Mid West Mental Health Services

Restrictive Practise Policy

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Chair Management Team			

Please note this policy was adapted from the Galway/Roscommon MHS with their permission.

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1.0 Introduction:

1.1 The Mid West Mental Health Services aims to reduce restrictive practices (Seclusion, Mechanical Means of Bodily Restraint and Physical Restraint) in line with Sharing the Vision (2020) Recommendation 92. However *"while a zero restraint and seclusion service may not always be achievable, due to safety requirements of service users and staff, there are examples where major reductions in the use of restraint are working effectively"* (Sharing the Vision (2020) p. 122).

1.2 Restrictive practices are only used in rare and exceptional circumstances as an emergency measure for the management of an individual's unsafe behaviour due to the:

a) Potential physical and psychological injury to the individual or staff,
b) Potential damage to the therapeutic relationship between individuals and staff,
c) Risks of infringing the Human Rights of an individual, their dignity and autonomy,
d) Potential that people who have experienced Trauma are more likely to be secluded (Hammer et al, 2011, elderert et al., 2007) and
e) The potential for re-traumatising the individual (Frueh et al, 2005, Hammer et al., 2011 & Litz and Gray, 2002).

1.3 The staff in the Midwest Mental Health Services are committed to providing a safe and therapeutic environment with the least possible restriction on patients admitted to Approved Centres, consistent with legal requirements and principles of best practice.

1.4 Staff in the Midwest Mental Health Service shall respect, as far as is reasonably practicable, the Human rights of all patients and their right to dignity, bodily integrity and privacy at all times while being treated in an approved Centre.

2.0 Policy Statement:

2.1 It is the duty of the Midwest Mental Health Service to ensure that restrictive practices (Mechanical Means of Bodily Restraint seclusion and physical restraint) are used as a last resort and when used are carried out in accordance with the terms of the Mental Health Act 2001 (as amended), the Mental Health Commission Rules Governing The Use of Seclusion (Mental Health Commission, 2022), Rules Governing the use of Mechanical Means of Bodily Restraint (Mental Health Commission 2022) and/or the Code of Practice on the use of Physical Restraint (Mental Health Commission, 2022).

3.0 Policy Purpose:

3.1 To clearly demonstrate:

I. How the approved centre aims to reduce or, where possible eliminate, the use of seclusion, mechanical means of bodily restraint and physical restraint within the approved centres,

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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, and

III. Clearly document how the approved centre will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of restrictive within the approved centre.

3.2 To ensure that as far as is reasonably practicable where a patient is physically restrained or secluded that their human rights, rights to dignity, bodily integrity and privacy are respected at all times. This includes cultural awareness and gender sensitivity.

3.3 To ensure that information on restrictive practices informs this restrictive practice reduction strategy and policy and any reviews of the document.

4.0 Legislation/Other Related Policies:

4.1 Mental Health Act 2001 (as amended).

4.2 Rules Governing the use of Seclusion (Mental Health Commission, 2022),

4.3 Rules Governing the use of Mechanical Means of Bodily Restraint (Mental Health Commission, 2022),

4.4 Code of Practice on the Use of Physical Restraint (Mental Health Commission, 2022).

4.5 The uses of restrictive practices in approved centres activities report (Mental Health Commission, 2020).

4.6 Seclusion and Physical Restraint Reduction Strategy: Consultation Report. (Mental Health Commission, 2014)

4.7 Evidence review to inform the review of the code of practice on the use of physical restraint and the rules governing seclusion and mechanical means of bodily restraint in inpatient Mental Health Services (RCSI Faculty of Nursing & Midwifery, 2022)

5.0 Scope of Policy:

5.1 This policy applies to all staff (including students under the supervision of qualified nursing staff) working in the Approved Centres of the Midwest Mental Health Service.

5.2 This policy applies to all episodes of seclusion, mechanical means of bodily restraint and physical restraint of patients in the Approved Centres in the Midwest Mental Health Services.

