Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Policy on Use and Management of Mechanical Means of Bodily Restraint

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
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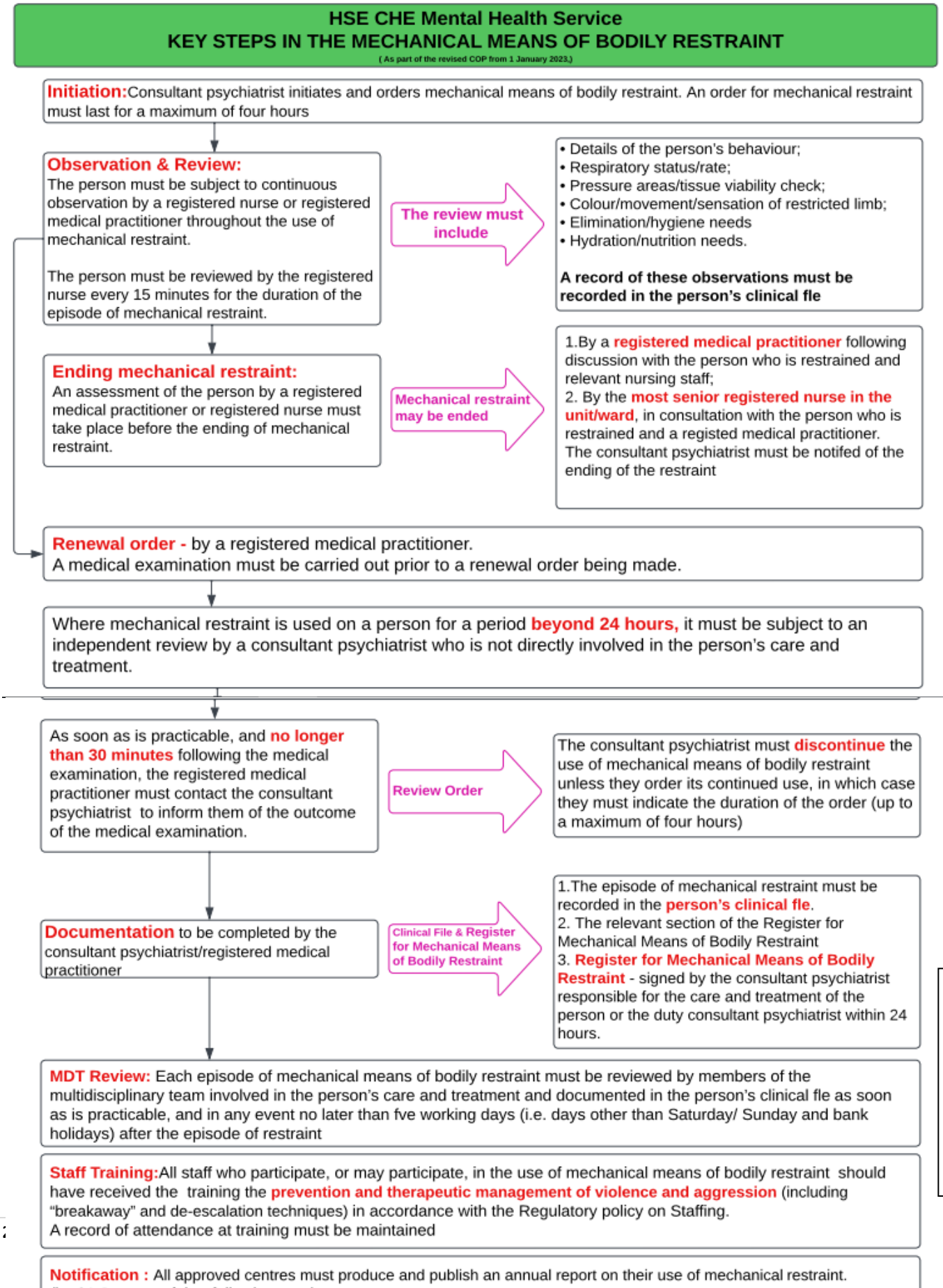
Version	Date Approved	List section numbers changed	Author
V6	01.01.2023	Part A & Part B	HSE:CHE:MHS: Dublin South East and Wicklow Mental Health Services Policy Development Group
V7 February 2024	wording CHE:MHS: Dublin South East and	HSE	Wicklow Mental Health Services Policy Development Group

