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:	Woodlands
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	10 October 2023
Centre ID:	OSV-0004891
Fieldwork ID:	MON-0040834

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
Tuesday 10 October 2023	10:15hrs to 16:30hrs	Mary Moore

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

This inspection was undertaken on behalf of the Chief Inspector as part of a thematic programme of inspections focussed on the use of restrictive practices. The inspector found there was good awareness and improved arrangements for the use and review of restrictive practices. The provider continued to review and amend these arrangements as it aimed to ensure that residents experienced minimal restrictions in their daily life. There were some gaps however and scope for improvement particularly in the context of the assessed needs of this particular cohort of residents. Some of this change was in progress.

A residential service was provided to three residents while a day service and some residential supports were provided to a fourth resident on a rotational basis. All four residents in the context of their disability and associated diagnoses had complex needs and were fully dependent on the staff team in relation to their activities of daily living. All four residents were wheelchair users and were not verbal communicators. The arrangements put in place by the provider reflected these high support needs. For example, the design and layout of the house, the staffing levels and the staff-skill mix.

On arrival at the house, one resident was arriving to attend their day service supported by a staff member and two other staff members were on duty in the house. Staff were diligent in establishing that the inspector was well and free of any symptoms that may have been indicative of illness that could have been transmitted to the residents and the staff team. The inspector was directed to the hand sanitising product that was prominently available in the main hallway. The house was busy as staff members completed residents' morning routines with them. One resident had left to attend an appointment with their General Practitioner (GP) supported by a fourth staff member. Ordinarily each resident had one-to-one staff support each day up to 20:00hrs. One staff member on the day of inspection was deployed mid-morning to another service in response to an unplanned absence. The person in charge told the inspector that this was a very rare occurrence.

The inspector noted the resources invested in the service since the last Health Information and Quality Authority (HIQA) inspection. For example, the planned extension to the house was nearing completion and was of a high standard. The additional bedroom, ensuite bathroom, corridor and doorways were spacious and supported accessibility for the resident. External groundworks to enhance the accessibility of the rear garden for all residents were also in progress. New wheelchair accessible transport had been provided as had two wheelchairs that were suited to "off-road" terrain.

Given the dependency levels and needs of all four residents there was a daily requirement for good consistent care such as in personal hygiene, assistance with meals and exercise programmes so that residents enjoyed the best possible health. The inspector saw how staff attended to these needs in an unhurried and respectful

manner. For example, bedroom and bathroom doors were closed while personal care was attended to. Staff members sat while assisting residents with their meals.
The person in charge and the frontline management team were actively working with the staff team to ensure a good and reasonable balance was achieved between residents' physical care needs and their psychosocial needs. On the day of inspection residents received on-site physical therapy and were seen in the afternoon to be afforded floor-time, to use their standing frames and alternative seating. As the inspection was concluding all four residents left the house with staff to accompany one resident home and to go for a local drive. On the days prior to this inspection two residents had enjoyed a night way in a hotel with accessible facilities supported by staff members.

While residents did not provide explicit feedback to the inspector on what life was like for them in this centre, two residents in particular used gestures and facial expressions to express their interest in the presence of the inspector and to respond to the inspector. Staff spoken with could readily describe to the inspector how each resident communicated how they were feeling, what it was they enjoyed doing and things that they did not like or enjoy. For example, a resident might put their hands over their ears if they wanted a quieter space or shuffle forward on their chair if they wanted some floor time. The inspector saw how one resident used their Lámh signs to communicate with staff. Communication, how to support good communication and promote resident choice and preference was a strong theme in the personal plan reviewed. Communication, consultation and ensuring residents had choice and control was a challenge in the context of the assessed needs of the residents. There was scope to improve and evidence how the restrictions that were a part of their daily routine were discussed with residents in a format that they understood.

The inspector did not meet with any resident representative. The person in charge described to the inspector how they and the staff team were in regular contact with all representatives. The person in charge had also sought formal feedback to inform the 2022 annual service review. All representatives had not responded to this request but those who did described the service provided as excellent.

Some representatives were met with more frequently than others. For example, where there was a regular pattern of visits to home. Family were also welcome to visit the service. A family had visited to celebrate a recent birthday. There were no restrictions on visits unless there was an identified risk such as in the event of an outbreak of infection.

Many of the interventions in use were unavoidable, were required to maintain resident health and wellbeing and not intended to be restrictive. For example, devices to ensure that residents maintained good posture and devices to ensure that residents did not fall from their wheelchairs. There was evidence of the use of alternatives such as low level beds, sensors and bed vacating alarms rather than using bedrails. It was recognised that these interventions could be restrictive on resident choice and limit their freedom of movement. For example, these interventions were reviewed as part of the providers restrictive practices procedures and staff were asked to record daily the opportunities that residents had to be out of

their wheelchairs, to enjoy some floor-time and alternative forms of seating. However, some of this recording was inconsistent and not quantified.

While residents requested, enjoyed and needed time out of their wheelchairs, the wheelchair was also what gave them freedom of movement and choice. The inspector observed how when a resident was placed on an alternative chair they could not get out of the chair without assistance from staff. While this change of seating was intended to be therapeutic it actually restricted the resident from exercising their expressed choices and preferences. The inspector and the person in charge observed as the resident by gesture indicated their preference to be in the kitchen where their peers and the staff team on duty were enjoying lunch. While a singular example this incident highlighted the dependence of residents on staff and the potential for therapeutic interventions to isolate and restrict residents from expressing their preferences and choices.

