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:	Ballinamore Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Tully, Ballinamore, Leitrim
Type of inspection:	Unannounced
Date of inspection:	07 November 2023
Centre ID:	OSV-0005290
Fieldwork ID:	MON-0040316

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
Tuesday 7 November 2023	09:45hrs to 17:00hrs	Catherine Rose Connolly Gargan

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

This was an unannounced focused inspection to review use of restrictive practices in Ballinamore Community Nursing Unit. Prior to this inspection, the centre's management completed a self-assessment questionnaire which reviewed their practices and their management of restrictions on residents living in the centre. From the inspector's observations and discussions with residents, it was evident that significant efforts were being made to ensure each resident was supported and encouraged to enjoy a fulfilled and meaningful life that considered their individual choices, capacities and safety.

A senior staff nurse was deputising for the person in charge on the day of this inspection and the regional practice development coordinator and provider representative were in the centre supporting staff and residents with preparations for the centre's annual remembrance service for deceased residents, taking place in the evening on the day of the inspection.

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 to residents, thus enabling residents to maintain their independence and dignity. The inspector observed that staff knew residents needs well and responded to them in a person centre way which ensured that each resident's individual needs were met. It was also clear that residents trusted staff caring for them and that they enjoyed each other's company.

Some restrictive practices were observed to be in use, for example, two residents had full length bedrails which they had requested for their safety and feelings of security in bed. While safety assessments and removal schedules were completed, alternatives tried did not include half-length bedrails which would not restrict these residents' independent access in and out of their beds as they wished. Two residents had sensor mats placed in their beds and seven residents had sensor mats on their chairs. An alarm was activated when the resident moved off these sensor mats and alerted staff to their need for assistance or supervision. While the reason for use of these sensor mats was to prevent falls, they potentially impacted on the free movement of these resident, as the alarm noise and or subsequent attention from staff could deter residents from moving. A hand mitten was in use to prevent a resident unintentionally injuring their skin at night. Residents' care plans clearly outlined the rationale for use of these restrictive devices and the precautions and checks to be maintained. However, the inspector observed that the alternatives trialled prior to their use were not consistently documented in the residents' care plans and this required improvement.

Ballinamore Community Nursing unit is a purpose-built facility operated by the Health Service Executive that provides accommodation for 20 residents who require long-term residential care. This centre is a modern building and is located in the town of Ballinamore. It is a short walk to the shops, library, cafes and church. Residents' bedroom accommodation consists of 18 single and one twin bedroom. All rooms have

fully accessible en-suite facilities. A variety of communal accommodation is available and includes sitting rooms, a dining area, a prayer room, a sitting area at the end of one corridor and a visitors' room.

The centre has a safe well cultivated outdoor garden area, accessible from the reception area that has features such as bird feeders, flowers, shrubs and an outdoor seating area in addition to seats outside the bedroom windows. Garden tools were available in the garden for residents' use as they wished. A large pressure pad was placed on the wall to facilitate residents to open the automatic doors to go out into the enclosed garden as they wished. However the inspector noted that when this door to the garden closed behind the resident, residents unable to use the key code located on the wall outside could not get back into the centre without staff support. Furthermore the inspector observed that access to the internal pressure pad was partially obstructed by a low table placed in front of it making it difficult to access for some residents. When this finding was brought to the attention of staff the table was relocated without delay.

The inspector visited each resident's bedroom and the communal areas and observed that the residents' living environment was bright, spacious, well maintained and was for the most part accessible to them. Although directional signage was available in the centre to orientate residents to key locations such as the dining room, sitting rooms, exit locations and other facilities within the home, this was limited. Staff told the inspector that improved signage was ordered and they were awaiting its delivery. Hand rails were in place along all corridors of the centre and there was additional seating provided in various locations for residents who may need a rest.

Noticeboards were placed in strategic locations so that residents could have easy access to information. For example, the results of a recent resident's satisfaction survey was displayed in graphical and large print format. Details regarding available advocacy services were also displayed.

