Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Praxis Care Mullingar
Name of provider:	Praxis Care
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	25 November 2019
Centre ID:	OSV-0001915
Fieldwork ID:	MON-0027405

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 Services for Children and Adults with Disabilities. 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 Support of Residents in Designated Centres for Persons (Children And Adults) with Disabilities) 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

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

limiting a person's access to certain activities or preventing them from exercising certain rights such as religious or civil liberties.

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
25 November 2019	Tanya Brady

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

This centre is home to four full time residents; with the fifth a shared placement between two residents who alternate time in the centre. Residents in the centre engaged with the inspector over the course of the day and there were a variety of communication abilities and modes used by all. Staff were heard to use communication strategies to support residents in their understanding as well as encouraging them to predict what was about to happen next in an interaction. Throughout the day residents were seen to come and go from the centre, some on visits with family and others out with staff or to day services, one resident who has one to one support engaged in activities in the centre throughout the day.

This centre is a large dormer bungalow set back from a busy road on the outskirts of a town. The house sits on a large site which is mainly set to grass, with entry through a locked electric gate with keypad access. Externally the grass was very uneven and difficult for residents to access, either due to them walking with unsteady gait or wheelchair users and the lawn was without paths. It was noted that a garden party that had been planned for the summer had had to be cancelled due to the poor condition of the garden and residents had expressed disappointment about this. The provider and person in charge acknowledged the condition of the garden and it was scheduled for maintenance, including improving access by fitting a ramp to the back door. Currently for two residents who are wheelchair users only one door in the house is accessible to them. In minutes of a residents' meeting it was noted that residents had requested flower beds and better grass.

Internally the centre had a comfortable and spacious sitting room that was used by residents throughout the day. One resident was seen to relax while flicking through a magazine and had their favourite film character figurines beside them. They explained that they loved specific films and showed the inspector how they liked to act out certain actions as per their favourite characters. The resident was also heard requesting staff support to make a phone call for them and the staff in response outlined the time of day when their family member would be home from work. All residents are supported by staff in an appropriate manner to use the telephone. The person in charge had as part of a review of external communication for residents ordered installation of WiFi in the centre and this was due to be installed within the month. One resident told the inspector that they were looking forward to this as they frequently used their personal tablet electronic device.

There was also a spacious dining room and attached conservatory where residents were seen to gather at mealtimes, for a cup of tea and one resident sat to complete a jigsaw at the table during the day. The windows and doors from the conservatory all had sensors that rang to alert staff if opened and staff were seen to disengage these at times over the day. Other windows downstairs were also alarmed and these again could be disengaged for periods of time, based on staff assessment, which was clearly guided in residents' behaviour support plans. The inspector joined two residents at the table during a mealtime and saw that they indicated preferred seats and looked towards the kitchen to request something to eat or drink. One resident

had a bag on the floor next to them, and shared items with the inspector such as family photographs and favourite music CDs. The kitchen which adjoined the dining room had a door which was locked and a keypad used to open it. Residents were on occasion observed to enter the kitchen accompanied by staff and supported to prepare a drink or a snack. A pictorial board was in place next to the door so that even residents with limited verbal communication could make specific requests and indicate when they wished to enter the kitchen. This restriction was in place for one individual and was currently the subject of review. Staff explained that they were trialling periods of time during the day with the keypad disengaged. This was a positive and welcome trial as the locked door had a significant impact on all individuals in the house, however it was noted that residents were not always aware when the lock was disengaged. In addition the inspector discussed with the person in charge that the addition of a handle would allow all residents to more easily open the door.

The residents all had individual bedrooms and these were decorated according to their personal choices with some covered in posters and soft toys as well as personal pieces of furniture. Two residents had bedrooms upstairs and the doors to both were fitted with an alarm that alerted staff when the doors were opened. Again the provider had shown a reduction in the use of the alarms over time with them now only used on occasion. The rationale for their use was clearly laid out for staff, who decided when to turn them on based on clearly outlined steps. Three residents had ground floor bedrooms. For one there was a high number of restrictive practices in place. Apart from a bed and two locked wardrobes there was no other furniture in the room. The bed was stripped bare during the day with bedding locked in the wardrobe along with the residents clothing and all toiletries. In addition, following a shower the shower head was removed and a bolt placed on the shower hose to prevent the shower from being switched on. The provider had been positive in their approach to reducing restrictive practices for this individual in a phased way. A previously locked toilet door was now unlocked at all times. The residents locked wardrobes were now in their bedroom and not in another room. Toiletries could be left out for short periods of time in the bathroom and finally the mattress was left on the bed now and not also removed. Despite the significant volume of restrictions for this one resident it was clear that the staff team were committed to continuously reviewing and trialling reductions and alternatives.

