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:	Milford Nursing Home
Name of provider:	Milford Care Centre
Address of centre:	Milford Care Centre, Plassey Park Road, Castletroy, Limerick
Type of inspection:	Unannounced
Date of inspection:	12 October 2023
Centre ID:	OSV-0000418
Fieldwork ID:	MON-0041054

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
Thursday 12 October 2023	10:00hrs to 17:00hrs	Sean Ryan
Thursday 12 October 2023	10:00hrs to 17:00hrs	Sarah Quilter-Lee

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

This was an unannounced inspection, focused on the use of restrictive practices in the designated centre. The findings of this inspection were that the service promoted a culture where a rights-based approach to care underpinned the delivery of a service to residents that was person-centred. Through observations and conversations with residents, it was evident that residents were supported to have a good quality of life and were encouraged and supported by staff and management to be independent.

Inspectors arrived to the centre during the morning time and were met by the person in charge and assistant director of nursing. Following an introductory meeting, inspectors walked through the centre and met with residents in their bedrooms and communal areas.

Residents were observed to be comfortable and relaxed in their environment. The atmosphere was calm, and care was observed to be delivered in an unhurried manner. Residents were observed to be content in their bedrooms enjoying a variety of activities that included watching television, chatting with staff, and reading the daily newspaper. Staff were seen to actively engage with residents when serving breakfast. The inspectors overheard polite conversation between residents and staff that included discussions about the activities planned for the day and local news. Some residents were observed walking through the corridors, and visiting other residents in their bedrooms for a chat.

Milford Nursing Home provides care for both male and female adults with a range of dependencies and needs. The centre is situated within the campus of Milford Care Centre, Castletroy, Co. Limerick. It is a two storey facility that can accommodate 69 residents in single bedrooms with full en-suite facilities. The centre provides residents with a variety of accessible private and communal space. The first floor was accessible to residents through stairs and a passenger lift that were secured by doors that were magnetically locked, and key code protected. Residents confirmed that they could access the stairs and passenger lift if they wished.

Externally, residents had unrestricted access to secure enclosed gardens that were appropriately furnished and maintained. Pathways were safe and accessible throughout the gardens. There was seating available in the garden for residents to use. Appropriately placed seating made it easier for residents with mobility issues to walk, as it allowed them to rest at various points. This practice ensured that people's mobility and independence was maximised.

The provider promoted a restraint-free environment in the centre, in line with local and national policy. While inspectors observed that there were 20 residents were using bedrails in the centre, there was evidence of a multi-disciplinary team approach to the assessment of risk in relation to the use of bedrails. Residents confirmed that they were actively involved in the assessment process, and their preferences were always taken into consideration during assessment.

The provider had a variety of alternative devices and equipment to support an initiative to reduce the use of bedrails. For example, a number of residents, who were assessed as being at risk of falling, used low beds. In bedrooms, alarms were in place for a small number of residents. The alarm sounders alerted staff to assist residents that were identified as at risk of falling. The provider also ensured that residents were not restricted within their environment. Inspectors saw that residents were free to access all areas of the centre, with the exception of clinical, storage and ancillary rooms. The front door to the centre was unlocked, and was supervised by administration staff. Eight residents who were identified as being at risk of leaving the centre unaccompanied and unnoticed were provided with bracelets that sounded an alarm should the residents attempt to leave the building.

Residents spoke positively about their experience of living in the centre and detailed how staff supported them to engage in activities of their choosing. Residents told the inspector that they did not feel restricted in any way, with the exception of some of their physical limitations that impacted on their mobility and ability to be fully independent. For example, some residents recognised that they were at risk of falls due to impaired mobility. Residents told the inspectors how staff were prompt to answer their call bell if they needed assistance to the toilet. Residents also told inspectors that staff were very 'considerate of their needs' and placed items of importance such as the call bell, water, and the television remote within easy reach for the residents. Some residents provided details of the assessment and consultation process they engaged in prior to using bedrails. Residents detailed how staff provided them with information, and explained the benefits and risks of using restrictions such as bedrails. Residents were provided with an information booklet to support informed decision-making.

