Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of a Restrictive Practice Thematic Inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Community Nursing Unit Abbeyleix
Name of provider:	Health Service Executive
Address of centre:	Ballinakill Road, Abbeyleix, Laois
Type of inspection:	Unannounced
Date of inspection:	19 December 2019
Centre ID:	OSV-0000527
Fieldwork ID:	MON-0028296

What is a thematic inspection?

The purpose of a thematic inspection is to drive quality improvement. Service providers are expected to use any learning from thematic inspection reports to drive continuous quality improvement which will ultimately be of benefit to the people living in designated centres.

Thematic inspections assess compliance against the National Standards **for Residential Care Settings for Older People in Ireland**. See Appendix 1 for a list of the relevant standards for this thematic programme.

There may be occasions during the course of a thematic inspection where inspectors form the view that the service is not in compliance with the regulations pertaining to restrictive practices. In such circumstances, the thematic inspection against the National Standards will cease and the inspector will proceed to a risk-based inspection against the appropriate regulations.

What is 'restrictive practice'?

Restrictive practices are defined in the *Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013* as **'the intentional restriction of a person's voluntary movement or behaviour'**.

Restrictive practices may be physical or environmental[1] in nature. They may also look to limit a person's choices or preferences (for example, access to cigarettes or certain foods), sometimes referred to as 'rights restraints'. A person can also experience restrictions through inaction. This means that the care and support a person requires to partake in normal daily activities are not being met within a reasonable timeframe. This thematic inspection is focussed on how service providers govern and manage the use of restrictive practices to ensure that people's rights are upheld, in so far as possible.

Physical restraint commonly involves any manual or physical method of restricting a person's movement. For example, physically holding the person back or holding them by the arm to prevent movement. **Environmental** restraint is the restriction of a person's access to their surroundings. This can include restricted access to external areas by means of a locked door or door that requires a code. It can also include limiting a person's access to certain activities or preventing them from exercising certain rights such as religious or civil liberties.

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[1] Chemical restraint does not form part of this thematic inspection programme.

About this report

This report outlines the findings on the day of inspection. There are three main sections:

- What the inspector observed and residents said on the day of inspection
- Oversight and quality improvement arrangements
- Overall judgment

In forming their overall judgment, inspectors will gather evidence by observing care practices, talking to residents, interviewing staff and management, and reviewing documentation. In doing so, they will take account of the relevant National Standards as laid out in the Appendix to this report.

This unannounced inspection was carried out during the following times:

Date	Inspector of Social Services
19 December 2019	Liz Foley

What the inspector observed and residents said on the day of inspection

This was an unannounced focussed inspection on the use of restrictive practices. This centre had three long stay residents and the remaining 17 beds were short stay consisting of three step-down beds and 14 respite beds. External doors were restricted by a swipe card system and staff were required to let in and out all residents and visitors to the centre; the service had already identified this as restrictive. One resident had a bed rail in place at their own request. Low beds and crash mats were observed in bedrooms and movement sensor beams were in place and available for some residents who required close monitoring due to their high risk of falls. These sensor beams did not restrict movement but alerted staff through the nurse call system to supervise or assist the resident as appropriate. There was a person-centred culture of care in the service and residents felt supported and safe.

There was a relaxed and homely atmosphere in this centre with residents observed in communal areas, mobilizing on corridors and some remained in their bedrooms. The centre was previously a district hospital and had been renovated and adapted over time. However some of its original features were not appropriate for older person's residential services, for example, high windows in bedrooms which residents could not see out. Resident's art work could be seen displayed throughout the centre. Residents told the inspector they had plenty to do during the day with one resident stating he was 'never as busy'. Residents were supported and encouraged to participate in the many activities provided. Residents with advanced needs were provided with suitable sensory activities and one-to-one time in accordance with their assessed needs. There was open access to all areas within the centre and open access to an enclosed sensory garden. The day care facility adjoined the centre and residents were encouraged to attend and access activities in the day care if they wished.