Another resident who spent time with the inspector had in their room a large television and comfort chair where they relaxed and watched a favourite programme. The resident was supported by additional staffing hours provided via an agency on a daily basis and they reported that they used these to access their community and to achieve goals such as one to one support to develop their literacy skills. This resident explained to the inspector that they used a wheelchair and found the doorways in the house narrow and in their latest chair it was harder to move freely through the house. They also outlined that they had to use an electric razor and considered this a restrictive practice as they would like a wet shave but understood why this decision was taken and could outline the reasons and that they were in agreement. They explained that they used a call bell the provider had installed for their use, as if their bedroom door was closed they were unable to independently open it but could do so if in their walking frame. They had been supported to use the providers' complaints

system and were happy that the provider had agreed to carry out some door widening throughout the house over time.

There was a monthly residents meeting in the house and it was seen from the minutes that there was frequent discussion on what restrictive practices meant and what was in place in the house and why. Specific residents could indicate that previous restrictions impacting them such as restricted access to fluids, were no longer in place. At other meetings residents were given photographs of the main environmental restrictions in place like the locked gate, the kitchen door and the locked shed in the garden and discussions were had on these. For some residents these discussions were repeated in individual key worker sessions. It was noted that additional individual restrictions were not consistently part of similar discussions nor had in place as yet pictorial explanations been provided for door alarms, sensor mats on beds or locked or reduced access to toiletries. It was also seen in minutes that residents had discussions on their human rights and easy read documents were available for them if they wished, one resident noted that they wanted to explore their right to education and were supported in accessing supports for reading development.

Staff that spoke with the inspector had an understanding of all restrictive practices that were in place in the centre. There had been a recent change of person in charge and staff reported that this brought an opportunity to review and reflect on practices in place. Staff were seen to fully engage with residents throughout the day and to be sensitive to individuals communication attempts and used their communicative cues when supporting them to make decisions. Staff that were familiar with residents supported them as part of annual reviews and restrictive practices are discussed in this forum. As part of the residents annual review restrictive practices impacting them were outlined and recorded in the minutes and if there were no objections then consent for continued use was deemed to be in place. Staff ensured that they supported residents in understanding as much as possible and would advocate on their behalf during these meetings.

For one resident who required two to one staffing while accessing the community, staff outlined how they were trying as much as possible to reduce the restriction of having two staff with them at all times. An example of this given to the inspector was when an individual went to reflexology sessions, when they were engaged one staff member would go outside to wait thus ensuring for the resident that they were not surrounded by too many people at all times.

Oversight and the Quality Improvement arrangements

The provider, person in charge and staff team were making every effort to promote an environment that uses minimal restrictions to maximise residents' independence as much as possible. Despite the number of restrictive practices in place in this centre the residents' safety and quality of life was central to decisions to implement them and they were continuously under revision.

There was a restrictive practice policy in place which was seen to be under review currently. The provider has yet to establish a restrictive practice committee at national level for oversight and review. Nonetheless they had recently established regional restrictive practice committees which had developed clear terms of reference. Membership of these committees were to include a regional governance and safeguarding officer, the head of operations as well as presently, an external consultant, who was under contract to provide guidance to the provider and relevant persons in charge. The provider was reviewing the templates used for persons in charge to record key performance indicators within their centre and restrictive practice was now included on these templates.

On a monthly basis there was a review of all 'untoward events' by the person in charge which incorporated all incidents or accidents that had occurred in the centre. Following this review the person in charge, along with the multidisciplinary team and staff team also reviewed any behaviour support plans in place. The corresponding restrictive practice in place was reviewed or if required an additional restriction could be suggested. It is envisaged that a referral will be made at this point to the regional oversight committee for all new restrictive practices and for any that had either increased or where suggested for removal. All restrictions were put in place following robust risk assessments which were reviewed every six months. The provider records restrictions on a register maintained for each individual and on a log for all environmental restrictions that relate to the centre. Changes over time could be observed from review of these, such as, previous restrictions now discontinued or changes in levels of restriction such as reduction in the use of the keypad lock on the kitchen door. Or for one resident where staff previously restricted their access to a preferred location in the house, by taking control of their wheelchair and moving them, this was no longer happening.

