Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Policy on Use of Physical Restraint in Approved Centres

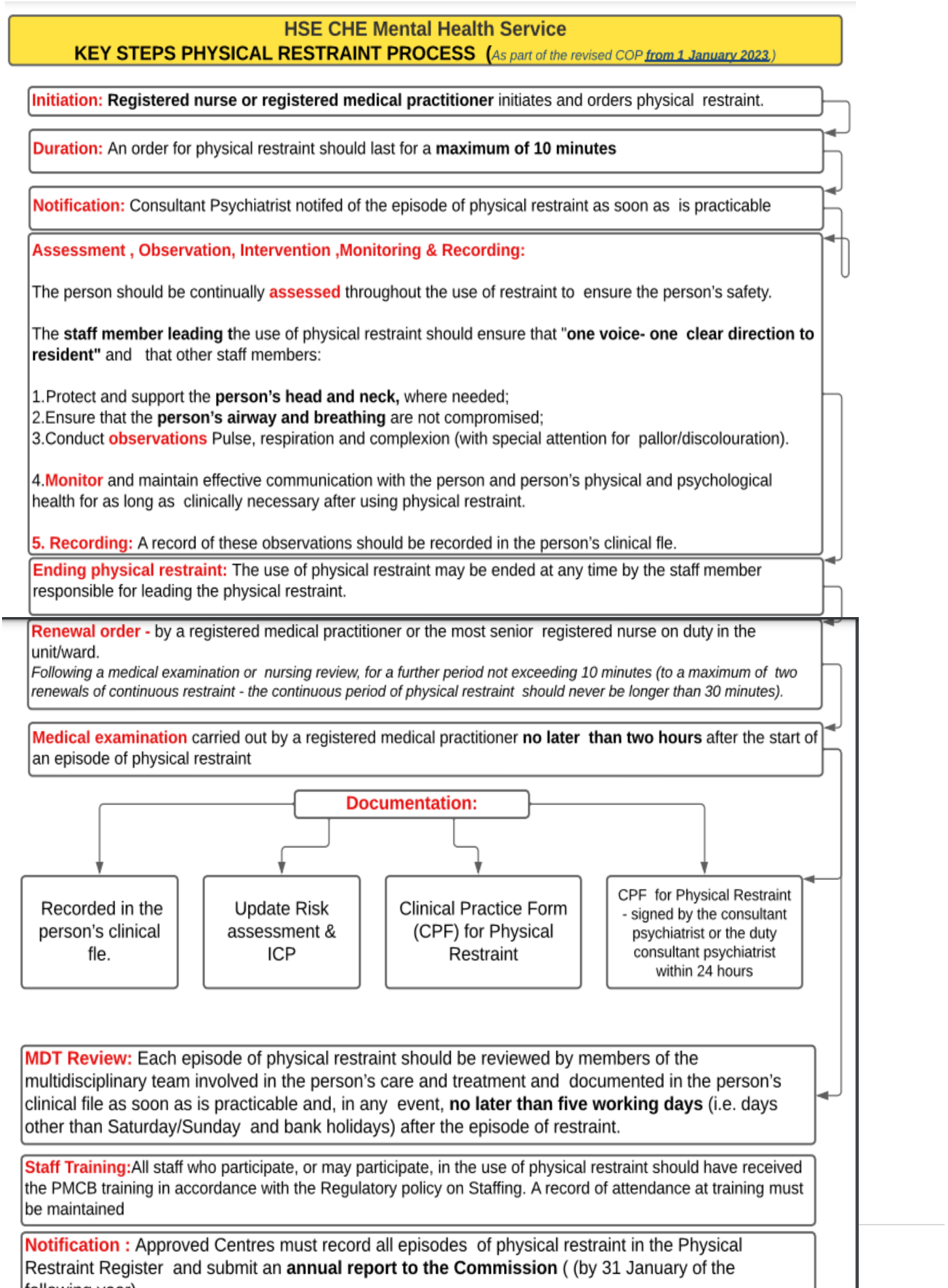
Policy ✓ Procedure ☐ Protocol ☐ Guideline ☐

Insert Service Name(s), Directorate and applicable Location(s):

Title of PPPG Development Group:	HSE:CHE:MHS: Dublin South East and Wicklow Mental Health Services Policy Development Group
Approved by:	HSE:CHE:MHS: Dublin South East and Wicklow Mental Health Services Policy Approval Governance Group
Reference Number:	HSE/DSE/WMHS/ COP_PR_V6
Version Number:	Version 7
Number of Pages:	28
Publication Date:	20.03.2024
Date for revision:	January 2025
Electronic Location:	N/A

Version	Date Approved	List section numbers changed	Author
V6	Jan 2023	Part A & Part B	HSE:CHE:MHS: Dublin South East and Wicklow Mental Health Services Policy Development Group
V7	Jan 2024 / QSEC meeting held 20.03.2024	Para 5 page 5	HSE:CHE:MHS: Dublin South East and Wicklow Mental Health Services Policy Development Group

Part A: KEY STEPS IN PHYSICAL RESTRAINT PROCESS



Part B:

1. Policy statement

This policy provides guidance in relation to the nature, circumstances, and use of physical restriction and restraint techniques currently adopted by the HSE CHE MHS. Its aim is to help all involved act appropriately and in a safe manner, ensuring effective responses in challenging situations. It sets out a framework of good practice, recognizing the need to ensure that all legal, ethical and professional issues have been taken into consideration.

