



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

Issued by the Chief Inspector

Name of designated centre:	Abbeylands Nursing Home
Name of provider:	Abbeylands Nursing Home & Alzheimer Unit Limited
Address of centre:	Carhoo, Kildorrery, Cork
Type of inspection:	Unannounced
Date of inspection:	11 August 2023
Centre ID:	OSV-0000187
Fieldwork ID:	MON-0040661

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 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 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
Friday 11 August 2023	09:30hrs to 17:30hrs	Siobhan Bourke

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

This was an unannounced, focused inspection on restrictive practices. From the observations made by the inspector it was evident that the person in charge and staff working in the centre strove to ensure residents' rights were promoted and respected in the centre. From the inspector's observations and what residents told the inspector, it was evident that residents living in the centre were supported to have a good quality of life.

On arrival to the centre, the inspector met with the centre's administrator and director of nursing. Following a short introductory meeting, the inspector was accompanied on a walk around the centre by the person in charge. Abbleylands nursing home is a single storey building and is registered to accommodate 50 residents in 16 single bedrooms and 17 double bedrooms. All bedrooms have en suite shower, toilet and hand wash sink with the exception of one single room, which had a hand wash sink only. The centre was divided into three suites namely, the Funcheon, the Blackwater and the Lee suites. The Lee Suite had a finger print controlled access door and was designated for residents living with dementia.

During the walkaround, the inspector saw that all doors leading to the large enclosed courtyard garden in the centre were open and could be freely accessed by residents and visitors. Pathways were safe and accessible throughout the gardens. There was seating available both inside and outside the centre. This made it easier for people with mobility issues to walk throughout the centre, as it allowed them to rest at various points. The centre also had well maintained outdoor spaces surrounding the centre. There was outdoor seating available, where residents could sit and view the countryside. The inspector saw that the external doors near reception were locked and required a keypad code to enable entry. The person in charge told the inspector that a small number of residents who were independent with mobility had the code to enable them to freely leave the centre, however, on discussion with the residents concerned, they did not use this. The person in charge agreed to review this with residents who had capacity so that they could freely access the external grounds should they wish.

During the morning, the inspector saw that many of the residents were up and ready for the day and were resting in the centre's communal rooms such as the dayrooms. Other residents were being assisted by care staff with their personal care. The inspector saw that staff knocked before entering the rooms. Staff who were providing care and assistance to residents were observed to provide this care in an unhurried and respectful manner, taking into account each resident's abilities. The inspector saw that privacy curtains in twin rooms still required review since the previous

inspection as they did not ensure residents' privacy and dignity at all times. The person in charge informed the inspector that these had been ordered but were awaiting fitting at the time of the inspection.

Many residents' bedrooms were nicely decorated with personal belongings such as photographs and artwork. The centre was clean and tidy in all areas. The corridors were wide with appropriate handrails fixed to the walls to assist residents to mobilise safely. The inspector saw many of the residents in the dementia specific unit participated in a game of ball in the morning with one of the care staff which residents seemed to enjoy. A resident, who loved walking, told the inspector how they enjoyed walking around the gardens and getting fresh air. A local priest attended the centre in the afternoon and celebrated mass with many of the centre's residents attending.

During the walkaround, the inspector saw that there was a low use of bedrails in the centre. Restrictive practices were reviewed at least every four months, with the purpose of reducing or eliminating the practice. Staff were aware of the potential negative impact of restrictive practices and had taken effective measures to reduce the use of bed rails from 14% of residents in 2022 to 7.5% of residents on the day of inspection.

Other restrictive practices in use were floor and seating sensor mats and motion sensors. For example, residents in bed with movement sensor mats placed beside the bed. An alarm was activated when the resident moved on or off the mat and alerted staff to assist or supervise the resident. While the reason for these sensor mats was to prevent falls, they potentially impacted on the free movement of the resident, as the noise and or subsequent attention from staff could deter a resident from moving. Care plans clearly outlined the rationale for use of these restrictive devices and the precautions and checks to be maintained. The inspector saw that the some of the sensor mats were connected to the call bell system and therefore a review of access to call bells for these residents was required to be assured that they could seek assistance, if needed, at all times and if they capacity to activate the call bell.