The door into the centre was secured with a key-code lock and staff controlled access in and out this door. There was also a door in each resident's bedroom to either the outdoor green area surrounding the centre premises or to the enclosed garden depending on the bedroom locations. These doors in the residents' bedrooms were locked with a key which residents did not have but residents who spoke with the inspector were aware they could request the key from staff. Although there was a general risk assessment in place as to the rationale for having all these external bedroom doors locked this did not reflect the individual needs of each resident and was not person centred to ensure this restriction was being used in the least restrictive manner for individual residents. For example the majority of residents were not at risk of leaving the centre unaccompanied, as many of the residents' needed a wheelchair and staff assistance to move around the centre.

The single bedrooms were spacious and their layout facilitated residents' with unobstructed access. The en-suite facilities had double leaf doors which could both be opened if needed. Toilet seats and grab rails were in contrasting colours to assist residents' with vision or cognition problems to easily identify these facilities and subsequent independent access. Comments from a number of residents who resided

in single bedrooms told the inspector that they 'loved' their bedroom, 'can get around the room without a bother' and one resident said that their bedroom kept them 'independent and safe from falling'.

These observations of the single bedrooms were in contrast to the inspector's observations in the twin bedroom. Both residents accommodated in the twin bedroom needed two staff and use of a hoist to transfer in and out of their beds and large assistive wheelchairs. The limited space available in these bedrooms did not ensure that each resident's privacy could be assured during their transfers and personal care. Furthermore the door to the ensuite was located close to this resident's bed which limited the space for the other resident to access the ensuite facilities without encroaching on this resident's bed space. The inspector also found that the storage arrangements meant that one resident did not have enough wardrobe space to store their clothes and personal belongings. The inspector spoke with both residents and one resident said the twin bedroom did not suit him and that they had requested to move to a single room when one became available.

The inspector observed two residents experiencing difficulty with opening a communal toilet door. Both residents were unable to push the door open and were walking away from it when staff intervened to assist them. Staff told the inspector that they were aware that this door and some other doors to residents' bedrooms had been identified as too heavy to push open and were discouraging residents' independence. The inspector was informed that the provider had a plan in place to make these doors easier to open.

Tables and chairs were arranged in the two communal sitting/dining rooms to facilitate residents using equipment to assist their mobility to move easily around these communal rooms and to sit comfortably at the tables. Residents' bedroom furniture was also designed to suit their height and ensure ease of access. Equipment needs were reviewed for individual residents to promote their independence, for example, a lower height toilet had been ordered for one resident.

There was no restrictions on residents' visitors and while some residents' visitors called to see then during the day, others were joining them for the remembrance service in the evening.

Most residents preferred to eat their meals together in the sitting/dining rooms and staff were attentive to their needs for assistance. Some residents who did not wish to have their meal in the dining room were supported to have their meal in their preferred location which was normally their own bedroom. There was a variety of menu options offered and even though residents had expressed their menu choices on the previous day, the inspector heard staff reoffering the menu choices available to residents in case they wished to change their menu choices. Residents told the inspector that they could have alternatives to the menu on offer if they wished. Moulds were used by kitchen staff to present food in a more appetising way for residents who needed modified diets.

Residents told inspector that they were consulted with about their care and about the organisation of the service. There was a variety of opportunities for residents to

engage in a meaningful social activities programme in this centre in accordance with residents' interests and capacities. Planning of the social activities schedule was driven by residents to suit their choices and preferred routines. For example, at a recent 'circle of friends' residents' meeting, residents discussed and rescheduled the regular Sunday live music sessions to Saturdays so they could watch the sports matches and meet their visitors.