HSE CHE MHS is committed to delivering the highest standards of health, safety, and welfare to its residents, visitors, and employees. Restricting or restraining any behavior should only be used when it is proportionate and reasonable to do so.

Restraint is a last resort intervention and will only be considered when all other practical means of managing the situation, such as de-escalation, involvement of family where appropriate, verbal persuasion, or gaining consent to taking medication, have failed or are judged likely to fail in the circumstances. The self-respect, dignity, privacy, cultural values, race, and any special needs of the patient should be considered in so far as is reasonably practicable.

The Code of Practice on the Use of Physical Restraint has been prepared by the Mental Health Commission, in accordance with Section 33(3)(e) of the Mental Health Act 2001-2018, for the guidance of persons working in the mental health services.

HSE CHE MHS policy on the Use of Physical Restraint in Approved Centres addresses the compliance requirements of the Judgement Support Framework (2022) that state "policies and procedures shall be available within the Approved Centre in relation to the use of physical restraint".
Related Documents

- Code of Practice on the Use of Physical Restraint in Approved Centres - (2022)
- Mental Health Act (2001-2018)
- Judgement Support Framework – Codes of Practice

2. Purpose.

This policy is intended as guidance for staff involved in the use of physical restraint in Approved Centres. Adherence to the Code of Practice will encourage continual efforts to avoid, reduce and, where possible, eliminate restrictive practices.

The 2001 Act does not impose a legal duty on staff working in mental health services to comply with Codes of Practice, but best practice requires that they be followed to ensure the 2001 Act is implemented consistently by staff working in mental health services. A failure to implement or follow this Code could be referred to during the course of legal proceedings.

3. Scope:

This policy is applicable to all residents, that is, persons receiving care and treatment in an approved centre.

This includes :

- ✓ Elm Mount Unit, St Vincent's University Hospital, Elm Park, Dublin 4
- ✓ LeBrun House & Whitethorn House, Vergemount Mental Health Facility, Clonskeagh Hospital, Clonskeagh, Dublin 6.
- ✓ Avonmore & Glencree Units, Newcastle Hospital, Greystones, Co Wicklow

4. Definition of Physical Restraint:

Physical restraint is defned 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"* (p7, Code of Practice on the Use of Physical Restraint, 2022).

5. Use of Physical Restraint

It is the policy of HSE CHE MHS that physical restraint is carried out on a case-by-case basis and is only used in rare and exceptional circumstances and only in the best interests of the service user when he/she poses an immediate threat of serious harm to self or others.

Physical Restraint should only be used after all alternative interventions to manage the resident's unsafe behaviour have been considered.

Physical Restraint is used in a professional manner and is based within an ethical and legal framework and where its use is based on a risk assessment.

Every effort should be made by staff to avoid the use of physical restraint.

Staff must assess planned or undertaken interventions based on their knowledge of the service users history and care plan.

Alternatives to physical restraint must be considered by staff and if possible attempted prior to the ordering and initiation of physical restraint.

Information will be provided to the person which includes information about the person`s rights and the processes in place for the implementation and monitoring of restrictive practices in Newcastle Hospital

6. Orders for Physical Restraint:

Physical restraint should only be initiated and ordered by registered medical practitioners or registered nurses in compliance with the physical restraint policy of the approved facility.

The order must confirm that no alternative, less restricted means of managing the person's presentation are available.

A designated member of staff should be responsible for leading the physical restraint of a resident and for monitoring the head and airway of the resident.

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 (See appendix 1 for immediate post restraints Sticker).

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.

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

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.

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

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.

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

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 fulfill legal and professional requirements. This should be recorded in the person's clinical file.

Registered proprietor or persons with delegated responsibility working within the approved center (MHA administrator) should notify each episode of Physical Restraint including the start date and time and the end date and time must be reported to the MHC within **three working days** of the commencement of the episode Via CIS CIS221 – Restrictive Practice

7. Resident Dignity & Safety

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.

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.

Where practicable, the person should have a staff member of the same gender present at all times during the episode of physical restraint.

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 defned lead. The staff member leading the use of physical restraint should ensure that other staff members:

- protect and support the person's head and neck, where needed;
- ensure that the person's airway and breathing are not compromised;
- 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;
- monitor and maintain effective communication with the person; and
- 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.

The level of force applied during physical restraint should be justifable, 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.

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

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

- neck holds
- the application of weight to the person's chest or back;
- 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;
- 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.
- 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 specifc training in its safe use. A record of the use of prone restraint should be entered in the person's clinical fle.

