggested for inclusion were: using a hoist; management of unruly behaviours; supporting independence; age-friendly communication and basic dementia training for all (with more specialised dementia training for some); hand hygiene and infection prevention and control; cultural training; asthma/COPD training and inhaler technique (if service-user has asthma or COPD).

Further areas of training suggested were: the integrated care system; grief and bereavement; and advance care planning.

Schedule 4. Records

This outlines the records which should be kept and made available for inspection. As outlined in Table 29 below, 76% agreed with the requirements in Schedule 4, 5% disagreed and 7% were unsure. This section did not generate very many comments.

Table 29: Agreement with requirements set out in Schedule 4: Records

Question 13: Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Schedule 4: Records	76%	5%	7%	13%	198

A public sector body said that the word 'sample' should be removed from the specified records; and that the status, outcome or resolution of any complaint should also be included.

Some submissions called for records to be stored electronically, and for workers to be provided with digital devices for secure record keeping and transmission. A home support service provider said that a live rostering system was needed to record schedules, and carers were seeking extra time to record duties and observations in care plan. It was suggested that there would need to be a review of existing IT systems to include rotas etc.

Another said the tone of this schedule was very negative with the main focus on disciplinary records – feedback from workers and service users should also be included.

It was suggested that basic demographic indicators be included such as ethnicity, Traveller, homeless etc to facilitate better service provision and planning.

A nursing body wanted detailed records kept of staffing levels, vacancies, turnover, absences, and job descriptions or for individual support plans to be recorded.

Some providers felt that there would be potential GDPR issues and employees would have to give consent regarding disciplinary issues and allegations being made available for inspection. Another said that arrangements would also have to be made for cases where supported individuals did not wish information to be stored in their home, as some had that preference.

Schedule 5. Supporting Person

This schedule defines what is meant by a supporting person in the regulations. As seen in Table 30 below, 77% agreed with the provisions set out here, 1% disagreed and 9% were unsure.

Table 30: Agreement with requirements of Schedule 5: Supporting Person

Question 13: Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Schedule 5: Supporting Person	77%	1%	9%	14%	198

A public sector body said this should be in the 'Definitions' section of the regulations. Some submissions said the wording of this section was unclear, though in contrast others said it was a welcome explanation.

A number of submissions noted that this section must comply with the ADMA provisions, and should specifically reference the Act, the Decision Support Service and the three levels of decision support, as providers had a direct responsibility to comply. An ageing advocacy body said separate guidance was needed for informal support arrangements including the role of family versus formal ADMA support.

A professional medical body said that the agreement between the service provider and service user (Section 5) should more clearly indicate that this should include in writing the service user's choice of personal advocate. It suggested that leaving this to Schedule 5 at the end was not adequate, and the emphasis in Schedule 5 on a supporting person's role conferred on him or her by law was too limited, and service users should have the possibility of nominating a chosen advocate/support person without recourse to formal legal declaration. Another submission said it should be clarified how the details of a supporting person be communicated to the service provider.

A healthcare organisation said that though Schedule 5 outlined what a supporting person is, and Schedule 6 outlined what a specified person is, the use of these terms throughout the regulations document was inconsistent and left them open to confusion.

Schedule 6. Specified Person

This schedule defines what is meant by a supporting person in the regulations. As seen in Table 31 below, 77% agreed with this, 1% disagreed and 8 were unsure.