Residents preferred to 'stay local' and went out on regular trips together to local amenities and places of interest which included a visit to their favourite coffee shop located a short distance from the nursing home. Four residents enjoyed weekly trips out with their families. The centre had links with the local tidy towns group and the schools. Students from the local secondary school regularly visited the residents and shared their musical talents with them. Residents had televisions and radios in their bedrooms and in the communal rooms. One resident who was listening to the radio in their bedroom told the inspector that they listened to the local radio station at home and continued to do so since coming into the nursing home. Some residents were reading the local and national newspapers and the activity coordinator was reading the local newspaper for others. Many of the residents told the inspector that they previously lived in the local community and were happy that they could continue to live among people and in an area that they knew well.

Without exception residents who spoke with the inspection said that they were 'more than satisfied' and 'very happy' with the care and support provided by the staff team. Overall residents said that there was good access to the local doctor, and they were facilitated to attend hospital services and appointments as they needed.

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 were varied, interesting and informed by residents' interests, preferences and capabilities All residents who spoke with the inspector said they felt safe and secure living in the centre and that if they had a problem or any concerns they could raise it with any member of staff and it would be 'sorted out' for them.

Oversight and the Quality Improvement arrangements

This inspection found that the provider was working towards achieving a restraint free environment for residents in the centre. However, improved oversight was needed to ensure that some practices found that posed restrictions on residents were identified and managed in line with the National Restraint policy.

All staff had attended bespoke training on restrictive practices. Staff were familiar with the relevant policies and guidance available to support their knowledge and

practice on restrictive practice and had taken steps to implement a number of the measures recommended in the guidance. For example, the centre now had a restrictive practice committee, which was been established to monitor and review all restrictive practices in the centre.

The centre's restrictive practice committee members included the person in charge, a clinical nurse manager and two staff on the unit of whatever grades were available on the days of the committee meetings. This resulted in changes to the committee membership from meeting to meeting and while this flexibility in membership gave opportunity to all staff to be involved, there was a risk that continuity would be lost. Restrictive practices were also a standing agenda item discussed at the weekly quality, risk and patient safety meetings and the six weekly regional meetings with the provider representative. Although the inspection found clear evidence that actions were been progressed, the notes of these weekly meetings did not clearly set out and record how these actions were implemented and therefore tracking of progress to completion was hindered.

The inspector reviewed the quality improvement plan on restrictive practices that had been developed by the restrictive practice committee members. This plan, while not fully completed, identified a number of areas for improvement. For example, staff were now to receive special training on positive behavioural support. In addition, the person in charge had identified the need for additional low height furniture for one residents and installation of a lower height toilet bowl so that one resident was better able to access the toilet independently.

The restraint register was used to record all restrictive practices currently in use in the centre. There was evidence that the register was reviewed on a regular basis. According to the restraint register two full-length bedrails were now in use. Full-length bedrails had not been used previously in 2023. Although, the alternatives trialled prior to the use of the restraints in use were discussed with the inspector, details of the alternatives trialled were not documented in the residents' records.

The senior staff nurse deputising for the person in charge discussed the process for admitting new people to the centre and was 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. In addition, they confirmed that all residents and their families or representatives were advised from the outset that the centre had a policy of being restraint-free. This meant that the use of bedrails was discouraged and less restrictive or safer alternatives were favoured. However, bedrails in use were being used on the request of residents, in the absence of trialling of non-restrictive alternative equipment such as half-length bedrails. Modified length bedrails were not available in the centre and this was an area where improvement could be made.

The inspector was satisfied that there were enough staff with appropriate knowledge and skills 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.

The inspector reviewed residents' care plan documentation and while, this information clearly directed generally good standards of care, improvements in assessments were needed to ensure residents could communicate effectively and were fully involved in their care decisions. For example residents who had known difficulties with receptive and expressive communication had not been referred for specialist assessment when local measures trialled to meet their communication needs failed. Another resident who loves listening to the radio told the inspector that their hearing impairment was affecting their enjoyment of this activity. This had not been identified in their communication needs assessment and therefore had not been addressed. Furthermore whilst the inspector was told that residents were always involved in their end of life care plans and advanced decisions in line with their preferences, their involvement was not always detailed in this decision documentation.

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.