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:	No.1 Fuchsia Drive
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	11 August 2023
Centre ID:	OSV-0004578
Fieldwork ID:	MON-0040559

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	Times of Inspection	Inspector of Social Services
Friday 11 August 2023	10:45hrs to 17:40hrs	Conor Dennehy

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

This inspection was an unannounced thematic inspection of this designated centre. It was intended to assess the provider's implementation of the 2013 National Standards for Residential Services for Children and Adults with Disabilities relating to physical restrictions, environmental restrictions and rights restrictions. The aim of this inspection was to drive service improvement in such areas for the benefit of residents. Overall, the inspection found that residents living in this centre were being supported to be as independent as possible in their daily lives.

Four residents were living in this centre and upon the inspector's arrival there, three of these residents were present with the inspector informed that the fourth resident was at work. The inspector greeted the three residents initially present. During this time one of the residents told the inspector about their birthday, an upcoming birthday party and of how they would be going to the Rose of Tralee festival the following week. As the inspector greeted another resident, they informed the inspector that they were going to the library and to feed some birds before leaving the centre independently.

The centre where these residents lived was seen to be presented in a homelike manner with the centre also observed to be generally clean and well-furnished. Each resident had their own individual bedrooms which were personalised to them. Two of these bedrooms were on the ground floor while the other two were on the first floor. It was indicated to the inspector that two residents had recently swapped bedrooms so that one resident could have their bedroom on the ground floor to better suit their needs. The inspector spoke with one of the residents involved in this who said that they had been asked about this and was happy to make the bedroom swap.

In another resident's bedroom, the inspector saw the presence of a bed leaver. This bed leaver had recently been notified to the Chief Inspector of Social Services as being a restrictive practice for this centre. However, based on the findings of this inspection this leaver appeared to be more of a standing aid for the resident and did not impact their ability to independently use their bed. This resident's bed was also seen to have a bed rail attached to it but this was in a lowered position and did not restrict the resident. Later on the inspector was informed that this bed rail was never used for the resident and had just come attached to the bed as standard.

Between two residents' bedrooms on the first floor, the inspector observed a locked press. This press had been observed to be locked during an August 2022 inspection of the centre. During the current inspection the press contained some archived files and Christmas decorations. It was indicated to the inspector though that there was no need for this press to be locked. Some presses with locks on them were also seen in the centre's kitchen-dining room. Some of these were unlocked but two of these were locked with the key to both presses hanging just above the presses. One of the presses appeared to store more archived files while the other press contained some residents' personal monies and related files.

Given the communal location where the residents' finances was stored and the availability of the key, the inspector queried the security of storage for the residents' finances. A recent unannounced visit to the centre by a representative of the provider had indicated also that there should be further exploration with residents of where they wanted to store their finances. It was indicted to the inspector though that it was the expressed will and preference of residents to store their money in the kitchen-dining room and that the key to the press was left available so that residents could access their finances independently when they wanted to.

The inspector was also informed that residents could keep their money in their bedrooms or on their person if they so wished to do so which some did. When speaking to one resident in their bedroom during the inspection, it was seen that the resident had their own wallet in their possession while all residents were indicated as having their own bank accounts and bank cards. Another resident was also overheard being encouraged by a staff member to retrieve some money themselves from the locked press in the kitchen-dining room later on the inspection.

Aside from the highlighted presses, the kitchen-dining room had a dining table present. However, during the inspection the inspector was informed that given their particular needs, one resident could not eat at this table and so had to have their meals in the centre's living room. It was also indicated that that efforts were being made to get an alternative dining table to enable the resident to return to having meals in kitchen-dining room. In the days following the inspection it was subsequently suggested that the resident could still choose to eat their meals in the kitchen-dining room but was increasingly using the living room following recommendations. This would continue until appropriate kitchen seating would be sourced for the resident.

This living room could be directly accessed via the kitchen-dining room with the latter room also having a door that led directly to the centre's utility room. During the early stages of this inspection it was observed by the inspector that this door was being locked. The door did have a thumb lock though and it was indicated that residents could use this independently to unlock the door if they wished to do so. In light of this it was unclear why the door was being locked. Towards the end of the inspection, it was observed that the door was unlocked. No resident was seen to attempt to access the utility room during the inspection but it was indicated that one resident could pass through this room occasionally.

The three residents who had been initially present during this inspection, were all spoken with by the inspector. All three indicated that they had lived in the centre a long time and liked living there. One of the residents told the inspector that they liked living in the centre because it was their home. This resident spoke positively of the support they received from staff members and indicated that while living in the centre, they were able to do the things that they wanted to do. When asked what things they liked to do the resident talked about going for walks and going out for meals. The resident also said that they liked staying in the house.

Another resident talked about going independently to the pub, gym and an educational centre in another town where the resident worked. The resident said that

they used a public rural transport service themselves to go to their job two days a week where they cut hedges. When asked by the inspector if there was anything they were unhappy about in the centre, the resident said that there was not but later indicated that they had to take showers on the ground floor as the shower in the upstairs bathroom beside the resident's bedroom was "not working so good". This shower was later checked by the inspector and did seem to be operational.

During the day, these three residents spent time in the centre but as highlighted earlier, one resident did leave centre independently to go a library. This resident returned briefly before departing again to go to a local community centre. The one staff on duty at the time asked the other two residents if they wanted to go the local community centre also. One of these residents wanted to go but the other did not. The staff member then supported the former resident to attend the community centre via the centre's vehicle while the other resident remained in the centre watching television. This resident seemed quite content with this.

In the afternoon, the two residents who had gone to the community centre returned to the centre for lunch. After this the three residents remained in the centre with one resident spending time packing as they prepared to leave the centre to go and stay with a relative for a holiday. To facilitate this the resident had to be taken via vehicle to meet their relative in another town by the one staff member on duty. Other residents were overheard being asked by staff if they wanted to come on this drive with these residents indicated that that they did. This included the fourth resident living in the centre who returned independently to the centre from work later in the afternoon.

This resident was briefly met by the inspector and indicated that they were getting on well and had been at work in a garden centre which they liked. Soon after all four residents got into the centre's vehicle and departed (the residents had not returned by the end of the inspection). It was observed though that when getting into this vehicle two residents, who both used rollators, were slower in getting into the vehicle than the other two residents. Risk assessments reviewed for both residents indicated that a new vehicle was needed to better suit these residents' mobility needs.

A staff member spoken with before they left the centre indicated that these residents were slower in getting in and out of the centre's present vehicle but that they could currently manage this. This staff member was one of two staff members that were present on the day of inspection with one staff taking over from the other during the inspection. Both of these staff were observed and overheard to be very caring and pleasant in their interactions with residents. For example, when one of the residents was preparing to leave the centre to get on the centre's vehicle, one of the staff highlighted to the resident that they may not need to wear a jacket as it could be hot outside and in the vehicle.

The four residents living this centre all communicated verbally and at various points residents were overheard being asked by both staff about what they wanted to do or what choices they wanted to make. These included asking if residents wanted to leave the centre and what they wanted to have for lunch. This provided evidence that residents were being treated in a respectful manner. Notes of residents' meetings

reviewed during this inspection also indicated that residents were being given information on their rights. For example, notes of a July 2023 residents' meeting indicated that privacy and standing up for themselves was discussed with residents.

Notes of these meeting indicated that residents did activities such as going to the cinema, having coffee, visiting a wildlife park and making day trips to towns in other counties. Complaints were also recorded as being discussed with residents during such meetings. However, the inspector did observe that some information about the centre's complaints process on display on a noticeboard in the kitchen-dining room needed updating. It was also noted that these residents' meetings appeared to be happening at an irregular frequency based on meeting notes reviewed.

Similarly, the inspector was informed that staff team meetings should be taking place every six to eight weeks but notes of only two such meetings from 2023 were seen on the day of inspection. It was indicated that the frequency of such meetings could have been impacted by annual leave. The inspector reviewed notes of the two 2023 staff meetings and read that restrictive practices was included an agenda item. Notes of both meetings indicated that there were no restrictive practices in use in the centre. Staff members spoken with also demonstrated a good awareness as what a restrictive practices was while a copy of the 2013 National Standards was also present in the centre.

In summary, staff members on duty were very caring, pleasant and respectful in their interactions with residents. Positive feedback on life in the centre was provided by residents spoken with. These residents were offered choice in daily lives and encouraged to be independent in how they went about the everyday lives.

The next section of the report presents the findings of this thematic inspection around the oversight and quality improvement arrangements as they relate to physical restrictions, environmental restrictions and rights restrictions.

