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

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| Name of designated centre: | Hollybrook Lodge |
| Name of provider: | St James's Hospital |
| Address of centre: | St Michael's Estate, Bulfin Road, Inchicore, Dublin 8 |
| Type of inspection: | Unannounced |
| Date of inspection: | 18 December 2023 |
| Centre ID: | OSV-0005053 |
| Fieldwork ID: | MON-0041967 |

## 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 |
|---|---|---|
| Monday 18 December 2023 | 08:37hrs to 16:45hrs | Bairbre Moynihan |

## 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 evident that residents had a good quality of life in the centre. Residents were supported to make choices about their daily routines, however, the centre had a high use of restrictive devices. These along with other findings will be discussed throughout the report.

The inspector arrived to the centre in the morning and was greeted by a clinical nurse manager. The inspector was guided on a tour of the premises and following this, the inspector met with the person in charge for a brief introductory meeting. The centre was decorated with Christmas trees and lights externally and internally in the centre.

On arrival, some residents were up and dressed and were having breakfast in the dining rooms and others were having breakfast at their bedsides. The centre is registered for 50 beds with 46 residents residing in the centre on the day of inspection. Resident accommodation was a mixture of single, twin and four-bedded rooms, all with en-suite facilities. The four vacant beds were designated by the registered provider for residents who required respite care. The inspector was informed that these were vacant since the COVID-19 pandemic and are used as isolation facilities, if required. The centre was laid out over two floors containing two wards – Robinson and McAleese. Each ward contained 25 beds, a sitting room and dining room partially divided by a partition. In addition, there was an activities room, hair salon and an oratory on the ground floor and a visitors' room on the first floor. The inspector observed multiple instances where staff were using residents' communal space for their rest periods. For example; in the activities room, the sitting room in Robinson ward and the visitors' room. Furthermore, no residents were observed in either sitting room during the day of inspection. A number of residents in both wards were observed at their bedsides throughout the day.

Residents had access to an external garden which could be accessed via the sitting and dining rooms on the ground floor and the activities room. Both these doors were unlocked and residents on the ground floor could freely access the garden if required. The main front door was unlocked with a security guard in place. Both wards were accessed via card access. The card access prevented residents from the first floor freely accessing the garden on the ground floor. A number of rooms in Robinson ward had their own access to the garden. Access to these doors was restricted by beds. None of these environmental restrictions had been identified by management and risk assessed.

Staff respected the privacy of residents and were observed knocking on residents' bedroom doors and requesting permission to enter on a number of occasions throughout the day. Residents informed the inspector that they liked living in the centre and were complimentary about the care they received.

Residents were consulted about the service through residents' meetings. Three monthly residents' meetings were held. These were facilitated by a designated contact person, who was an independent person who attended onsite and advocated for residents. The designated contact persons held a separate meeting with representatives from the management team in St James's Hospital and discussed the issues raised by residents in meetings and their own observations of the centre. A residents' satisfaction survey was completed in October 2023. Results were collated at the time of inspection and included a time bound action plan. One of the actions included a review of the activities calendar.

The dining experience was observed by the inspector. Approximately 11 residents attended the dining room in Robinson ward. The remaining residents remained at their bedside. A small number of residents spoken with during this time confirmed that they preferred to eat in their rooms. Residents were provided with a choice at mealtimes, including residents who required a modified diet. Residents were verbally provided with the menu choice in the morning time, however, the menu was not on display for residents to view and remind them of the choice they made.

One activities co-ordinator was employed who worked Monday to Friday. A healthcare assistant was assigned to activities at the weekend. No activities were scheduled or observed in the morning. The hairdresser was onsite and attended two days a week. An external provider attended onsite in the afternoon and residents attended dancing in the activities room. Those residents who were unable to dance, observed and moved to the music in their seats. A resident informed the inspector about a trip to a café on Grafton Street the week prior to inspection and about how much they enjoyed it. Another resident informed the inspector how they loved the music on Thursdays. The Christmas party was celebrated with residents and their friends and family members on the Saturday prior to inspection on the grounds of the centre. A number of residents informed the inspector about how much they enjoyed it. Residents who wished to smoke were supported to attend the designated smoking area in the garden.

## Oversight and the Quality Improvement arrangements

The inspector found that improvements were required to reduce the use of restrictive practices in the centre.