Residents were supported to pursue interests that involved an element of positive risk-taking. For example, residents were encouraged to go on outings with their family and friends to socialise, while other residents went home at weekends. Some residents were supported to attend events such as music concerts and local museums. Residents told the inspectors that staff never made them feel like 'something was not possible'. This was in the context of a resident who had attended a family event but required support and the use of assistive equipment to attend the event. The residents told the inspectors that 'staff go above and beyond for you', and this made them feel 'respected'.

Residents were encouraged to personalise their own rooms and many contained items personal to that individual. Many residents had decorated their rooms with photos and memorabilia and some residents had brought in their own furniture. There were no restrictions on when residents could access their bedrooms. Bedrooms were observed to be laid out to meet the needs of residents and support their independence. For example, overhead hoists were installed in a significant number of bedrooms. Doors were sufficiently wide to allow residents with mobility aids to access their en-suite facilities with ease, and appropriately placed handrails ensured residents could undertake activities independently.

Residents had a restrictive practice care plan in place which contained person-centred details that clearly outlined the rationale for use of these practices, and included any

alternatives trialled. Care plans were reviewed at a minimum of every four months. There were also care plans in place for residents that experienced responsive behaviour (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The care plans were person-centred and provided guidance to staff on how to support the residents to manage their responsive behaviours. Residents and relatives spoken with stated they were involved in the decision-making process and discussions regarding their care.

Residents reported that staff were kind, caring, and attentive to their needs. They described how staff respected their privacy, and their right to choose. Some residents preferred to remain in bed until late in the morning, and staff respected their choice. Staff were seen to ensure that privacy screens were drawn on bedroom door windows, and that bedroom and bathroom doors were closed before assisting residents with their care needs.

There were a variety of formal and informal methods of communication between the management team. It was clearly evident that management knew residents and their relatives well. Residents were consulted through opportunistic chats and formal residents' meetings. It was evident that residents were consulted about their care, such as where they would like to spend their time, the quality of food and activities. This ensured that residents' rights were upheld, such as having the right to freedom of expression, the right to complain, to hold opinions and to receive and impart information and ideas, particularly regarding the organisation of the service. For example, residents had contributed to the development of information pamphlets on bed safety. The pamphlets provided residents with information about beds and bedrails and supported them to make an informed decision on whether or not to use bedrails.

Residents living in the centre had access to a wide range of assistive equipment such as electric wheelchairs, rollators, walking aids, low-low beds, and sensor alarms to enable them to be as independent as possible.

Communication aids, signage, picture aids, telephones, radios, newspapers, and magazines were available to residents. Inspectors observed a range of stimulating and engaging activities that provided opportunities for socialisation and recreation. Staff demonstrated an understood their role and responsibilities regarding socialisation and engagement with residents.

There was large notice boards displayed on both floors in the centre. Notice boards displayed a variety of information for residents. This included information on safeguarding services, the complaints procedure, fall's prevention, bed safety information, and independent advocacy services.

Visitors were seen coming and going throughout the day. Visitors expressed their satisfaction with the quality of the service provided to their relatives, and confirmed that there were no visiting restrictions in place. Residents told inspectors that they could meet their visitors in the privacy of their own bedrooms, or in designated visiting areas.

The following section of this report details the findings in relation to the overall delivery of the service, and how the provider is assured that an effective and safe service is provided to the residents living in the centre.

Oversight and the Quality Improvement arrangements

Overall, inspectors found that there was a positive approach to reducing restrictive practices and promoting a restraint free environment in this centre. There was effective governance and leadership in the centre that supported a commitment to quality improvement with respect to restrictive practices, person-centred care, and promoting residents' rights.

The person in charge had completed the self-assessment questionnaire prior to the inspection and submitted it to the Office of the Chief Inspector for review. The person in charge had assessed the standards relevant to restrictive practices as being Compliant. A quality improvement action plan was in place to drive quality improvement and reduce the use of restrictive practices in the centre. This included quality improvement actions with regard to the provision of resources to support the reduction in bedrails, enhanced training for staff, educational documents to raise awareness about the various types of restrictive practices, and their subsequent impact on the rights' of the residents'.