5.3 This policy should be read in conjunction with the documents in section 4.0.

5.4 Mechanical means of bodily restraint is not used in the following approved centres:

I. Adult Acute Admission Unit 5b,UHL
II. Acute Psychiatric Unit Ennis,

5.5 Seclusion is not used in the following approved centres:

I. Adult Acute Admission Unit 5b,UHL
II. Approved Centre Tearmann Ward, St. Camillus Hospital
III. Approved Centre Cappahard Lodge, Ennis.

5.6 Mechanical means of bodily restraint is only used for the management of enduring risk of harm to a patient. Examples include bed rails or lap belts. Their use however is regularly reviewed and assessed to ensure they continue to be required and that they are not posing a risk of injury to the patient e.g. a confused patient climbing over a bed rail.

5.7 This policy will be reviewed every 3 years or may be reviewed as a result of any changes to relevant legislation or identification of areas for improvement as a result of the learning accrued from practice, including any incidents or near misses or on the recommendations of the inspector of mental health services or other regulators.

6.0 Definitions:

6.1 Approved Centre: a hospital or in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder, which is registered on the Register of Approved Centres in accordance with Section 63 of the Mental Health Act 2001.

6.2 Break away techniques: A set of physical skills to help separate or break away from an aggressor in a safe manner. They do not involve the use of restraint.

6.3 Clinical Governance: A system for improving the standard of clinical practice including clinical audit, education and training, research and development, risk management, clinical effectiveness and openness.

6.4 De-escalation: The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression.

6.5 Duty Consultant Psychiatrist: A consultant Psychiatrist who is acting for or covering for the Responsible Consultant Psychiatrist.

6.6 Enduring Self-harm: Self-harming behaviour resulting from any cause or risk to the person which is a constant feature of a person's behaviour or presentation that may cause the person physical injury and is not amenable to non-restraining therapeutic interventions.

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6.7 Mechanical Means of Bodily Restraint: "the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a person's body" (Mental Health Commission, 2022).

6.8 Patient: A patient includes voluntary or involuntary patient admitted to the approved centre.

6.9 Physical Restraint: Is defined by the Mental Health Commission (2022) as "the use of physical force (by one or more persons) for the purpose of preventing the free movement of a person's body when the person poses an immediate threat of serious harm to self or others".

6.10 Positive behaviour support: involves assessments that look beyond the behaviour of a person and seek to understand the causes or triggers of the behaviours. These causes may be social, environmental, cognitive, or emotional. The approach is one of behaviour change as opposed to behaviour management.

6.11 Responsible Consultant Psychiatrist: the consultant psychiatrist responsible for the care and treatment of the patient.

6.12 Restrictive Practices: Means the use of Seclusion, physical or mechanical means of bodily restraint within the approved centre.

6.13 Seclusion Room: A dedicated and specifically designed room used only for the purposes of secluding a patient.

6.14 Seclusion: "*the placing or leaving of a person in any room alone, at any time, day or night, such that the person is prevented from leaving the room by any means*" (Mental Health Commission 2022).

6.15 Trauma: physical injury, or lasting emotional response that often results from living through a distressing event. Experiencing a traumatic event can harm a persons' sense of safety, sense of self and ability to regulate emotions and navigate relationships.

6.16 Trauma-informed care: "..an approach which acknowledges that many people who experience mental health difficulties may have experienced some form of trauma in their life. A trauma-informed approach seeks to resist traumatising or re-traumatising persons using mental health services and staff (Mental Health Commission, 2022).

6.17 Treatment: in relation to a detained patient includes the administration of physical, psychological and other remedies relating to the care and rehabilitation of a patient under medical supervision, intended for the purposes of ameliorating a mental disorder.