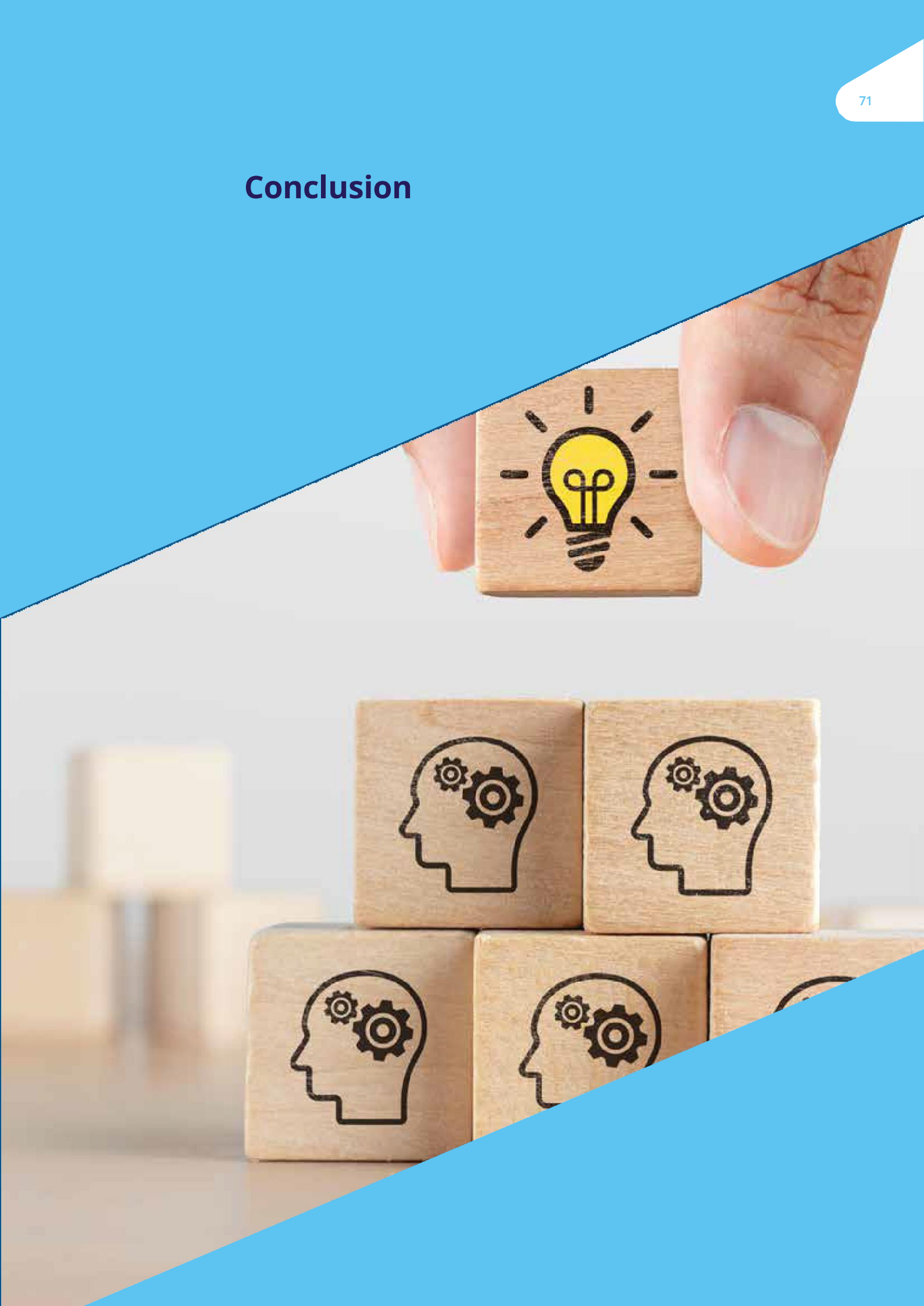
Table 31: Agreement with requirements of Schedule 6: Specified Person

Question 13: Do you agree with the requirements set out in ...	Yes	No	Unsure	No answer	Number
Schedule 6: Specified Person	77%	1%	8%	14%	198

A public sector body said this should be in the definitions section of the regulations (as with Schedule 5). A number of submissions warned that this was an informal role with no legal basis and might jar with the provisions of the ADMA. A disability advocacy group said that more safeguards were needed to prevent abuse of power.

A service user said the definition was too vague and open to abuse, especially in context of the ADMA and amendments due to that in coming months.

Conclusion



Conclusion

This report produced by the Institute of Public Health sets out an analysis of the quantitative and qualitative responses to the Department of Health on a public consultation on new Draft Regulations for Providers of Home Support Services. IPH in this report does not comment on or evaluate the representativeness of the submissions made to this public consultation or the views expressed by respondents and is not aligned with any particular viewpoint.

A recap of the overarching messages that arose across the public consultation submissions is outlined below.

