



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

Issued by the Chief Inspector

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| Name of designated centre: | SVC-SDN |
| Name of provider: | Avista CLG |
| Address of centre: | Dublin 7 |
| Type of inspection: | Unannounced |
| Date of inspection: | 21 November 2023 |
| Centre ID: | OSV-0004023 |
| Fieldwork ID: | MON-0041397 |

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 environmental¹ 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 |
|----------------------------|----------------------|------------------------------|
| Wednesday 22 November 2023 | 10:30hrs to 16:30hrs | Maureen Burns Rees |

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

From what the inspector observed, it was evident that residents living in the centre lived a good quality of life where they were facilitated to enjoy each day to the maximum of their capacity while at the same time being protected. However, at the time of inspection there were a number of staff vacancies, which had the potential to have a negative impact in terms of consistency of care and implementation of arrangements for restrictive practices. The resident in the self-contained apartment had limited access to cooking facilities in their apartment which restricted their access to hot meals.

The residents living in the centre presented with complex needs. Consequently, it had been assessed and agreed by a multidisciplinary team that a number of restrictions were required to support the residents, and to ensure their safety and welfare. Restrictions in place were subject to regular review and were considered to be the least restrictive environment possible, considering the identified risks for residents.

There were plans to de-congregate the centre in line with the HSE National Strategy - "Time to move on from congregated settings - A strategy for community inclusion". The three residents in the main house had been identified to transition to more suitable accommodation within the community. A defined time-line for the de-congregation of these residents had not yet been determined but suitable accommodation for the three residents had been identified. A discovery process had been completed with the identified residents and their families. The purpose of this was to determine the individual residents' needs, will and preferences in relation to their future life plans as they transition to live in their own home within the community. The provider had a 'transforming lives' lead who was responsible for coordinating the de-congregation process. A number of management and staff had completed enhanced quality 'good lives' training for de-congregation.

The centre comprised of a three bedroom semi-detached bungalow and a separate one bed-roomed apartment. The centre was registered to accommodate a total of four residents, with three in the main house and one in the self contained apartment. There were no vacancies at the time of this inspection. Each of the residents had been living in the centre for an extended period.

The centre was found to be comfortable and accessible. There was a medium sized garden for the main house and a separate smaller garden for the individual apartment. The main house had a newly renovated kitchen, a laundry room, a sitting come dining room and a separate smaller sitting room. The apartment was located a walking distance from the centre and was nicely decorated. It comprised of an ensuite bedroom and a sitting come dining come kitchenette area. There were limited cooking facilities available in the kitchenette. It was reported that the resident used the kitchen in the main house to cook and prepare their meals but preferred to eat in their own apartment. This meant that the resident with the support of staff needed to carry the residents main meals to their apartment for dining. However, it was noted that there were no facilities within the apartment to reheat a meal should it become cool during transfer. Each of the residents in both areas had their own

bedroom which had been personalised to their own taste. This promoted the residents' independence and dignity, and recognised their individuality and personal preferences.

On the day of inspection, the inspector met briefly with each of the four residents living in the centre. Warm interactions between the residents and staff caring for them was observed. One of the residents was observed to enjoy a foot massage by staff following a walk. Other residents were observed to enjoy having lunch together following trips to the gym and attending their respective day service programmes. A number of the residents were unable to tell the inspector their views of the service but appeared in good form and comfortable in the company of staff. Staff reported to the inspector that they felt the residents were happy living in the centre and that staff had a close relationship with each of the residents. The inspector did not have an opportunity to meet with the families of any of the residents but it was reported that they were happy with the care and support provided in the centre.

There was an atmosphere of friendliness in the centre. Numerous photos of the residents from now and when they were younger were on display. Staff were observed to interact with residents in a caring and respectful manner. For example, staff were observed to seek a resident's permission to enter their bedroom and to support a resident who was anxious transitioning from the centre in a kind and supportive manner.

Residents and their representatives were consulted and communicated with, about the environment and restrictions in place and their review. It was noted that a number of restrictions had been reduced and or removed in the preceding period in consultation with the residents and their families. For example, locks on press doors in the kitchen had been removed. There was evidence of key working meetings with the residents in relation to their needs, preferences and choices regarding restrictive practices in the centre.

