Approved Centre Name:
Acute Psychiatric Unit Ennis

The total number of persons that the centre can accommodate at any one time	**39**
The total number of persons that were admitted during the reporting period	**395**
The total number of persons who were secluded during the reporting period	**6**

Rules Governing the Use of Mechanical Means of Bodily Restraint

Issued Pursuant to Section 69(2) of the Mental Health Act 2001-2018.

The total number of persons who were mechanically restrained	1
The total number of episodes of mechanically restrained	0
The shortest episode of mechanically restraint	0
The longest total episode of mechanically restraint	0
The total number of persons who were mechanically restrained as a result of mechanical means of bodily restraint for enduring risk of harm to self or others	0

A statement about the effectiveness of the approved centre's actions to reduce and, where possible, eliminate mechanical means of bodily restraint
Mechanical means of bodily restraint is not used in the AC.

A statement about the approved centre's compliance with the rules governing the use of mechanical means of bodily restraint
N/A

A statement about the compliance with the approved centre's own reduction policy
The AC does not use Mechanical Means of Bodily Restraint. In the event that mechanical means of bodily restraint is required, all aspects of the Rules governing the Use of Mechanical Means of Bodily Restraint and the local CPPPG on Mechanical Means of Bodily Restraint would be adhered to and implemented

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Rules Governing the Use of Seclusion

Issued Pursuant to Section 69(2) of the Mental Health Act 2001-2018.

The total number of seclusion episodes	**8**
The shortest episode of seclusion	**2hrs**
The longest episode of seclusion	**28hrs**

A statement about the effectiveness of the approved centre's actions to reduce or, where possible, eliminate the use of seclusion

The restrictive practice policy was developed in Sept 2023. The AC aim to reduce and where possible eliminate the use of restrictive interventions. It is the policy of the AC to ensure that the rights of patients are not compromised unless it is necessary to prevent harm to patients or others. The purpose of this policy is to prevent aggression and violence by ensuring a high standard of care is delivered and to assist patients to find more effective ways of dealing with their emotions. This policy outlines how the AC aims to provide positive behaviour support as a means of reducing or, where possible eliminating, the use of seclusion within the approved centre. Seclusion will only be used as a last resort where other less invasive interventions have been unsuccessful and there will be a focus on reducing and where possible eliminating the use of seclusion. The establishment of review and oversight committee is responsible for the oversight of episodes of seclusion and when it is used. The review and oversight committee are accountable to the Registered Proprietor Nominee and meet quarterly to review each episode of seclusion to;

1. Determine if there was compliance with the rules governing the use of seclusion for each episode of seclusion reviewed.
2. Determine if there was compliance with the approved centre's own policies and procedures relating to seclusion
3. Identify and document any areas for improvement.
4. Identify the actions, the persons responsible, and the timeframes for completion of any actions.
5. Provide assurance to the Registered Proprietor Nominee that each use of physical restraint was in accordance with the Mental Health Commission's Rules.
6. Produce a report following each meeting of the review and oversight committee. This report should be made available to staff who participate, or may participate, in the use of seclusion to promote on-going learning and awareness. This report should also be available to the Mental Health Commission upon request.

A statement about the approved centre's compliance with the rules governing the use of seclusion

The AC ensure compliance with the Rules by undertaking the following; the use of seclusion is a last resort and is always ordered by a registered medical practitioner/nurse under the supervision of a Consultant Psychiatrist. In the event of seclusion, the resident is fully informed at all times. Cultural awareness/gender sensitivity are considered at all times. Patient safety and dignity is paramount in the event of an episode. In the event of seclusion, the seclusion register is completed and notified to the MHC. The AC has re-designed its seclusion facilities to ensure compliance with the MHC Rules. The service has introduced a seclusion pathway booklet to guide and assist staff to ensure compliance with the Rules. Each episode of seclusion is discussed with the resident if they so wish and an opportunity afforded to them to discuss the episode of seclusion. Each episode is reviewed by the resident MDT whereby

1. antecedent events which contributed to the seclusion can be identified if any
2. a review of missed opportunities for earlier intervention
3. de-escalation techniques and less invasive interventions to be used going forward
4. the duration of the episode
5. considerations following the in person debriefing session

will be reviewed.