This was a good service and overall the provider had effective systems in place for maintaining oversight of the service including the use of restrictive interventions. There was evidence of improvement and reduction in the level of restrictions in use. However, there were some gaps and inconsistencies. The primary finding of this inspection was the need to develop the awareness that was there in relation to the use of physical and environmental restrictions so that they did not inadvertently and unintentionally restrict residents' freedom of choice and movement.

Oversight and the Quality Improvement arrangements

The person in charge had completed the Health Information and Quality Authority (HIQA) self-assessment questionnaire and had identified good practice but also a number of areas for improvement in relation to restrictive practices. Based on these inspection findings this was a reasonable and accurate assessment of practice in the centre. For example, the scope to improve communication and consultation.

Some of these improvements were in progress. The community manager confirmed for the inspector that the restrictive practice steering committee had recently met and a revised and updated policy on the promotion of a restraint free environment had been circulated for review and comment. The provider had also recently issued a questionnaire to all services as it sought to gather data on the number and type of restrictions in use across it services. The inspector reviewed the questionnaire. The questionnaire addressed many important areas but it was quantitative in nature and did not ask staff about more nuanced restrictions or rights restrictions. Their inclusion may have prompted staff to identify practice not previously viewed or identified as restrictive and therefore drive quality improvement.

The provider had a statement of purpose and function that set out the number of residents and the range of needs that could be met in the service. The provider operated the service as outlined in the statement of purpose.

As discussed in the opening section of this report ordinarily each resident had one-to-one staff support each day up to 20:00hrs. The provider had (given the assessed needs of the residents and a planned increase in occupancy) recently changed the night-time staffing arrangements to two staff on waking duty. This was responsive to the needs of the residents but also possible risks such as fire. Simulated drills had established that two staff were required to safely and efficiently evacuate the residents.

The person in charge could rationalise on the basis of risk to the inspector how interventions such as bed-vacating alarms and other monitors would still be used even with waking staff in place. The person in charge could explain how these alarms meant that residents' bedroom doors could be safely closed at night and, residents were not subjected to a higher level of restriction such as bedrails. The person in charge was however open to ongoing review and reduction where possible. For example, the use of a visual monitor was recently ceased with a clear protocol put in place for any possible re-introduction.

There was limited turnover of staff and no significant staffing challenges. Staff spoken with confirmed this. The person in charge called unannounced to the house and convened regular staff meetings. The range of relevant training provided to staff included on-line and face-to-face safeguarding training, training in positive behaviour support and de-escalation and intervention techniques. Staff had recently been provided with refresher training in performing clinical holds required at times to facilitate medical care. However, training such as in the prevention or minimisation of

restrictive practices and promoting a human rights-based approach to care was not included in the programme of staff training.

The provider had enhanced the governance structure and the staff-skill mix since the last HIQA inspection. For example, nursing advice, care and supervision was now included in the staff skill-mix in addition to two lead social care workers. However, there was some evidence that further discussion was needed to ensure that there was clarity on individual roles and responsibilities.

For example, the inspector noted that the standard of personal planning had improved since the last HIQA inspection. The plans had been streamlined and the personal outcomes measures (POMS) format had been introduced. Staff had recorded how they had included the resident in their plan and how the resident had used eye contact when certain possible activities and goals were suggested such as swimming. Residents had good access to the services and clinicians that they needed such as their GP, dentist, speech and language therapy and dietitian. However, the inspector noted a new recent clinical recommendation. While documented, the care plan had not been updated and there was no evidence that the change had been implemented. The staff team on duty were not aware of the change.

The assessed needs of the residents and the assessment of associated risks informed the interventions in use. The person in charge maintained an active register of the risk identified in the centre and how it was managed. This included controls such as the alarms and sensors in use. The review of accidents and incidents that occurred informed the updating of the risk assessments and the review of controls. Such objective review had led to the reduction plan for the visual monitor.

The person in charge also monitored the use of any as needed medicines. There were prescriptions and protocols in use to guide staff on their administration. However, there was inconsistency between the prescribed indication for one such medicine and the administration protocol and the indications in practice (anxiety and self-injurious behaviour).

In addition, while it was stated that no bedrail was in use the inspector saw that one bedrail was continuously in place. The person in charge confirmed that the bedrail and the associated padding remained in place when the room was used by a different resident. Therefore, there was an absence of individuality and person centred assessment to this arrangement.

Formal quality assurance systems included the completion of the annual service review and the quality and safety reviews required at a minimum of six-monthly intervals. These reviews based on records seen were completed on schedule and included restrictive practice as a line of enquiry. In addition to the risk assessments mentioned above restrictive practice protocol and review forms were also in place as outlined in the provider's policy.

In summary, this was a good service and the provider itself had identified areas where it could improve and minimise the risk and the impact of the restrictions in place. For example, in relation to communication and evidencing how resident choice

and control in the context of their dependence and disabilities was facilitated and documented. Some of this was reflected in the personal plan. However, monitoring the progress of the improvement needed would have benefitted from an explicit restraint specific quality improvement plan.

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.