Residents' rights in relation to the use of restrictive practices were being upheld in the centre. While restrictive practices were deemed necessary, it was considered that these were being implemented in a way that did not unduly compromise the dignity and quality of life of the individual resident. It was observed that staff treated residents with dignity and respect and that their privacy was respected. Residents were supported to develop an awareness of restrictive practices through regular key working meetings. They were provided with information about restrictive practices in an accessible format which was appropriate to their communication needs and preferences. The impact of specific restrictions for other residents were considered. Human rights assessments were completed for each resident to ascertain the impact of any restrictions on their rights. It was noted that restrictive practices in place were discussed as part of resident's individual annual reviews with family members present.

The residents' were actively supported and encouraged to maintain connections with their friends and families without unnecessary restrictions. This included video and

voice call and visits to the centre and to their family homes. There were no restrictions on visits in the centre.

The residents were supported to engage in meaningful activities in the centre, which were not subject to unnecessary restrictions. Through key working meetings and resident house meetings, residents' will and preference were ascertained regarding their day-to-day lives, links with the community and activities that they wanted to undertake. There was evidence that positive risk taking was supported in facilitating residents' choices and preferences in a non restrictive manner.

Some residents were reluctant to engage in many activities. Only one of the four residents were engaged on a sessional basis in a formal day service programme. Each of the residents had a dedicated staff member working with them each day who engaged in individualised activities with them. Examples of activities engaged in by the residents included, Jigsaws and board games, walks to local scenic areas, arts and crafts, listening to music, trips using public transport, shopping and meals out and massage therapy. There was a gym and a swimming pool located on the campus which it was reported that a number of the residents enjoyed using on a regular basis. There was also a horticulturist working on the campus and residents had access to a weekly session to work with them. The centre had access to two vehicles which were shared with the adjacent centre, for use by the residents to access activities within the community.

Staff met with, had a good knowledge of what constitutes a restrictive practice and of the restrictive practices which had been assessed as required in the centre. Staff spoke of evidence to support the use of specific restrictive practices following assessment of the support needs of individual residents. Staff were conscious of the risks involved and the impact that the use of restrictive practices had on an individual resident's rights and liberty. All restrictive practices used were subject to regular review with the purpose to reduce or eliminate where possible their use. There were detailed behaviour support plans in place to provide guidance and direction for staff regarding supporting residents and the use of restrictive practices.

Oversight and the Quality Improvement arrangements

The provider and staff made every effort to promote an environment that had the least possible restrictions so as to maximise residents' independence and autonomy. However, there were a number of staff vacancies at the time of inspection which had the potential to negatively impact consistency of care and restrictive practice arrangements. In addition, there were limited cooking facilities in the apartment. This resident cooked and prepared a number of their meals in the main house but chose to eat their meals in their own apartment. The apartment was a distance from the main house. However, there were no facilities to keep this resident's food warm during transit or to reheat it in the apartment.

There were appropriate governance and management systems in place which ensured that restrictive practices were accurately recorded, monitored and regularly reviewed with the aim of reducing and or eliminating restrictive practices where possible. The CNM3 completed six monthly unannounced visits which included information on all restrictions used in the centre in that period. The PIC and CNM3 reviewed all incidents relating to RPs. There was a human rights committee which met on a regular basis. The provider had a human rights officer in place for advice and support. The multidisciplinary team held regular meetings to review all restrictive practices. Their objective was to have oversight of the appropriateness of all restrictive practices in use in the centre.

The centre was managed by a suitably qualified and experienced person. The person in charge held a degree in applied social studies and was in the final stages of completing a masters in social care leadership and management. She had a good knowledge of the assessed needs and support requirements for each of the residents and of the regulatory requirements. She was in a full time position and was not responsible for any other designated centre. There were regular staff meetings and all restrictive practices were discussed at these meetings.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge reported to the clinical nurse manager, grade 3(CNM3), who in turn reported to the service manager. The person in charge and CNM3 held formal meetings on a regular basis and reviewed restrictive practices as part of these meetings.

