Mid-West Mental Health Services

Policy and Procedures on the Use of Physical Restraint in Approved Centres

Policy/Procedure/ Guideline Title	**Policy and Procedure on the Use of Physical Restraint in Approved Centres**		
Document reference number	**CP12**	**Document developed by**	**MWMH CPPPG Management Group**
Revision number	**12**	**Responsibility for Evaluation and Audit**	**MWMH CPPPG Management Group**
Approval date	**Dec 2019**	**Responsibility for Implementation**	**ECD, Consultant Psychiatrists, DONs, HODs, ADONs, CNMs**
Revision Date	**February 2024**		
Next Revision Date	**February 2025**		
Document approved by:	**CPPPG Committee CHO3 Mental Health Services**		
Chair Management Team			

This CPPPG is electronically and centrally controlled. Managers are responsible for ensuring that any hard copies in circulation in their areas are the most current version of this PPPG.

Table of Contents:

1.0 Policy Statement

2.0 Purpose

3.0 Scope

4.0 Legislation and other related policies

5.0 Abbreviations and Definitions
- 5.1 Abbreviations (in alphabetical order)
- 5.2 Definitions

6.0 Roles and Responsibilities

7.0 Principles Underpinning the use of Physical Restraint

8.0 Procedures
- 8.1 Orders for Physical Restraint
- 8.2 Patient Dignity and Safety
- 8.3 Ending the Use of Physical Restraint
- 8.4 Recording of Physical Restraint Episodes
- 8.5 Children
- 8.6 Special Considerations for Older Resident/Patients
- 8.7 Clinical Governance

9.0 Implementation Plan

10.0 Staff Training

11.0 Revision & Audit

12.0 References

13.0 Approval Document

14.0 Appendices

1. **Patient Debriefing Tool Following Physical Restraint**
2. **MDT Debriefing Tool Following Physical Restraint**
3. **Clinical Practice Form for Physical Restraint**
4. **Data Required for Annual Report**
5. **MOAT Assessment**

Note: The Mid-West Mental Health Service gives permission for parts or all of this CPPPG to be adapted or used by other healthcare organisations provided the Mid-West Mental Health Service is acknowledged in the new document. Where parts or this entire document are used or referenced in new PPPG documents elsewhere, the Mid-West Mental Health Service accepts no responsibility for the content as applied to those areas.

1.0 Policy Statement

The Mid-West Mental Health Services are committed to ensuring a safe and therapeutic environment for resident/patients in Approved Centres. To this end physical restraint will be practiced within a culture of respect and in a manner which ensures the rights of residents.

Physical restraint will be carried out by professionals as defined in this policy who have undertaken a course in the Professional Management of Complex Behaviours (PMCB) as identified by the **Mid-West Mental Health Service**.

The Mid West Mental Health Services are committed to reducing the incidents of physical interventions by means of preventative strategies in the management of violence and aggression in line with current international best practice/evidence. The policy aims to ensure that where patients are physically restrained the dignity and safety of the patient is paramount.

2.0 Purpose

The purpose of this policy and procedures is to ensure safe and therapeutic practices around restraint in line with MHC Code of Practice on the Use of Physical Restraint Issued Pursuant to Section 33(3)(e) of the Mental Health Act 2001-2018 (September 2022).

This policy does not override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the resident and/or guardian or carer and members of MDT.

3.0 Scope

This policy applies to nursing and medical staff, members of the MDT as defined by the MHC and nursing students in the Mental Health Services Approved Centers. In this policy the term patient covers both voluntary and involuntary patients. Where sections specifically relate to patients detained under the MHA 2001 the term involuntary patient is used.

4.0 Legislation and Other Related Policies

This policy and Procedures is written with due regard to the MHC Code of Practice on the Use of Physical Restraint, Issued Pursuant to Section 33(3)(e) of the Mental Health Act 2001-2018 (September 2022). NICE Guidelines (2015) Violence and aggression: short-term management in mental health, health and community setting, A guide for trainers and commissioners of training and Linking Services and Safety, Together Creating Safer Places of Service- Strategy for Managing Work-Related Aggression and Violence within the Irish Health service (2008), Mental Health Commission Seclusion and Restraint Reduction Strategy (2014), MHC The Use of Restrictive practices in Approved Centres, Promoting Quality, Safety and Human Rights in mental health, Activities Report 2021 (September 2022).

Other related policies:

- CP07: Recording clinical information
- Mental Health Act 2001
- Statutory Instrument No.551 of 2006: Mental Health Act 2001 (Approved Centres) Regulations 2006.
- MHC Code of Practice on the use of physical restraint Issued Pursuant to Section 33(3)(e) of the Mental Health Act 2001-2018 (September 2022).
- MHC Seclusion and Restraint Reduction Strategy 2014.
- CP22: Policy and Procedures for the Use of Seclusion.
- MHC Rules Governing the Use of Seclusion (2022).
- CP41: Policy on ligature risk reduction
- Code of Practice Relating to the Admission of Children under the Mental Health Act 2001(2006) and the addendum to the Code of Practice Relating to Admission of Children under the Mental Health Act 2001 (July 2009).
- HSE Child Protection and Welfare Policy 2019.
- HSE Policy on the prevention and Management of Work Related Aggression and Violence 2018.
- Mental Health Commission Judgement Support Framework (2022).

