Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Community Hospital of the Assumption
Name of provider:	Health Service Executive
Address of centre:	Leigh Road, Thurles, Tipperary
Type of inspection:	Unannounced
Date of inspection:	23 August 2023
Centre ID:	OSV-0000662
Fieldwork ID:	MON-0040775

What is a thematic inspection?

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

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

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

What is 'restrictive practice'?

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

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

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

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

About this report

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

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

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

This unannounced inspection was carried out during the following times:

Date	Times of Inspection	Inspector of Social Services
Wednesday 23 August 2023	09:45hrs to 18:00hrs	Catherine Furey

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

This was an unannounced inspection to monitor the use of restrictive practices in the designated centre. Through discussions with residents and staff, and from the observations of the inspector on the day, it was clear that residents enjoyed a good quality of life in the centre. Residents were generally supported to make choices about their daily routines, for example, they could choose when to go get up, or go to bed for a rest. The inspector identified that some residents had limited choice in where to dine, and others were unable to wander the extent of the designated centre due to restrictive devices such as monitoring tags. These findings are discussed throughout the report.

The inspector arrived to the centre in the morning and was welcomed in by staff. Some residents were up and dressed, seated in communal areas and having breakfast and some others were still in bed. There was plenty of space within the centre for residents to mobilise. The centre is comprised of residential accommodation laid out in three distinct units, which opened into a shared communal areas including an oratory, quiet room and dining room. Each unit contains their own small dining and sitting room.

Residents told the inspector that they were consulted with about their care and about the organisation of the service. Residents felt safe in the centre and their privacy and dignity was respected. Residents told inspectors they liked living in the centre and that staff were always respectful and supportive. Staff were observed providing timely and discreet assistance, enabling residents to maintain their independence and dignity. Staff were familiar with residents' individual needs and provided care in accordance with individual resident's choices and preferences. Staff demonstrated good understanding of safeguarding procedures and responsive behaviours (how persons with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Activities provided in the centre were varied and informed by residents' interests, preferences and capabilities. There were four staff allocated to delivering the diversional therapy programme which consisted of large and small group activities, one-to-one therapies, celebrations and outings. Residents who wished to smoke were supported to smoke in a designated area to the front of the centre. The garden was a no-smoking zone.

Residents' movements within the centre were generally kept to their own distinct units. This was despite the larger communal areas and corridors being designed for all residents to use. There was a small number of residents whose safety was assessed as being at risk, should they leave the centre unsupervised. These residents wore a monitoring tag, which alerted staff once the resident moved past a certain point. On the two units where these monitoring tags were in use, the inspector found that the alarm went off as soon as the resident went past the nurse's station, before ever leaving the unit. This practice was restrictive in nature, as the resident was unable to wander out of the unit and into the larger communal areas. Staff told the

inspector that should the resident get out of the units, a further alarm along the corridor would alert. Staff said this was because the main door to the centre was not locked, however it was monitored by a receptionist.

In addition to the restrictions on wandering throughout the indoor areas of the centre, the inspector observed that the door to the external courtyard from Unit C, and the door to an enclosed garden area from Unit B also alarmed if opened by a resident with a monitoring tag. These door were also heavy, requiring some force to engage the push-bar opening device. These doors would be difficult for the majority of residents to open independently. The impact of these restrictions is discussed further in the report.

The inspector observed a large number of physically-restrictive devices such as bedrails in use. As discussed in the next section of the report, the assessment process prior to applying a bedrail required review, as the current process was not in line with best-practice, national guidance. In addition, there was a number of residents in bed, with movement sensor mats placed beside the bed. An alarm was activated when the resident moved on or off the mat, which alerted staff to assist or supervise the resident. While the reason for these sensor mats was to prevent falls, they could potentially impact on the free movement of the resident, as the noise and or subsequent attention from staff could deter a resident from moving.