February 2024 1) page 2/17 , Debriefing , 2)Changed wording on page 6/17 , presentation to replace behaviour, 3) 7/17 expand the debrief process of the restrictive practice ,4) 8/17 risk assessment template reflected.

Part A:



This must be reflected in the Residents ICP

Part B:

1. Policy Statement

- ✓ It is the policy of Community Healthcare East (Dublin South East / Wicklow) to ensure that a safe, caring and therapeutic environment exists for residents within the Approved Centre's.

- ✓ In this regard the mechanical means of bodily restraint of a resident should be used only as a last resort and when all other alternative interventions have been considered or where the resident poses an immediate threat of serious harm to self or others.

- ✓ Cultural awareness and gender sensitivity are demonstrated when considering the use of mechanical means of bodily restraint.

- ✓ It is used in settings where the safety of residents, staff and visitors is regarded as being essential and equal.

- ✓ Mechanical means of bodily restraint is used in a professional manner and is based within an ethical and legal framework.

2. Purpose

- ✓ The purpose of this policy is to ensure that residents are treated with dignity and respect at all times during the use of mechanical means of bodily restraint.

- ✓ The purpose of this policy is to provide procedural guidelines for staff in relation to the management of mechanical means of bodily restraint.

- ✓ The purpose of this policy is to adhere to the Mental Health Commission's Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (2009).

This policy is applicable to the three Approved Centres in Community Healthcare East–

- ✓ Elm Mount Upper – St. Vincent's University Hospital
- ✓ Elm Mount Lower- St. Vincent's University Hospital
- ✓ Glencree – Newcastle Hospital
- ✓ Avonmore Unit – Newcastle Hospital
- ✓ Le Brun House – Vergemount
- ✓ Whitethorn House – Vergemount

This policy applies to all relevant staff working in Approved Centres in Community Healthcare East.

This policy applies to all residents within the Approved Centres in Community Healthcare East.

3. Legislation and Related policies:

- ✓ Mental Health Commission (2022) Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint. Dublin: Mental Health Commission.
- ✓ Mental Health Commission – Judgement Support Framework (2022) Dublin: Mental Health Commission
- ✓ Mental Health Commission – Addendum to Judgement Support Framework (2022) Dublin: Mental Health Commission
- ✓ Mental Health Commission – Guidance Document on Individual Care Planning Mental Health Services (2012) Dublin: Mental Health Commission
- ✓ Mental Health Act 2001, Section 69 - Bodily restraint and seclusion

(1) *"A person shall not place a resident in seclusion or apply mechanical means of bodily restraint to the resident unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the resident from injuring himself or herself or others and unless the seclusion or* restraint *complies with such rules.*

(2) *The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a resident.*

(3) *A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.*

(4) *In this section "resident" includes – child in respect of whom an order under section 25 is in force, and a voluntary resident"*

4. Definition

The Mental Health Commission defines Mechanical Means of Bodily Restraint as *'"the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a person's body" (MHC, 2022)*
For all other relevant definitions please see Glossary of terms for CHE.

5. Procedure:

5.1. ORDERS FOR MECHANICAL MEANS OF BODILY RESTRAINT:

- The use of mechanical means of bodily restraint must only be initiated and ordered by a consultant psychiatrist.
- The order must confirm that there are no other less restrictive ways available to manage the person's presentation.
- The use of mechanical means of bodily restraint must only occur following as comprehensive an assessment of the person as is practicable. A copy of the risk assessment must be made available to the Mental Health Commission on request.
- The consultant psychiatrist must record the matter in the clinical file and on the Register for Mechanical Means of Bodily Restraint.
- There must be a medical examination of the person who has been restrained by a registered medical practitioner as soon as is practicable and, in any event, no later than four hours after the commencement of the episode of mechanical means of bodily restraint.
- As soon as is practicable, and no later than 30 minutes following the medical examination, the registered medical practitioner must contact the consultant psychiatrist responsible for the care and treatment of the person, or the duty consultant psychiatrist, to inform them of the outcome of the medical examination.
- The consultant psychiatrist must discontinue the use of mechanical means of bodily restraint unless they order its continued use.
- The registered medical practitioner must record this consultation in the clinical file and indicate on the Register for Mechanical Means of Bodily Restraint that the consultant psychiatrist ordered or did not order the continued use of mechanical means of bodily restraint.
- If the consultant psychiatrist orders the continued use of mechanical means of bodily restraint, they must also indicate the duration of the order, and this must be recorded on the Register for Mechanical Means of Bodily Restraint. Each order is for a maximum of four hours. A registered medical practitioner must undertake a medical examination of the person prior to each order of mechanical restraint being renewed.
- The consultant psychiatrist responsible for the care and treatment of the person, or duty consultant psychiatrist, must undertake a medical examination of the person and sign the Register for Mechanical Means of Bodily Restraint within 24 hours of the commencement of the mechanical restraint episode. The examination must be recorded in the person's clinical file.
- The person must be informed of the reasons for, likely duration of, and the circumstances which will lead to the discontinuation of mechanical means of bodily restraint.
- The person's representative must be informed of the person's restraint and a record of this communication must be entered in the person's clinical file.

5.2. DIGNITY AND SAFETY

- Any specific requirements or needs of the person in relation to the use of mechanical means of bodily restraint noted in the person's individual care plan must be addressed.
- The principles of trauma-informed care must underpin the use of restraint on a person.
- Where practicable, the person must have a staff member of the same gender present during the initiation of the restraint

- The person must be subject to continuous observation by a registered nurse or registered medical practitioner throughout the use of mechanical means of bodily restraint to ensure the person's safety.

- The person must be reviewed by the registered nurse every fifteen minutes for the duration of the episode of mechanical restraint.

- The review must include the following:

✓ details of the person's presentation ;
✓ respiratory status/rate;
✓ pressure areas/tissue viability check;
✓ colour/movement/sensation of restricted limb(s);
✓ whether elimination/hygiene needs were met;
✓ whether hydration/nutrition needs were met.

- A record of these observations must be recorded in the person's clinical file.
- All staff members involved in the use of mechanical restraint must have undertaken appropriate training, in the prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques).

5.3. ENDING THE USE OF MECHANICAL MEANS OF BODILY RESTRAINT

- An assessment of the person by a registered medical practitioner or a registered nurse must take place before the ending of mechanical means of bodily restraint. This assessment must be recorded in the person's clinical file.
- Mechanical Restraint may be ended:
    - ✓ by a registered medical practitioner at any time following discussion with the person who is restrained and relevant nursing staff;
    - ✓ by the most senior registered nurse in the unit/ward, in consultation with the person who is restrained and a registered medical practitioner.
- Where medical restraint is ended by a registered medical practitioner or the most senior registered nurse on duty in the unit/ward, the consultant

psychiatrist responsible for the care and treatment of the person, or the duty consultant psychiatrist acting on their behalf, must be notified.

- The time, date and reason for ending the mechanical means of bodily restraint must be recorded in the person's clinical file on the date that the mechanical means of bodily restraint ends.