5.0 Abbreviations and Definitions

5.1 Abbreviations (in alphabetical order):

- ADON: Assistant Director of Nursing
- CNM: Clinical Nurse Manager
- CPPPG: Clinical Polices Procedures Protocols and Guidelines
- DON: Director of Nursing
- ECD: Executive Clinical Director
- HOD: Heads of Discipline
- MWMH: Mid-West, Mental Health (Refers to Clare, Limerick and North Tipperary)
- MDT: Multi-Disciplinary Team
- MHA: Mental Health Act
- MHC: Mental Health Commission
- NCHD: Non Consultant Hospital Doctor
- PMCB: Professional Management of Complex Behaviours

5.2 Definitions:

- **Definition of Physical Restraint:** Physical restraint is defined as 'the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident/patients body when he or she poses an immediate threat of serious harm to self or others' MHC (2022).
- **Definition of 'Prone':** Face down position.
- **Definition of 'Supine':** Face up position.
- **Child means a person under the age of 18 years other than a person who is or has been married.**

6.0 Roles and Responsibilities

- All multi-disciplinary staff working in the MWMH inpatient areas are responsible for complying with this CPPPG.
- Staff as identified on the front sheet of this CPPPG are responsible for the implementation of this CPPPG.
- The MWMH CPPPG Strategic Management Group is responsible for overseeing the implementation and review of this PPPG
- Responsibility for revision and audit is outlined in Section 8 of this CPPPG.

7.0 Principles underpinning the use of physical Restraint

7.1 Approved centres should recognise the inherent rights of a person to personal dignity and freedom in accordance with national and international human rights instruments and legislation.

7.2 The use of physical restraint may increase the risk of trauma and may trigger symptoms of previous experiences of trauma. Therefore, it should only be used in rare and exceptional circumstances as an emergency measure.

7.3 Persons who are restrained should be treated with dignity and respect at all times before, during, and after the restraint.

7.4 Persons who are restrained should be fully informed and involved in all decisions regarding their care and treatment to include all matters relating to the use of physical restraint. The views of persons who are restrained should be listened to, taken into account and recorded.

7.5 As physical restraint compromises a person's liberty, its use should be the safest and least restrictive option of last resort necessary to manage the immediate situation, be proportionate to the assessed risk, and employed for the shortest possible duration. Its use should only occur following reasonable attempts to use alternative means of de-escalation to enable the person to regain self-control.

7.6 Communication with persons who are restrained should be clear, open and transparent, free of medical or legal jargon, and staff should communicate with empathy, compassion and care. Persons who have a sensory impairment may experience an increased level of trauma during physical restraint and staff should address the additional communication needs of these persons.

7.7 The views of family members, representatives and nominated support persons, should be taken into account, where appropriate.

7.8 Cultural awareness and gender sensitivity should be taken into account at all times, and should inform the approved centre's policies and procedures for the use of physical restraint.

7.9 Physical restraint should be used in a professional manner and its use should be based within a legal and ethical framework.

8.0 Procedures

8.1 Orders for Physical Restraint

8.1.1 Physical restraint should only be initiated and ordered by registered medical practitioners, or registered nurses in accordance with the approved centre's policy on physical restraint.

8.1.2 The order should confirm that there are no other less restrictive ways available to manage the person's presentation.

8.1.3 The consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist should be notified of the physical restraint order as soon as is practicable, and this should be recorded in the person's clinical file.

8.1.4 As soon as is practicable, and no later than **two hours** after the start of an episode of physical restraint, a medical examination of the person by a registered medical practitioner should take place. This should include an assessment of any physical impacts of the restraint episode on the person, as well as a record of any psychological and/or emotional trauma caused to the person as a result of the restraint.

8.1.5 An order for physical restraint should last for a **maximum of 10 minutes.**

8.1.6 An episode of physical restraint may be extended by a renewal order made by a registered medical practitioner or the most senior registered nurse on duty in the unit/ward following a medical examination or nursing review, for a further period not exceeding 10 minutes - to a maximum of two renewals of continuous restraint. The continuous period of physical restraint should never be longer than 30 minutes. The reasons for renewing the order, and the time that the nursing review or medical examination took place, should be clearly recorded in the person's clinical file.

8.1.7 a) The episode of physical restraint should be recorded in the person's clinical file.

b) The relevant section of the "Clinical Practice Form for Physical Restraint" should also be completed by the person who initiated and ordered the use of physical restraint as soon as is practicable and no later than three hours after the conclusion of the episode of physical restraint.

c) The Clinical Practice Form for Physical Restraint should also be signed by the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist as soon as is practicable and in any event within 24 hours.

8.1.8 The person should be informed of the reasons for, and the circumstances which will lead to the discontinuation of, physical restraint unless the provision of such information might be prejudicial to the person's mental health, well-being or emotional condition. If informed of the reasons, a record of this should be recorded in the person's clinical file as soon as is practicable. In the event that this communication does not occur, a record explaining why it has not occurred should be entered in the person's clinical file as soon as is practicable.