The Office of the Chief Inspector emailed a self-assessment questionnaire to the registered provider in June 2023. The self-assessment questionnaire was not returned, however there was no obligation on the registered provider to return it. Notwithstanding this, the person in charge had completed it and provided it to the inspector onsite. This was subsequently submitted to the Chief Inspector of Social Services during the day of inspection. The person in charge assessed the standards relevant to restrictive practices as being compliant. No member of the management team was available to attend the feedback meeting at the end of the inspection and this was held via video conference the following day. The management team acknowledged that further improvement was required in relation the identification of restrictions in the centre.

The inspector was satisfied that there was 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. Good training compliance levels were identified in "A Human Right Based approach for health and social care services" and all except six staff had completed safeguarding training. The inspector was informed that dementia training was not mandatory in the centre and that dementia training had commenced in the last few months. Management were unsure if the training covered the use of restrictive practices. Seventy-four percent of staff had completed dementia training. Staff were able to identify the more common types of restraint, however, further education on restrictive practices is required so staff are empowered to promote a restraint-free environment.

The governance, management and oversight in the centre in relation to restraint required strengthening. A three monthly "Residential Care Operational Quality Review Group" meeting was held with the registered provider, person participating in management and person in charge attending. However, restrictive practices were not an agenda item at this meeting or any staff meeting. Notwithstanding this, bedrails formed part of the inter-disciplinary meeting where residents were discussed. There was evidence that bedrails were ticked and signed by a member of the inter-disciplinary team if required, but no evidence that alternatives to bedrails were discussed. Audits on the documentation of restrictive practices were completed in one ward but not in the other ward. No time-bound action plan accompanied the audits.

The inspector requested the centre's policy on restraint. This was not available for review and an alternative policy was provided that was not applicable to the designated centre. The centre had a high use of bedrails with twenty-four percent of residents having a bedrail in place. Bedrail risk assessments were completed and reviewed four monthly, however, they did not include a section on the trialling of

alternatives to bedrails. This led to the high usage of bedrails, despite alternatives such as low profile beds, fall reduction mats and sensor mats being available in the centre.

Residents using bedrails had a restrictive care plan in place which was generally person centred and updated four monthly or more frequently if required. Of the six care plans viewed, one indicated that less restrictive options were trialled but the care plan did not indicate what alternatives and for the length of time. The inspector was informed that some of the residents had requested bedrails however, there was no documentation of consent or a discussion with the resident, their family or care representative about the risks associated with the use of bedrails. Safety checks for bedrails were in place and monitored every two hours.

Hollybrook Lodge did not have a restraint register. Restraints were recorded on a weekly residential profile. No documentation was available for the inspector to observe if there was a decrease in the use of restrictive practices in the centre. Furthermore, not all restrictions in the centre were documented, for example, environmental restrictions as discussed earlier in the report and the inspector identified a small number of residents in tilt chairs. Furthermore, a resident's lighter was held by nursing staff. While this was held for safety reasons, it was not identified as a restriction and a risk assessment completed. Restrictions identified by management included 11 residents who had bedrails in place, eight residents who had bed wedges, six residents with sensor mats and two residents with chair alarm mats.

Responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were well managed. Residents with behaviours that challenged were assigned a healthcare assistant who supervised one to two residents. Each of these residents had an enhanced care observation chart in place. These were frequently completed and described the triggers and the intervention that had taken place. The registered provider had a policy on managing behaviours that challenge, however, this was a policy devised for St James's Hospital and was not specific to the residential care setting. For example; the policy described giving residents with behaviours that challenge a yellow card which is a warning that lasts two weeks. The policy does not take into account residents that had behaviours that challenge due to cognitive impairment.

The incidents and complaints logs were reviewed. No incidents were documented in relation to restraint, however, the inspector identified four peer to peer incidents that required reporting to the Chief Inspector. These were reported following the inspection. Furthermore, no trending of these incidents was taking place to identify trends. This is a missed opportunity for learning. The registered provider had not received any complaints in relation to restrictive practices. The complaints policy and procedure was reviewed. This was updated in August 2022 which pre-dated the change in the regulations in March 2023. These required review to ensure they were in line with Regulation 34. Residents had access to advocacy services. Posters and information were on display on noticeboards in the centre.

Overall, the inspector identified that while residents enjoyed a good quality of life, improvements were required in the governance, management, oversight, and documentation and auditing of restrictive practices.

# 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. |

# 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 | |
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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 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 | |
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| 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 | |
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| 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 | |
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| 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 | |
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| 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. |

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| 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** | |
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| 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** | |
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| 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** | |
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| 4.3 | Each resident experiences care that supports their physical, behavioural and psychological wellbeing. |