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: | St Joseph's Hospital |
| Name of provider: | Bon Secours Health System CLG |
| Address of centre: | Mount Desert, Lee Road, Cork, Cork |
| Type of inspection: | Unannounced |
| Date of inspection: | 30 October 2024 |
| Centre ID: | OSV-0000284 |
| Fieldwork ID: | MON-0043889 |

## 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 |
|---|---|---|
| Wednesday 30 October 2024 | 09:00hrs to 17:30hrs | Breeda Desmond |

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

This was a good service that strove to provide a human-rights based approach to care to support people have a good quality of life; a restraint-free service and environment was promoted and encouraged that enabled residents' independence and autonomy. The inspector spoke with several residents during the inspection, in day rooms, dining rooms, and residents' bedrooms. The atmosphere was relaxed and care was delivered in an unhurried manner. Residents reported that staff encouraged them to part-take in different activities, that staff were lovely and kind, helpful and fun with lots of laughs. The provider respected the rights of residents to maintain meaningful relationships with people who were important to them, and outings with families and friends were encouraged and facilitated.

St Joseph's Hospital Mt Desert is a single-storey facility with basement, which is registered to accommodate 103 residents; there were 97 residents residing there at the time of inspection. The centre is divided into four self-contained units, namely, Daffodil, Bluebell, Lee side and Woodland. On arrival to the centre the inspector was guided through the risk management procedures of hand hygiene and signing-in process. The inspector advised the person in charge and assistant persons in charge (ADONs) that the purpose of this inspection was to review themes associated with a restrictive practice thematic inspection.

Some residents were in the process of getting up, some were relaxing and listening to the radio or TV in their bedroom, others were in the activities room having morning coffee and chat before going to mass in the church at 11am, and a few residents were in the dining rooms having breakfast.

Residents spoken with at breakfast were having a variety of options for breakfast and enjoying each other's company. They knew the person in charge who accompanied the inspector, and lovely socialisation and interaction was observed. Other residents required assistance with their breakfast and they were helped in a respectful manner. The inspector also spoke with residents during their main meal at lunch time; in general, staff actively engaged with residents and provided assistance appropriately, however, on one unit, meal-time was not appropriately supervised to ensure residents had a good dining experience, even though the nurse was seated at the nurses' station in view of the dining room. Residents gave positive feedback about the food served, the choice at every meal. Meals were pleasantly presented and looked appetising. The daily menu choice was displayed in the dining room and on dining tables, and in general, tables were appropriately laid before residents came to dining rooms, however, on some units, tables were not set and the only condiments on the table at lunch time were sachets of sugar. Meal times were protected in that medications rounds were undertaken before and after meal times to enable residents enjoy their dining experience uninterrupted.

Mid-morning and mid-afternoon refreshments were served in the day rooms and residents' bedrooms; this was undertaken in a social and relaxed manner. The activity programme was variety and seen to be good fun, interactive and residents were encouraged in accordance with their ability. Residents reported that they looked forward to the different activities including the exercise programme that was

facilitated later in the morning. There were two exercise bikes and residents were seen to use these throughout the day. Other activities included, newspaper reading, drawing and art work. Residents reported that they would be starting Christmas wreath making the following week. They said that the 'animal road show' visited in September with exotic creatures such as snakes – the magic show was on site the week prior to the inspection and residents said that was great fun. The residents' communication board was displayed outside the activities room; this had the minutes of the most recent residents' meetings displayed. The activities schedule showed the weekly planned activities and this was updated weekly to show the changing entertainment.

While access to the front reception was secure after 5pm, the code information was displayed enabling residents and visitors to independently access the outdoors. Advisory signage was displayed on long corridors to orientate residents to areas such as the day rooms, dining room and bedrooms.

Bedroom accommodation comprised single and twin occupancy bedrooms and were seen to be spacious with good room for their bedside chair, locker, storage facilities for residents' belongings, and use of assistive equipment if required. Most televisions were inserted as part of the large vanity unit in bedrooms and at an appropriate height for residents to view while in bed or sitting out in their armchair. Residents' bedrooms were decorated in accordance with residents' wishes and preferences. Many residents had brought in mementos from home and were decorated with lampshades, fairy lights, plants, and bookshelves for example. All bedrooms had en suite facilities, however, in twin bedroom occupancy, there was just one shelf in the en suite for both residents to store their toileteries.