8. Ending the Use of Physical Restraint:

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

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

An in-person debrief with the person who was restrained should follow every episode of physical restraint. This debrief should be person-centred and should:

- 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;
- 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;
- 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;
- include a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future;
- include a discussion regarding the person's preferences in the event that a restrictive intervention is needed in the future for example preferences in relation to which restrictive intervention they would not like to be used;
- 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 fle.

Each episode of physical restraint should be reviewed by members of the multidisciplinary team involved in the resident's care and treatment and documented in the resident's clinical file as soon as is practicable and in any event no later than 2 normal working days (i.e. days other than Saturday/Sunday and bank holidays) after the episode of restraint.

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

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

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.

9. Recording the Use of Physical Restraint:

All uses of physical restraint should be clearly recorded in the person's clinical fle.

All uses of physical restraint should be clearly recorded on the Clinical Practice Form for Physical Restraint (see Appendix).

Each episode of Physical Restraint including the start date and time and the end date and time must be reported to the MHC within **three working days** of the commencement of the episode via CIS.

The completed form should be placed in the person's clinical fle and a copy should be available to the Mental Health Commission on request.

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 should be available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.

10. Post- MDT Review

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 fle as soon as is practicable and, in any event, no later than fve working days (i.e. days other than Saturday/Sunday and bank holidays) after the episode of restraint.

The review should include the following:

- the identifcation of the trigger/antecedent events which contributed to the restraint episode;
- a review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support;
- the identifcation of alternative de-escalation strategies to be used in future;
- the duration of the restraint episode and whether this was for the shortest possible duration;
- considerations of the outcomes of the person-centred debrief, if available; and
- an assessment of the factors in the physical environment that may have contributed to the use of restraint.

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.

Individualized care plans should incorporate interventions that have been found to be effective in reducing the need for restraint.

The approved center should have a clinical review process to provide consultation in the development of treatment interventions that reduce the use of restraint and/or for residents who are not responding to current treatment efforts.

11. Child Residents:

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.

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.

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.

12. Health safety and welfare of Staff:

12.1. Staff de-briefing:

Debriefing should serve as a learning/support/supervision opportunity for staff to process restraint episodes and their associated feelings and actions. This forum should remain professionally focused with an appropriate referral arrangement for staff if indicated. Debriefing should explore how staff, individually and collectively, might avoid future occurrences by identifying the trigger/antecedent events which contributed to the occurrence and identifying alternative de-escalation strategies to be used in future. Debriefing should review events leading up to restraint, what worked well, and less so, and what alternatives might be tried in future. Its is the responsibility of the person incharge of the unit to ensure that staff de- briefing is completed with in the timeframe.

The two stages of staff debriefing:

1. Post-incident support (Immediately after the PR):

Post-incident support focuses on the immediate physical and emotional well-being of the people involved. Staff can 'check in' immediately or soon after an incident by reassuring, showing care, and genuinely listening to the staff's voice. This support can also include managing practicalities (e.g. any injuries), capturing key issues, and taking stock of the situation.

2. Post-incident learning (Within 3 days after the PR) Applying the Gibbs' Reflective Model:

This focuses on learning about the PR event and how it can be reduced or avoided in the future. Because it aims to understand what happened and why it is a mixture of teaching and support. It should be carried out after a period of 'cool down' so that emotions can settle and people are in a better place to reflect.

Using Gibbs' Reflective Model (6 steps, see appendix 5) helps to identify strengths, areas for development, and actions taken to enhance your professional skills. Steps 1 - 3 relate to what happened during the experience and steps 4 - 6 focus on how you could improve on the experience and outcome in the future.

Debriefing should be recorded including follow-up plans or actions decided upon

12.2. staff well-being (The "ASSIST ME" model of staff support)

It is crucial to recognize the importance of line managers, peers, and colleagues offering their support to staff in the event of any incident.Being available for staff and knowing his/her story surrounding the event of physical restraint is crucial. Staff require a safe and confidential space to discuss the event and can find this therapeutic (See appendix 3, The "ASSIST ME" model of staff support).

12.3. Staff Training

All clinical staff will be made aware of the practice guidance in the prediction, prevention, and management of escalating behaviourr by their line manager through the use of this policy.

All staff who participate, or may participate, in the use of physical restraint should have received the appropriate training(professional management of complex behavior in clinical practice_ PMCB) in its use and in the related policies and procedures.

PMCB provides training in line with
contemporary person-centered, trauma-informed, and recovery-oriented best-practice.

PMCB is tailored to services through trained PMCB instructors who carry out the Matrix of Organizational Analysis of Training (MOAT) which offers physical and theoretical training according to service requirements.

Training in PMCB is required to be undertaken as follows;

1) All Staff working in Acute mental health facilities –4 -days of PMCB
2) All Staff – 2 yearly Refresher (One-day de-escalation and disengagements
3) Instructor available on request to reassess training needs as necessary

A record of attendance at training should be maintained

12.4. Staffing and its implication:

Ensure multi-disciplinary collaboration in the local implementation of the restraint reduction intervention and the development of personal centered plan & intervention.