There was adequate supervision of residents with current staffing levels suitable to the assessed needs of the residents. Staff were aware of the restrictive nature of the swipe access doors and some felt it was required for security and had not considered the impact on residents' freedom. While this may be paternalistic, it was a practice that had evolved in the service and was not intended to restrict but to maintain safety. The service had already submitted a request for funding for an alternative less restrictive system to be installed; this would support residents' autonomy and rights and enable them to move freely as desired. Staff were supported to perform their respective roles with ongoing mandatory training however, there had not been any specific training provided in restrictive practices. Dementia training for most staff members also required updating. The impact of the lack of training was low as restrictive practice use was low in the centre. The person in charge undertook to source suitable training for all staff.

Residents told the inspector that staff were always supportive and respectful. There was a proactive and open approach to feedback from both residents and their families. There were quarterly resident meetings and residents confirmed that their feedback was welcomed daily in an informal way and that the service always acted on

any request made. Advocacy services were available from the national agency for advocacy which was advertised in the centre. Some residents had multiple stays in the centre and had come to know the staff well. All staff were highly complimented for their kindness, professionalism and the exceptional care provided. Residents could choose when to get up and retire to bed, what activities to participate in and could decline activities for alone time if wished. The food was highly complimented and residents had a choice at every meal. Complaints were managed in accordance with national policy and residents told the inspector they could express any concern to any member of staff if they needed to.

The centre did not maintain a register of restrictive practices, however, a risk assessment was in place for the restrictive door system in use. One bed rail was in use; this had been risk assessed and safety checks were in place as per the centre's policy. Less restrictive options had not been trialled in accordance with the resident's wishes. The care plan for bed rails was detailed to guide staff to provide care and was reviewed every four months.

Oversight and the Quality Improvement arrangements

The centre had not completed the self-assessment questionnaire, however, they had identified and taken steps to reduce restrictive practices in line with their policy and the national policy on restraint. The major impact of the improvements were found in the use of bed rails which was now only at one. The centre had identified the restrictive nature of the swipe access on external doors and was waiting funding to install a more suitable system. There was an ongoing commitment in reducing restrictive practices and the centre had invested in technology to support this. Sensor beams had been installed in some bedrooms to monitor the movement of residents who were at risk of falling; this did not stop residents from moving but alerted staff so that they could supervise or assist the residents as appropriate.

Less restrictive equipment was available including low beds and crash mats. The availability of half bed rails may help the service eliminate the use of restrictive full bed rails for some residents who choose to have bed rails up. While smoking was facilitated outdoors in the service there was no sheltered area for residents to use if the weather was bad; this impacted on their choice.

The inspector discussed training with the person in charge and the senior nurse manager during the inspection who undertook to source appropriate training for all staff in restrictive practices and update dementia training.

There was good oversight of restrictive practices in the centre with ongoing auditing and feedback informing quality and safety improvement in the centre. Risks associated with restrictive practices, particularly the door system, were identified and controls were in place to mitigate these risks.

There was good falls management and residents were supported to be as independent as possible. Allied health professionals supported the residents when required to maintain and manage their activities of daily living. All incidents were recorded and appropriately investigated with evidence of shared learning and ongoing quality and safety improvement. There was access on site to the physiotherapist and occupational therapist.

There was a centre specific policy on the management of restrictive practices which was developed from the HSE’s policy. Language in the policy was sometimes paternalistic and the policy regularly referred to restraints and enablers both of which are not in line with the HIQA guidelines for promoting a care environment that is free from restrictive practice.

Overall Judgment

The following section describes the overall judgment made by the inspector in respect of how the service performed when assessed against the National Standards.

Substantially Compliant	Residents received a good, safe service but their quality of life would be enhanced by improvements in the management and reduction of restrictive practices.