The establishment of review and oversight committee is responsible for the oversight of physical restraint and where it is used. The review and oversight committee are accountable to the Registered Proprietor Nominee and meet quarterly to review each episode of physical restraint to;

1. Determine if there was compliance with the Rules governing the Use of Seclusion for each episode of seclusion reviewed.
2. Determine if there was compliance with the approved centre's own policies and procedures relating to seclusion
3. Identify and document any areas for improvement.
4. Identify the actions, the persons responsible, and the timeframes for completion of any actions.
5. Provide assurance to the Registered Proprietor Nominee that each use of Seclusion was in accordance with the Mental Health Commission's Rules.
6. Produce a report following each meeting of the review and oversight committee. This report should be made available to staff who participate, or may participate, in seclusion to promote on-going learning and awareness. This report should also be available to the Mental Health Commission upon request.

The eight interventions outlined within the Seclusion and Restraint Reduction Strategy (MHC 2014) will frame the work of the Review and Oversight Committee

a. Leadership
b. Engagement
c. Education
d. Debriefing
e. Data
f. Environment
g. Regulation
h. Staffing.

A statement about the compliance with the approved centre's own reduction policy

A statement about the compliance with the approved centre's own reduction policy

The service has developed a policy on the use of restrictive practices, Sept 2023

All staff are encouraged to read and understand this policy.

All Staff must be trained in PMCB, as this is a mandatory requirement.

Refresher training must be completed within 24 months.

PMCB training is provided to staff by certified PMCB instructors, this training incorporates the reduction of the use of restrictive practices.

A record of staff attendance at training is maintained and these are available to the Mental Health Commission upon request.

All HSE staff, students and volunteers irrespective of role or grade have completed Children First Training, this is a mandatory requirement.

All clinical staff are encouraged to undertake Mental Health Commission e-learning resources on HSELand.

HSELAND modules include:

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• Module 1: Changes to the Rules and Code of Practice on Restrictive Practices
• Module 2: Changes to the Rules governing the use of Seclusion.
• Module 3: Changes to the Code of Practice on Physical Restraint
A working group has been established re trauma informed care and a plan is in development to roll out training to all staff. All staff have been requested to complete the HSE Land module 'Becoming trauma aware an introduction to Psychological Trauma'.
The AC has provided decider skills training to AC staff
Plan to roll out Positive behaviour support training
A debriefing tool has been developed to support the resident following an episode of PR
All episodes of PR are reviewed by the multidisciplinary team and data is recorded to aid analysis.
Action plans are developed to aid in the eliminate and/or reduction of physical restraint
The inclusion of the reduction policy as a standing item on senior management team meetings.

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Code of Practice on the Use of Physical Restraint

Issued Pursuant to Section 33(3)(e) of the Mental Health Act 2001-2018

The total number of persons who were physically restrained during the reporting period	15
The total number of episodes of physical restraint	31
The shortest episode of physical restraint	1min
The longest episode of physical restraint	31min

A statement about the effectiveness of the approved centre's actions to eliminate, where possible, and reduce physical restraint
The restrictive practice policy was developed in Sept 2023. The AC aim to reduce and where possible eliminate the use of restrictive interventions. It is the policy of the AC to ensure that the rights of patients are not compromised unless it is necessary to prevent harm to patients or others. The purpose of this policy is to prevent aggression and violence by ensuring a high standard of care is delivered and to assist patients to find more effective ways of dealing with their emotions. This policy outlines how the AC aims to provide positive behaviour support as a means of reducing or, where possible eliminating, the use of physical restraint within the approved centre. Physical restraint will only be used as a last resort where other less invasive interventions have been unsuccessful and there will be a focus on reducing and where possible eliminating physical restraint. The establishment of review and oversight committee is responsible for the oversight of physical restraint and where it is used. The review and oversight committee are accountable to the Registered Proprietor Nominee and meet quarterly to review each episode of physical restraint to; 1. Determine if there was compliance with the code of practice on the use of physical restraint for each episode of physical restraint reviewed. 2. Determine if there was compliance with the approved centre's own policies and procedures relating to physical restraint 3. Identify and document any areas for improvement. 4. Identify the actions, the persons responsible, and the timeframes for completion of any actions. 5. Provide assurance to the Registered Proprietor Nominee that each use of physical restraint was in accordance with the Mental Health Commission's Code of Practices and Rules. 6. Produce a report following each meeting of the review and oversight committee. This report should be made available to staff who participate, or may participate, in physical restraint to promote on-going learning and awareness. This report should also be available to the Mental Health Commission upon request.