Review staff scheduling/rostering to:

- Explore opportunities to minimise prolonged working with acutely unwell residents;
- Ensure that adequate staff are available at critical times, such as during transitions, at change of shift, in the evening, and at times of high acuity;
- Consider the staff mix who implement interventions in terms of age, gender, training and education, experience, and ability to relate to service users.

13. Physical restraint reduction strategy:

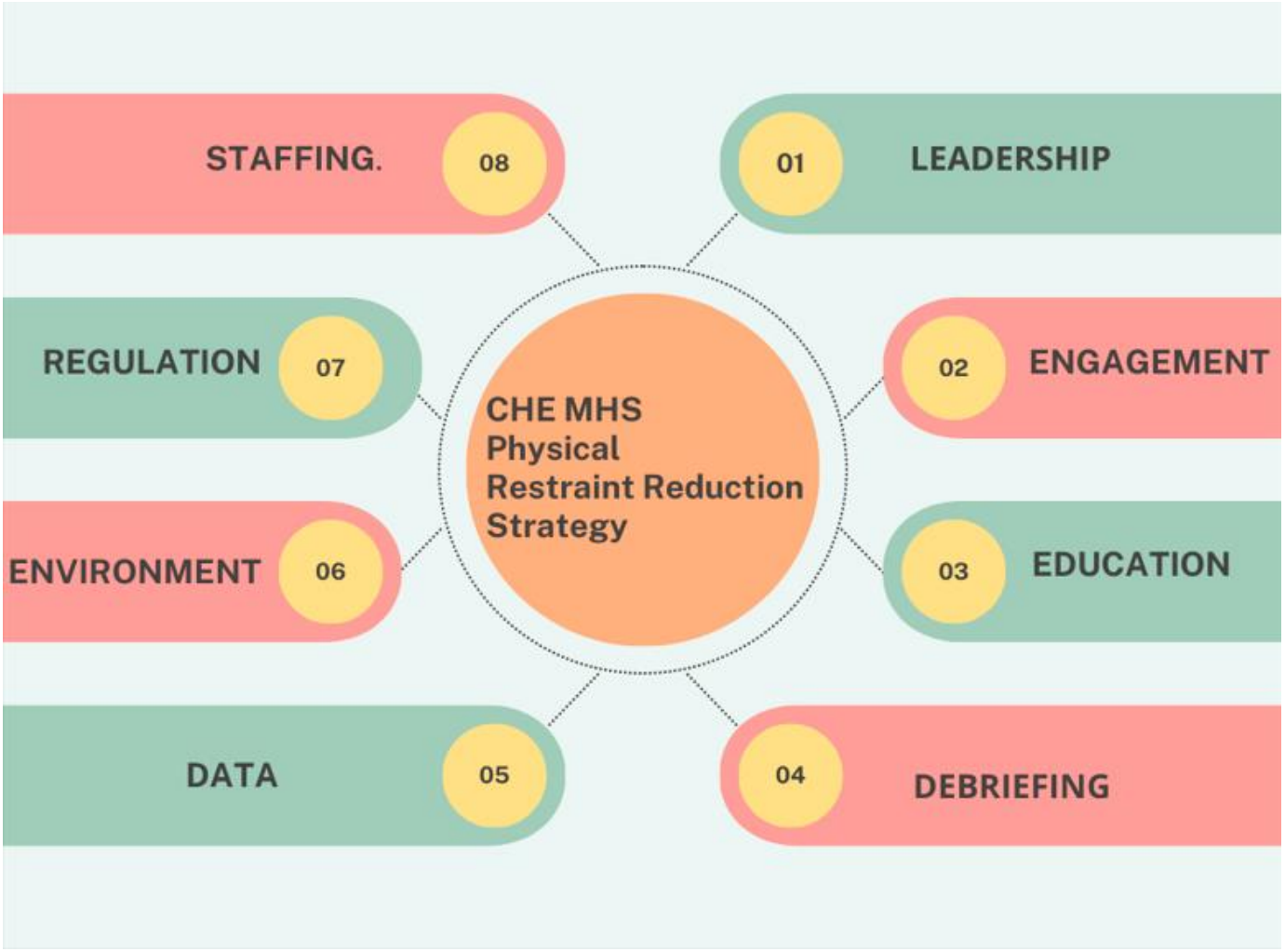
    The CHE MHS is committed to the reduction of both the frequency and duration of physical restraint episodes across DSE & WMHS.

The goals of the Restraint reduction strategy include:

- Raising awareness of restrictive practices in CHE MHS
- Providing an opportunity for services to review current practices and encourage exploration of alternative approaches
- Fostering a trauma-informed culture respective of human rights, collaboration, and recovery
- Creating a therapeutic mental health service environment;
- Providing organizations with a list of evidence-based actions that have been demonstrated to assist in efforts to reduce the use of restrictive practices.

(See appendix 4 for Physical restraint reduction strategy)

The strategy was restructured into eight key intervention themes including;



14. **Audit and Evaluation:**

A quarterly analysis must be completed to identify opportunities for improvement of physical restraint processes and for the effective implementation of physical restraint reduction strategy.