Key Themes

The following are the overarching messages from the consultation responses:

- It was recognised that home support regulations are key to providing better quality of service and guidance for all involved in home support services. This view was consistent across all sectors including service users, providers and state bodies.
- It was felt that by specifying minimum standards, the regulations would create a level playing field for providers that would ensure higher and more consistent standards of delivery.
- A large majority felt that the regulations would provide greater protection to service users which was particularly important if they were vulnerable due to ill health or reduced cognitive ability.
- Clarity was sought by all sectors on how the regulations relate to the overall architecture of publicly funded home support provision. This includes primary legislation, HIQA standards and the current and future models of home support provision including the new statutory scheme and funding mechanisms. This was considered important both for understanding how the regulations fit into the home support scheme, and in relation to specific provisions such as contracts with service users and needs assessments.
- Clarity was sought on HIQA's role as the regulator of home support providers and the HSE's role as Commissioner of Services and funder under these regulations.
- There was a concern that the regulations reflected a form of home support provision that had been mapped from the model of services for older people and did not adequately reflect the need for flexibility and active service-user direction.
- There was widespread support across all sectors for having minimum qualifications for home support workers to improve service standards. On the other hand, there was also strong concern that this could worsen existing staffing and recruitment shortages by driving competent workers out of the workplace and deterring potential recruits who felt unable to achieve the required formal qualification levels.
- Many submissions hoped that mandatory qualifications would lead to clearer career pathways and better pay and conditions in the home support sector. Improved conditions for home support workers were seen as vital to creating a more sustainable workforce and high quality service for home support service users.

- Respondents indicated that the implementation of the regulations could be onerous for providers and home support workers in terms of increased record keeping and documentation, and that this could impact negatively on the service user.
- There were concerns that some types of home support service are excluded from the regulations, particularly services for children, services by healthcare professionals and services provided by individuals directly employed by service users.
- Stronger governance structures were sought such as minimum qualifications for managers and more active and formal service user representation and feedback to ensure greater oversight and improved service.

Appendices

Appendices

Appendix 1. List of respondents to public consultation

Alphabetical List of organisations that made submissions: This includes both survey and freeform submissions. N.B, some organisations made multiple different submissions, the organisation name is only referred to once.

A Ghra Care Services Ltd

Age Action

Alliance of Healthcare Assistants in Ireland (AHCAI)

ALONE

Arklow South Wicklow Home Care Service CLG

Asthma Society of Ireland

Better Living Homecare

Blanchardstown and Inner City Home Care CLG

Brothers of Charity Services, Ireland, West Region

Care At Home

Caregivers Ireland Dublin West Home Help

Céile Care

Chime

Christian Science Committees on Publication for United Kingdom and Ireland

Citizens Information Board

Clannad Care Ltd

Clarecare- Home support Provider CHO3

Comfort Keepers

Dementia Services Information and Development Centre

Dublin Home Care Partners

Family Carers Ireland

Finglas Home Help/Care Organisation CLG

HaloCare Group

Health Information and Quality Authority (HIQA)

Health Service Executive (HSE);

Home & Community Care Ireland

Home Care Direct

Home Care Providers Alliance

Home Instead

Inclusion Ireland

Independent Living Movement Ireland

Irish Association of Social Workers

Irish Centre for Social Gerontology, National University of Ireland Galway.

Irish College of General Practitioners

Irish Dementia Working Group

Irish HomeCare

Irish Hospice Foundation

Irish Nurses and Midwives Organisation

Irish Society of Chartered Physiotherapists

Irish Society of Physicians in Geriatric Medicine

Irish Wheelchair Association

Leopardstown Park Hospital

Liberties & Rialto Home Help Services

MDI, Muscular Dystrophy Ireland

ME Advocates Ireland (MEAI)

MG LifeCare Limited T/A Caremark Wicklow East

Migrant Rights Centre Ireland

National Community Care Network

National Disability Authority

Nua Healthcare Services

Nursing and Midwifery Board of Ireland

Offaly Centre for Independent Living

RAH Home Care Ltd. T/A Right at Home

Roscommon Home Care Services Ltd T/A RHS Home Care

Royal Homecare

Safeguarding Ireland

Sage Advocacy clg

Servisource t/a MyHomecare

SIPTU Health Division

Social Workers (stroke and age related health care) Tallaght University Hospital,.