The centre was managed with an emphasis on promoting people's autonomy and independence. Inspectors were satisfied that residents were supported to pursue their own choices and preferences and that their rights were respected. It was clear to the inspectors that the person in charge played a leadership role in ensuring the ethos of the centre was focused on promoting residents' rights. This allowed residents to engage in activities of their choosing and pursue interests that involved an element of positive risk-taking.

The registered provider had a policy in place for the use of restraint and restrictive practices that underpinned the arrangements in place to identify, monitor, and manage the use of restrictive practices in the centre. Staff were provided with access to the document, and cited the policy as the principal guiding document to underpin the assessment and management of restrictive practices in the centre.

There were effective governance structures in place to support oversight in relation to restrictive practices. The person in charge collated and monitored information in relation to restrictive practices. This information was analysed and trended in conjunction with information in relation to the incidence of resident falls to identify trends and review the effectiveness of actions taken to reduce the incident of physical restraints such as bedrails. A multi-disciplinary team committee had been established to monitor and review the incidence of restrictive practices in the centre. This review included an assessment of compliance with the centre's restrictive practice policy and procedure, the use physical and environmental restraints, and the allocation of resources to reduce the incidence of restrictive practices.

The provider had arrangements in place to monitor and oversee the use of restrictive practices in the centre. Restrictive practices were monitored in the centre's key performance indicators, and the centre's restrictive practice register. The register contained details of physical restraints such as bedrails, and details of residents who

were provided with alarms to promote their safety. Inspectors found some inconsistencies within the restraint register. For example, not all residents who were provided with the use of bedrails were identified on the register.

There were arrangements in place to evaluate and improve the quality and safety of the service provided to residents through scheduled audits. This included an annual audit of restrictive practices, and unannounced observational audits that were carried out in April, June and July 2023. An annual restrictive practice audit had been completed in February 2023 and assessed physical and environmental restrictions in the centre. The audit examined compliance with the centre's procedures to ensure restrictive practices were appropriate and proportionate to the needs of the residents' concerned. There was evidence that the findings were analysed, trended, and compared to the previous year's audit results to measure progress. The findings of the completed audit were that there had been a reduction in the incidence of restrictive practices in the centre, but compliance with resident's assessments and care plans required further improvement. Inspectors found that some of the issues identified in the February 2023 audit had not been resolved. For example, an assessment of risk had not been completed for a resident using physical restraints, and records of safety checks for other residents using physical restraints were inconsistently maintained. Therefore, inspectors found that the systems to monitor, evaluate, and improve the quality and safety of the service required some improvement to ensure that restrictive practices were accurately recorded, monitored, and regularly reviewed to support reduction or elimination of their 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, instead of having bed rails raised. The physical environment was set out to maximise resident's independence with regards to flooring, lighting, signage, and handrails along corridors. Inspectors were satisfied that no resident was restricted in their movement or choices, due to a lack of resources or equipment.

Staff were supported and facilitated to attend training relevant to their role such as safeguarding vulnerable people, restrictive practices, and supporting residents with complex behaviours, and positive behavioural support. Staff were generally knowledgeable about restrictive practices, the management of restraints, and the actions they would take if they had a safeguarding concern. Staff confirmed that there were adequate staff, with the appropriate skill-mix to meet the needs of the resident's.

Inspectors reviewed the care plans for residents who were assessed as requiring the use of bed rails. There was evidence to show that staff had trialled alternative less restrictive methods. However, inspectors identified that some resident records did not contain an assessment of resident's needs, risks, or alternatives to bedrails trialled prior to the decision to implement the use of physical restraint.

Following assessments and care planning, the multi-disciplinary team input was sought to support the assessments and decision-making process to enable best outcomes for residents. Care plans generally identified the restraint in use, the

rational for the restraint, residents consent, and identified that restraint should be checked at certain intervals.
Complaints were recorded separately to the residents' care plans. The complaints notice was on display but the procedure had been updated in line with recent guidance. There was a notice advising residents of the contact details of independent advocacy services should they require assistance with making a complaint.

Overall, inspectors found that while there were some areas for improvement, there was a positive culture in Milford Nursing Home, with an emphasis on a restraint free environment to support a good quality of life that promoted the overall wellbeing of residents while living 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.