8.1.9 a) As soon as is practicable, and if it is the person's wish in accordance with their individual care plan, the person's representative should be informed of the person's restraint and a record of this communication should be placed in the person's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred should be entered in the person's clinical file.

b) Where it is the person's wish in accordance with their individual care plan that the person's representative is not to be informed of the person's restraint, no such communication should occur outside the course of that necessary to fulfil legal and professional requirements. This should be recorded in the person's clinical file.

8.1.10 The Registered Proprietor or nominated representative should notify the Mental Health Commission of the start time and date, and the end time and date of each episode of physical restraint in the format specified by the Mental Health Commission, and within the timeframes set by the Mental Health Commission.

8.2 Patient Dignity and Safety

8.2.1 Staff involved in the use of physical restraint should be aware of, and have taken into account, any relevant entries in the person's individual care plan, pertaining to the person's specific requirements or needs in relation to the use of physical restraint.

8.2.2 It should be assumed that any person who is restrained may have a past history of trauma and/or abuse. Therefore, the principles of trauma-informed care should underpin the use of restraint on a person.

8.2.3 The person should have a staff member of the same gender present at all times during the episode of physical restraint.

8.2.4 All staff members involved in the use of physical restraint should have undertaken appropriate training in accordance with the policy outlined in MHC Code of Practice on the Use of Physical Restraint (2022) section 8.2.

8.2.5 The person should be continually assessed throughout the use of restraint to ensure the person's safety. Approved centres should ensure that physical restraint is only undertaken by staff who work closely together as a team, understand each other's roles and have a clearly defined lead. The staff member leading the use of physical restraint should ensure that other staff members:

i. protect and support the person's head and neck, where needed;

ii. ensure that the person's airway and breathing are not compromised;

iii. conduct observations, including vital clinical indicators such as the monitoring of pulse, respiration and complexion (with special attention for pallor/discolouration).

These observations should be recorded and staff should be trained so that they are competent to interpret these vital signs;

iv. monitor and maintain effective communication with the person; and

v. monitor the person's physical and psychological health for as long as clinically necessary after using physical restraint. A record of these observations should be recorded in the person's clinical file.

8.2.6 The level of force applied during physical restraint should be justifiable, appropriate, reasonable, and proportionate to the situation and minimal force should be applied. In the exceptional circumstance where it is considered necessary to use physical restraint on persons who are physically unwell, frail, physically disabled, pregnant or obese, the procedure should be approached with extreme caution and care.

8.2.7 The use of holds that have the potential to inflict pain is prohibited.

8.2.8 The following present a very high risk of harm to the person and should be avoided:

i. neck holds;

ii. the application of weight to the person's chest or back;

iii. the use of physical restraint that interferes with the person's airway, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen, or obstructing the mouth or nose;

iv. the use of physical restraint in a way that interferes with the person's ability to communicate, for example by obstructing the eyes, ears or mouth.

8.2.9 Use of physical restraint involving the person in the "prone", face down position is only permitted in the most exceptional of circumstances by staff who have received appropriate and specific training in its safe use. A record of the use of prone restraint should be entered in the person's clinical file.

8.3 Ending the Use of Physical Restraint

8.3.1 The use of physical restraint may be ended at any time by the staff member responsible for leading the physical restraint.

8.3.2. The time, date, and reason for ending the physical restraint should be recorded in the person's clinical file on the date that the physical restraint ends.

8.3.3 An in-person debrief with the person who was restrained should follow every episode of physical restraint. *(See Appendix 1)* This debrief should be person-centred and should:

i. give the person the opportunity to discuss the physical restraint with members of the multidisciplinary team involved in the person's care and treatment as part of a structured debrief process;

ii. occur within two working days (i.e. days other than Saturday/Sunday and bank holidays) of the episode of physical restraint unless it is the preference of the person who was restrained to have the debrief outside of this timeframe. The person's preferences regarding the timing of the debrief should be recorded;

iii. respect the decision of the person not to participate in a debrief, if that is their wish. If the person declines to participate in the debrief, a record of this should be maintained and recorded in the person's clinical file;

iv. include a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future;

v. include a discussion regarding the person's preferences in the event where a restrictive intervention is needed in the future for example preferences in relation to which restrictive intervention they would not like to be used;

vi. give the person the option of having their representative or their nominated support person attend the debrief with them, and, if the person's representative or nominated support person does not attend the debrief, a record of the reasons why this did not occur should be recorded in the person's clinical file.

8.3.4 Where multiple episodes of physical restraint occur within a 48-hour timeframe, these episodes may be reviewed during a single debrief in accordance with point 8.3.3 ii

8.3.5. A record should be kept of the offer of the debriefing, whether it was accepted and the outcome. The person's individual care plan should be updated to reflect the outcome of the debrief, and in particular, the person's preferences in relation to restrictive interventions going forward.

8.3.6 A record of all attendees who were present at the debrief should be maintained and be recorded in the person's clinical file.