The Alzheimer Society of Ireland

The Disability Federation of Ireland

The Great Care Co-op CLG

The National Advocacy Service for People with Disabilities

The National Federation of Voluntary Service Providers Supporting People with Intellectual Disability

The Ombudsman for Children's Office (OCO)

The Rehab Group

Voice of Vision Impairment

West Limerick Independent Living CLG

Appendix 2: Suggested amendments to definitions

Suggested amendments to definitions outlined in Section 2 of the Draft Regulation are outlined first, followed by suggestions for additional definitions and/or clarifications of terms.

Suggested amendments to definitions in Section 2 of the Draft Regulations

Abuse

A number of submissions called for changes to the definition of 'abuse' to align it with other laws, standards or policies and to broaden its remit to include other areas such as discriminatory abuse, organisational abuse, coercive control and third party abuse.

It was noted the current definition in the draft regulations was not in line with that used in HIQA's National Standards for Adult Safeguarding or with the HSE definition, or that included in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Advocacy

A number of submissions wanted the definition of 'advocacy' to be revised and expanded. One wanted it to refer to the categories of decision support under the new Decision Support Service and the Assisted Decision-Making (Capacity) Acts (ADMA).

> ***"Advocacy is a process of empowerment of individuals or groups which includes taking action to help people say what they want, secure their rights, represent their interests or obtain the services they need. Advocacy can be undertaken by individuals themselves, by their friends and relations, by peers and those who have had similar experiences, and/or by trained volunteers and professionals. Advocacy is taking action to help people say what they want and helping them to secure their rights."*** **Advocacy group**

Another group recommended using the definition of representative advocacy outlined in Safeguarding Ireland's scoping document on Independent Advocacy in Ireland Current Context and Future Challenges.

Commissioner of services

A number of submissions wanted greater clarity about what was meant by 'Commissioner of services' and who the commissioner of services is with regards to needs assessment. A public sector body felt that the current definition was an outmoded definition, relying on a "time for task" approach and should include a holistic assessment of needs. A public sector body said the definition should include more detail on the role and responsibilities of the Commissioner of Services and might need to explicitly name the HSE as this to clarify its role to providers.

Direct arrangement

A small number of submissions requested clarity on the term 'direct arrangement', and particularly what was meant by 'third-party intermediary' and 'commissioner of services'. One submission noted the term was defined but not used in the draft regulations.

Enabling

A small number of submissions in the advocacy and healthcare sector noted difficulties with the term 'enabling' because of the absence of accepted definitions, the overlap with rehabilitation and the different types of reablement teams within the HSE, some of which included only healthcare professionals, and some of which included home support workers. One advocacy group suggested 'empower' was a better term because enable was ability-based language whereas empowerment was more focused on self-determination. There was also a query about what was meant by the related term 'person-centred enablement' in Schedule 2 (15).

Home

A few submissions from professional or public bodies were concerned that the definition of 'home' was narrow and might exclude people who were homeless or living in non-permanent dwellings such as caravans. Suggestions included removing the word 'permanent' and/or substituting the word 'dwelling' with 'location'.

Home support

Most of the submissions in relation to the definition of home support are discussed in the Scope section as they refer more to what is included and what is not, rather than specific variants of wording. One submission asked for clarification of the difference between home support and home care.

Home support worker

A number of submissions called for a clearer definition of the term 'home support worker', though again many of these related to the scope of what is covered under 'home support' and are discussed in that section. One said that the definition of 'home support worker' should make reference to their employment by a service provider. Another submission said that 'home support workers' should be referred to as such consistently, and not as 'staff'.

Instrumental Activities of Daily Living (IADL)

It was requested that a review of definitions including IADL should be undertaken to ensure they align with national and international clinical best practice.

Needs assessment

Some submissions wanted clarification of the definition and particularly about whether specific tools or assessments are to be used for them.

Personal Assistance (PA)

A number of submissions wanted changes to the definition of 'personal assistance' (PA). A public sector body said it should be changed to emphasise choice, control and self-direction in line with Article 19 of the UN Convention on Rights of Persons with Disabilities and DOH/HSE quality of life outcome domains. It said this would require amending other aspects of the regulations such as needs assessment and personal support plan, service provision and qualifications, training and development. Another public sector body said it needed to be defined in greater detail to clarify if it included supports provided to people

with disabilities having regard to the specific nature of current PA services provided/funded by the HSE. An advocacy body said a definition of 'Independent Living' was also required if Personal Assistance Services were regulated and provided for.