6.18 Unsafe behaviour: When a patient acts in such a way that he or she may injure himself/herself or others.

7.0 Responsibilities:

7.1 Registered Proprietor:

7.1.1 The Registered Proprietor is responsible for:

a) Ensuring that the resources required are allocated to the Midwest Mental Health Services to comply with the Mental Health Act 2001 (as amended) and the Rules Governing the use of Seclusion (Mental Health Commission, 2022) and HSE policies on the management of violence and aggression (2018).
b) Ensuring that a restrictive practice reduction policy is published on their website.
c) Appointing a named senior nurse manager responsible for the reduction of seclusion in each of the approved centres.
d) Ensuring a report on the use of physical restraint is compiled and published on their website, within 6 months to the end of the calendar year and ensuring it is available to the public on request.
e) Ensuring that their nominees has established a multidisciplinary review and oversight committee to analyse in detail each episode of restrictive practices in each approved centre.
f) Ensuring that each episode of physical restraint, seclusion or enduring mechanical means of bodily restraint are in compliance with the Code of Practice on the use of physical restraint (Mental Health Commission 2022), Rules governing the use of Seclusion (Mental Health Commission 2022) and/or the Rules governing the use of mechanical of bodily restraint (Mental Health Commission 2022).
g) Having overall accountability for the use of restrictive practices use in the approved centre.
h) Having overall accountability for the restrictive practice reduction policy.

7.2 Chairperson of the Restrictive Practise committee: (Appointed by the registered proprietor)

7.2.1 It is the responsibility of the appointed Chairperson of the Restrictive Practise committeein the approved centre for:

I. Reducing the use of restrictive practices in the approved centre,
II. Ensuring the restrictive practices reduction strategy and policy is implemented and reviewed as required,
III. Ensuring the Multidisciplinary Review and Oversight Committee meets and reviews all episodes of restrictive practices in the approved centre.
IV. Ensure this policy is adhered to and reviewed within the required time-frames.
V. Compile and publish an activity report on the use of restrictive practices on the registered proprietor's website.

7.3 Treating Multidisciplinary Team:

It is the responsibility of the treating multidisciplinary team to:

7.3.1 Support in as far as reasonably practicable the implementation of a restrictive practice reduction strategy and policy and to promote alternatives to restrictive practices where safe to do so.

7.3.2 Use of alternatives to restrictive practices in the first instance and consider restrictive practices are only used as a last resort and for the shortest period possible.

7.3.3 Provide documentary evidence for the need to use restrictive practices.

7.3.4 Ensure that where used episodes of restrictive practices comply with the relevant code of practice or rule.

7.3.5 Review each episode of restrictive practices with the patient within the required time-frames and identify:

I. Antecedents to dangerous behaviours,
II. Alternatives that can be utilised in the future,
III. Amending the individual's recovery care plan to address antecedent/trigger factors.
IV. Record actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person.
V. Provide suggestions on possible quality initiatives that will further reduce restrictive practices in the approved centre.

7.3.6 Attend any training/education required relating to the reduction of restrictive practices.

7.3.7 Ensure that all staff are familiar with and implement this policy.

7.3.8 Ensure that all staff have signed that they have read and understood this policy.

7.4 Multidisciplinary review and oversight committee:

It is the responsibility of the Multidisciplinary review and oversight committee to:

7.4.1 Meet at least quarterly (or more frequently if required) to review each episode of restrictive practices in the approved centre,

7.4.2 Determine if the episode of restrictive practice was in compliance with the relevant code of practice or rule,

7.4.3 Determine if the episode of restrictive practice was in compliance with the Mid West Mental Health Services policy on seclusion, physical restraint or the use of lap belt policy (enduring mechanical means of bodily restraint),

7.4.4 Identify and document any areas for improvement,

7.4.5 Identify the actions, the person/s responsible and the timeframes for completion of any actions,

7.4.6 Provide assurance that each episode of restrictive practice used in the approved centre is in compliance with the relevant code of practice or rule,

7.4.7 Produce minutes of each meeting and any reports (including actions and person/s responsible). Minutes and any reports must be available to staff involved in restrictive practices (to promote on-going awareness and learning). Minutes and reports must also be available to the inspector of mental health services on request or during annual inspections.