Oversight and the Quality Improvement arrangements

The provider did have systems in place for the review and monitoring of restrictive practices although a policy in this area was due a review at the time of inspection. One restriction on a resident in their home at the time of inspection had not been reflected in a risk assessment. Other matters though had been risk assessed to promote residents' independence.

In advance of this thematic inspection the provider was invited to complete to self-assessment tool intended to measure this centre's performance against the 2013 National Standards as they related to physical restrictions, environmental restrictions and rights restrictions. These standards and the questionnaire was dived up into eight specific themes. This self-assessment was completed and submitted for review in advance of this inspection. Overall, the completed questionnaire suggested a good level of progress towards the National Standards with only Theme 7 Responsive Workforce highlighted as needing quality improvement.

The self-assessment suggested that the quality improvement needed in this area was the introduction of a new log of restrictions to enhance awareness of restrictions. During this inspection the inspector queried if a quality improvement plan was in place in response to the self-assessment's findings. The inspector was informed that no quality improvement plan was needed as a template for a log of restrictions had been created and there were no restrictions currently in place. While a bed leaver had previously been notified as being a restrictive practice in the centre, as highlighted earlier in this report this did not appear to be restrictive in nature.

However, given that a new table was needed for one resident to consistently eat in the centre's kitchen-dining room, this did appear to be a restriction on the resident at the time of inspection. In the completed self-assessment the provider outlined how different forms of restrictions were to be reviewed but the current situation with the resident and the kitchen-dining table had not gone through such review processes. For example, given the resident's needs, their use of the existing kitchen-dining table presented a possible health and safety issue but a risk assessment related to the health and safety issue did not directly reference any issues with the existing kitchen-dining room table.

Aside from risk assessments it was also indicated that any restrictions in the centre, depending on their nature, could be reviewed by either the provider's rights review committee or behavioural standards committee. It was suggested during this inspection that there could be some overlap between these two committees but that no matter in this centre had been referred to either committee. As such it was not possible on this inspection to assess how either committee functioned in practice for

any restrictive practice for the current centre. Despite this, the intended role and functioning of the behavioural standards committee was outlined in the provider's regional restrictive practice policy.

This policy was present in the centre on the day of inspection and was dated September 2021. It was also indicated that this policy was due to be reviewed again in September 2022 but the inspector was informed that the timeframe for this review had been extended until September 2023. This was to give the provider more time to consider further changes to the policy in light of recent developments in Irish law. While this process was ongoing at the time of the inspection, the inspector reviewed the existing policy and noted that it provided for any restrictive practices to be considered within the context of human rights and dignity. The policy indicated that residents or their families/guardians were to be informed and consulted around restrictive practices while also outlining a process for the sanctioning, review and monitoring of these.

Outside of the operations of the behavioural standards committee, the provider did have other means to monitor any restrictive practices in the centre. These included six monthly provider unannounced visits to the centre. One such had such been completed in June 2023 and, while this was the first such visit since August 2022, the report of this visit did include a specific section on restrictive practices. The June 2023 provider unannounced visit report indicated that there no restrictive practices in the centre but the locked press on the first floor was not referenced. Further exploration around areas such as resident consultation and residents' ownership over their monies was encouraged in the report though.

Rights assessments were also carried out for residents on an individual basis with these contained with residents' personal plans. The inspector reviewed two residents' rights assessments which had both been conducted on 8 August 2022 and noted that these covered areas such as possessions, residents' home, money, privacy and consultation. No rights restrictions were identified in either assessment. The inspector did observe though that this centre was staffed by one staff member at a time and queried if such staffing arrangements could impact residents' ability to do chosen activities away from the centre, particularly if there was not a consensus amongst the four residents living in the centre around what they wanted do.

However, the staff spoken with during this inspection outlined the steps they would take to ensure that all residents were able to do the things they wanted. For example, one staff member outlined how they would seek to compromise amongst residents. A second staff member outlined how if some residents wanted to go do an activity away from the centre with staff support and other residents did not wish to leave the centre, additional staff support could be obtained to facilitate all residents' choices. It was noted on the day of inspection that residents were asked if they wanted to leave

the centre at times and that residents' choices for these were respected. All four residents had also been risk assessed as being capable to remain alone in the centre without staff support. This promoted residents' independence and positive risk taking.

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 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.