Person centred

A few submissions called for amendments to this definition to reflect the will of the service-user more strongly. This included changing 'where practicable' to 'where feasible' or another term; adding 'personal goals' after 'individual needs'; and replacing the word 'involves' with 'empowers'

Reablement

Some submissions said the definition of 'reablement' related more to rehabilitation and there needed to be a clearer definition of what it applied to, and a distinction between what was done by healthcare professionals and by home support workers. One submission said the term 'time limited' should be removed as it could be an ongoing process. It was suggested that a review of definitions including reablement be undertaken to ensure they align with national and international clinical best practice.

Safeguarding

Several submissions called for an expansion of the definition of 'safeguarding' in line with the HIQA/Mental Health Commission National Standards on Safeguarding. Another submission said the current definition was too limited and paternalistic and should align with Assisted Decision Making (ADMA) legislation and with the principles of the HIQA standards in respecting and upholding the rights and wellbeing of a person and empowering them to live a life free from abuse.

Service-user

One advocacy group said that many people did not like the expression 'service-user' and would like it replaced with 'people supported by a service'. A home support provider said that if the definition confirmed it referred to services for persons with a disability, then the terminology should reflect the social care model as opposed to the medical care model.

Service provider

One submission noted that the term 'service provider' or 'home support provider" should be consistent throughout the regulation and not used interchangeably. A service provider said that it should specify that all organisations and individuals in receipt of funds to provide a 'home support service' would be required to obtain a licence to operate. There is further discussion of that point in the Scope section.

Specified person

A number of submissions from advocacy groups and a service-user warned that 'specified person' was an informal role with no legal basis and might jar with the provisions of the ADMA Act. An advocacy body said that more safeguards were needed to prevent abuse of power, e.g. requiring service providers to check the specified person was acting on the will and preference of the service-user. A service-user said the definition was too vague and possibly open to misuse/abuse, particularly in the context of the ADMA Act. It was also noted that use of 'specified person" and of 'supporting person' should be included

throughout the regulations in relevant sections including sections 3-10, 14, 18 and 21. See also Schedule 6 for discussion of this.

Supporting person

Although welcomed by some, several submissions said the definition should be clearer. A healthcare organisation said the term 'supporting person' was not used in the Assisted Decision Making (Capacity) Act 2015 (ADMA) and might need to be revised in line with that and the forthcoming Decision Support Service. A professional representative body said that the emphasis on a supporting person's role conferred on him or her by law was too limited, and service users should have the possibility of nominating a chosen advocate/ support person without recourse to formal legal declaration. See also Schedule 5 for discussion of this.

Additional terms where definitions or clarity sought

The following terms are not included in the current list of definitions in Section 2 of the draft regulations, but submissions requested definitions or clarifications about their meaning.

Authority

Clarity and consistency were sought on who the 'Authority' referred to in the regulations is.

Complaints

Some submissions wanted clarity on what constituted a complaint in Section 18 that needed to be investigated or reported, i.e., did it include issues that were easily resolved.

Contract

A few submissions suggested replacing the term "contract" in Section 11 with 'agreement'.

Exercise

A number of submissions asked for clarification of what was meant by 'exercise' because it could have many different meanings and was important to define. Some suggested that using terms like support for physical activity or support for movement might be preferable.

Healthcare Professional /Health Professional

A number of submissions asked for a definition of 'healthcare professional' or 'health professional' to be included. In regard to the exclusion of services by healthcare professionals, A public sector regulator said it should state that it was "clinical interventions" provided only by registered healthcare professionals that were excluded, rather than "services" provided by them to make it clear that the regulations apply to the providers rather than the individual practitioners. Another public sector body said clarity was required on whether 'health professional' referred to health and social care professionals under the Health Act 2007 or was analogous to the term 'medical practitioner' under the Health Act 2007. Several submissions wanted the term 'health professional' to be replaced with 'health and social care professional' in the regulations in relation to needs assessment etc.