7.4.8 To ensure that the restrictive practices reduction strategy is implemented in the approved centre.

7.5 Heads of Disciplines:

7.5.1 It is the responsibility of heads of disciplines to ensure that staff in their area of responsibility:

I. Implement and adhere to this policy,
II. Read and sign (either electronically or in hard copy) that they have read and understood the policy,
III. Participate in any review of an episode/s of restrictive practice as may be required.

8.0 Restrictive Practices Reduction Strategy:

8.1 The Restrictive practices reduction strategy is guided by:

I. The code of practice on the use of physical restraint,
II. The Rules on the use of Mechanical Means of Bodily Restraint,
III. The Rules governing the use of Seclusion,
IV. Sharing the vision (2020) Recommendation 92,
V. Restrictive practices are an infringement of a person's constitutional right to liberty and bodily integrity and should only be used when absolutely necessary, where other alternatives have failed and when used for the shortest period of time, with each episode critically reviewed.
VI. The principles of recovery,
VII. The strategy focuses on the following areas:
   a) Post incident reviews,
   b) Workforce Development,
   c) Specific Reduction tools in use,
   d) Data to inform practice, and
   e) Leadership.

9.0 Leadership:

9.1 Staff working in approved centres must recognise the inherent rights of a person to personal dignity and freedom in accordance with national and international human rights instruments and legislation.

9.2 Leadership refers to the support for, and the strong commitment to, seclusion and restraint reduction efforts among senior administrative and clinical staff within mental health services. Proactive and persistent leadership has been highlighted in many systematic reviews to be pivotal in achieving reductions in seclusion and restraint use (Mental Health Commission 2014).

9.3 Key actions include:

a) Restrictive practices reduction as an explicit goal within the mission, vision and philosophy of care statements of Midwest Mental Health Services.
b) Engage staff at all levels in relation to this policy and provide opportunities for staff at all levels to participate in the ongoing developments in relation to restrictive practice reduction.
c) Implement an organisational culture which embodies a collaborative and recovery oriented approach and an atmosphere of mutual engagement and respect.
d) Ensure the recovery ethos is evident in recovery care planning and all reviews of episodes of restrictive practices,
e) Monitor progress on actions identified in the reducing restrictive practices strategy,
f) Ensure all episodes of restrictive practices are reviewed by members of the treating multidisciplinary team within the required timeframes,
g) Ensure that the patient or their nominated representative participates in the Multidisciplinary review of the episode of restrictive practice,
h) Ensure the Multidisciplinary review and oversight committee meet at least quarterly, review each episode of restrictive practice,
i) Have the restrictive practice reduction strategy as a standing item on the agenda of the team business meetings and the overarching Governance Group.

10.0 The Use of Data to inform practice:

10.1 Approved Centre databases are a prerequisite for systems to monitor their seclusion and restraint practice and reduction efforts in line with other national efforts. Without such a database the service would be unable to establish with any certainty whether services are reducing the use of seclusion and physical restraint (Mental Health Commission, 2014).

10.2 Databases will record information on restrictive practices to aid analysis of:

a) Trends,
b) Lengths of episodes
c) Number of episodes,
d) Time of day of initiation of episode,
e) Time of day of ending of episode,

Patients with recurring episodes of restrictive practices.

10.3 The Mid West Multidisciplinary Review and Oversight Committee for Restrictive Practices will review the databases for restrictive practices in the approved centre and produce an annual report on the use of restrictive practices used within 6 months of the end of calendar year.