At the time of inspection, the full complement of staff were not in place. There were 2.5 whole time equivalent staff vacancies. Recruitment for these positions was underway. The vacancies were being covered by a small number of regular relief and agency staff. This provided some consistency of care but there remained the potential for a negative impact in terms of consistency of care and implementation of arrangements for restrictive practices.

All staff had received appropriate training specific to residents' need. Training provided included safeguarding and managing challenging behaviour. The provider had developed a training programme specific for restrictive practices which focused

on reducing or eliminating restrictive practices. However, only two of the staff team had completed that training at the time of inspection. In addition, there were a small number of staff overdue to attend refresher training in the management of challenging behaviour. Suitable staff supervision arrangements were in place to ensure that the care staff provided used the least possible restrictive practices for the shortest duration, in accordance with best practice.

There were policies and procedures in place for restrictive practices which were in line with national policy and legislative requirements. The centre's statement of purpose had recently been reviewed and outlined the specific needs that could be met in the centre and the admission criteria. Staff resource and support requirements were determined for each resident based on an assessment of their needs. Each of the residents' needs were assessed from a rights perspective as well as a safety perspective.

Records were accurately maintained of all restrictive practices in use. This meant that the provider could identify notable features or trends. This provided assurances that restrictive practices were being used in accordance with how they were prescribed and provided opportunities to reduce or remove restrictive practices where possible. There was a restrictive practices register in place which was subject to regular reviews. All restrictive practices were agreed and signed off by the individual and their families. All restrictive practices were reviewed with a team approach on a regular basis and at a minimum of a six monthly period.

All restrictive practices in use in the centre had been identified and appropriately assessed. These assessments considered the specific circumstance for their use, the appropriateness of the restriction being used, the identified risk and if a less restrictive measure was possible. There was evidence that advice would routinely be sought from the provider's behavioural analyst on alternative strategies and to ensure the least possible restriction was put in place. It was noted that in the preceding period a number of restrictions had been reduced or removed in the centre. For example, locks had been removed from a number of press doors in the kitchen of the main house and the requirement for swipe access to the laundry room had been removed meaning that residents could readily access this area. There was evidence of previous unsuccessful trials and reduction plans for other restrictions. These trials were considered to have caused residents' distress and to have negatively impacted upon aspects of their daily lives.

A number of the residents presented with complex behaviours which could be difficult for staff to manage. Behaviour support plans were in place for residents identified to require same and these provided a good level of detail to guide staff in supporting the resident and aimed at reducing restrictive practices in place. The residents and staff team had access to support from a psychologist and a clinical nurse specialist in positive behaviour support.

There were measures in place to protect the residents from being harmed or suffering from abuse. All safeguarding incidents had been appropriately responded to. The provider had a safeguarding policy in place and a staff member spoken with was aware of safeguarding procedures. The person in charge and staff were aware of the

safeguarding risks inherent in using restrictive practices and made every effort to promote the least restrictive environment possible. It was considered that the restrictions in place did not unduely impact on residents' physical behavioural and psychological well being.

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.

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| 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. |
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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 | |
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| 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 | |
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| 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) | <i>The use of available resources is planned and managed to provide child-centred, effective and safe residential services and supports to children.</i> |

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

| Theme: Use of Information | |
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| 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 | |
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| 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) | <i>Each child exercises choice and experiences care and support in everyday life.</i> |
| 1.4 | Each person develops and maintains personal relationships and links with the community in accordance with their wishes. |
| 1.4 (Child Services) | <i>Each child develops and maintains relationships and links with family and the community.</i> |
| 1.5 | Each person has access to information, provided in a format appropriate to their communication needs. |
| 1.5 (Child Services) | <i>Each child has access to information, provided in an accessible format that takes account of their communication needs.</i> |
| 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) | <i>Each child participates in decision making, has access to an advocate, and consent is obtained in accordance with legislation and current best practice guidelines.</i> |
| 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 | |
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| 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) | <i>Each child has a personal plan which details their needs and outlines the supports required to maximise their personal development and quality of life.</i> |
| 2.2 | The residential service is homely and accessible and promotes the privacy, dignity and welfare of each person/child. |

| Theme: Safe Services | |
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| 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 |

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| | assessed as being required due to a serious risk to their safety and welfare. |
| 3.3 (Child Services) | <i>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.</i> |

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