The inspector observed lunch time on some of the units. Most residents stayed in their respective units on the day of inspection, as these each had a small dining and sitting room contained within. Food was delivered via the main kitchen in a temperature-controlled trolley and served directly to residents and there was choice provided for all residents. Staff confirmed that the main dining room was only used by a small number of residents. Records of recent staff meetings identified that the dining room had been closed for a period of time, as multi-task attendants found that it was challenging to organise assisting residents from the units. The inspector observed a well-staffed service and the person in charge outlined that following a series of engagements with staff that the dining room had recently opened up again.

Residents' concerns and complaints were acted on in a timely manner. The centre had an advocate who visited regularly and attended the previous two residents' forum meetings. Residents who could not express their own opinions were represented by a family member or a care representative. Residents who lacked capacity to make decisions in relation to some aspects of care were supported by members of the multidisciplinary team and family members to ensure positive outcomes which represented their best interest.

The residents and staff met during this inspection appeared comfortable being together with some warm interactions observed and overheard by the inspector.

Oversight and the Quality Improvement arrangements

The centre had completed the self-assessment questionnaire and had familiarised themselves with the guidance and material published in support of this thematic inspection. They had also taken steps to implement some of the measures which were suggested in the guidance. For example, management were in the process of setting up a committee to lead a targeted improvement plan to reduce the number of restrictive practices in the centre. There was training in restrictive practices scheduled in the near future and following this, the centre was planning to fully adopt a restraint-free environment.

The inspector reviewed the centre's policy on restraint. Practice in the centre was not seen to be consistent with the policy. The policy states that bedrails may be used when there is clear evidence that an extensive range of alternative measures have been trialled for a reasonable period of time, however, the inspector found that this was not adopted in practice. For example, the current bedrail risk assessment in use did not include any section relating to the use of alternatives. To that effect, staff were assessing the risk of using bedrails, without consideration of a range of alternatives to the bedrail. This directly led to a high usage of bedrails, despite alternatives such as low profile beds, falls reduction mats and sensor mats being available in the centre.

Residents using any of these devices had a restrictive practice care plan in place which were generally person-centred, outlined the rationale for use of these practices and were updated regularly. However, the care plans were based on the risk assessment completed, and as these did not reflect alternatives to restraints, care plans did not routinely include this information either. The management team outlined that informed consent was always sought from the resident, or where appropriate, their care representative. The documentation of consent could be improved, to ensure that all individuals are aware of the risks associated with bedrails, and to ensure that all pertinent information is provided to the individuals.

Staff in each of the three units maintained separate registers of restraints. There was uncertainty amongst different staff as to the definition of restraint. For example, some staff identified that a half bedrail was a restraint, even though the resident could move freely from bed. This meant that the total numbers of restraints logged in the register was overstated. Management had identified this knowledge deficit and stated that the upcoming training in restrictive practice would improve staff understanding of restraints.

The inspector identified a restrictive practice that was not recorded on the register. This practice related to the access to secure outdoor areas by means of doors which emitted an alarm when residents wearing a monitoring tag attempted to open them. Inspectors were advised by several staff that these doors were opened on days when the weather permitted. However, this practice potentially inhibits residents' ability to enjoy the outdoor areas at a time of their own choosing. Management were advised

that they should review this practice. The register should also reflect that the doors cannot be easily opened by residents independently.

The person in charge and assistant director of nursing spoke to inspectors about the process for admitting new residents to the centre. They were clear that all prospective residents were comprehensively assessed to ensure that the centre had the capacity to provide them with care in accordance with their needs. The management team was also very clear that bedrails would not be used on the request of residents' family or representatives.

The inspector was satisfied that there were enough staff members in the centre, with a sufficient skill mix, to ensure that care was provided to residents in a manner that promoted their dignity and autonomy. There was no evidence of restrictive practices being used as a result of a lack of staffing resources.

Overall, Community Hospital of the Assumption was open to adopting a culture of positive-risk taking and person-centred care. While opportunities for improvement were identified during the inspection, it was clear that residents enjoyed a good quality of life in the centre.

Overall Judgment

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

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

Appendix 1

The National Standards

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

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

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

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

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

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

List of National Standards used for this thematic inspection:

Capacity and capability

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

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

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

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

Quality and safety

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

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

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

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

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