8.3.7 Any use of a restrictive intervention may be traumatic for the person who experiences it. Appropriate emotional support should be provided to the person in the direct aftermath of the episode. Staff should also offer support, if appropriate, to other persons who may have witnessed the restraint of the person.

8.4 Recording of Physical Restraint Episodes

8.4.1 All uses of physical restraint must be clearly recorded in the resident/patients clinical file.

8.4.2 All uses of physical restraint must be clearly recorded on the *'Clinical Practice Form for Physical Restraint (see Appendix 3)* in accordance with provision 3.7 of the Mental Health Commission Code of Practice on the Use of Physical Restraint 2022.

8.4.3 The completed form must be placed in the resident/patients clinical file and a copy must be available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.

8.4.4 Clinical incident forms must be completed for all incidents of restraint.

8.4.5 A record of notification or if resident wishes non-notification of the patient's family or representative of the patients physical restraint should be made in the patient's clinical file. This may be reviewed by the inspector of mental health services during the inspection process.

8.5 Children

In addition to the above which apply to all patients the following considerations apply to children being provided care and treatment in approved centres:

8.5.1 Upon admission to an approved centre that uses physical restraint on children, a documented risk assessment should be carried out by a registered medical practitioner or registered nurse. This should show that careful consideration has been given to the potential effects of restraining a child or adolescent, having regard to the physical status and emotional development of the child, and their particular vulnerability to trauma and harm as a result of restrictive interventions. The outcome of the risk assessment should determine if physical restraint can be safely used or not.

8.5.2 Children should have the reasons for, and the circumstances which will lead to the discontinuation of restraint, explained in a way that the child can understand and in a format that is appropriate to their age. A record should be maintained of this communication and clearly outline how it met the child's individual communication needs.

8.5.3 An approved centre physically restraining a child should ensure the child's parent or guardian is informed as soon as possible of the child's physical restraint and the circumstances which led to the child being physically restrained. The child's parent or guardian should also be informed when the episode of physical restraint has ended.

8.5.4 An approved centre physically restraining a child should have in place child protection policies and procedures in line with relevant legislation and regulations made thereunder.

8.5.5 An approved centre physically restraining a child should have a policy and procedures in place addressing appropriate training for staff in relation to child protection.

8.6 Special Considerations for Older Resident/Patients

8.6.1 To ensure safe, effective management of aggression and violence for older people, or younger people with a Dementia, staff working with older people require training in dementia care, managing behaviors that challenge and person centered approaches to care.

8.6.2 Physical restraint should only be used in the best interest of the patient when this patient poses an immediate threat of serious harm to him/herself or others and all alternative interventions to manage the patient's unsafe behavior have been considered.

8.6.3 In the case of a person with dementia, identification of unmet needs and consideration of techniques that may lead to the change in behaviour must be considered by the treating multi-disciplinary team.

8.6.4 Where possible all alternatives and dementia specific environmental strategies must be used as alternative to physical restraint.

8.6.5 Calming language and approach should be used as the patient may not be orientated and may feel frightened and confused.

8.6.6 Special consideration must be given to the risks associated with the use of physical restraint for older people and all staff must be trained in these risks.

8.6.7 The duration of the period of physical restraint should be minimum necessary to protect the patient or others from immediate and serious harm.

8.7 Clinical Governance

8.7.1 (a) The ADONs and HOD;s responsible for each clinical rea in the Approved centres must maintain a written record indicating all staff involved in physical have read and understood the policy.

(b) The record must be available to the Mental Health Commission on request.

8.7.2 Physical restraint should never be used:

i) to ameliorate operational difficulties including where there are staff shortages;
ii) as a punitive action;
iii) solely to protect property;
iv) as a substitute for other less restrictive interventions.

8.7.3 Each episode of physical restraint should be reviewed by members of the multidisciplinary team involved in the person's care and treatment and documented in the person's clinical file as soon as is practicable and, in any event, no later than five working days (i.e. days other than Saturday/Sunday and bank holidays) after the episode of restraint. The review should include the following*: (See appendix 2)*

i. the identification of the trigger/antecedent events which contributed to the restraint episode;

ii. a review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support;

iii. the identification of alternative de-escalation strategies to be used in future;

iv. the duration of the restraint episode and whether this was for the shortest possible duration;

v. considerations of the outcomes of the person-centred debrief, if available;

vi. an assessment of the factors in the physical environment that may have contributed to the use of restraint.

8.7.4 The multidisciplinary team review should be documented and should record actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person.

8.7.5. Every approved centre that uses, or permits the use of, physical restraint, should develop and implement a reduction policy, which should be published on the Registered Proprietor's website. This policy should:

i. clearly document how the approved centre aims to reduce, or where possible eliminate, the use of physical restraint within the approved centre;

ii. address leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice;

iii. clearly document how the approved centre will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of physical restraint within the approved centre.

8.7.6 The Registered Proprietor has overall accountability for the reduction policy. The Registered Proprietor should appoint a named senior manager who is responsible for the approved centre's reduction of physical restraint.