Home environmental risk assessment

Some wanted a definition of 'home environmental risk assessment' in the definitions section. Several submissions requested clarity on who carried this out and what constituted acceptable risks in the home environment.

Independent Living

A few submissions called for 'Independent Living' principles to be included in the regulations and one said a definition of this was needed to ensure personal assistance services were provided for in the regulations.

Inexperienced worker

There were two requests for clarification of the term 'inexperienced worker' which is used in Section 13 in relation to supervision and shadowing requirements.

Personal relationship

A public sector regulator stated the definition of what constituted a 'personal relationship' between a service-user and a worker (point (b) in the exemptions listed on page 3) might need further consideration as it could give rise to abuse where persons avoid being subject to the regulations by virtue of having a certain type of relationship with the service-user.

Person centred enablement

It was queried what 'person-centred enablement' is in Schedule 2 (15).

Provider of last resort

Clarity was requested as to whether the HSE would be the 'provider of last resort' (as referenced in the Health Act 2007) as this would impose significant obligations on it in the event of a removal of licence to operate as a service provider. A public sector body noted that this was particularly important as the closure of a home support provider could impact hundreds of people and would require detailed provisions. It was suggested this was particularly important in HSE Community Health Organisations (CHOs) without direct service provision.

Appendix 3: Survey questionnaire

Fields marked with * are mandatory.

Draft Regulations for Providers of Home Support Services: Public Consultation Survey

An Roinn Sláinte
Department of Health

Draft Regulations for Providers of Home Support Services: Public Consultation Survey
The Department of Health has launched a public consultation on draft regulations for providers of home support services. These regulations set out the minimum requirements that public, private, and not-for-profit

How to make a response?

This survey consists of 3 sections, with 14 questions in total. Section 1 asks you to provide information about yourself. Section 2 asks you to provide general feedback on the draft regulations. Finally, Section 3

invites you to provide focused feedback on the different parts of the draft regulations.

Only Section 1 of the survey is mandatory. This allows you to give as much or as little feedback as you

Where the survey gives you the opportunity to provide written feedback, please be aware that this is limited

What we will do with your response?

A report on the findings of the public consultation will be prepared by the Institute of Public Health for the Department of Health. Your views will contribute to the further development of legislation governing home

Privacy Notice

By completing this survey, you are agreeing to take part in the public consultation.

Personal, confidential or commercially sensitive information should not be included in your submission. If personally identifiable details are included they will be deleted. All submissions and survey answers are subject to release under the Freedom of Information (FOI) Act 2014 and are also subject to Data Protection legislation.

The Department's Privacy Policy can be viewed here.

Queries

Should you have any queries in relation to this survey, please contact HSRConsultation@health.gov.ie

Section 1. About you

*** Question 1:**

Are you providing feedback as:

- ○ an individual
- ○ on behalf of an organisation

Question 2:

If answer is "an individual"
Which of the following best represents your view?

- ○ a person who has used or is currently using home support services
- ○ a family member of a person using home support services
- ○ a home support worker
- ○ a healthcare professional involved in hospital or community services
- ○ a member of the public
- ○ other (please give details below):

If selected 'other' above, please give details here:

Question 2:

If answer is “on behalf of an organisation”, please give the name of the organisation.

Is the organisation?

- a home support provider or network
- a trade union or worker representative body
- a representative or advocacy body for disability or older people
- a public sector body or regulator
- a healthcare or medical organisation or body
- other (please give details below):

If selected 'other' above, please give details here:

Section 2. Overall feedback

Question 3:

Do you agree that the home support regulations should cover the following types of activity for those who need

	Yes	No	Unsure
Physical assistance with mobility, washing, mealtimes and using the bathroom, or reminders/ supervision of these activities where necessary			
Reminding or supervising someone to take medication			
Helping someone to do everyday activities such as shopping, cooking and cleaning			
Exercise and social engagement inside and outside the home			
Care for the emotional welfare of the service-user, such as listening and providing encouragement			
Personal assistance (that is a package of assistance provided to support independence, health and social engagement)			

Please comment (optional) - max 200 words

1200 character(s) maximum

Question 4:

Do you agree that the following types of service are **NOT** covered by these home support regulations?