10.4 The report should include:

a) aggregate data that should not identify any individuals,
b) a statement about the effectiveness of the Midwest Mental Health Services approved centre's actions to eliminate, where possible, and reduce restrictive practices,
c) a statement about the approved centre's compliance with the code of practice on the use of physical restraint, rules governing use of seclusion and rules governing the use of Mechanical Means of Bodily Restraint where used,
d) a statement about the compliance with the approved centre's own restrictive practice reduction policy,
e) The total number of persons that the approved centre can accommodate at any one time,
f) The total number of persons that were admitted during the reporting period,
g) The total number of persons who were physically restrained during the reporting period,
h) The total number of episodes of physical restraint,
i) The shortest episode of physical restraint,
j) The longest episode of physical restraint,
k) The total number of persons who were secluded during the reporting period,
l) The total number of episodes of seclusion,
m) The shortest episode of seclusion,
n) The longest episode of seclusion,
o) Injuries to staff or patients.

10.5 The Registered Proprietors nominee will sign the report and publish it on the appropriate website.

10.6 Data should be utilised to inform staff education and training to improve practice.

10.7 The Mid West Multidisciplinary Review and Oversight Committee for Restrictive Practices will review and consider what additional information/variables may be required to inform the ongoing review of restrictive practices.

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10.8 Data will be available to staff and multidisciplinary teams so that they can measure the effects of their efforts to reduce the use of restrictive practices.

11.0 Specific Reduction Tools in Use:

11.1 The Mid West Mental Health Services have systems in place to assess, manage and monitor risk, and approaches to support desclation, these are reviewed as necessary to ensure the service develop additional supports and approaches in line with recommended practices.

11.2 The Mid West Mental Health services utilise a debriefing tool following an episode of seclusion to assist in the identification of triggers, patterns and precipitating factors to the event.

11.3 Based on an understanding of the person and their mental health needs during their time in an approved centre, ways of supporting the person can be included as part of their overall plan of care, the following proactive strategies maybe utilised:

i. Use of de-escalation Techniques,
ii. Use of low arousal approaches,
iii. Consistency in approach ensuring that interventions are implemented in the same manner by each staff member,
iv. Listening to service users and their family, actively seeking involvement in care planning,
v. Appropriate use of higher levels of observation,
vi. Offering an opportunity for choice e.g. how service user spends their time, their food choices,
vii. Encouragement of Autonomy – creating opportunities for choice, learning and recovery planning,
viii. Using appropriate communication strategies i.e. matching communication to the persons communication ability e.g. using a communication passport, interpreter services, visual aids,
ix. Providing opportunity for positive social interactions including staff, other residents, family, and community contacts,
x. Use of safety plans informed from previous reviews,
xi. Sensory rooms,
xii. Sensory modulation interventions,
xiii. Emotional self management,
xiv. Apply learning from Previous Risk assessments,
xv. Applying learning from debriefing, service user feedback, audit findings and what can be done differently.

12.0 Workforce Development:

12.1 The staff of the approved centre are educated on trauma informed care and the principles of recovery. Other training requirements are detailed in section 15.0.

12.2 Data analysis will be utilised to inform staff education and training to improve practice.

12.3 Reviews of episodes of restrictive practices will be available to staff of the approved centre to inform future practice.

12.4 Staff will be encouraged to reflect on their actions pre, during and following an episode of restrictive practice with the aim of identifying areas of improvement in practice.

12.5 Staff involved in seclusion and physical restraint mandatory training in the management of aggression and violence provided by appropriately trained PMCB instructors in the Midwest Mental Health Services.

12.6 Within the training staff will learn de-escalation skills, alternatives to physical restraint and seclusion and the monitoring of the safety of the person during and after the physical restraint. The training will also include an introduction to trauma-informed care, cultural competence, human rights, including the legal principles of restrictive interventions and positive behaviour support.

12.7 All staff will be encouraged to attend clinical supervision.

13.0 Post incident reviews:

13.1 **Post incident reviews focus on:**

a) Reviewing each episode of restrictive practice to ensure compliance with policy, rules and/or codes of practice,
b) Analysing data,
c) Establishing antecedents to behaviour,
d) Seeking if alternatives worked,
e) To reduce/prevent the use of restrictive practices in the future,
f) Informing education training and quality improvements,
g) Supporting patients following an episode of restrictive practices, Supporting staff following an episode of restrictive practices.