The inspector observed that residents were dressed smartly in clothes and accessories of their choice. Age appropriate background music was playing in the dayroom, and dining room during meal time. Residents' rang call bells throughout the day and while some were answered quickly, there were delays in answering others.

Residents had access to advocacy services and there were information posters displaying this information which reflected the change in legislation and current material available. Other information displayed for resident to peruse included the complaints procedure, safeguarding officer on site, residents' guide, and inspection reports as well as local community information and health-related leaflets. Residents had access to four secure well-maintained landscaped gardens located throughout the centre with seating areas throughout, and scenic views of the River Lee Valley and surrounding woodlands. There are rest seating areas along corridors with views of either the enclosed gardens or the avenue leading into the centre.

Visitors were seen calling throughout the day and they were made welcome, were known to staff who actively engaged with them.

## Oversight and the Quality Improvement arrangements

The provider had a robust governance structure in place to promote and enable a quality service. The person in charge was responsible for the service on a day-to-day basis and she was supported on site by two assistant directors of nursing and four clinical nurse managers. The person representing the registered provider was accessible by the person in charge. The national quality manager was easily accessible and was on-site on a regular basis and came to the centre to support the person in charge and staff for the inspection. She supported the service in promoting a restraint-free environment including facilitating ongoing professional training, staff development, and was open to feedback and suggestions in promoting a rights' based approach to delivery of care. The clinical director consultant geriatrician was on site on a weekly basis and provided specialist care as well as governance support. Also on site was the recently appointed manager for human resources.

Clinical nurse managers rotated on duty at weekends to provided managerial support for the service at weekends and a senior nurse was responsible for the service on night duty. In general, CNMs completed audits and oversight of these was provided by the ADONs who had responsibility for two units each. CNMs were also champion leads for infection prevention and control, falls risk management, medication management and restrictive practice to enable better outcomes for residents.

The person in charge had completed the self-assessment of the service regarding restrictive practices, overview and management regarding promoting a restraint-free environment. This included audits such as restrictive practice assessment and implementation in line with national policy, medication audits which included psychotropic prescriptions, privacy and dignity of residents and activities; all of which informed the clinical governance meetings. They assessed the service as being compliant.

There were policies in place including one to support and promote a restraint-free environment including emergency or unplanned use of restrictive interventions to guide practice. Staff had information differentiating non-cognitive symptoms of dementia, for example, delusions, hallucinations and anxiety with associated pathways to the holistic management of longstanding responsive behaviours. Another policy supported staff in the safety and appropriate management of residents' property and finances. Regarding management of complaints – a review of complaints logged showed that while issues were recorded, two were seen to be possible abusive interactions, one verbal and one of neglect, however, they were dealt with as complaints and not safeguarding concerns.

Staff had completed on-line training regarding safeguarding vulnerable adults and in-person training had commenced on site for safeguarding; other mandatory training facilitated included behaviours that challenge, restrictive practice, and manual handling and lifting with ongoing training scheduled to ensure all staff training remained current. There was no agency staff in the centre; there was good staff retention which supported better continuity of care enabling better outcomes for residents. A sample of staff and volunteer files were examined and they had all the

necessary requirements as part of safeguarding residents. A review of duty rosters showed adequate care staffing levels for the size and layout of the centre on day and night duty. Nonetheless, feedback as part of the recent residents' survey suggested better oversight of skill mix of staff, as often there would be only male staff on duty on a unit, so residents may not have choice regarding personal care delivery.

Clinical governance committee meetings included restrictive practice as part of their agenda. Restrictive practice committee meetings had commenced and were facilitated every two months. Minutes of these meetings demonstrated that items such as advanced care directives, assistive decision-making with decision support services were discussed; these were being rolled-out to enable all residents make decisions in accordance with their wishes and beliefs.

Minutes of residents meetings were reviewed and these showed good attendance of residents. Staff representatives from catering, maintenance, care staff, pastoral care and HR attended these meetings to accept feedback first-hand and to respond immediately to resident queries. Actions plans were developed following these meetings with responsibility assigned to ensure issues were resolved in a timely manner. These action plans were also displayed on notice boards alongside the minutes of meetings for residents to review.