8.7.7 All information gathered regarding the use of physical restraint should be held in the approved centre and used to compile an annual report on the use of physical restraint at the approved centre. This report, which should be signed by the Registered Proprietor Nominee, should be made publicly available on the Registered Proprietor's website within six months of the end of the calendar year and available, upon request, to the public.
The annual report should contain:

i. aggregate data that should not identify any individuals;
ii. a statement about the effectiveness of the approved centre's actions to eliminate, where possible, and reduce physical restraint;
iii. a statement about the approved centre's compliance with the code of practice on the use of physical restraint;
iv. a statement about the compliance with the approved centre's own reduction policy;
v. the data as specified in *Appendix 4.*

All approved centres should produce and publish an annual report on the use of physical restraint. Where physical restraint has not been used in the relevant 12-month period, then points i and ii above should only be reported on.

8.7.8 A multidisciplinary review and oversight committee, which is accountable to the Registered Proprietor Nominee, should be established at each approved centre to analyse in detail every episode of physical restraint. The committee should meet at least quarterly and should:

i. determine if there was compliance with the code of practice on the use of physical restraint for each episode of physical restraint reviewed;
ii. determine if there was compliance with the approved centre's own policies and procedures relating to physical restraint;
iii. identify and document any areas for improvement;
iv. identify the actions, the persons responsible, and the timeframes for completion of any actions;
vi. provide assurance to the Registered Proprietor Nominee that each use of physical restraint was in accordance with the Mental Health Commission's Code of Practice;
vii. produce a report following each meeting of the review and oversight committee. This report should be made available to staff who participate, or may participate, in physical restraint, to promote on-going learning and awareness. This report should also be available to the Mental Health Commission upon request.

8.7.9. The Registered Proprietor has overall accountability for the use of physical restraint in the approved centre.

9.0 Implementation Plan

9.1 It is the responsibility of the ECD, Consultant Psychiatrists, DONs, HODs, ADONs, and CNM's in charge of the clinical areas, to ensure this policy and protocol is implemented.

9.2 It is the responsibility of all staff identified in Section 3 of this CPPPG to implement and sign to say they have read and understood this CPPPG and to maintain in each clinical area a record of same to be available for inspection as the MHC requires or for audit as required.

10.0 Staff Training

10.1 Staff rostered to approved centres will receive training in physical restraint. This training will be based on the MOAT assessment (Matrix of Organizational Analysis of Training) *(see Appendix 5)* by a currently accredited PMCB Instructor. This assessment tool takes into consideration; patient population need, clinical risk in relation to physical restraint and high risk populations, health and safety, professional requirements, physical environment and organisational expectations.

10.2 Security personnel are only permitted to support in emergency situations and must be directly supervised by a registered nurse. These staff will be provided with training in the role of security staff in emergency situations in approved centres.

10.3 All physical restraint training programmes must include alternatives to physical restraint and international evidence associated with restraint reduction.

10.4 Staff identified above must receive a refresher programme **at least every 24 months** in physical interventions (BILD, 2010). Where this refresher has not taken place within 24 months, staff will have to complete the full programme and will not be eligible for a refresher.

10.5 Training will be provided by an appropriately qualified and currently accredited person as identified by the Mid-West Mental Health Services.

10.6 Training identified will be mandatory and will be approved by the appropriate member of the MWMHS management team.

10.7 A record of attendance at this training will be maintained by the administrator for the PMCB team, ADONs for each Clinical Area in the approved centre for nursing staff, by the Executive Medical Director for medical staff and by the Heads of Discipline for all other professionals.

10.8 Special consideration must be given to the risks associated with the use of physical restraint for children and older people and all staff working in areas where this is likely to occur must be trained in these risks.

10.9 Provision of all training programmes should be reviewed on a two yearly basis by a currently accredited PMCB Instructor to ensure current best evidence/practice, relevance to that defined area, and effectiveness in practice.

10.10 The content of all training programmes and associated unit by unit assessment documentation will be maintained for review or as required by the administrator of the PMCB Team in the PDU.

11.0 Revision and Audit

11.1 The MWMH CPPPG Strategic Management Group is responsible for the evaluation and audit of this PPPG

11.2 The HODs, Consultant Psychiatrists and Clinical Nurse Managers are responsible for auditing the PPPG under the direction of the MWMH CPPPG Strategic Management Group.

11.3 The MW MH CPPPG Strategic Management Group is responsible for ensuring feedback is provided to relevant employees as required.

11.4 Review will occur by the date identified on the front sheet of this PPPG and in any case within one year.

12.0 References

All references identified are available by CPPPG reference number through the Chair of the CPPPG Strategic Management Group.