	Yes	No	Unsure
Services for people aged less than 18	○	○	○
Home support by a family member or friend	○	○	○
Home support services that are unpaid	○	○	○
A paid employment relationship between an individual home support worker and one service-user	○	○	○
Services provided only by registered healthcare professionals (such as nurses or physiotherapists)	○	○	○

Please comment (optional) - max 200 words

1200 character(s) maximum

Question 5:

These regulations will require all home support workers to have minimum educational qualifications, or to get these within a set timeframe.
Do you agree with this?

- ○ Yes
- ○ No
- ○ Unsure

Please comment (optional) - max 200 words

1200 character(s) maximum

Question 6:

Question 7:

What do you consider will be the benefits of introducing these regulations for home support providers?
Please tick any or all that apply:

- ☐ better quality and consistency of service
- ☐ greater protection for service users
- ☐ guidance for all involved in home support services
- ☐ other

Please give reasons for your answer (optional):

Question 8:

Do you have any concerns about the introduction of these regulations?

- ○ Yes
- ○ No
- ○ Unsure

Please comment (optional) - max 200 words

1200 character(s) maximum

Section 3. Feedback by section on the Draft Regulations for providers of home support services

The next section seeks feedback on specific sections of the draft regulations. The full regulations can be found here. A Plain English summary of these sections can be found here.

Service Delivery

Question 9:

Do you agree with the requirements set out in sections 3 - 10 under Service Delivery?

	Yes	No	Unsure
Section 3. Statement of Purpose	○	○	○
Section 4. Principles of Service Delivery	○	○	○
Section 5. Contract between Service-User and Home Support Provider	○	○	○
Section 6. Needs Assessment and Personal Support Plan	○	○	○
Section 7. Management of Records	○	○	○
Section 8. Service Provision	○	○	○
Section 9. Medication Management Support	○	○	○
Section 10. Safeguarding and Protection of the Service-User	○	○	○

Please comment or state any changes you feel are needed (optional) - max 200 words

1200 character(s) maximum

Staffing

Question 10:

Do you agree with the requirements set out in sections 11 – 13 under Staffing?

	Yes	No	Unsure
Section 11. Staffing	○	○	○
Section 12. Qualifications, Training and Development	○	○	○
Section 13. Supervision of Staff	○	○	○

Please comment or state any changes you feel are needed (optional) - max 200 words

1200 character(s) maximum

Corporate Governance

Question 11:

Do you agree with the requirements set out in sections 14 -16 under Corporate Governance?

	Yes	No	Unsure
Section 14. Management of the Service	○	○	○
Section 15. Reporting Data to Regulator	○	○	○
Section 16. Financial Procedures	○	○	○

Please comment or state any changes you feel are needed (optional) - max 200 words

1200 character(s) maximum

Corporate Oversight

Question 12:

Do you agree with the requirements set out in sections 17– 21 under Corporate Oversight?

	Yes	No	Unsure
Section 17. Policies and Procedures.	○	○	○
Section 18. Complaints Procedure	○	○	○
Section 19. Infection Prevention and Control	○	○	○
Section 20. Health and Safety	○	○	○
Section 21. Governance, Management and Quality Assurance	○	○	○

Please comment or state any changes you feel are needed (optional) - max 200 words

1200 character(s) maximum

Schedules

Question 13:

Do you agree with the requirements set out in Schedules 1 - 6 providing more detail about what is required in specific areas?

	Yes	No	Unsure
Schedule 1. Statement of Purpose	○	○	○
Schedule 2. Policies and Procedures	○	○	○
Schedule 3. Induction Training	○	○	○
Schedule 4. Records	○	○	○
Schedule 5. Supporting Person	○	○	○
Schedule 6. Specified Person	○	○	○

Please comment or state any changes you feel are needed (optional) - max 200 words

1200 character(s) maximum

Overall comment (Final question)

Question 14:

Please use the box below to provide any additional comments you have about these draft regulations (optional) - max 200 words

Appendix 4: Link to draft regulations and associated consultation documentation

The Draft Regulations for Providers of Home Support Services may be accessed on the government public consultation website here.

https://www.gov.ie/en/consultation/81506-public-consultation-on-draft-regulations-for-providers-of-home support-services/

A Plain English Summary and Easy Read Summary are also available on that site.

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