The provider has additionally introduced a system of quarterly reviews of all restrictive practices in place and recorded on either the log or the register. These reviews requested that the person in charge evaluate the associated risk and decide if it continued. Additionally a review of the measures in place to ensure they remain effective was requested and finally that the restrictive practice in place was the least restrictive and most reasonable.

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.

Compliant	Residents enjoyed a good quality of life where the culture, ethos and delivery of care were focused on reducing or eliminating the use of restrictive practices.

Appendix 1

The National Standards

This inspection is based on the *National Standards for Residential Services for Children and Adults with Disabilities (2013).* 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 adults and children 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 of adults and children with disabilities 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:

- **Individualised Supports and Care** — how residential services place children and adults at the centre of what they do.
- **Effective Services** — how residential services deliver best outcomes and a good quality of life for children and adults , using best available evidence and information.
- **Safe Services** — how residential services protect children and adults 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 development for children and adults.

List of National Standards used for this thematic inspection (standards that only apply to children's services are marked in italics):

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 person 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.

Theme: Use of Resources	
6.1	The use of available resources is planned and managed to provide person-centred, effective and safe services and supports to people living in the residential service.
6.1 (Child Services)	*The use of available resources is planned and managed to provide child-centred, effective and safe residential services and supports to children.*

Theme: Responsive Workforce	
7.2	Staff have the required competencies to manage and deliver person-centred, effective and safe services to people living in the residential service.
7.2 (Child Services)	*Staff have the required competencies to manage and deliver child-centred, effective and safe services to children.*
7.3	Staff are supported and supervised to carry out their duties to protect and promote the care and welfare of people living in the residential service.
7.3 (Child Services)	*Staff are supported and supervised to carry out their duties to protect and promote the care and welfare of children.*
7.4	Training is provided to staff to improve outcomes for people living in the residential service.
7.4 (Child Services)	*Training is provided to staff to improve outcomes for children.*

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

Quality and safety

Theme: Individualised supports and care	
1.1	The rights and diversity of each person/child are respected and promoted.
1.2	The privacy and dignity of each person/child are respected.
1.3	Each person exercises choice and control in their daily life in accordance with their preferences.
1.3 (Child Services)	*Each child exercises choice and experiences care and support in everyday life.*
1.4	Each person develops and maintains personal relationships and links with the community in accordance with their wishes.
1.4 (Child Services)	*Each child develops and maintains relationships and links with family and the community.*
1.5	Each person has access to information, provided in a format appropriate to their communication needs.
1.5 (Child Services)	*Each child has access to information, provided in an accessible format that takes account of their communication needs.*
1.6	Each person makes decisions and, has access to an advocate and consent is obtained in accordance with legislation and current best practice guidelines.
1.6 (Child Services)	*Each child participates in decision making, has access to an advocate, and consent is obtained in accordance with legislation and current best practice guidelines.*
1.7	Each person's/child's complaints and concerns are listened to and acted upon in a timely, supportive and effective manner.

Theme: Effective Services	
2.1	Each person has a personal plan which details their needs and outlines the supports required to maximise their personal development and quality of life, in accordance with their wishes.
2.1 (Child Services)	*Each child has a personal plan which details their needs and outlines the supports required to maximise their personal development and quality of life.*
2.2	The residential service is homely and accessible and promotes the privacy, dignity and welfare of each person/child.

Theme: Safe Services	
3.1	Each person/child is protected from abuse and neglect and their safety and welfare is promoted.
3.2	Each person/child experiences care that supports positive behaviour and emotional wellbeing.
3.3	People living in the residential service are not subjected to a restrictive procedure unless there is evidence that it has been assessed as being

	required due to a serious risk to their safety and welfare.
3.3 (Child Services)	*Children are not subjected to a restrictive procedure unless there is evidence that it has been assessed as being required due to a serious risk to their safety and welfare.*

Theme: Health and Wellbeing	
4.3	The health and development of each person/child is promoted.