An annual audit must be undertaken to determine compliance to the physical restraint policies and procedures to ensure they are being fully and effectively implemented and adhered to in clinical practice.

It is the responsibility of Clinical Nurse Manager 3 to ensure that analysis and audit are completed and circulated with all relevant stakeholders within the timeframe.

An Approved Centre must review its policy and procedure on the use of physical restraint as required but at minimum on an annual basis.

Incident reports shall be recorded for non-compliances identified in relation to the processes for the use of physical restraint.

All information gathered by the Approved Centre regarding the use of physical restraint must be used to compile an annual report on the use of physical restraint. This report must be available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.

REFRENCES:

Attorney General (2001) Mental Health Act. Dublin: Government of Ireland.

Attorney General (2006) Statutory Instruments No. 551 of 2006 Mental Health Act 2001 (Approved Centres)
Regulations. Dublin: Government of Ireland.

Gibbs, G., 1988. *Learning by Doing: A Guide to a Teaching And Learning Methods*. Oxford,Polytechnic: Further Educational Unit.

Mental Health Commission (2022) Code of Practice on the Use of Physical Restraint in Approved Centres. Ed 2. Dublin: Mental Health Commission.

Mental Health Commission (2022) Seclusion and Restraint Reduction Strategy. Dublin: Mental Health Commission.

Mental Health Commission (2022) Judgement Support Framework Code of practice . Dublin: Mental Health Commission.

Mental Health Commission (2007) Quality Framework – Mental Health Services in Ireland. Mental Health Commission, Dublin

Mental Health Commission *Code of Practice on Admission, Transfer and Discharge To and From an Approved Centre (MHC) 2009.* Mental Health Commission, Dublin

Mental Health Commission (2012) *Guidance Document on Individual Care Planning Mental Health Services.* Health Service Executive, Dublin

NICE (2015) Violence and Aggression: short-term management in mental health, health and community settings. Available at: www.nice.org.uk/guidance/ng10

Appendix I - Staff Member 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

Appendix II - Revision History Sheet:

Document Control No. - (Revision No.)	
Section	Changes Made

Appendix III:

The "Assist Me" model of staff support

	Action	Example
A	Acknowledge with empathy the incident that has occurred and the impact on the member of staff. Assess the impact of the incident on the member of staff and on their ability to continue normal work .	"I came to see you as soon as I heard what happened. This must be very difficult for you" "How are you doing?" "How are you coping?" "How are you feeling right now" "Are you ok to be here?"
S	Sorry - express regret for their experience	"I am so sorry that this has happened. Sometimes despite our best efforts things can go wrong". "I am so sorry that you have had this experience and for the distress this is causing you".
S	Story – allow time and space for the member of staff to talk about what happened and how they are feeling - using active listening skills. Demonstrate your understanding of their story through the feedback process Share personal experiences, as appropriate	"You may find it helpful to talk about how you are feeling right now" "Would you like go for a cup of coffee and we can have a chat about what happened?" "What I'm hearing from you is…. Is that correct? Is there anything else you want to tell me or talk about?" "Can I tell you about an experience of my own, how I felt and what I found helped me at that time?"
I	Inquire – encourage questions Information – provide answers/information	"What questions do you have that I can perhaps help you with?" "Is there anything I can help you with at this time?" "Would it help if I told you what happens next and what you can expect in relation to the

		management of this incident?"
S	**Supports Solutions**	**(a) Informal emotional support:** "My door is open for you. I will be checking in with you regularly to see how you are doing if that is okay with you. In the meantime if you do wish to talk about this or discuss anything with me please come and see me or give me a call. Can I arrange for someone to collect you from work?" **(b) Formal emotional support:** • Assess any immediate needs, discuss with the member of staff and arrange, with their knowledge and consent, a referral to the relevant support services, as required. • Provide information on the supports provided by the HSE Employee Assistance Programme (EAP) which can be accessed by managers and staff e.g. counselling, crisis intervention and Critical Incident Stress Management (CISM) response. • Discuss the benefits of CISM and organise, with the consent of the staff member, one to one or team CISM response as soon as is practical. Click here to access further

		information on CISM. • Consider referral to the HSE Occupational Health Department for additional support, as required. • Provide staff support information leaflets/ brochures, and signpost to the HSE Workplace Health and Wellbeing Unit website here. Contact the EAP national phone number on 0818 327 327 to speak to someone who can help. This service includes access to internal EAP services and external 24/7 counselling support. **(c) Practical Support:** • Provide an opportunity for the member of staff to take time out from their normal work, if required. Staff should be involved in and have input to any decision made regarding the same. Many staff find it more helpful to remain at work. Allocation to different duties may benefit initially if it is practical to do so. • Provide practical support and information in relation to the incident review process and how the staff member might assist/ contribute to this process. e.g. encourage the member of staff to write up their recollection of the incident as soon as possible for their own record. Ensure that they are kept updated and involved in the incident review/open disclosure process. • Provide information and support in relation to communicating with the

		patient/service user following the incident and preparing for open disclosure discussions. • Ensure that they are encouraged to provide their insight into the steps being taken to try to reduce the risk of a recurrence of the incident. • Establish the learning from the incident, at individual and organisational level and provide on-going support.
T	Travel – providing continued support and reassurance going forward and throughout the incident review/open disclosure process	"I am here to support you." "I will assist you in any way I can"
M	Maintain contact Monitor progress Moving forward	Ensure that there is continued contact with the staff member to prevent feelings of isolation. Continually monitor and assess the staff member's response to the incident and their response to any interventions. Provide guidance and support on their return to normal work.
E	End – reaching a stage of closure from the event. Evaluate	Establish when the staff member has reached a stage of closure from the incident as it is important at this stage not to keep re-opening the incident with them. Leave your door open to them if they should require any further assistance. Review the support provided with the staff member involved.

		Consider feedback and establish any learning which may benefit other staff.

Appendix 4:

CHE MHS Physical restraint reduction strategy:

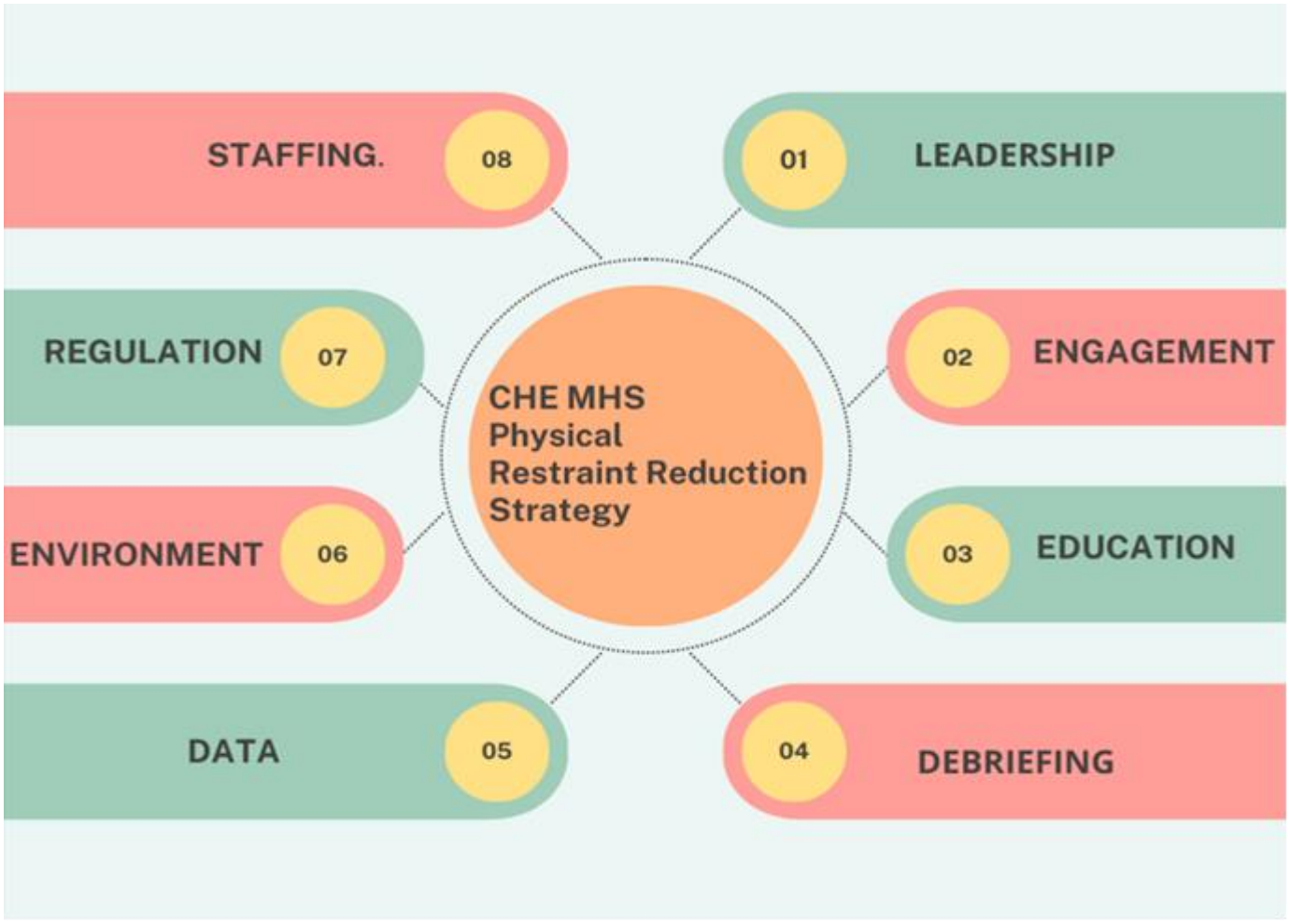
The development of restrictive physical interventions (RPI) to manage challenging behaviours based upon control and restraint during the 1980s and 1990s led to widespread professional disquiet and campaigning to improve the policies, training and application of physical techniques. This included the promotion of a value base within which physical techniques should be used. This value base may be summarised as any use of physical interventions must be in the person's best interests, 'least restrictive' and used as the last resort following preventive strategies. The last resort principle implies that services should be able to demonstrate support plans to prevent or reduce the frequency and/or restrictiveness of PI used in individual cases. This stargegy proposes that adopting explicit policies and practice to reduce restrictive PI is likely to be more effective in improving quality of support as opposed to solely managing PI use.

Literature review:

Whilst little is known about what might be the 'right' levels of RPI use, it is known that RPI is used commonly in response to challenging behaviour and often associated with other restrictive responses to challenging behaviours, including seclusion, multi and frequent 'as required' psychotropic medication use (Emerson et al., 2000; Harris, 2002; McGill et al., 2008, In Press). Moreover, the series of actions and reactions surrounding RPI use is associated with injury/harm to the participants, staff and service users. Injury, both physical (Spreat et al., 1986; Hill & Spreat 1987; Harris et al., 1996) and/or emotional (Sequeira & Halstead, 2001; Murphy et al., 1996) may be experienced. In the latter two studies service users described their experience of being subject to RPI. Themes that emerged were overwhelmingly negative, with pain, anxiety and mental distress, anger, and the perception that the staff were experiencing anger, hatred and feelings of enjoyment during the interventions. Two subsequent papers have examined the responses of staff and service users to the same RPI event. Staff involved experienced similar negative, emotions and thoughts (Hawkins et al., 2005; Fish & Culshaw, 2005). In the latter study, conducted in a medium secure unit, staff reported feeling upset and guilty following the use of restraint and that this use was always as the 'last resort'. However, from the client perspective this was not the case. McIntyre Undercover (November 1999) showed graphically how the use of RPI can become part of abusive and restrictive care environments.

Apart from the inherent physical risks, significant psychological distress has also been associated with involvement in, or witnessing of, these measures. Service users have reported feelings of anger, abandonment, depression, despondency and re-enactment of previous traumas. Personnel similarly have reported feelings of intense fear, stress, ambivalence, guilt and disappointment that situations were not resolved in a more benign fashion .

Reduction Strategy



1. **Leadership:**

- Develop CHE MHS wide specific physical restraint reduction plans which include goals, objectives, persons responsible, actions and specified timelines.
- Engage staff at all levels in relation to the restraint reduction strategy and provide opportunities for staff at all levels to participate in the development of the service specific restraint reduction plan.
- Monitor progress on actions specified in restraint reduction plans and allocate responsibility to someone to evaluate progression of specified goals.
- Include the progress of the restraint reduction plan as a standing item on the agenda of multidisciplinary team meetings.

- Develop a safe and accessible process for staff and others to provide comments, ideas, recommendations, concerns, to the wider team members regarding the reduction project.

- Utilise networking between mental health services to facilitate the sharing of best practice by including restraint reduction on the agenda of regional and/or national forums.

2. <u>Engagement:</u>

- Upon admission, orient service users and their families to the approved centre and the care and treatment programme.

- Implement a structured risk assessment with an evidence base in reducing use of seclusion and restraint.

- Ensure that staff interaction with service users is in compliance with the Rules and Code of practice related to service user monitoring during episodes of seclusion and/or restraint.

- Emphasis on patient-centeredness and the importance of service user and family involvement in care and treatment planning.

- Communications with service users and families is respectful of their needs and situations.

- Make use of objective service user satisfaction surveys which are undertaken by persons external to the centre, to inform decision making.

3. Training and education:

- Services has implement a restraint reduction training programme , PMCB , since 2021.

- Require attendance at training and consider classification of training as mandatory for all multidisciplinary staff working within approved centres

- Require new staff to attend training during orientation and monitor congruence

- Include learning informed by debriefings and data analysis in future training.

- HSELand training programme on COP restrictive practice.

- Combine coaching and supervision with training in order to ensure transfer of learning to practice.

4. Debriefing:

- Service User:
  As required by the MHC Rules and Code of Practice, service users should be debriefed following an episode of restraint. Specifically, the service user must be afforded the opportunity to discuss the episode with members of the multi-disciplinary team involved in his or her care and treatment.

- Staff:

  It is equally important that staff members have the opportunity to debrief following episodes of seclusion and/or restraint. While the opportunities for reflective learning is the core of staff debriefing, it also provides a safe and supportive environment in which staff can work through issues and/or feelings that may have emerged during an episode. The focus must be on supportive enhancement of professional practice, and that staff are aware of the organisational support mechanisms in place should an issue cause personal distress.

- The Organisation:

  The third component of debriefing is the organisational review which may identify either preventive or remedial quality improvements. Occurrences are reviewed to identify measures which might prevent re-occurrence, or broader improvements which are necessary across the service. Conduct a formal review of each episode of restraint after the debriefing of the service user/advocate and staff member. ındividualised treatment plans should incorporate interventions that have been found to be effective in reducing the need for seclusion and restraint.

5. <u>Data collection and analysis :</u>

All approved centres will at a minimum record both unit specific and centre-wide data including the:

- Number of episodes of physical restraint used each month
- Number of administrations of involuntary medication used each month
- Number of service users physically restrained each month
- Number of service users administered involuntary medication each month.
- Service user injury rates during restraint episodes each month
- Staff injury rates sustained during restraint episodes each month
- Staff injury rates caused by service users during violent episodes each month
- Staff involved in occurrences
- Adverse events, both unit specific and centre-wide

Ensure compliance with all MHC Codes of practice related to the recording of data on the use of physical restraint.

Ensure data on the use of these interventions is submitted to the Mental Health Commission within the time frame.

Examine the feasibility of collecting additional data on restraint to include:

- Use of alternative strategies to replace seclusion and restraint;
- Themes and outcomes of debriefings.

Make data routinely available to staff and multidisciplinary teams so that they can measure the effects of their efforts to reduce the use of restraint.

Benchmark data collected in your service with that collected on restraint in other approved centres where appropriate.

6. <u>Physical and care environment:</u>

- Ensure that décor is warm with appropriate use of colour, furnishings and plants.
- Ensure a clear and full view of ward space where service users interact with each other.
- Ensure that all signage, including unit rules, is written in person-friendly positive language.
- Ensure the environment furnishings balance comfort with safety.
- Ensure furnishings are in a good state of repair.
- Arrange furniture to facilitate service user and staff interaction.
- Use sound-reducing materials, such as carpeting and ceiling tiles, to reduce noise in living areas
- where appropriate.
- Ensure seclusion rooms balance needs for safety with privacy, e.g. by minimising blind corners.
- Ensure seclusion rooms have appropriate and adequate temperature controls to promote a
- calming environment.
- Ensure seclusion rooms have adjustable soft lighting and consider soothing effects, including
- clouds and blue sky.
- Ensure seclusion rooms minimise isolation and provide visual orientation, including natural
- lighting and environmental cues (for example, being aware of the time).
- Examine the feasibility of removing seclusion rooms and replacing them with comfortable rooms for
- quiet time to assist service users should they need to practice “self-calming”, thereby reducing the restrictive intervention.

7. <u>Regulation:</u>

- Ensure full compliance with all requirements of the Code of Practice on the Use of Physical Restraint in Approved Centres.

- Each approved centre shall have a policy which explicitly addresses the:
  o Use of physical interventions
  o Administration of involuntary of intramuscular or intravenous medication against the individual’s clear objection.

- Each approved centre will ensure that all polices on the use of physical restraint are current, fully compliant with the relevant MHC Rules and Codes of Practice, and explicit as to the efforts in place to reduce the use of seclusion and restraint.

8. <u>Staffing:</u>

Appendix 5: the Gibbs' Reflective Model:

Step 1 – Description

- This should be a brief description of the experience or event to set the scene and give context.

Step 2 – Feelings

- Consider what you were thinking and how you felt before the experience.
- How did you feel during the experience?
- How did you feel after the experience?
- This is another short descriptive step, rather than being analytical.
- Description
- Feeling
- Analysis Evaluation
- Conclusion
- Action Plan

Step 3 – Evaluation

- Evaluation looks objectively at both positive and negative aspects of the experience.
- Describe key elements that went particularly well.
- Was there anything that did not go well or did not work?
- If appropriate, you can include what others did or did not do well.

Step 4 – Analysis

- Analysis attempts to explain why the experience was positive or negative and should form the
- largest section of your reflection. Take into account points made in the previous steps and identify
- any factors which helped you e.g. previous experiences, carrying out research or consulting with
- others. Consider your role in the experience and how you contributed to the success of this
- experience?
- If things did not go to plan, why do you think this was e.g. lack of preparation or external factors
- beyond your control?
- It can be useful to consider other people who were involved in the experience. Did they have
- similar views or reactions to you? If not, why do you think that was the case?

Step 5 – Conclusion

- Focus on what you have learned.
- Are there any skills you developed as a result of the experience? If so, how would you apply them in
- future experiences or situations?
- Are there areas of knowledge or particular skills you now need to develop?
- Is there anything you would do differently in the future? Try to give specific examples.

Step 6 – Action Plan

- What specific actions can you now take to build on your knowledge or skills?
- You could include any training that would benefit you (formal or otherwise), as well as identifying
- sources of information or support (people or resources)

Appendix 6:

Policy Governance:

Ratified at the QSEC Meeting:

Date of meeting: 20.03.2024 record of ratification in minutes of meeting)

Executive Approval:

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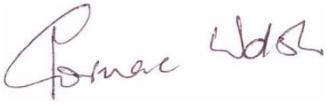
Dr Larkin Feeney
Executive Clinical Director
Community Healthcare East



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Cormac Walsh
Area Director of Nursing
Community Healthcare East

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Martina Behan,
General Manager,
Community Healthcare East