14.0 Governance:

14.1 Restrictive practices must never be used:

a) to ameliorate operational difficulties including where there are staff shortages;
b) as a punitive action;
c) where mechanical means of bodily restraint is also in use;

d) solely to protect property;
e) as a substitute for less restrictive interventions.

14.2 A review of an episode of restrictive practices should take place by members of the Multidisciplinary team within the timelines of the relevant code of practice or rule. The review should consider:

a) What antecedents lead to the initiating of the episode,
b) What alternatives could be used in the future,
c) Any missed opportunities for early intervention in line with positive behavioural support,
d) the identification of alternative de-escalation strategies to be used in future;
e) The duration of the episode and was it for the shortest period possible,
f) The behaviour of the patient prior to initiation of the episode,
g) The management of the episode,
h) The patients understanding of the need for restrictive practice and their behaviour that resulted in the use of the restrictive practice,
i) Alternatives methods that the patient can use to ventilate their feelings,
j) Methods to improve patient's self-control and early interventions to manage behaviour safely,
k) Outcomes from the patient's debrief,
l) The recovery care plan,
m) The patients experience of the episode,
n) Assessment of physical environmental factors that may have contributed to the initiation of the episode,
o) A restrictive practice reduction plan for the individual patient.

14.3 The review should be documented in the patient's clinical file.

14.4 A multidisciplinary review and oversight committee (accountable to the Registered Proprietor) will;

a) Meet quarterly,
b) Analyse in detail every episode of restrictive practices,
c) Determine if an episode is in compliance with the relevant code of practice, rule, regulation or the Mental Health Act 2001 (as amended) ,
d) Determine if the episode of restrictive practice is in compliance with the approved centre's own policies, procedures and guidelines,
e) Identify, document and action any areas for improvement,
f) Identify a person or persons responsible and timeframes for completion of any actions,
g) Promote learning from episodes of restrictive practices including any suggestions for reducing same,
h) Assure the registered proprietor that episodes of restrictive practices are in compliance with the relevant code or practice, rule, regulation and/or the Mental Health Act 2001 (as amended),
i) Produce a report following each meeting on the quarterly review of restrictive practices made available for all staff involved in the use of restrictive practices and the Mental Health Commission and the inspector of Mental Health Services as required.

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14.5 Restrictive practices reduction strategy is on the agenda of business meetings and the overarching governance group meeting.

14.6 Reports on the use of restrictive practices in the approved centre are available to staff, the inspector of mental health services, the Mental Health Commission and are published on the registered proprietor's web site.

14.7 The Registered Proprietor has overall accountability for the use of seclusion in the approved centre.

15.0 Staff Training:

15.1 All relevant staff involved in restrictive practices must receive training on their i.e. training is mandatory.

15.2 This training will be provided by appropriately qualified PMCB instructor.

15.3 This training will be provided every two years.

15.4 Areas covered in the training includes:

a) Alternatives to the use of seclusion/physical restraint,
b) Trauma informed care,
c) Culture and ethnicity,
d) Human Rights,
e) Legal and ethical frame work,
f) Principles on the use of seclusion,
g) Rules & policy on seclusion, physical restraint and Mechanical Means of Bodily Restraint (where required),
h) Mental Health Act 2001 (Relevant sections),
i) Management of Aggression and violence (including breakaway and de-escalation),
j) Positive behavioural support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic.
k) Physical Restraint and dangers of restraint,
l) Monitoring patient while in seclusion,
m) Reviews of patient while in seclusion (Medical & Nursing),
n) Needs of the patient while in seclusion,
o) Documentation,
p) Risk assessment,
q) Ending seclusion,
r) Review of episode of seclusion,
s) Amending care plan and safety plan,
t) Seclusion reduction strategy.