Residents had access to a multi-disciplinary team (MDT) to help in their assessments including assessments of restrictive practices. The MDT comprised the consultant geriatrician, physiotherapy, general practitioner and psychiatry of old age when required, along with access to the national screening programme. Documentation reflected consultation and discussion was an on-going process regarding people's care and welfare including restrictive practice.

At the time of inspection, restrictive practices in use included bed rails, low low beds, alarm mats, recliner chairs, and the occasional administration of psychotropic medications. The number of bed rails in use had dramatically reduced following the implementation of national policy and the appointment of a champion lead in the centre. Psychotropic medication usage was under constant review; where a resident was identified as requiring an increased amount of PRNs, the GP reviewed the resident's prescription and adjusted it accordingly in consultation with the resident when possible. Nonetheless, a review of prescriptions was required regarding medications to be crushed as this facility was not seen to be used effectively and medication that should not be crushed were being crushed inadvertently and possibly outside their licencing protocol.

The health care needs of residents were well supported with a doctor on site daily from Monday to Friday. The clinical director was a consultant geriatrician who provided additional support to residents and staff. Documentation demonstrated that residents had access to a range of health care professional with regular reviews by the physiotherapist, occupational therapist (OT), chiropody, tissue viability nurse (TVN), dietitian and the speech and language therapist (SALT). There were no delays in residents being reviewed following referral to specialist services. The service was not a pension agent for any resident.

Residents had access to assistive equipment such as wheelchairs and walking frames to enable them to be as independent as possible. Many aspects of the physical environment enabled independence, for example, the flooring of bedrooms, hallways and communal areas did not have floor sashes to enable freer mobility, especially for residents using mobility aids. Good lighting on wide corridors also facilitated safer mobility. Nonetheless, some communal rooms such as the dayroom on Bluebell and the Potel room did not have swing-free doors to enable these doors to remain open and inviting to residents to amble into.

Pre-admission assessment template enabled a comprehensive holistic psycho-social appraisal to be complete to be assured the service could cater for residents' assessed needs. A sample of assessments and plans of care were reviewed; while some were excellent and provided a holistic picture to inform individualised care, others did not have such detail or were blank and contained no information to inform individualised care. In addition, others were not updated with the changing needs of the resident, to enable best outcomes for the resident.

Behavioural support plans were evidenced with the associated observational tool (Antecedent, Behaviour, Control) to enable possible cause of changes in behaviours to be established to enable staff to implement appropriate actions and supports to deliver safe person-centred care. A sample of personal emergency evacuation plans showed the assistance required for evacuation of residents both day and night times.

Consent forms were examined; where possible, the resident signed their own consent regarding interventions including restrictive practice; however, a review of the consent form was required to ensure it was in compliance with current legislation regarding others signing the form. Restrictive practice register was maintained along with daily records for monitoring restrictive practice in line with current legislation.

Safety pauses were facilitated daily and the inspector attended one of these. Comprehensive holistic information was relayed by care staff to the nurse such as their well-being status, and care and welfare. Staff were seen to be very knowledgeable regarding residents' in their care. Staff highlighted when residents were off their base-line and required additional supports; they detailed the additional supports they were providing to enable residents have a better day such as having a duvet day and would return in the afternoon and offer them a shower for example.

Transfer documentation [for occasions when residents required acute care for example] to ensure residents would be cared for in accordance with their current needs, were comprehensively completed in the sample seen.

The inspector was satisfied that no resident was unduly restricted in their movement or choices due to a lack of appropriate resources, equipment or technology.

In conclusion, while a restraint-free environment was championed to support a good quality of life that promoted the overall wellbeing and independence of residents in accordance with their statement of purpose, better oversight was necessary regarding their complaints management to ensure all residents were appropriately safeguarded.

# 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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| **Compliant** | Residents enjoyed a good quality of life where the culture, ethos and delivery of care were focused on reducing or eliminating the use 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 | |
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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 | |
|---|---|
| 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** | |
|---|---|
| 4.3 | Each resident experiences care that supports their physical, behavioural and psychological wellbeing. |