Appendix 1

The National Standards

This inspection is based on the *National Standards for Residential Care Settings for Older People in Ireland (2016).* Only those National Standards which are relevant to restrictive practices are included under the respective theme. Under each theme there will be a description of what a good service looks like and what this means for the resident.

The standards are comprised of two dimensions: Capacity and capability; and Quality and safety.

There are four themes under each of the two dimensions. The **Capacity and Capability** dimension includes the following four themes:

- **Leadership, Governance and Management** — the arrangements put in place by a residential service for accountability, decision-making, risk management as well as meeting its strategic, statutory and financial obligations.
- **Use of Resources** — using resources effectively and efficiently to deliver best achievable outcomes for people for the money and resources used.
- **Responsive Workforce** — planning, recruiting, managing and organising staff with the necessary numbers, skills and competencies to respond to the needs and preferences of people in residential services.
- **Use of Information** — actively using information as a resource for planning, delivering, monitoring, managing and improving care.

The **Quality and Safety** dimension includes the following four themes:

- **Person-centred Care and Support** — how residential services place people at the centre of what they do.
- **Effective Services** — how residential services deliver best outcomes and a good quality of life for people, using best available evidence and information.
- **Safe Services** — how residential services protect people and promote their welfare. Safe services also avoid, prevent and minimise harm and learn from things when they go wrong.
- **Health and Wellbeing** — how residential services identify and promote optimum health and wellbeing for people.

List of National Standards used for this thematic inspection:

Capacity and capability

Theme: Leadership, Governance and Management	
5.1	The residential service performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect each resident and promote their welfare.
5.2	The residential service has effective leadership, governance and management arrangements in place and clear lines of accountability.
5.3	The residential service has a publicly available statement of purpose that accurately and clearly describes the services provided.
5.4	The quality of care and experience of residents are monitored, reviewed and improved on an ongoing basis.

Theme: Use of Resources	
6.1	The use of resources is planned and managed to provide person-centred, effective and safe services and supports to residents.

Theme: Responsive Workforce	
7.2	Staff have the required competencies to manage and deliver person-centred, effective and safe services to all residents.
7.3	Staff are supported and supervised to carry out their duties to protect and promote the care and welfare of all residents.
7.4	Training is provided to staff to improve outcomes for all residents.

Theme: Use of Information	
8.1	Information is used to plan and deliver person-centred, safe and effective residential services and supports.

Quality and safety

Theme: Person-centred Care and Support	
1.1	The rights and diversity of each resident are respected and safeguarded.
1.2	The privacy and dignity of each resident are respected.
1.3	Each resident has a right to exercise choice and to have their needs and preferences taken into account in the planning, design and delivery of services.
1.4	Each resident develops and maintains personal relationships and links with the community in accordance with their wishes.
1.5	Each resident has access to information, provided in a format appropriate to their communication needs and preferences.

1.6	Each resident, where appropriate, is facilitated to make informed decisions, has access to an advocate and their consent is obtained in accordance with legislation and current evidence-based guidelines.
1.7	Each resident's complaints and concerns are listened to and acted upon in a timely, supportive and effective manner.

Theme: Effective Services	
2.1	Each resident has a care plan, based on an ongoing comprehensive assessment of their needs which is implemented, evaluated and reviewed, reflects their changing needs and outlines the supports required to maximise their quality of life in accordance with their wishes.
2.6	The residential service is homely and accessible and provides adequate physical space to meet each resident's assessed needs.

Theme: Safe Services	
3.1	Each resident is safeguarded from abuse and neglect and their safety and welfare is promoted.
3.2	The residential service has effective arrangements in place to manage risk and protect residents from the risk of harm.
3.5	Arrangements to protect residents from harm promote bodily integrity, personal liberty and a restraint-free environment in accordance with national policy.

Theme: Health and Wellbeing	
4.3	Each resident experiences care that supports their physical, behavioural and psychological wellbeing.