In general, residents and relatives spoken with stated they were involved in the decision-making process and that there were on-going discussions regarding their care, and this was observed. The use of movement sensor devices and key-pad access doors on all external doors were not identified as restrictive and required review in order to promote a restraint free environment. The person in charge agreed to review this on the day of inspection.

The inspector observed the lunchtime meal where residents were provided with choice of what they ate. It was also observed that residents were able to choose to have their meals in the communal areas or in their bedrooms. Residents that required

assistance with their meals in their own rooms also had staff available to assist. The inspector saw that mobility aids were left in position near residents who required them during their meals so that they could leave the dining room independently if they wished.

The inspector spent time observing staff and resident engagement during the day. There were adequate staffing levels and 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. Residents were consulted about the service through residents' meetings which took place regularly. A review of minutes of these meetings indicated that action was taken in relation to feedback provided by residents. Findings from a recent residents' survey were also mainly positive.

Residents also had access to an external advocate who attended the centre regularly. The person in charge had arranged for a representative from the national patient advocacy service to attend the centre to speak with residents to inform them of the services provided in June 2023. The inspector was informed that over 20 residents attended this meeting. Communication aids, signage, picture aids, telephones, radios, newspapers were available for residents.

Visitors were observed throughout the day in the seating areas throughout the centre and in residents' bedrooms. Visitors and residents told the inspector that visits were unrestricted and residents were supported to go out with their relatives where possible.

Residents and relatives who spoke with the inspector were, in general, complimentary regarding the staff and services provided. Relatives and staff described a person centred approach to care provision and good communication in regard to residents' care needs and lives.

Oversight and the Quality Improvement arrangements

Overall, the inspector found that management and staff were working to improve the quality of residents' lives through reduction in use of restrictive practices and promoting residents rights. The person in charge completed the self-assessment questionnaire prior to the inspection and assessed the standards relevant to restrictive practices as being compliant. During the course of the inspection, the person in charge acknowledged that further improvement was required to in relation to these practices and committed to quality improvement in this area.

The centre had a statement of purpose that clearly outlined the services available and specific care needs provided such as a dementia specific unit. Staff confirmed that there were adequate staff and a good skill mix in order to meet residents' needs. The inspector spoke with staff about restrictive practices and management of restraint. Staff members were knowledgeable and displayed good understanding of the definition of restraint. Staff were appropriately trained in safeguarding vulnerable adults, behaviours that challenge and restrictive practice and face to face training was provided in the centre.

The centre had a policy in place in regard to restrictive practices, which was written in plain English and promoted the rights of residents. In general, it was in line with national policy, however, further review was required to ensure that it supported practice in relation to the frequency of safety checks when restrictive practices such as bed rails are in use.

The centre had access to equipment and resources that ensured care could be provided in the least restrictive manner to all residents. Where necessary and appropriate, residents had access to low-low beds and crash mats instead of having bed rails raised. The inspector found that where restrictive practices were in use they were assessed, alternatives had been trialled, safety checks were in place and the practices subject to ongoing review. Care plans reflected the care given and staff were familiar with safety aspects and with individual's preferences and wishes. The physical environment was set out to maximise residents' independence with regards to flooring, lighting and handrails along corridors.

The person in charge maintained a register of restrictive practices in the centre. The numbers using bedrails on the day of inspection was low, a total of three out of 40 residents. This record was kept under constant review by the management team and was comprehensive and detailed with regard to bedrails. The person in charge had good oversight of the management of bedrails and their use in the centre and monitored this through the weekly clinical indicator report and regular audit. Where

bedrails or other devices such as sensor mats were in use a comprehensive risk assessment had been completed and were reflected in care plans reviewed. However, further review of the register of restrictive practices in use in the centre was required as for example, it did not include the door locks to the centre, the sensor mats or motion sensors in use in the centre.

Overall, the inspector identified that management and staff were working to provide a restraint free environment for residents living in the centre, however some improvements were required to further enhance the quality of life for residents.

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.
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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.
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