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15.5 Recommend Training modules are also available on HSELand also include:

a) Equality and Human rights in the public service,
b) Person Centred Cultures,
c) Becoming trauma aware,
d) Positive behavioural support,

16.0 Restrictive Practice Reduction Strategy key priorities:

23.1 The Midwest Mental Health Services aims to reduce restrictive practices by:

a) Education and training of staff on the use of Seclusion, Mechanical Means of Bodily Restraint, physical restraint with emphasis on,
   i. Building positive therapeutic relationships,
   ii. Supporting positive behaviour,
   iii. Understanding the patients individual life story (trauma, abuse, etc.),
   iv. Emphasis on observation and de-escalation,
   v. Identification of triggers specific to the individual,
   vi. Risk assessment and risk management,
   vii. Proportionate restrictive practices as a last resort.
b) Alternatives to seclusion,
   i. Use of time out/step down area,
   ii. Increased nursing observation level,
   iii. Quiet area/Bedroom/low stimulus environment,
   iv. Ensure a recovery approach to care (patient participation in care planning),
   v. Safety Plan/individual Care Plan interventions for behaviour,
   vi. Medication,
   vii. Combination of interventions.
c) Reviewing Data:
   i. Times of incidents
   ii. Locations of incidents,
   iii. Length of time of restraint/seclusion,
   iv. Initiation of restraint/seclusion,,
   v. Reasons for initiating restraint/seclusion,,
   vi. Analysis of audit results.
d) Reviewing annually the seclusion, mechanical means of bodily restraint and physical restraint policies,
e) Conducting the review of an episode of restrictive practice with a focus on:
   i. Identification of antecedents individual to the person,
   ii. Interventions/strategies for the individual to appropriately avoid or manage behaviours.
   iii. Giving the patient an opportunity to discuss episode of restrictive practice with members of the multidisciplinary team,
   iv. Giving staff an opportunity to discuss episode of restrictive practice,
   v. Review of medication management.
   vi. Updating the safety and care plan for the individual patient.
f) Premises:
   i. Maintain privacy of individuals,
   ii. Provide appropriate recreational activities for patients,

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iii. Maintenance programme to ensure the decor of the unit is maintained,
iv. Provide where possible relaxation areas.
v. Comfortable warm environment that promotes recovery, rest and sleep at night.

g) Patient engagement:
i. Patient staff meetings,
ii. Patients are involved in planning their care,

h) Staffing:
i. Appropriately qualified and trained staff,
ii. Staffing appropriate to patient dependency levels,
iii. Staff supports available for staff including clinical supervision, employee support, counselling

i) Leadership/governance:
i. Senior staff to take a lead in the restrictive practice reduction strategy.
ii. The service regularly reviews episodes of restrictive practice at business meetings.
iii. Strategy is communicated across the service.
iv. Complaints process utilised by patients and/or relatives.

j) Regulation:
i. Compliance with rules and codes of practice.

k) Audit of practice.

NOTE: This is not and exhaustive list.

17.0 Monitoring, Audit and Evaluation:

17.1 This policy will be audited and monitored for continuous quality improvement.

18.0 Abbreviations:

12.1 CCTV= Closed Circuit Television.
12.2 HSE = Health Service Executive.
12.3 MDT= Multidisciplinary Team.
12.4 MHA = Mental Health Act 2001 (as amended).
12.5 MHC= Mental Health Commission.

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19.0 References:

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Clinical PPPG Approval Document

Policy No: CP47

Policy Title: Restrictive Practise Policy

Date of Approval: September 2023

Date for Implementation: September 2023

This Policy was reviewed and recommended by the Executive Clinical Director and Director or Nursing on behalf of the CPPPG 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 Service

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

Signature Sheet:

I have read, understand and agree to adhere to the attached Policy, Procedure, Protocol or Guideline:

Print Name	Signature	Area of Work	Date: