Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Sunville
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	22 August 2023
Centre ID:	OSV-0005874
Fieldwork ID:	MON-0040833

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 Services for Children and Adults with Disabilities. 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 Support of Residents in Designated Centres for Persons (Children And Adults) with Disabilities) 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

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

limiting a person's access to certain activities or preventing them from exercising certain rights such as religious or civil liberties.

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 22 August 2023	10:00hrs to 18:30hrs	Mary Moore

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

This inspection was undertaken on behalf of the Chief Inspector as part of a thematic programme of inspections focussed on the use of restrictive practices. The inspector found that the provider was in the process of reviewing its existing restrictive practice arrangements with the objective of reducing and eliminating where possible the use of restrictive practices and, assuring their use where they were deemed necessary. The provider's efforts in this regard were evident. However, the inspector also found inconsistencies in practice and evidence that the provider's objective did not always translate into day-to-day practice.

This designated centre is comprised of three separate apartments with one resident residing in each apartment. The inspector visited all three apartments and met with two of the three residents living in the centre. One resident had a planned trip after their day service.

The inspector saw that the provider had completed the modifications it said it would in one resident's apartment to enhance the accessibility of the resident's bathroom. Each apartment presented well and the residents met with had a clear sense of ownership and home. Resident's personalised their apartments to suit their preferences. There were no evident environmental restrictions.

On arrival at the first apartment the inspector was greeted by the resident who answered the doorbell. The resident remembered the inspector from previous inspections but the inspector invited the resident and the staff member on duty to view the inspector's photo identification. The resident invited the inspector into their apartment. The resident's living area had been redecorated and the resident confirmed that they had chosen the paint colours with support from the staff team. The resident was happy to chat about their plans for the day and their life in general. The resident was due to return to work that afternoon following their summer holidays and was looking forward to this.

The resident said that they loved their apartment, reported that they had a wonderful life, named individual staff members that supported them and said that they had a great team of staff. When the person in charge arrived to facilitate this inspection it was evident that the resident was very familiar and comfortable with them and repeated much of what had been discussed with the inspector. For example, there was discussion of family some of whom lived locally, trips to local cafes and restaurants and a planned trip to Brighton with support from staff. The resident had recently travelled to Dublin with a peer and support staff. The resident was, based on the routines observed and records seen, out and about in the local community each day.

The resident was asked and was more than happy for the inspector to remain in the apartment while the resident went out with staff to complete some shopping. The resident had written their own shopping list but the inspector noted that the staff member and not the resident had custody of the resident's bankcard. There was a

financial restrictive practice in place and evidence that the resident was in agreement with this restriction. However, there was scope to improve the working of this restriction. In general, the resident was observed to have good independence in their routines and in their home. The resident returned to the apartment to independently prepare their own lunch before leaving again for work supported by a staff member. The resident wished the inspector well and invited the inspector to call again.

One resident attended an off-site vocational training programme and the inspector was still on site when they returned to their apartment in the late afternoon. The resident answered the doorbell, checked that the inspector was well and free of any symptoms of illness that could be transmitted and invited the inspector into their home. The resident chatted easily about many matters. For example, the resident had experienced a significant bereavement earlier in the year and spoke about this. It was evident that the resident was very informed and very much part of these events and appeared to be coping well with the loss. The resident invited the inspector to see their recently redecorated bedroom and described how they had discussed and agreed with management who should pay for the replacement of items such as their wardrobe. The resident said that they had requested that the provider pay for this and they had. The resident also discussed happier significant life events and plans and shared personal photographs with the inspector.

The resident understood the role of the inspector and the resident shared information that was pertinent to these inspection findings. It was clear that the resident had a very good understanding of their right to independence and autonomous decision making. The resident understood that staff would not want them to be exposed to risk or harm. However, the resident described this as "mothering" and discussed support that while perhaps well intended, limited the resident's choices and preferences. For example, the resident said that previously they had not been allowed to chop their own vegetables because they had once cut themselves accidently with a knife. The resident had recently highlighted this restriction and the provider had addressed this practice. The resident said that they had more control now in their apartment but they wanted more independence in the community. For example, walking to the nearby vocational training centre and using public transport without staff support. The resident told the inspector that they were happy they could do these activities independently and safely. The provider was aware of this request and had a risk assessment and a plan put in place to support this independence for the resident. The resident did have a risk assessed period each day where they could spend time in their apartment without direct support from staff.

It was evident however from this discussion with the resident that there were other occasions when the resident's choices and preferences had not been facilitated and, the resident may not have had reasonable control and informed input into decisions that impacted on them. For example, where they went and what they did. This will be discussed further in the next section of this report. The provider was aware of one matter raised by the resident where their expressed preference was not facilitated. The provider confirmed that a complaint from the resident was in process.

The inspector concluded that the provider was reviewing the restrictive practices in place and was striving to promote resident independence and autonomy. The

provider was aware of the challenges that could arise to good person centred practice when restrictions conflicted with residents' rights, choices and preferences. The provider was also aware of the support staff needed so that they had the confidence to facilitate positive risk taking with and for residents. The staff team had been provided with some specific in-house training that aimed to raise staff awareness of resident's rights and restrictive practices. Further training was planned.

However, while there were restrictive practices that were readily identifiable a greater body of work was needed to consistently monitor, identify and correct practice that unintentionally resulted in human rights restrictions such as those described above. In general, the inspector found much improvement was needed in the maintenance of and access to records. This included the documentation that supported and informed the use of restrictive practices but also in relation to the day-to-day support provided to residents. This included how residents were supported to explore their personal hopes and objectives particularly where these were significant life decisions.

Oversight and the Quality Improvement arrangements

The provider had increased awareness of what constituted a restrictive practice and how such practices if not appropriately and correctly sanctioned and used, impacted on residents' rights and their quality of life. The provider was open to review and change and understood the support staff needed so that they were comfortable with supporting safe positive risk taking with and for residents.

The person in charge had attended and was very positive about the webinar organised by HIQA to prepare providers and persons in charge for these thematic inspections. The provider had established a restrictive practice steering committee and had plans to establish an independent human rights committee that would oversee the sanctioning and review of restrictive practices. It was also planned to establish an annual restrictive practice survey and maintain a register of all restrictive practices in use. Management had attended internal training that addressed the relationship between restrictive practices and human rights and it was planned that this training would be provided to all staff.

The restrictive practice committee was in the process of reviewing the provider's policy on the promotion of services that were free of restrictive practices. The final draft was not yet agreed and, based on the inspector's review of the current draft there was scope to further develop this policy. For example, based on these inspection findings better guidance was needed as to how and where discussions and agreements with residents about restrictive practices were recorded. Amendment was also needed to the guidance in the policy on the notification requirements to HIQA of the use of restrictive procedures as this was not correct and could result in inconsistent reporting. Local procedures for the use of any unplanned restrictions had been put in place but was not yet included in the policy so as to ensure consistency and standardisation of practice. Finalisation of the policy was dependent on the establishment of structures such as the planned human rights committee.

There were systems in place for maintaining oversight of the use of restrictive practices. This included the review of incidents that occurred and the use of documents referred to as restrictive practice review forms. Quality assurance systems such as the quality and safety reviews to be completed by the provider at a minimum every six-months included the review of the use of restrictive practices. There were three explicitly identified restrictions in use in this service at the time of the most recent review: restrictions on residents' management of their personal monies, the use of a door alarm at night and, a daily fluid intake restriction.

The most recent review completed in May 2023 had found deficits in the use of these restrictive practices such as the absence of a supporting risk assessment and incorrect sign off of the restrictive practice review form. These were partially addressed. The risk assessment was in place but the review form was not signed off as specified by the provider itself.

In relation to the restrictive practice review forms and the supporting risk assessments the inspector found that where controls were specified as a justification for the ongoing requirement of a restriction there was inadequate evidence as to how and when these controls were implemented. For example, in relation to the financial restriction a control was ongoing training and education for the resident to develop and assess their financial management skills. However, there was very limited explicit evidence as to what this programme of education and assessment was, how often it was completed and how effective it was. Therefore it was not adequately evidenced how the process of review established that the ongoing need for the restriction was valid. The inspector was advised that this process of education was informal.

There was explicit evidence that the resident had agreed to the restriction but the review of this consultation and agreement did not coincide with the reviews of the ongoing need for the restriction. There was scope to review and perhaps lessen the restrictive nature of the restriction. For example, the resident was supervised at all times by staff, but a staff member always had custody of the resident's bank card. A very restrictive daily cash (as opposed to automated debits) spending-budgeting plan was also in place. The resident did not participate in the daily reconciliation completed by staff of their spending and balances. This may have been one way of developing the residents understanding of financial management.

There was evidence of review and change that impacted positively on residents. For example, in consultation with the relevant clinician the daily fluid restriction was changed to recommended guidance. Practical steps had been taken to support the resident and staff such as purchasing smaller quantities of fluids. Staff could describe to the inspector how when the daily fluid intake was managed as a restriction this had led to challenges at times between the resident and the staff team. While there was still a requirement to manage the resident's daily fluid intake removing the dimension of restriction, control and refusal appeared to have eased the associated anxieties.

The person in charge attended regular staff meetings where safeguarding, restrictions and residents rights were discussed. The staff team had received in-house site-specific safeguarding training from the designated officer and reflective practice sessions were also facilitated by the senior psychologist. A staff member spoken with was aware of the explicitly identified restrictive practices in use in the centre. The staff member was aware of recent changes made.

However, based on these inspection findings governance including restrictive practice governance had not identified other restrictive practices in this service. For example, the restrictions on one resident's participation in some of their daily routines such as their access to their washing machine. The resident confirmed to the inspector that these restrictions were now addressed and they had raised them. Discussion between the resident, the inspector and the person in charge highlighted other restrictions on recent choices and preferences the resident had expressed such as where they went, how they travelled and what they did. For example, the resident discussed with the inspector and the person in charge a recent trip to the cinema with a peer and supported by staff. The resident said that they had not enjoyed the film and said that parts of the film had frightened them. When asked, the resident said that they did not

know what type of film they were going to see. The resident also discussed how they had said they wanted to go to a water recreational facility twice but they were told that they could only go once. There was some evidence that this may have been attributed to the staff-skill mix but the person in charge said that this could have been discussed, planned for and facilitated. The resident was acutely aware of how some decisions made by the staff team had the potential to impact and restrict their peer's choices such as having restricted access to transport.

There was inconsistency in how risk, resident independence, autonomy and choice was viewed, facilitated, planned for and supported. For example, there was a new plan and a risk assessment for facilitating better community independence for the resident but none for significant developments in the resident's life and significant life plans that they had. The person in charge understood that education and support were fundamental to residents being fully autonomous in all of their decisions. However, this was not consistently demonstrated in the resident's personal plan.

Overall, much improvement was needed in the process of personal planning with and for residents. For example, a comprehensive individual plan was not in place for a resident within 28 days of the resident's admission to the service. Parts of the plan were not updated to reflect changes such as change to the resident's financial arrangements, associated restrictions and the reason for these. Documentation was not always in place in an agreed location where it could be readily accessed. For example, while the person in charge had devised new guidance for the amended daily fluid intake plan this updated guidance was not in the resident's personal plan. Better oversight was needed to ensure that each day residents were meaningfully consulted with, were active participants and could direct within reason their plan and the service they received.

Residents did have access to the clinicians and services that they needed for their overall health and well-being such as their general practitioner (GP), psychiatry and positive behaviour support. There was one active recent referral for positive behaviour support input. There was no direct association as such between this referral and restrictions in use. It was planned however that the positive behaviour support plan would address and support the resident and the staff team with the revised clinical guidance in relation to the recommended daily fluid intake.

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 Services for Children and Adults with Disabilities (2013).* 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 adults and children 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 of adults and children with disabilities 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:

- **Individualised Supports and Care** — how residential services place children and adults at the centre of what they do.
- **Effective Services** — how residential services deliver best outcomes and a good quality of life for children and adults , using best available evidence and information.
- **Safe Services** — how residential services protect children and adults 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 development for children and adults.

List of National Standards used for this thematic inspection (standards that only apply to children's services are marked in italics):

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 person 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.

Theme: Use of Resources	
6.1	The use of available resources is planned and managed to provide person-centred, effective and safe services and supports to people living in the residential service.
6.1 (Child Services)	*The use of available resources is planned and managed to provide child-centred, effective and safe residential services and supports to children.*

Theme: Responsive Workforce	
7.2	Staff have the required competencies to manage and deliver person-centred, effective and safe services to people living in the residential service.
7.2 (Child Services)	*Staff have the required competencies to manage and deliver child-centred, effective and safe services to children.*
7.3	Staff are supported and supervised to carry out their duties to protect and promote the care and welfare of people living in the residential service.
7.3 (Child Services)	*Staff are supported and supervised to carry out their duties to protect and promote the care and welfare of children.*
7.4	Training is provided to staff to improve outcomes for people living in the residential service.
7.4 (Child Services)	*Training is provided to staff to improve outcomes for children.*

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

Quality and safety

Theme: Individualised supports and care	
1.1	The rights and diversity of each person/child are respected and promoted.
1.2	The privacy and dignity of each person/child are respected.
1.3	Each person exercises choice and control in their daily life in accordance with their preferences.
1.3 (Child Services)	*Each child exercises choice and experiences care and support in everyday life.*
1.4	Each person develops and maintains personal relationships and links with the community in accordance with their wishes.
1.4 (Child Services)	*Each child develops and maintains relationships and links with family and the community.*
1.5	Each person has access to information, provided in a format appropriate to their communication needs.
1.5 (Child Services)	*Each child has access to information, provided in an accessible format that takes account of their communication needs.*
1.6	Each person makes decisions and, has access to an advocate and consent is obtained in accordance with legislation and current best practice guidelines.
1.6 (Child Services)	*Each child participates in decision making, has access to an advocate, and consent is obtained in accordance with legislation and current best practice guidelines.*
1.7	Each person's/child's complaints and concerns are listened to and acted upon in a timely, supportive and effective manner.

Theme: Effective Services	
2.1	Each person has a personal plan which details their needs and outlines the supports required to maximise their personal development and quality of life, in accordance with their wishes.
2.1 (Child Services)	*Each child has a personal plan which details their needs and outlines the supports required to maximise their personal development and quality of life.*
2.2	The residential service is homely and accessible and promotes the privacy, dignity and welfare of each person/child.

Theme: Safe Services	
3.1	Each person/child is protected from abuse and neglect and their safety and welfare is promoted.
3.2	Each person/child experiences care that supports positive behaviour and emotional wellbeing.
3.3	People living in the residential service are not subjected to a restrictive procedure unless there is evidence that it has been

	assessed as being required due to a serious risk to their safety and welfare.
3.3 (Child Services)	*Children are not subjected to a restrictive procedure unless there is evidence that it has been assessed as being required due to a serious risk to their safety and welfare.*

Theme: Health and Wellbeing	
4.3	The health and development of each person/child is promoted.