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A statement about the approved centre's compliance with the code of practice on the use of physical restraint
The AC ensure compliance with the COP by undertaking the following; the use of PR is a last resort and is always ordered by a registered medical practitioner/nurse under the supervision of a Consultant Psychiatrist. In the event of PR, the resident is fully informed and involved in the decision making process. Cultural awareness/gender sensitivity are considered at all times. Patient safety and dignity is paramount in the event of an episode. In the event of PR, the clinical practice form is completed and notified to the MHC. The service has introduced a PR booklet to guide and assist staff to ensure compliance with the COP. Each episode of PR is discussed with the resident if they so wish and an opportunity afforded to them to discuss the episode of PR. Each episode is reviewed by the resident MDT whereby 1. antecedent events which contributed to the PR can be identified if any 2. a review of missed opportunities for earlier intervention 3. de-escalation techniques and less invasive interventions to be used going forward 4. the duration of the episode 5. considerations following the in person debriefing session will be reviewed. The establishment of review and oversight committee is responsible for the oversight of physical restraint and where it is used. The review and oversight committee are accountable to the Registered Proprietor Nominee and meet quarterly to review each episode of physical restraint to; 1. Determine if there was compliance with the code of practice on the use of physical restraint for each episode of physical restraint reviewed. 2. Determine if there was compliance with the approved centre's own policies and procedures relating to physical restraint 3. Identify and document any areas for improvement. 4. Identify the actions, the persons responsible, and the timeframes for completion of any actions. 5. Provide assurance to the Registered Proprietor Nominee that each use of physical restraint was in accordance with the Mental Health Commission's Code of Practices and Rules. 6. Produce a report following each meeting of the review and oversight committee. This report should be made available to staff who participate, or may participate, in physical restraint to promote on-going learning and awareness. This report should also be available to the Mental Health Commission upon request. The eight interventions outlined within the Seclusion and Restraint Reduction Strategy (MHC 2014) will frame the work of the Review and Oversight Committee a. Leadership b. Engagement c. Education d. Debriefing e. Data f. Environment g. Regulation h. Staffing.

Approved Centre Name:
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A statement about the compliance with the approved centre's own reduction policy
The service has developed a policy on the use of restrictive practices. All staff are encouraged to read and understand this policy. All Staff must be trained in PMCB, as this is a mandatory requirement. Refresher training must be completed within 24 months. PMCB training is provided to staff by certified PMCB instructors, this training incorporates the reduction of the use of restrictive practices. A record of staff attendance at training is maintained and these are available to the Mental Health Commission upon request. All HSE staff, students and volunteers irrespective of role or grade have completed Children First Training, this is a mandatory requirement. All clinical staff are encouraged to undertake Mental Health Commission e learning resources on HSELand. HSELAND modules include: • Module 1: Changes to the Rules and Code of Practice on Restrictive Practices • Module 2: Changes to the Rules governing seclusion. • Module 3: Changes to the Code of Practice on Physical Restraint A working group has been established re trauma informed care and a plan is in development to roll out training to all staff. All staff have been requested to complete the HSE Land module 'Becoming trauma aware an introduction to Psychological Trauma'. The AC has provided decider skills training to AC staff Plan to roll out Positive behaviour support training A debriefing tool has been developed to support the resident following an episode of PR All episodes of PR are reviewed by the multidisciplinary team and data is recorded to aid analysis. Action plans are developed to aid in the elimination and/or reduction of physical restraint The inclusion of the reduction policy as a standing item on senior management.

Signed by Registered Proprietor Nominee: Aiden O'Neill
**If you don't have a Digital Signature, typing your name will be accepted as your signature.*