- An in-person debrief with the person who was restrained must follow every episode of mechanical means of bodily restraint. This debrief must be person centred and must:

  ✓ give the person the opportunity to discuss the mechanical means of bodily 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 mechanical restraint unless it is the preference of the person who was restrained to have the debrief outside of this timeframe;

  ✓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 must 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;

  ✓The person's individual care plan must be updated to reflect the outcome of the debrief

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

  ✓Include a conversation regarding the persons preferences in the event where a restrictive intervention is needed in the future e.g. preferences in relation to which restrictive intervention they would like like to be used, and – offer the person the option of having their representative or nominated person support person attend the debrief with them and , if the personrepresentative or nominctaed support person

6. RECORDING THE USE OF MECHANICAL MEANS OF BODILY RESTRAINT

- ✓ All uses of mechanical means of bodily restraint must be clearly recorded in the person's clinical file**.**

- ✓ All uses of mechanical means of bodily restraint must be clearly recorded on the Register for Mechanical Means of Bodily Restraint.

- ✓ Registered proprietor or persons with delegated responsibility working within the approved centre (MHA administrator) should notify all episodes of mechanical means of bodily restraint to **prevent an immediate threat to self or others** in the Mechanical Means of Bodily Restraint Register and submit a Notification to the Commission including the start date and time and the end date and time within three working days Via CIS CIS221 – Restrictive Practice.

7. Child Residents – Mechanical Means of Bodily Restraint is used for Immediate Threat of Serious harm to self or others or enduring Risk of Harm to Self or Others.

The following Rules apply in Community Healthcare East approved centres providing care and treatment for children while awaiting transfer to an appropriate facility.

- ✓ All approved centre in Community Healthcare East engaging in mechanical restraint of a child have child protection policies and procedures in line with children first legislation.

- ✓ At least one member of staff is trained in Children First, as per Regulation 26, 4.14 Judgement Support Framework "At least one staff member is trained in Children First, unless the approved centre is a CAMHS unit where all staff are trained"(Children First Act, 2015).

8. Use of mechanical means of bodily restraint for enduring risk of harm to self or others.

- ✓ The use of mechanical means of bodily restraint on an ongoing basis for enduring risk of harm to self or others may be appropriate in certain clinical situations but must be used only to address an identified clinical need and/or risk. Examples include the use of cot sides, bed rails, and lap belts.
- ✓ A risk assessment of the safety and suitability of the mechanical restraint for the person has been undertaken *(see appendix 7 for risk assessment of bed rails)*
- ✓ The risk assessment has been reviewed and updated regularly - at least quarterly - in line with the person's individual care plan.
- ✓ The multidisciplinary team has developed a plan of care for each person who is restrained by mechanical means. *The clinical file must contain a contemporaneous record that specifies the following*
    - *That there is an enduring risk of harm to self and others.*
    - *That less restrictive alternatives have not been unsuccessful*

- *The type of mechanical restraint*
- *The situation where mechanical means of bodily restraint is being applied*
- *The duration of the restraint*
- *The duration of the order.*

✓ Mechanical means of bodily restraint for enduring risk of harm to self or others must be ordered by a registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the person, or the duty consultant psychiatrist acting on their behalf.

✓ Mechanical means of bodily restraint for enduring risk of harm to self or others ordered is not required to be entered on the Register for Mechanical Means of Bodily Restraint for Immediate Threat to Self or Others.

✓ A review of all persons at the approved centre who are/were the subject of Part 4 of the **Use of mechanical means of bodily restraint** in the previous quarter must take place to determine the appropriateness of the use of this restrictive practice. This review must be undertaken by the multidisciplinary review and oversight committee and must outline the arrangements that are in place at the approved centre to reduce or, where possible, eliminate the use of mechanical means of bodily restraint as it relates to Part 4 of these Rules.

✓ All information gathered regarding the use of mechanical means of bodily restraint for enduring risk or harm to self or others must be held in the approved centre and used to compile an annual report on the use of mechanical means of bodily restraint for enduring risk or harm to self or others at the approved centre.

✓ Registered proprietor or persons with delegated responsibility working within the approved centre (MHA administrator) should notify the Mental Health Commission about the use of mechanical restraint for **enduring risk to self or others** in the format specified by the Mental Health Commission, 6 monthly (January-June report due by 31 August each year) (July-December report due by 28 February the following year) Via CIS CIS222 – Mechanical Restraint Part 4.

9. Mechanical retrains and staff debriefing:

The goal of staff debriefing is to improve communication, identify areas for improvement, and prevent similar incidents from happening in the future. The debriefing typically includes a review of the Mechanical retrains incident, an evaluation of the response, and the identification of any corrective actions that need to be taken.

The staff debriefing process typically involves several phases, including:

1. Information Gathering: The first step is to gather information about the incident or event that lead to the use of Mechanical retrains. This may include reviewing reports, interviewing staff and witnesses, and collecting any relevant documents or evidence.

2. Review and Analysis: The next step is to review and analyze the information that has been gathered. This may include identifying any issues or concerns that emerged during the incident, and determining what actions were taken to address them.

3. Discussion: The debriefing typically includes a discussion among staff who were involved in the incident or event. This provides an opportunity for staff to share their perspectives and experiences, and to identify any areas for improvement.

4. Identification of Lessons Learned: Staff debriefing should be focused on identifying any lessons learned from the incident or event. This can help to prevent similar incidents from happening in the future.
5. Action Plan: After identifying any lessons learned, an action plan should be developed. The action plan should include specific steps that will be taken to address any issues or concerns that were identified during the debriefing.

6. Follow-up: The last step is to follow up on the action plan, to ensure that the corrective actions are being implemented and that the incident or event is not repeated.

It's important to note that staff debriefing process should be conducted in a non-punitive and non-blaming manner, and the goal is to improve overall performance and to prevent similar incidents from happening in the future.

The Gibbs Reflective Cycle model could be used for the process of reflection and staff debriefing sessions.
The cycle consists of six phases:

1. Description: The individual describes the incident or experience in detail, including what happened, when, and where.

2. Feelings: The individual reflects on their emotions and feelings during the incident or experience.

3. Evaluation: The individual evaluates the incident or experience, considering what was positive and negative about it.

4. Analysis: The individual analyzes the incident or experience, considering what happened and why.

5. Conclusion: The individual reaches a conclusion about the incident or experience and what could be done differently in the future.

6. Action Plan: The individual develops an action plan for how to handle similar situations in the future.

   By working through each of the phases of the Gibbs Reflective Cycle, staff and team can process and learn from their experiences in a structured and thoughtful way.

10. Mechanical restraints reduction strategies:

Mechanical restraints reduction plans typically involve a comprehensive approach that addresses both the immediate and long-term needs of residents.

Such plans usually include the following elements:

1. **Assessment:** Regularly review the use of mechanical restraints to identify patterns and trends.

2. **Training:** Provide staff with training on non-violent crisis intervention techniques, de-escalation strategies, and alternatives to mechanical restraints.

3. **Protocols and policies:** Develop and implement protocols and policies that guide the use of mechanical restraints, including when and how they can be used, and the process for monitoring and documenting their use.

4. **Alternative methods:** Explore and implement alternative methods of restraint, such as soft ties or wristbands with alarms, that are less restrictive

5. **Treatment planning:** Develop individualized treatment plans for patients that take into account their specific needs and circumstances.

6. **Multidisciplinary approach:** Encourage a multidisciplinary approach involving psychiatry, nursing, social work, and other relevant healthcare professionals in the planning and implementation of restraint reduction plans.

7. **Monitoring and evaluation:** Regularly monitor and evaluate the effectiveness of restraint reduction plans and make adjustments as needed.

8. **Family and caregiver involvement:** Encourage family and caregiver involvement in treatment planning and decision-making to promote continuity of care and support for patients.

9. **Trauma-informed care:** Implement trauma-informed care approach in order to understand and respond to the complex needs of patients with trauma history.

10. **Data collection and analysis:** Collect and analyze data on the use of mechanical restraints to identify areas for improvement and measure progress towards reducing their use.

11. Clinical Governance:

- ✓ Mechanical means of bodily restraint must never be used to ameliorate operational difficulties e.g. staff shortages.

- ✓ Each approved center has a written policy in relation to the use of mechanical means of bodily restraint, and it identifies who may carry out mechanical means of bodily restraint, include a section regarding the provision of information to the resident and includes a section which details how the approved centre is attempting to reduce the use of mechanical means of bodily restraint, where applicable.

- ✓ The written policy on mechanical means of bodily restraint specifies how the approved centre reviews cases of mechanical means of bodily restraint.

- ✓ The approved centre maintains a written record indicating that all staff involved in mechanical means of bodily restraint have read and understood the policy. The record must be available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.

- ✓ An approved centre must review its policy on mechanical means of bodily restraint as required and in any event at least on an annual basis.

- ✓ The multi-disciplinary team must develop a plan of care for each resident who is restrained by mechanical means. This plan of care must include a brief description on alternatives to mechanical restraint to be considered.

- ✓ Each episode of mechanical means of bodily restraint must be reviewed by members of the multi-disciplinary team involved in the resident's care and treatment.

- ✓ The principles of the Open Disclosure Policy will be incorporated into this policy.

12. Training and Education:

- ✓ Training in the application and use of approved restraint devices should be provided on a regular basis or as required to staff in the designated care setting /unit. This will be delivered by an appropriately qualified person.

- ✓ Training will be provided on the individual needs of both residents and staff. The frequency of training and the mandatory nature of the training will be identified.

- ✓ A record of all training must be maintained.
- ✓ It is the responsibility of all relevant staff to be aware of, have read, implement and comply with this policy. This is documented in PPPG signature sheet.
- ✓ It is the responsibility of all relevant staff to articulate the processes in relation to this policy.

13. Revision & Audit:

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

An annual audit must be undertaken to determine compliance to the mechanical 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 mechanical 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 mechanical restraint

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

Bibliography

- Department of Children and Youth Affairs, 2015. *Childrens First,* Dublin : Government Publications.
- Government of Ireland , 2001. *Mental Health Act, 2001,* Dublin: Stationery Office.
- Government of Ireland, 1991. *Child Care Act, 1991,* Dublin : Government of Ireland.
- Health Service Executive, 2009. *Risk Management in Mental Health Service Guidance Document,* Dublin : HSE.
- Higgins, A., Morrissey, J., Doyle, J. & A, G., 2015. *Best Practice Principles for Risk Assessment and Safety Planning for Nurses working in Mental Health Services,* Dublin : Health Service Executive .
- Mental Health Commission, 2007. *Quality Framework,* Mental Health Commission : Dublin.
- Mental Health Commission, 2022. *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint. ,* Dublin : Mental Health Commisison.
- Mental Health Commission, 2012. *Guidance Document on Individual Care Planning ,* Dublin : Mental Health Commission.
- Mental Health Commission, 2014. *Seclusion and Restraint Reduction Strategy,* Dublin: Mental Health Commission.
- Mental Health Commission, 2015. *Addendum to Judgement Support Framework,* Dublin : Mental Health Commission .
- Mental Health Commission, 2015. *Mental Health (Amendment) Act 2015,* Dublin : Stationery Office.
- Mental HealthCommission, , 2022. *Judgment Support Framework (Version 4),* Dublin : Mental Health Commission . *CHO*

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 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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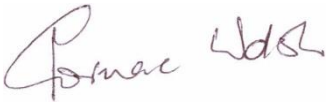
Dr Larkin Feeney
Executive Clinical Director
Community Healthcare East



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Cormac Walsh
Area Director of Nursing
Community Healthcare East

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Martina Behan,
General Manager,
Community Healthcare East