Reference	CPPPG Ref No.
Mental Health Commission of Ireland (2022) *Code of Practice on the use of Physical Restraint in Approved Centers.* Dublin: Government Publications.	55
BILD (2010) *Code of Practice for the use and Reduction of Restrictive Physical Interventions. A guide for trainers and commissioners of training.* Third edition. Glasgow: BILD Publications.	54
Mc Kenna, K (2008) *Linking Services and Safety, Together Creating Safer Places of Service- Strategy for Managing Work-Related Aggression and Violence within the Irish Health Service.* Ireland: HSE.	56
NICE (2015) *Violence and Aggression: Short-term Management in mental health, health and community settings.* UK: National Institute for Health and Care Excellence.	
MHC (2014) Seclusion and Restraint Reduction Strategy. Ireland: Mental Health Commission.	
MHC (2022) *The Use of Restrictive Practices in Approved Centers. Promoting Quality, Safety and Human Rights in Mental Health, Activities Report 2021.* Ireland: Mental Health Commission.	
HSE (2018) Policy on Prevention and Management of Work Related Aggression and Violence. Ireland: HSE	
MHC (2022) *Judgement Support Framework Special Edition for use during Covid 19 pandemic 2022.* Ireland: Mental Health Commission.	
HSE (2019) *HSE Child Protection and Welfare Policy.* Ireland: HSE	

13.0 Approval Document

MWMH
Clinical PPPG Approval Document

Policy No: CP12

Policy Title: Policy and Procedures for the Use of Physical Restraint in Approved Centres

Date of Approval: **February 2024**

Date for Implementation: **February 2024**

This Policy was reviewed and recommended by the Executive Clinical Director and Director of Nursing on behalf of the CPPPG Strategic Management Group to the Mid-West Mental Health Management Team for sign-off by the Chair

Dr Tom Reynolds
Executive Clinical Director
Mid-West, Mental Health

Mr. James Harrington
Interim Area Director of Nursing
Mid-West Mental Health Service

APPENDIX 1
PATIENT DEBRIEFING TOOL FOLLOWING PHYSICAL RESTRAINT

To be completed as soon as is practical after an episode of Physical Restraint
(Within two working days or prior to discharge or if it is the decision of the client to have the debrief at a later time)

Date: _____ **Time:** _____

Present at Debrief: (Print and signature)

If nominated support person or representative not present for de-brief, please document reason for absence

_____
_____
_____

1. Would you like to discuss your recent episode of Physical Restraint? Yes ❒ No ❒
*if no please respect their wish to not participate and document here

_____
_____
_____
_____
_____

2. What is your understanding of why you were Physically Restrained?

_____
_____
_____
_____
_____

3. Alternative de-escalation strategies that you would prefer in the future in an effort to avoid the use of restrictive interventions

_____
_____

4. **Preference of restrictive intervention in the future should its use be unavoidable (i.e which intervention you would not like to be used)**

Other Comments/Concerns

Signature: _____ **(Nurse/MDT member leading debrief)**

Signature: _____ **(Client)**

Date: _____

APPENDIX 2
MDT REVIEW TOOL FOLLOWING PHYSICAL RESTRAINT

To be completed as soon as is practical after an episode of Physical Restraint
(no later than five working days after the episode of restraint)

Date: _____ **Time:** _____

Present at Debrief: (Print and signature)

1. What were the triggers/antecedents that contributed to the episode of restraint?

_____
_____
_____
_____
_____

2. Were there any missed opportunities for earlier intervention?

_____
_____
_____
_____
_____

3. Alternative de-escalation strategies that could be implemented in the future in an effort to avoid the use of restrictive interventions

_____
_____
_____
_____

4. Were there any factors in the physical environment that may have contributed to the episode of restraint

5. Was the restraint for the shortest possible duration?

6. Consideration/Outcomes of the person centred debrief (if held)

7. Follow up plans to eliminate or reduce restrictive interventions in the future

Update individual care plan to reflect outcome of debriefing and preferences in relation to restrictive interventions going forward.

Appendix 3 – Clinical Practice form for Physical Restraint

Person's Details	
1. First Name:	**2. Surname:**
3. Date of Birth: _____/_____/_____ (dd/mm/yyyy)	**4. Gender:** Male ☐ Female ☐ Other ☐
5. Person's Medical Record Number:	

Location	
6. Approved Centre Name:	**7. Unit Name:**

Physical Restraint Details	
8. Physical Restraint Order Type: First restraint order ☐ First Renewal order* ☐ Second Renewal order* ☐ As per provision 3.5, a physical restraint order should last for a maximum of 10 minutes. A renewal order should be made if it is necessary to renew the episode of physical restraint beyond ten minutes.	
9. Date restraint commenced: _____/_____/_____ (dd/mm/yyyy)	**10. Time restraint commenced:** ____:____ (24hr clock e.g. 2.41pm is written as 14.41)
11 (a) Who initiated and ordered physical restraint: Name (print): _____ Job title (print): _____ Signed: _____ **11 (b) Who led the physical restraint episode in accordance with provision 4.5:** Name (print): _____ Job title (print): _____ Signed: _____	

11 (c) Who assisted with the physical restraint:

Name (print): _____ Job title (print): _____

Signed: _____

Name (print): _____ Job title (print): _____

Signed: _____

Name (print): _____ Job title (print): _____

Signed: _____

Name (print): _____ Job title (print): _____

Signed:

12. Details of what each member of staff named above was doing during the episode of physical restraint:

13. Why is physical restraint being ordered/renewed?

Immediate threat of serious harm to self ☐

Actual harm caused to self ☐

Immediate threat of serious harm to others ☐

Actual harm caused to others ☐

Transfer to seclusion room ☐

To administer medication/treatment (excluding nasogastric feeding) ☐

To administer nasogastric feeding ☐

Other (please specify) ☐ _____

Please provide further details on the above:

14: Alternative means of de-escalation attempted prior to the use of physical restraint:

Verbal Intervention ☐ Medication offered / administered ☐

Time Out / One to One Nursing / Seclusion ☐ No alternatives attempted ☐

Other (please specify) ☐ _____

Please provide further details on the above:

15. Type of physical restraint used:

Prone ☐
Supine ☐
Side ☐
Upright ☐
Other (please specify) ☐ _____

Please provide further details

16. Was the person's representative informed of the person's physical restraint?

Yes ☐ No ☐

If no, please explain the reasons why this did not occur:

17. Order:

I _____ have assessed _____ on

Date: ____/____/_____ at ____ hrs ____ mins and I order the use of physical restraint from Date: ____/____/_____ at ____ hrs ____ mins for up to a maximum of ____minutes

Name (print): _____ Signed: _____

Date: ____/____/_____ at ____hrs ____mins (24 hr clock e.g. 2.41pm is written as 14.41)

18. Physical restraint has been ordered under the supervision of the:
Please tick as appropriate and sign below:

Consultant psychiatrist responsible for the care and treatment of the person ☐

Duty consultant psychiatrist ☐

Name (print): _____ Signed: _____

Date: ____/____/_____ at ____hrs ____mins (24 hr clock e.g. 2.41pm is written as 14.41)

19. Physical restraint ended ☐ Physical restraint renewed* ☐

Who ended/renewed physical restraint:

Name (print): _____ Signed: _____

Date physical restraint ended / renewed: ____/____/_____ (dd/mm/yyyy)

Time physical restraint ended / renewed: ____ : ____ (24 hr clock e.g. 2.41pm is written as 14.41)

** If physical restraint is renewed, a new Clinical Practice Form and Order should be completed.*

20. Did the medical examination of the person take place within two hours of the commencement of the restraint episode?

Yes ☐ No* ☐

If yes, please complete the following:

Name of the registered medical practitioner who conducted the medical examination:

_____

Date and time of medical examination:

Date: ____/____/_____ at ____hrs ____mins

*If no, please provide further details:

21. To be completed by the person who ended/renewed physical restraint

Did the physical restraint episode result in any injury to the person? Yes ☐ No ☐

If yes, please provide further details:

APPENDIX 4: Data required for MHC as part of annual report.

1. The total number of persons that the approved centre can accommodate at any one time*
2. The total number of persons that were admitted during the reporting period*
3. The total number of persons who were physically restrained during the reporting period*
4. The total number of episodes of physical restraint
5. The shortest episode of physical restraint
6. The longest episode of physical restraint

**Where this number is five or less the report should state "less than or equal to five".*

Appendix 5: MOAT Assessment

TRAINING
IN THE
PROFESSIONAL MANAGEMENT OF
AGGRESSION & VIOLENCE
[PMAV]

MOAT ASSESSMENT©
[MATRIX OF ORGANISATIONAL ANALYSIS OF TRAINING]

CONSULTATION EVALUATION AND PLANNING RECORD

© McKenna 2006. This instrument may be used solely within the Health Service Executive by those properly instructed in its use. Within the Health Service Executive it may be used for educational, service and/or research use (with proper acknowledgement) with the exceptions of advertising, endorsement or commercial purposes. It may not be reproduced, given to any third party or used outside of Health Service Executive without the written permission of the author.

MATRIX OF ORGANISATIONAL ANALYSIS OF TRAINING [MOAT]

Explanatory Notes

Work related violence is a serious problem within healthcare which diminishes the quality of working life for staff, compromises organizational effectiveness and ultimately impacts negatively on the provision of care services. While there has been increasing recognition that manifestations of aggression and violence vary greatly between and within services, what is clear is that staff may be affected irrespective of their work location, occupation, or department (McKenna 2004).

Recognition of the indisputable risks to service users and staff associated with the management of work related aggression and violence imposes professional, statutory, and moral imperatives upon organisations to provide staff with safe, effective and appropriate training. The provision of such training has been reported to reduce associated risks, improve staff effectiveness and result in cost savings from reduced injuries and related expenses. The provision of training should not however be considered solely in the context of risk alone. From a service perspective, the provision of compassionate and skillful care requires that staff are competent to recognise, assess, and intervene with individuals experiencing difficulty controlling their behaviour.

The effective management of work related violence, requires that training be embedded within a governance framework which adequately and equitably addresses concerns from clinical practice, health and safety, risk management, and corporate policy perspectives. In response to evidence based concerns the HSE developed the Professional Management of Aggression and Violence (PMAV) programme to address training concerns from each of these perspectives. This programme prepares staff from multiple disciplines to function as instructors who are competent to design and provide training that is needs assessed, service specific, fit for purpose, and responsive to the various manifestations of aggression and violence encountered within diverse clinical settings.

Instructors will evaluate training needs by working closely with staff and service managers to identify service specific challenges related to aggression and violence, review health and safety and risk management concerns, and consider the legislative and policy frameworks within which services are provided. This MOAT instrument, as a framework, provides a structure which guides this consultation and provides a record of the decision making process.

To effectively complete the training needs analysis will requires that the instructor liaise closely with the service manager in the first instance. Having identified the relevant concerns

from a service perspective, consideration will then be given to Health & Safety, Risk Management, and Legal and policy concerns.
In summary the instructor will need the opportunity to liaise with

- The service area in which training is being planned
- Those responsible for health & safety including safety representatives
- Those responsible for risk management
- Leadership personnel including team leaders and service managers

From this process, the instructor will design, develop, and deliver training in the management of aggression and violence which:

- **RESPONDS TO THE SAFETY AND PRACTICE CONCERNS WITHIN SERVICE SETTINGS**
- **ADDRESSES STATUTORY HEALTH AND SAFETY OBLIGATIONS**
- **ADDRESSES CORPORATE RISK MANAGEMENT CONCERNS,**
- **IS CONGRUENT WITH ORGANIZATIONAL PHILOSOPHY AND POLICY**
- **INCLUDES ONLY INTERVENTIONS WHICH ARE PROFESSIONALLY, LEGALLY, AND ORGANISATIONALLY PERMISSIBLE**

The instructor will submit a proposed draft programme of training in all instances to the service manager or their designee for review and agreement prior to commencement. On completion of training the instructor will meet with the service manager or designee to review the training provision and evaluation.

PMAV Instructors HSE West Mid West

Name	Service	Telephone	Email
Siobhan Corbett	L.M.H.S		Siobhan.corbett@hse.ie
Arthur Rogers	L.M.H.S		Arthur.rogers@hse.ie
Síofra Devine	C.M.H.S	087 9764528	Siofra.devine@hse.ie
Tony Strand	C.M.H.S		Tony.strand@hse.ie

The instructor coordinating the PMAV training assessed at this time is:	
Telephone:	**Email:**

PRACTICE SETTING CONSULTATION

Venue:	
Date:	
Key Informants:	
Name :	Title:
KEY INFORMANT/CONTACT	
PREFERRED KEY INFORMANT:	
OFFICE:	MOBILE:
FAX NUMBER:	
E-MAIL ADDRESS(ES):	
PREFERRED CONTACT METHOD TIME:	

Consultation Notes:

Key Training Implications:
Prevention, recognition and responding to aggressive incidents for all staff members
De-escalation techniques for all trainers
Physical disengagement skills training for all staff
Awareness of Position, posture and proximity
Role expectation and health and safety considerations when responding to incidents
Introduction and implementation of safe work practice sheet.

HEALTH & SAFETY ADVISOR CONSULTATION

Venue:	
Date:	Time:
Key Informants:	
Name:	Title:
KEY INFORMANT/CONTACT	
PREFERRED KEY INFORMANT:	
OFFICE:	**MOBILE:**
E-MAIL ADDRESS(ES):	
PREFERRED CONTACT METHOD TIME:	

Consultation Notes:

RISK ADVISOR CONSULTATION

Venue:	
Date:	Time:
Key Informants:	
Name	Title
KEY INFORMANT/CONTACT	
PREFERRED KEY INFORMANT:	
OFFICE:	MOBILE:
E-MAIL ADDRESS(ES):	
PREFERRED CONTACT METHOD TIME:	

Consultation Notes:

Consultation Summary & Key Training Implications:

SERVICE DIRECTOR CONSULTATION I

Venue: St. Joseph's Hospital	
Date:	Time:
Key Informants:	
Name	Title
KEY INFORMANT/CONTACT	
PREFERRED KEY INFORMANT:	
OFFICE:	MOBILE:
E-MAIL ADDRESS(ES):	
PREFERRED CONTACT METHOD TIME:	

Consultation Notes:

Contd....

Service Director Consultation Contd....

Consultation Summary & Key Training Implications:		
Agreed Actions:		
Actions:	**Date**	**Person**

Training Programme in the Professional Management of Complex Behaviours [PMCB]

Day 1-

TIME	TOPIC	INSTRUCTOR

SERVICE DIRECTOR FOLLOW-UP CONSULTATION II

Venue:	
Date:	Time:
Key Informants:	
Name	Title

Consultation Notes:

Contd....

SERVICE DIRECTOR CONSULTATION CONTD....

Consultation Summary & Key Training Implications:		
Training Implementation Plan:		
Actions:	**Date**	**Person**
Training Dates:		
Participant Numbers:		
Trainers:		
Trainer Release/Approval:		
Venues:		
Equipment:		
Meals:		
Evaluation/Follow-up:		
SIGNATURE:		

TRAINING RECORD

Venue:	
Date:	Time:
Participants:	
Trainers:	
Lead Trainer:	

Course Notes:

Occurrences/Injuries:

Instructor Name:	Signature:	Date:

SERVICE DIRECTOR FEEDBACK SESSION III

Summary Key Training Feedback:	
Completion of Course Content:	
Participant Competence:	
Participant Course Evaluation:	
Venue Equipment Issues	
Issues Concerns identified:	
Evaluation/Follow-up:	
Signature:	
(PMAV Instructor)	