Policy, Guideline and Procedure Manuals
Department: Galway/Roscommon Mental Health Service

Policy Title: Physical Restraint and the Management of Aggression and Violence (including restrictive practice reduction).

Regulation: N/A

Rule Applicable: Mental Health Commission Rules Governing The Use of Seclusion and Mechanical Means of Bodily Restraint (2009) and the Addendum to the Rules January 2011

Code of Practice Applicable: Use of Physical Restraint.

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Dr. Amanda Burke, Clinical Director.

Date: 07/09/2023

Helen Earley, Area Director of Nursing.

Date: 07/09/2023

Steve Jackson, General Manager.

Date: 07/09/2023

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1.0 Introduction:

1.1 Galway Roscommon Mental Health Services aims to reduce restrictive practices 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 Physical restraint is 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) Risks associated with physical restraint,
c) Potential damage to the therapeutic relationship between individuals and staff,
d) Risks of infringing the Human Rights of an individual, their dignity and autonomy,
e) Potential for Trauma and re-traumatising the individual (Cusack et al, 2018).

1.3 The purposes of physical restraint are:

a) To take immediate control of a dangerous situation;
b) To contain or limit the patient's freedom for no longer than is necessary;
c) To end or reduce significantly the danger to the patient or others.

1.2 The most common reasons for the use of physical restraint are:

a) Physical assault;
b) Dangerous threatening or destructive behaviour;
c) Self-harm or risk of physical injury by accident;
d) Extreme and prolonged over-activity likely to lead to physical exhaustion.

1.3 The basic considerations which should underline any methods aimed at reducing and eliminating unacceptable behaviour should take account of:

a) The need for individual care planning;
b) Risk assessment;
c) The physical condition of the patient;
d) Patients communication needs or difficulties,
e) The physical environment of the ward or unit;
f) The need to maintain adequate staffing levels.

1.4 Physical restraint may also be necessary to administer an injection or take bloods from an involuntary detained patient as part of their treatment under the relevant admission or renewal order (see High Court Decision MX V's HSE 2011 & 2012).

1.5 Where violent/aggressive incident occurs the overall aim is to deescalate the incident in the first instance and where possible use alternatives to Physical restraint.

1.6 The management of aggression and violence centres around:

a) Staff training.
b) Early identification and management of antecedents and/or trigger factors.
c) De-escalation where possible.
d) Consideration of alternatives to physical restraint.
e) Assessment of Risk.
f) Protection of the patient, other patients/persons and staff.
g) Review of the episode of physical restraint.
h) Debriefing of staff following an episode of physical restrain.
i) Amending the individuals recovery care plan to address antecedent/trigger factors.

1.7 Galway Roscommon Mental Health Services have introduced a Physical Restraint Care Pathway and associated review sticker as a quality initiative.

2.0 Policy Statement:

2.1 It is the policy of the Galway/Roscommon Mental Health Service that where physical restraint of patients is required, it is effected in strict conformity with the terms of the Mental Health Act 2001 and the Code of Practice on the use of Physical Restraint in Approved Centres (Mental Health Commission, 2022).

2.2 This policy aims to direct staff to formalise good practice in physical restraint procedures in Galway/Roscommon Mental Health Services in accordance with the terms of the Mental Health Act 2001 and the code of practice on the use of Physical Restraint in Approved Centres (Mental Health Commission, 2022).

2.3 In exceptional circumstances where there is a risk to the patient, other persons or staff the physical restraint of a patient may be required outside of the approved centre e.g. where a patient is attending a day centre, day hospital or other mental health facility. In such circumstances the physical restraint is not covered by the code of practice on physical restraint but staff should use the principals and standards outlined in the code and this policy when using physical restraint.

2.4 This policy aims to ensure that where patients are physically restrained the:

a) dignity and safety of the individual is paramount,

b) individual is communicated with in an open, transparent and empathic manner where staff demonstrate compassion and care at all stages of the procedure.

3.0 Legislation/Other Related Policies:

3.1 Mental Health Act 2001 (as amended).

3.2 Statutory Instrument No. 551 of 2006: Mental Health Act 2001 (Approved Centres) Regulations 2006.

3.3 Code of Practice on the use of Physical Restraint in Approved Centres (Mental Health Commission 2022).

3.4 Code of Practice Relating to the Admission of Children Under the Mental Health Act 2001 (2006) and the Addendum to the Code of Practice Relating to the Admission of Children Under the Mental Health Act 2001 (July 2009).

3.5 Rules Governing the use of Seclusion (Mental Health Commission 2009)

3.6 **EXT-GRMHS-HSE-22** HSE Policy on the Prevention and Management of Work Related Aggression and Violence 2018.

3.7 **EXT-GRMHS-HSE-29** Linking Service and Safety: Strategy for management of work related violence and aggression 2008.

3.8 **PPG-GRMHS-CLN-14** Health and Safety (Patients, Staff & Visitors).

3.9 **PPG-GRMHS-CLN-17** Risk Management incorporating Death Notification and Incident reporting.

3.10 **PPG-GRMHS-CLN-21** Seclusion Policy.

3.11 **PPG-GRMHS-CLN-27** Admission of a Child (including Family Liaison).

3.12 **PPG-GRMHS-CLN-28** One-to-one supervision of a child.

3.13 **PPG-GRMHS-CLN-59** Protocol for staff safety in the management of violence and aggression.

3.14 Galway/Roscommon Physical Restraint Pathway.

3.15 Galway/Roscommon Seclusion Pathway.

4.0 Scope of the Policy:

4.1 This policy applies to all staff (and students under the supervision of qualified staff, where applicable) working in Galway/Roscommon Mental Health Services who have been trained to physically restrain a patient.

4.2 Physical restraint is conducted as an emergency measure, in a professional manner by staff and within a legal and ethical framework to protect the human rights, privacy, dignity and autonomy of the person being restrained.

4.3 This policy is applicable to both detained (including a child under a section 25 order) and voluntary patients.

4.4 In as far as reasonably practicable, the person who is being restrained should be included in all decisions being made. This includes their views and preferences.

4.5 This policy should be read in conjunction with the Mental Health Act 2001 (as amended) and the Code of Practice on the use of Physical Restraint (Mental Health Commission, 2022).

4.6 The policy is not intended to substitute for any of the documents in section 3.0, and therefore should be read in conjunction with them.

4.7 This policy should be reviewed annually or 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.

4.8 **In this policy the term patient covers both voluntary and involuntary patients. Where sections specifically relate to patients detained under the MHA 2001 the term involuntary patient is used.**

5.0 Definitions:

5.1 An Involuntary Admission is defined as the admission of a person to an approved centre under an admission order or a renewal order and who meets the criteria for mental disorder as defined in the Mental Health Act 2001 (as amended).

5.2 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 (as amended).

5.3 Child means a person under the age of 18 years other than a person who is or has been married.

5.4 Episode of Physical Restraint: Means the time physical restraint commences to the time physical restraint is ended.

5.5 Involuntary patient: Means a patient detained under the Mental Health Act 2001 (as amended).

5.6 Order for Physical Restraint: Clinical practice form (Appendix 1) completed by the senior nurse or registered medical practitioner initiating and ordering an episode of physical restraint. This order lasts for a maximum period of 10 minutes and then if required must be renewed by a renewal order by the senior nurse or registered medical practitioner. All sections of the form must be completed within the required timeframes:

a) initiating and ordering-completed no later than 3 hours after the conclusion of the episode of physical restraint.
b) Medical examination-within 2 hours of the commencement of the restraint episode.
c) Consultant Psychiatrist/Duty Consultant Psychiatrist: within 24 hours.

5.7 Person/Individual/Patient: A person receiving care and treatment in an approved centre.

5.8 Period of Physical Restraint: the length of time an individual order for physical restraint lasts, which cannot exceed 10 minutes.

5.9 Physical Restraint: The use of physical force by one or more persons for the purposes of preventing the free movement of a patient's body when he or she poses an immediate threat of serious harm to self or others (Mental Health Commission, 2022).

5.10 Registered Proprietor: The person whose name is entered in the register as the person carrying on the centre (Section 62, Mental Health Act, 2001 (as amended)).

5.11 Renewal order: In rare and exceptional cases where the episode of physical restraint is required to be extended beyond the a 10 minute period, a new clinical practice form indicating Renewal order (Appendix 1, section 8 "Physical restraint order type") must be completed by the most senior registered nurse of the ward or the registered medical practitioner to extend the episode of physical restraint to a further maximum period of 10 minutes from the time of the ending of the initial order. A further renewal order may be made for a further period of 10 minutes, after which the episode of

physical restraint must end i.e. an episode of physical restraint cannot exceed 30 minutes in total.

5.12 Representative: An individual chosen by the person who is being cared for (e.g. friend, family member, advocate) or a legal professional appointed by the person, statutory organisation or court to represent the person.

5.13 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.

5.14 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).

5.15 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.

5.16 (Work Related) Violence: *"Any incident where staff are abused, threatened, or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, wellbeing or health"* (Linking Service with Safety *Together creating safer places of service*, 2008).

6.0 Responsibilities:

6.1 Organisational:

6.1.1 The Registered Proprietor is responsible for:

a) Ensuring that the resources required are allocated to Galway/Roscommon Mental Health Services to comply with the Mental Health Act 2001 (as amended) and the Code of Practice on the use of Physical Restraint (Mental Health Commission, 2022) and HSE policies on the management of violence and aggression (2018).
b) Notifying the Mental Health Commission of the start time and date and the end time and date of each episode of physical restraint.
c) Ensuring that a restrictive practice reduction policy is published on their website.
d) Appointing a named senior nurse manager responsible for the reduction of physical restraint in the approved centre.

e) 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.
f) Ensuring that their nominee has established a review and oversight committee to analyse in detail each episode of physical restraint.
g) Ensuring that each episode of physical restraint is in compliance with the Code of Practice on the use of physical restraint (mental Health Commission 2022).
h) Having overall accountability for the use of physical restraint in the Approved Centre.
i) Having overall accountability for the restrictive practice reduction policy.

6.2 Senior Manager: (Nominated by the registered proprietor)

6.2.1 It is the responsibility of the nominated senior manager for reducing the use of physical restraint in the approved centre.

6.3 Management:

6.3.1 It is the responsibility of line managers to ensure all their staff are aware of and adhere to this policy.

6.3.2 It is the responsibility of line managers to ensure their staff have the appropriate training on the management of violence and aggression commensurate with their role.

6.3.3 Line managers should maintain records of staff attendance at the management of violence and aggression training including when updates are due.

6.3.4 Line managers must ensure that staff are released to attend training programmes as required.

6.3.5 Line managers should make staff aware of the risk register and the safety alarm system provided for the management of aggression and violence.

6.3.6 It is the responsibility of senior management to support in as far as reasonably practicable the implementation of a restrictive practice reduction strategy and to promote alternatives to restrictive practices where safe to do so.

6.4 Registered Medical Practitioner:

6.4.1 It is the responsibility of the registered medical practitioner initiating physical restraint to:
a) Ensure the episode of physical restraint is in compliance with the Mental Health Commission Code of Practice on the use of Physical Restraint (2022).
b) Initiate and order the use of physical restraint,

c) Inform the patient of their rights, presented in accessible and format,
d) Notify the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist of the physical restraint of the individual as soon as practicable, and record this in the patients clinical file,
e) As soon as practicable and no later than 2 hours after the commencement of the episode of physical restraint complete a medical examination of the patient and record this in the patient's clinical file,
f) Complete the Clinical Practice form within 3 hours of the commencement of the episode of physical restraint,
g) In rear and exceptional circumstances where a period of physical restraint needs to be extended, renew an order for physical restraint up to a maximum of 30 minutes in total i.e. 3 x 10 minutes.
h) End the episode of physical restraint as soon as it is safe to do so,
i) Record the episode of physical restraint and all reviews in the persons clinical file,
j) Participate in a debriefing with the patient within two working days,
k) Participate in a Multi-disciplinary review of the episode of physical restraint within 5 working days after the episode of restraint,
l) Participate in the approved centre review and oversight group with a view of reducing the use of restrictive practices.

6.4.2 Where physical restraint is not initiated by a registered medical practitioner it is their responsibility to:

a) As soon as practicable and no later than 2 hours after the commencement of the episode of physical restraint complete a medical examination of the patient and record this in the patient's clinical file,
b) Complete the relevant section of the clinical practice form,
c) Ensure that the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist is aware of the physical restraint of the individual.

6.5 Senior Registered Nurse:

6.5.1 The most senior registered nurse on duty in the ward where the physical restraint is initiated is responsible for:

a) Ensure the episode of physical restraint is in compliance with the Mental Health Commission Code of Practice on the use of Physical Restraint (2022),
b) Initiate and order the use of physical restraint,

c) Inform the patient of their rights, presented in accessible and format,
d) Notify the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist of the physical restraint of the individual as soon as practicable, and record this in the patients clinical file,
e) Ensure that as soon as practicable and no later than 2 hours after the commencement of the episode of physical restraint a medical examination of the patient is completed,
f) Complete the Clinical Practice form within 3 hours of the commencement of the episode of physical restraint,
g) In rear and exceptional circumstances where a period of physical restraint needs to be extended, renew an order for physical restraint up to a maximum of 30 minutes in total i.e. 3 x 10 minutes.
h) End the episode of physical restraint as soon as it is safe to do so,
i) Record the episode of physical restraint and all reviews in the persons clinical file,
j) Participate in a debriefing with the patient within two working days,
k) Participate in a Multi-disciplinary review of the episode of physical restraint within 5 working days after the episode of restraint,
l) Participate in the approved centre review and oversight group with a view of reducing the use of restrictive practices.

6.6 Multidisciplinary Oversight Committee

6.6.1 Members of the review and oversight committee are responsible for:

a) Reviewing all episodes of restrictive practices,
b) Ensuring compliance with the code of practice on the use of physical restraint (Mental Health Commission, 2022) and the approved centres policies,
c) Quality assurance and learning areas of improvement from the use of episodes of physical restraint,
d) Reporting to the registered proprietor.

6.7 Staff:

6.7.1 It is the responsibility of the Clinical Nurse Manager to ensure that all staff are familiar with and implement this policy.

6.7.2 It is the responsibility of the treating team to ensure that the clinical practice form for physical restraint is completed in full and within the required timelines (Appendix 1) and filed in the patient's clinical file.

6.7.3 It is the responsibility of the treating team/duty doctor to ensure that a medical examination of the person is conducted no later than 2 hours after the start of the episode of physical restraint.

6.7.4 It is the responsibility of all staff using physical restraint to ensure they are trained in its use and update their training as required. Including the location and use of safety alarms.

6.7.5 It is the responsibility of all staff using physical restraint to be aware of the patients risk assessment and care/treatment plan.

6.7.6 It is the responsibility of all staff restraining a patient to avoid:
a) Neck Holds
b) The application of heavy weight to the patient's chest or back.
c) To complete the physical restraint clinical practice form within the required timeframe.

6.7.7 It is the responsibility of each member of staff to ensure they have signed (or acknowledged on Q-Pulse) that they have read and understood this policy.

7.0 Principals Underpinning Physical Restraint:

7.1 Physical restraint should be used in rare and exceptional circumstances and only in the best interests of the patient when he or she poses an immediate threat of serious harm to self or others. It is an emergency measure used to manage a person's unsafe behaviour.

7.2 Physical restraint should only be used after all alternative interventions to manage the patient's unsafe behaviour have been considered. This may include de-escalation and talk down techniques.

7.3 The use of physical restraint is not prolonged beyond the period that is strictly necessary to prevent immediate and serious harm to the patient or others.

7.4 The use of physical restraint should be proportional and minimal force should be applied.

7.6 Physical restraint is used in a professional manner and is based within an ethical and legal framework, to protect as far as reasonable possible the dignity, privacy, autonomy and human rights of the person being physically restrained.

7.7 Physical restraint is used in settings where the safety of patients, staff and visitors is regarded as being essential and equal.

7.8 Use of physical restraint is based on a risk assessment (Appendix 2) (to include assessment of the patient's physical condition e.g. elderly patients, patients with cardiac conditions). The Risk assessment record is completed after the episode of physical restraint.

7.9 The use of physical restraint is based on best available evidence and contemporary practice, by trained staff who work closely together as a team to manage the episode of physical restraint safely and in compliance with the Mental Health Commission code of practice on the use of physical restraint (2022) and best practice in the use of physical restraint.

7.10 The three person restraint team should be aware of the patients care and treatment plan, advanced directives and/or injuries/vulnerabilities which may contraindicate the use of certain restraint holds or techniques.

7.11 During the period of physical restraint staff should continue to communicate with the patient aiming to end the episode of physical restraint. Communication must be open honest, empathic, compassionate and caring.

7.12 Cultural awareness and gender sensitivity are demonstrated when considering the use of and when using physical restraint. Where a female is being restrained and where practical there should be a female member of staff present.

7.13 A trauma-informed care approach should be utilised in the use of any restrictive practice. Patients may have experienced trauma in the past and therefore may not be able to regulate their emotional response or behaviours. The resulting impairment in mood and behaviour regulation leads to subsequent maturational difficulties, such as an inability to establish effective interpersonal relationships, regulate emotions, and learn from own and others' experiences (Schore, 2003).

7.14 Staff may not be aware of previous trauma in a patient's life but should assume trauma and/or abuse may have been experienced by the patient.

7.15 For some patients (especially children) physical restraint or certain types of holds may negatively reconnect them to prior abusive experiences and trauma associated with it. This information if known should inform the management of physical restraint episode. If highlighted as a result of an episode of physical restraint it should inform the management of future episodes of physical restraint.

7.16 The patient's physical condition should be considered before initiating physical restraint.

7.17 An order for a period of physical restraint may only last for 10 minutes. If required the order must then be renewed. Each period is for a maximum of 10 minutes to a maximum of 30 minutes after which the episode of

physical restraint must end. A clinical practice form must be completed for each period of physical restraint.

7.18 Each episode of physical restraint should be reviewed within two working days (excluding bank holidays and weekends) (see 18.0).

8.0 Steps/considerations to prevent the use of Physical Restraint:

8.1 Continuous unobtrusive observations and early interventions by staff to meet the needs of patients will assist in the prevention of aggressive outbursts.

8.2 Preventative and de-escalation measures must be initiated as the first means of avoiding violence and aggression.

8.3 Patients with a history of violence and aggression should have a risk assessment and a relevant care/treatment plan drawn up by their named nurse, in collaboration with the treating consultant and the Multidisciplinary Team and if possible, the patient themselves.

8.4 The findings of any risk assessment should be considered e.g. to identify and avoid any trigger that could lead to violent behaviour.

8.5 Completion of An Adult Sensory Profile and sensory plan (sensory modulation interventions) may assist the patient in identifying antecedents to aggressive behaviours and identify self-calming strategies to avoid aggressive behaviours.

8.6 The patient should be asked to highlight in the care/treatment plan antecedents to behaviour that may have led to their restraint in the past. They may also at this point indicate restraint techniques/holds that may cause them distress due to a past history of abuse (see 7.11).

8.7 Allow/encourage the patient to ventilate their anger verbally rather than physically.

8.8 Consider the relocation to a low stimulus or quieter environment.

8.9 The emphasis on the use of physical restraint as a last resort.

8.10 The individual should be asked to stop his/her behaviour.

8.11 Steps should be taken to avoid the need for restraint, through dialogue, negotiation, diversion or compromise. Do not allow the patient to be backed into a psychological corner. (The patient's dignity and respect must be maintained at all times).

8.12 Failing to secure a patient's compliance with one form of intervention is not the automatic signal for a more forceful response.

8.13 The most appropriate person should negotiate with the patient.

8.14 Gender, age, and race issues must be taken into account (e.g. pregnancy, children, and older adult patients).

8.15 The presences of additional staff may/may not abate the patient's behaviour.

8.16 The use of physical restraint may be traumatic for a patient and staff. The risk of trauma and/or re-traumatised a patient should be assessed during and following an episode of physical restraint.

8.17 A trauma informed care approach should inform the care and treatment of patients. The principles of trauma-informed care include (Appendix 3):

a) Safety.
b) Trustworthiness & transparency.
c) Peer support.
d) Collaboration & mutuality.
e) Empowerment & choice.
f) Cultural, historical & gender issues.

8.18 Special consideration should be given to the use of restrictive practices on:

a) Children/young adults,
b) Vulnerable adults,
c) Confused frail or elderly patient's,
d) Patients with physical disabilities.

9.0 Alternatives to Physical Restraint:

9.1 Physical Restraint is a last option where other alternatives have failed. Alternatives include:

a. Unobtrusive general observations,
b. Behavioural support plans,
c. Care planning to identify and address antecedents/trigger factors,
d. De-escalation/Verbal intervention
e. Sensory modulation and self-calming strategies,
f. Safewards model (10 interventions) Appendix 4),
g. Use of medication e.g. PRN, Rapid Tranquilisation
h. Disengagement/Breakaway
i. physical deflection
j. Time out
k. One to one nursing
l. Seclusion

Note: this is not an exhaustive list.

10.0 Infection Prevention and Control:

10.1 Due to the Covid-19 Pandemic the following infection prevention and control measures must be adhered to where there is a suspect or confirmed Covid case.

10.2 All staff must wear personal Protective Equipment when restraining a patient with suspect or Covid-19 positive result. This will require careful planning and should be noted at the safety pause meetings (where these occur).

10.3 Where possible continue with de-escalate measures, while the restraint team don their Personal Protective Equipment over scrubs.

10.4 Where possible hazmat suits should be worn during the episode of restraint as they are more robust than gowns. Staff require training on donning and doffing Hazmat suits due to the risk of self contamination when removing a suite.

10.5 Staff should be aware of the possibility of the patient coughing/sneezing or spitting during the episode of restraint.

10.6 If the Personal Protective Equipment, (gown or Hazmat suit) is damaged during the restraint the nurse should change their scrubs, shower (if necessary) and change into new scrubs.

10.7 Staff must adhere to the correct procedure for doffing Personal Protective Equipment including hand hygiene when the episode of physical restraint has ended.

NOTE: Infection prevention and control guidelines are updated regularly. Covid measures only apply where necessary.

11.0 Good Practice During Physical Restraint:

11.1 Physical Restraint is a last resort, if initiated it is done so on the basis of a risk assessment i.e. there is an immediate danger to the patient or others which cannot be managed using available alternatives. The risks are assessed prior to (and monitored during) the restraint and documented following the restraint.

11.2 The person initiating physical restraint should use their clinical judgement, taking into consideration, the patient, the patient's history, specific information in the patient's care and treatment plan, the circumstances, risk of injury to self and others, and any other relevant factors e.g. known physical conditions, should be the ultimate factor in deciding if physical restraint is necessary (Appendix 2). It should then only be carried out when sufficient appropriately trained staff are available to carry out the process safely.

11.3 In particular extreme caution should be used when physically restraining vulnerable patient's including:

a) Physically unwell,
b) Obese,
c) Frail,
d) Children,
e) Pregnant, or
f) Physical disabled.

11.4 Make a visual check for weapons or items that may be used as weapons.

11.5 Identify leader and team members prior to physical intervention.

11.6 The use of physical restraint should **ALWAYS** be the last resort and for the shortest time necessary.

11.7 If a patient requires restraint then the least intrusive method should be used requiring only minimum or reasonable force.

11.8 The restraint team leader will ensure:

a) The patient's head and neck is supported (as needed),
b) Continuous observation of the persons airway and breathing to ensure that it is not compromised due to the restraint,
c) Monitor the patient's pulse, respiration and pallor or skin/lips for signs of respiratory distress/compromise,
d) Interpret patients vital signs (pulse, respiration and pallor) taking immediate action if a risk is posed to the patient,
e) A record of the patients pulse, respiration and pallor is made,
f) Maintain effective communication with the patient during the episode of physical restraint, using de-escalation techniques to assist the patient regain control of their behaviour/emotions,
g) Ensure the patients senses are not interfered with, to ensure open effective communication,
h) Observe and monitor the patient's physical, emotional and psychological health following the episode of physical restraint until such time as the patient has recovered.

11.9 Staff should take account of the understanding, age, gender, mental state, and physical ability of the patient.

11.10 Continued efforts to de-escalate the situation should be attempted during the restraint. Staff should communicate with the patient in an open honest compassionate and caring way, keeping them informed of what is happening and when the restraint will end.

11.11 The team leader monitors the patient during the episode of physical restraint to avoid injury e.g. positional asphyxia. An adequate source of

light will aid the observation of the patient during physical restraint especially during night time.

11.12 There should be continual communication (verbal and non-verbal) between the team leader, patient, and the remainder of the team. The team leader should inform the patient of the reasons for, likely duration of and the circumstances which will lead to the discontinuation of physical restraint (unless such information would be prejudicial to the patients mental health or wellbeing). Where this communication does not take place a record of this should be made in the patient clinical file.

11.13 When possible, the other patients and staff not involved with the physical restraint should be relocated to another area.

11.14 Only staff trained in control and restraint procedures should be involved in the incident (and only use approved techniques). If other staff are required, they should take direction from the trained individuals; this will reduce the risk of accidental injury to staff or patient.

11.15 Restraint must be discontinued when members of staff restraining the patient agree that the patient is once again in control of him/herself.

11.16 Staff will at all times demonstrate unconditional positive regard and ensure that communication between the patient and staff is not allowed to deteriorate into a verbal confrontation.

11.17 Staff should be aware of the potential of trauma for other patient's witnessing an event where an episode of physical restraint is initiated including the episode of physical restraint itself. They may feel unsafe and vulnerable as a result and require support after the event.

11.18 Following a physical restraint episode the patient must be informed of their right to:

a) Participate in a debriefing, if they wish,
b) Have the debriefing within two working days of the episode of physical restraint or at their preferred time outside this timeframe,
c) Have a nominated representative participate in a debriefing,
d) Participate in a multidisciplinary review of the episode of physical restraint, if they wish,
e) Have their care plan reviewed to include strategies/interventions aimed at preventing the use of restrictive practices,
f) Express preferences for the management of their physical restraint in the future if the situation arises,
g) Make a compliment or complaint.

NOTE: this information should be in accessible language and format. The Mental Health Commission information leaflet: "What you need to know about the Code of Practice on Physical Restraint" may be used.

12.0 Initiating and ordering Physical Restraint:

12.1 Physical restraint may only be initiated and ordered by a Registered Medical Practitioner, or a Registered Nurse (Mental Health Commission, 2022).

12.2 The patient 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 is prejudicial to the person's mental health, wellbeing or emotional condition.

12.3 The person initiating and ordering the use of physical restraint must as soon as is practicable:

a) Notify the patients treating consultant or the consultant on duty. This must be recorded in the patient's clinical file.
b) Complete the clinical practice form (Appendix 1) as soon as is practicable and no later than 3 hours after the episode of physical restraint.

12.4 An order for physical restraint lasts for a maximum period of 10 minutes.

12.5 The patient must be examined by a registered medical practitioner as soon as is practicable and in any case no later than 2 hours after the initiation of physical restraint. This must include a physical examination of the patient to assess for any possible injuries during the episode of restraint. If a patient refuses to co-operate the review will be limited to the observations of the patient that the doctor can make. The refusal and any observations made should be clearly documented within the patient record.

12.6 The treating consultant psychiatrist or consultant on duty must sign the clinical practice form (section 18) as soon as practicable or in any event within 24 hours.

12.7 If physical restraint is required to be extended beyond the initial 10 minute period, then a **renewal order** must be made by a **registered medical practitioner or the most senior registered nurse on duty in the ward** following a medical examination or nursing review of the patient for a further period not exceeding 10 minutes. A new clinical practice form must be completed for each renewal order and a record of the reasons for the renewal/s documented as well as the medical examination or nursing review (to include Date and Time of the review/examination) should be recorded in the person's clinical file.

12.8 A maximum extension of 2 renewal orders can be made i.e. an episode of physical restraint **cannot exceed 30 minutes**.

12.9 The clinical practice form for the use of physical restraint must be completed within the required time periods and a copy filed in the patient's clinical file.

12.10 A record of the episode of restraint including all nursing reviews/observations and medical examinations, should be documented in the patient's clinical file.

12.11 As soon as is practicable and with the patient's wish/preference as documented in their recovery care plan, the patient's representative should be informed of the patient's physical restraint. In the event this notification does not occur, the rational for not notifying the person's representative must be documented clearly in the person's clinical file.

12.12 Where the patient does not wish to notify their representative of his or her physical restraint, no such communication should occur except that which is necessary to fulfil legal and professional requirements.

12.13 Notification or non-notification of representatives **must** be recorded in the patient's clinical file.

13.0 Patient Dignity & Safety:

13.1 Staff involved in physical restraint should be aware of and give consideration to any requirements specified in the patient's care and treatment plan e.g. advance directives, patient preferences, communication difficulties, preferences for notification of a representative, or physical problems which could cause a risk during the episode of restraint.

13.2 A risk assessment should be conducted before the initiation of physical restraint. The aim of the risk assessment is to establish known risk factors for the patient which will be monitored during the episode of restraint. This risk assessment will be documented in the risk assessment record (Appendix 2) after the episode of restraint.

13.3 The person initiating physical restraint should ensure that there is sufficient staff to physically restrain the patient thereby avoiding possible injury to the patient, staff or others.

13.4 Staff restraining patients should be aware of any instructions or advanced directives in the patients care plan. These may include the request by the patient not to use certain types of holds due to past traumatic experiences e.g. physical or sexual abuse.

13.5 A designated member of staff will take the lead in directing the physical restraint while also monitoring the patients head and airway.

13.6 The lead person must be satisfied that the patient's airway is clear at all times and should be observing for positional asphyxia.

13.7 To ensure proper monitoring of the airway there must be adequate lighting to observe the patients respirations and colour of lips.

13.8 The patient should be continually assessed throughout the episode of restraint to ensure their safety. Holds used should not compromise the patient's respiration. The leader should continue to communicate with the patient to de-escalate the situation and end the physical restraint as soon as possible.

13.9 Where practicable gender sensitivity should be considered throughout the episode of physical restraint.

13.10 Staff should be aware of the dangers of restraint including:

a) Psychosocial injury (Trauma).
b) Soft-tissue injury.
c) Articular or bone injury.
d) Respiratory restriction.
e) Cardiac Compromise.

13.11 The use of holds intended to deliberately inflict pain is strictly prohibited as being contrary to patients care ethics.

13.12 The following should be avoided -

a) Neck holds
b) The application of heavy weight to the patient's chest or back.
c) Holds that deliberately inflict pain,
d) Holds that prevent the patient from communicating or interfering with their speech, vision or hearing.

NOTE: The use of the prone (face down) position is only permitted to be used in exceptional circumstances by staff who have received the appropriate training. Where this position is used the rational for its use must be clearly documented in the patient's clinical file.

14.0 Risk Register:

14.1 The risk of violence and aggression should be assessed and entered onto the local risk register. This assessment must include all control measures in place to manage the risk of violence and aggression.

14.2 The details of the risk register must be made know to all staff working in the area including relevant contract and agency.

14.3 The risk register is updated as required usually quarterly and/or after any serious incidents.

15.0 Risk assessment stages:

15.1 The risk assessment consists of two stages:

I. Risk assessment of the situation,
II. Risk assessment of the patient.

15.2 When risk assessing the situation consideration is given to:

a) The behaviour of the patient (danger to self or others),
b) Other interventions have failed or the situation does not lend it to alternatives,
c) The surroundings,
d) The presence of sufficient staff to safely restrain the patient.

15.3 When risk assessing the patient during the restraint consideration is given to:

a) The patients know physical condition,
b) Communication difficulties,
c) Dangers of restraint.

15.4 Staff restraining a patient must be aware of the dangers of restraint and monitor the patient carefully during the episode of restraint.

15.5 It may not be possible to document a full risk assessment on the patient prior to the restraint. However staff are trained to assess risk during restraint and these are then recorded on the risk assessment record after the episode of restraint.

15.6 The risk assessment record should be reviewed during the review of the episode of restraint and amendments made to the patients care plan if necessary.

NOTE: Not all risks may be known prior to an episode of physical restraint, as patients may have undiagnosed/unknown underlying physical conditions. The review of the episode of physical restraint therefore may highlight information that may be important in the future episodes of restraint, care and/or treatment.

16.0 Use of Security Staff/Gardaí During an Episode of Physical Restraint:

16.1 In exceptional circumstances security staff or the Gardaí may be required to assist the 3 person restraint team during an episode of physical restraint.

16.2 The intervention of the Gardaí or Security staff is on the basis of the risks posed to the patient, staff or others and on the basis that it is the only option available to staff at the particular time and is deemed necessary for the safety of all concerned.

16.3 The staff member leading the restraint will continue to give directions in relation to the physical restraint of the patient and monitor the patient's airway.

16.4 Security staff must be trained in the management of aggression and violence.

16.5 They will only intervene when directed to by the team leader. The team leader will direct their interventions and continue to monitor the patient to ensure their safety.

16.6 Where security or Gardaí are used to assist in the restraint of the patient the rational for this must be documented in the patient's clinical file.

17.0 Ending the Use of Physical Restraint:

17.1 Physical restraint should be ended as soon as it is safe to do so. The team leader will continue to communicate with the patient to de-escalate the situation with the aim of ending physical restraint as soon as possible.

17.2 The designated member of staff responsible for leading the physical restraint and monitoring the head and airway of the patient will make the decision to end the physical restraint.

17.3 Consideration should be given to close observation, continuous observation or seclusion as a means to end physical restraint.

17.4 The patient may be de-escalated to a chair and the physical restraint ended in a seated position.

17.5 A bean bag is used in the seclusion room to enable staff to de-escalate physical restraint and place the patient in a comfortable position so that the staff can exit the seclusion room safely. Staff training covers the use of a beanbag to exit the seclusion room safely.

17.6 Physical restraint can have an emotional effect on both patients and staff. Therefore support and debriefing are essential following an episode of restraint. Patients react in an individual way to physical restraint and the aftercare should take account of this.

17.7 Patients may experience thoughts of "..*retaliation, loss of personal freedom or shame*.." (MAPA 2015). The therapeutic and trust relationship between staff and patient may need to be rebuilt.

17.8 Following physical restraint, the patient concerned should be afforded the opportunity to discuss the episode with members of the multi-disciplinary team involved in his or her care and treatment as soon as is practicable. This review must be documented in the patient's clinical file.

17.9 The time, date and reason for ending the episode of physical restraint must be recorded in the patient clinical file and section 19 of the clinical practice form (Appendix 1) by the person ending the episode of physical restraint.

18.0 Debriefing following an episode of physical restraint:

18.1 The patient should be offered the opportunity to attend a person-centred debriefing session following each episode of physical restraint.

18.2 The personal choice of the patient to attend or not attend must be respected. If the patient does not wish to attend a record of this should be made in the patient's clinical file.

18.3 The debriefing session should take place within two working days of the ending of the episode of physical restraint. If the patient chooses to have the debriefing session outside of this timeframe, their preference should be respected. This includes if the wish to have a representative or nominated support person to attend the debriefing with them.

18.4 If the patient's representative or nominated support person does not attend the debriefing a record of this should be made in the patient's clinical file.

18.5 The debrief will include explore with the patient:

a) What antecedents lead to the initiating of physical restraint.
b) What alternatives could be used in the future.
c) The behaviour of the patient prior to initiation of physical restraint.
d) The management of the episode.
e) Any injuries during the episode of restraint.
f) The patient understanding of the need for physical restraint and their behaviour that resulted in the use of physical restraint.
g) Alternatives methods that the patient can use to ventilate their feelings.
h) Methods to improve patient's self-control and early interventions to manage behaviour safely.
i) The patients individual care plan.
j) The patients experience of physical restraint.
k) A physical restraint reduction plan based on the findings of the review.

18.6 Multiple episodes of physical restraint within the same 48-hour time frame may be included in the same debriefing.

18.7 A record of attendance at the debriefing should be recorded in the patient's clinical file.

18.8 Where a patient decides not to attend a debriefing they make a written submission on their preferences for the future use of physical restraint

e.g. certain holds not to be used as they find them distressing and their care plan updated accordingly.

18.9 Due to the risk of trauma appropriate emotional support should be offered to:

a) The patient,
b) The staff involved in the restraint,
c) Anyone witnessing the physical restraint of the patient i.e. other patients.

19.0 Recording the use of Physical Restraint:

19.1 All episodes of physical restraint should be clearly recorded in the patient's clinical file and on the *"Clinical Practice Form for Physical Restraint"* prescribed by the Mental Health Commission (Appendix 1).

19.2 The completed clinical practice form should be placed in the patient's clinical file and a copy should be available to the Inspector of Mental Health Services and/or the Mental Health Commission on request.

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

19.4 The Physical Restraint check list (Appendix 2) should be used to ensure that the restraint complies with the Code of Practice on the use of Physical Restraint in the Approved Centre.

19.5 Galway Roscommon Mental Health Services have introduced a Physical Restraint Care Pathway and associated review sticker as a quality initiative. This document will be used on a pilot basis and reviewed as part of a quality improvement and compliance process.

20.0 Review of Episode of Physical Restraint:

20.1 Each episode of restraint must be reviewed by members of the multidisciplinary team involved in the care and treatment of the patient, as soon as is practicable and no later than 5 working days after the episode.

20.2 The review should consider:

a) What antecedents/triggers which lead to the initiating of physical restraint,
b) What alternative de-escalation strategies could be used in the future,
c) The management of the episode,
d) A review of any missed opportunities for early intervention, in line with the principles of positive behavioural support (Appendix 5)

e) The duration of the episode of restraint and was it for the shortest period possible,
f) Any injuries during the episode of restraint,
g) Outcomes from the person centred debriefing (if completed),
h) Assessment of any factors which may have contributed to the initiating of restraint,

NOTE: Positive behaviour support aims to identify and mitigate the triggers that generate behaviours and if done successfully it can reduce the chances of a behaviour occurring. Some of these strategies include; Avoid or minimize known triggers. Use distraction or redirection away from the trigger.

20.3 The review should be documented in the patient's clinical record and their care plan updated to include:
a) Actions decided on,
b) Follow-up plans to reduce or eliminate restrictive practices for the patient.
c) Updates to the patient's care plan.

20.4 Patients clinical files, clinical practice forms and documented reviews of episodes of physical restraint should be made available to the inspector of mental health services on request.

NOTE: where a patient is also secluded the review of the physical restraint and the use of seclusion can occur at the same time, but must be documented separately.

21.0 Review of Episode of Physical Restraint (Staff Review):

21.1 The effects of the episode of physical restraint on staff should be reviewed at the time of the patient review.

21.2 The review should consider (in addition to relevant information from the patient review):

a) What alternatives (if any) were considered by staff.
b) Risk assessments conducted before and during the episode of restraint.
c) The management of the episode, staff involved, holds used and rational for use.
d) Information available at the time from the patients individual care plan.
e) The staff members experience of physical restraint.
f) Any learning/recommendations for the future.

22.0 Multidisciplinary review and oversight committee:

22.1 The approved centre multidisciplinary review and oversight committee are accountable to the registered proprietor and 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 centres 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.

23.0 Staff Training:

23.1 Staff training on the management of aggression and violence is mandatory.

23.2 It is essential that staff physically restraining patients have up to date training, aware of the patient's needs and familiar with the patients care plan. If staff are unfamiliar with the patient and information in their care plan they may assist under the direction of the restraint leader.

23.3 Nominated members of staff are qualified instructors in the management of aggression and violence programme (MAPA or TMV) and will roll out this training to staff of the mental health services commensurate with their role.

23.4 In approved centres only trained nursing services staff and medical staff will physically restrain patients. Their training must be up to date and refreshed as required.

23.5 Programmes used in GRMHS are:

a) Management of Actual and Potential Violence (MAPA) for all staff.
Training Modules:
I. The Crisis development model
II. Non Verbal Behaviour and Para verbal communication
III. Verbal intervention
IV. Precipitating factors/Rational Detachment and integrated experience
V. Fear and anxiety
VI. Decision Making (Human Rights)
VII. Physical Intervention/Disengagement/ Theory & Practice

VIII. Physical Interventions Holding/ Theory & Practice
IX. Post crisis approaches.
X. Monitoring for the adverse effects of restraint on the patient.

NOTE: Alternatives to physical restraint are addressed throughout each module, to ensure that restraint is used as a last resort.

b) The Therapeutic Management of Violence (TMV) for all nursing staff and designated multitask attendants.

Training Modules:

I. Theories on Violence & Mental Health
II. De-escalation Skills & alternatives to restraint
III. Physical Skills- Breakaway
IV. Ethics Law and Restraint (Human Rights)
V. Introduction to teamwork
VI. Dangers of Restraint
VII. Restraint & Seclusion
VIII. Debriefing
IX. Safewards.
X. Monitoring for the adverse effects of restraint on the patient.

NOTE: Alternatives to physical restraint are addressed throughout each module, to ensure that restraint is used as a last resort.

23.6 Each programme takes account of the needs of the individual patient including patients of a different culture, gender and those with an intellectual disability.

23.7 In order to safely restraint a patient staff must be up to date with current training. Other staff (trained in the use of physical restraint) may assist, but would not lead as they may not be familiar with the needs of the patient.

23.8 Refresher training is required every two years.

23.9 Staff training records are maintained in the approved centre and are available for inspection by regulators.

23.10 Additional training will be provided on Sensory Modulation assessment, strategies and planning by Occupational Therapy staff.

23.11 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,

23.12 All staff involved in the review or episode of physical restraint should have completed training on Mental Health Act 2001 (As amended).

24.0 Physical Restraint of a Child:

24.1 Children are not admitted to Galway Roscommon Mental Health Services adult approved centres. In the unlikely event that an exception is made the following applies.

24.2 The admission of children to an adult approved centre is governed by the Code of Practice Relating to the Admission of Children Under the Mental Health Act 2001 (2006) and the Addendum to the Code of Practice Relating to the Admission of Children Under the Mental Health Act 2001 (July 2009) and Galway/Roscommon Mental Health Services policies on the admission of children and one to one supervision of the child.

24.3 Children may be particular vulnerable (both physically and psychologically) to physical restraint. Therefore restrictive practices including physical restraint should be used with extreme caution and informed by the potential adverse effects that may occur including:

a) Physical injury,
b) Psychological trauma (being restrained or witnessing an episode of restraint).

24.4 On admission every child should have a risk assessment completed by a registered nurse or registered medical practitioner to assess risks (physical and psychological) of the potential effects of an episode of physical restraint would have on a child. This should inform the care and treatment plan if restrictive practices should be used for that individual child. All staff should be aware of this risk assessment and the care and treatment plan for the child.

24.5 In rear and exceptional circumstances where a child is required to be restrained the actions of staff should be proportionate to the circumstances that led to a child needing to be physically restrained (DOH & C, 2001 section 6.28).

24.6 The physical restraint of the child will follow the same process as for an adult informed by the risk assessment on admission. He child must be communicated with during the restraint and informed of:

a) The reasons for the physical restraint,
b) What circumstances will lead to the ending of the episode of physical restraint.

24.7 The communicate must be in child friendly language and must be recorded in the clinical record.

24.8 All episodes of physical restraint are notified to the child's parent or guardian as soon as is practicable and a record of this is documented in the child's clinical file.

24.9 The child's parent or guardian should be informed when the episode of physical restraint has ended. A record of this should be made in the child's clinical record.

25.0 Procedure for managing a violent/aggressive incident:

25.1 Where violent/aggressive incident occurs the overall aim is to deescalate the incident in the first instance.

25.2 A risk assessment should inform the course of action to be taken.

25.3 When a violent/aggressive incident is in danger of escalating the panic alarm system should be activated immediately and responders assist in the restraint (if required).

25.4 The safety of the patient, other patients and staff are paramount.

25.5 The Clinical Nurse Manager/nurse in charge should delegate staff in the following way:

a) The Clinical Nurse Manager/nurse in charge must contact the doctor and when he/she arrives he/she should be involved in containing the incident as well as prescribing/reviewing any necessary medication.

b) Ensure adequate staff are present to diffuse the situation.

c) All unnecessary personnel, both staff and patients, should be asked to leave the area.

25.6 The patient should be removed, if possible, to a quiet area of the ward, e.g. side-room.

25.7 All articles of furniture that could prove dangerous should be removed from the immediate area.

25.8 Staff should use de-escalation techniques to prevent the incident escalating.

25.9 Where de-escalation techniques fail and the patient poses an immediate threat of serious harm to self or others the patient may be physically restrained.

25.10 The leader monitors the patients head and airway.

25.11 When medication has to be administered intramuscularly and physical restraint is unavoidable, i.e. where the patient exhibits violent behaviour, it should be borne in mind that restraint must be a therapeutic measure, and it should be carried out as professionally as any other treatment. Physically restraining the patient should not be prolonged beyond the period which is strictly necessary to prevent immediate and serious harm to the patient or others.

25.12 At all times, it is very important to talk to the patient and explain to him/her what is being done.

25.13 Physical restraint may be ended by the leader at any time. To ensure physical restraint is not prolonged the patient may be require to be placed into seclusion or placed on high observation.

25.14 Incident forms should be completed if either the patient or members of staff are injured. A Special Report should also be written, as well as the usual reports in the clinical file and Daily Report Book.

25.15 Incident reviews should be regarded as a learning event. Any new learning being communicated to staff.

26.0 Occupational Health and Employee Assistance:

26.1 Staff exposed to incidents of aggression and violence should be advised of supports available locally, Employee assistance programmes and Occupational Health.

27.0 Staff Assaults:

27.1 Where a patient or other person assaults a staff member the Gardaí may be informed.

27.2 The staff member will be required to make a statement to the Gardaí in order for the Gardaí to take proceedings against the individual accused of the assault.

27.3 Line managers should support their staff in making statements to the Gardaí.

28.0 Restrictive Practice Reduction Strategy:

28.1 Galway/Roscommon Mental Health Services aims to reduce seclusion by:

a) Education and training of staff on the use of physical restraint with emphasis on,
   i. Building positive therapeutic relationships,
   ii. Supporting positive behaviour,
   iii. Understanding the patients individual life story (trauma, abuse, ect.),
   iv. Emphasis on observation and de-escalation,

v. Identification of triggers specific to the individual,
vi. Proportionate restraint 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. Sensory Modulation tool kit (Appendix 6),
viii. Combination of interventions.

c) Reviewing Data:
i. Times of incidents
ii. Locations of incidents,
iii. Length of time of restraint,
iv. Initiation of restraint,
v. Reasons for initiating restraint,
vi. Analysis of audit results.

d) Reviewing annually the seclusion policy,

e) Conducting the review of an episode of seclusion 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 restraint with members of the multidisciplinary team,
iv. Giving staff an opportunity to discuss episode of restraint,
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,
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.

28.2 This restrictive practice reduction strategy will be implemented incrementally and will develop over a period of time. It is also dependent on additional resources for some interventions.

29.0 Safewards:

29.1 Galway/Roscommon Mental Health Services has commenced the Safewards Model (Bowers 2014) within each Approved Centre. Safewards Model is an evidenced with the aim of reducing conflict and containment (Lee et al, 2021).

29.2 A Safewards steering committee provides oversight for local Safewards implementation groups and the introduction, monitoring and evaluation of Safewards.

29.3 Staff and Service users are involved in the implementation of key interventions and work together to make improvements within Approved Centres.

29.4 Two interventions "Mutual Help Meetings" and "Mutual Expectations" have been chosen to commence the introduction of Safewards Model, with the remain 8 interventions being introduced incrementally.

30.0 Damage to Property:

30.1 Any person found to have caused damage to property may be pursued by management for the costs and/or criminal proceedings against the individual.

31.0 Governance of Restrictive Practices:

31.1 The use of restrictive practices are closely monitored by the review and oversight group of the approved centre to ensure the human rights of the individual patient are protected (in far as reasonably practicable) and that where used it is a last resort, practiced within the legal and ethical framework.

31.2 As part of a review staff initiating, ordering and/or participating in the use of restrictive practices will be required to reflect on each event and consider if the situation could be managed in a different way.

31.3 Physical restraint cannot be used for:
a) Staff shortages,
b) As a punishment,
c) Solely to protect property,
d) As a substitute for other less restrictive interventions.

31.4 Only trained and experienced nursing and medical staff can participate in the physical restraint of an individual.

32.0 Reporting of the use of restrictive practices:

32.1 The registered proprietor should notify the Mental Health Commission of the start time and date and end time and date of each Episode of physical restraint.

32.2 Data on the use of physical restraint must be held in the approved centre and used to produce an annual report on the use of physical restraint in the approved centre signed by the registered proprietor nominee.

32.3 The report must be publically available on the registered proprietors website within 6 months of the end of the calendar year. The report should contain the following:

a) aggregate data that should not identify any individuals;
b) a statement about the effectiveness of the approved centre's actions to eliminate, where possible, and reduce physical restraint;
c) a statement about the approved centre's compliance with the code of practice on the use of physical restraint;
d) a statement about the compliance with the approved centre's own reduction policy; and
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

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

33.0 Audit:

33.1 The use of physical restraint will be audited using the audit tool in Appendix 2 or comparable audit tool.

34.0 Abbreviations:

34.1 MHA 2001= Mental Health Act 2001.
34.2 MAPA= Management of Actual and Potential Violence
34.3 TMV= Therapeutic Management of Violence

35.0 Production and Consultation Trail:

35.1 Version 17 of this document was amended on the recommendations of the Inspector of Mental Health Services in September 2023.

35.2 The document was sent to the Executive management team for signing in September 2023.

35.3 Changes were notified to the governance group in September 2023.

36.0 Implementation of Policy:

36.1 Following sign off this policy will be uploaded to Q-Pulse. Staff will be notified by email of its implementation date and a contact person if any questions arise.

36.2 Staff will acknowledge the policy via Q-Pulse as evidence that they have read and understood the policy.

37.0 References:

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37.9 Mental Health Commission (2009)**.** *Code of Practice on the Use of Physical Restraint in Approved Centres.* Mental Health Commission, Dublin. Available on line @ **www.mhcirl.ie**

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37.12 Mental Health Commission (2019) The use of Restrictive Practices in Approved Centres. Available on line @**www.mhcirl.ie**

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38.0 Appendix 1: Clinical Practice Form Physical Restraint.

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

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

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

11 (c) Who assisted with the physical restraint:

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

Signed: _____

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

Signed: _____

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

Signed: _____

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

Signed:

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

13. Why is physical restraint being ordered/renewed?

- Immediate threat of serious harm to self ☐
- Actual harm caused to self ☐
- Immediate threat of serious harm to others ☐
- Actual harm caused to others ☐
- Transfer to seclusion room ☐
- To administer medication/treatment (excluding nasogastric feeding) ☐
- To administer nasogastric feeding ☐
- Other (please specify) ☐ _____

Please provide further details on the above:

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

Verbal Intervention ☐ Medication offered / administered ☐

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

Other (please specify) ☐ _____

Please provide further details on the above:

15. Type of physical restraint used:

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

Please provide further details

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

Yes ☐ No ☐

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

17. Order:

I _____ have assessed _____ on

Date: ____/____/_____ at ____ hrs ____ mins and I order the use of physical

restraint from Date: ____/____/_____ at ____ hrs ____ mins for up to a

maximum of ____minutes

Name (print): _____ Signed: _____

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

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

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

Duty consultant psychiatrist ☐

Name (print): _____ Signed: _____

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

19. Physical restraint ended ☐ Physical restraint renewed* ☐

Who ended/renewed physical restraint:

Name (print): _____ Signed: _____

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

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

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

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

Yes ☐ No* ☐

If yes, please complete the following:

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

Date and time of medical examination:

Date: ____/____/_____ at ____hrs ____mins

*If no, please provide further details:

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

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

If yes, please provide further details:

39.0 Appendix 2: Physical Restraint Risk assessment & Checklist/Audit Tool.

Galway/Roscommon Mental Health Services Document No.: **RF-GRMHS-CLN-31**

Physical Restraint Risk Assessment Record: NOTE: All Information on the patient may not be available or known prior to the patient's physical restraint.

PHYSICAL RESTRAINT RISK ASSESSMENT RECORD.			
Patient is an Adult or Child (Restraint techniques will be proportionate)			
Patient or others are a immediate harm due to the patients behaviour	Y	N	
Alternatives to Physical Restraint have been unsuccessful	Y	N	
Patients Physical/Mental Condition			
Information from the patient care plan has been considered prior to restraint	Y	N	
Patient has communication difficulties	Y	N	U/K
Patient has a history of Cardiac problems	Y	N	U/K
Patient has a history of Respiratory problems	Y	N	U/K
Patient has a history of skeletal or muscular problems (e.g. osteoporosis, previous fractures, arthritis, Muscular dystrophy etc.)	Y	N	U/K
The patient is obese	Y	N	
The patient is Pregnant	Y **N/A**	N	U/K
Serious Mental illness	Y	N	U/K
Intellectual Disability or cognitive impairment	Y	N	U/K
History of sexual/physical abuse	Y	N	U/K
Ethnicity			
Are there Cultural or Ethnic factors than need consideration during restraint	Y	N	
Gender			
Is there at least one staff member of the same gender as the patient on the restraint team	Y	N	
Medication (sedation)/Intoxication			
The risk of physical restraint increased by: Medication (Sedation)..... Intoxication (Alcohol or illicit drugs).....	Y Y	N N	 U/K
Environment			
There is an adequate light source to observe the patient while being restrained	Y	N	N/A
In so far as reasonably practicable all objects and potential weapons are removed from the area	Y	N	
Staff have enough space to safely physically restrain the patient in the area	Y	N	
Visitors and other patients have been removed from the area.	Y	N	

Risk Rating	Tick Box
High – there is a risk to the patient due to their underlying physical condition	
Medium – background risk but no imminent risk	
Low – no evidence of risk	

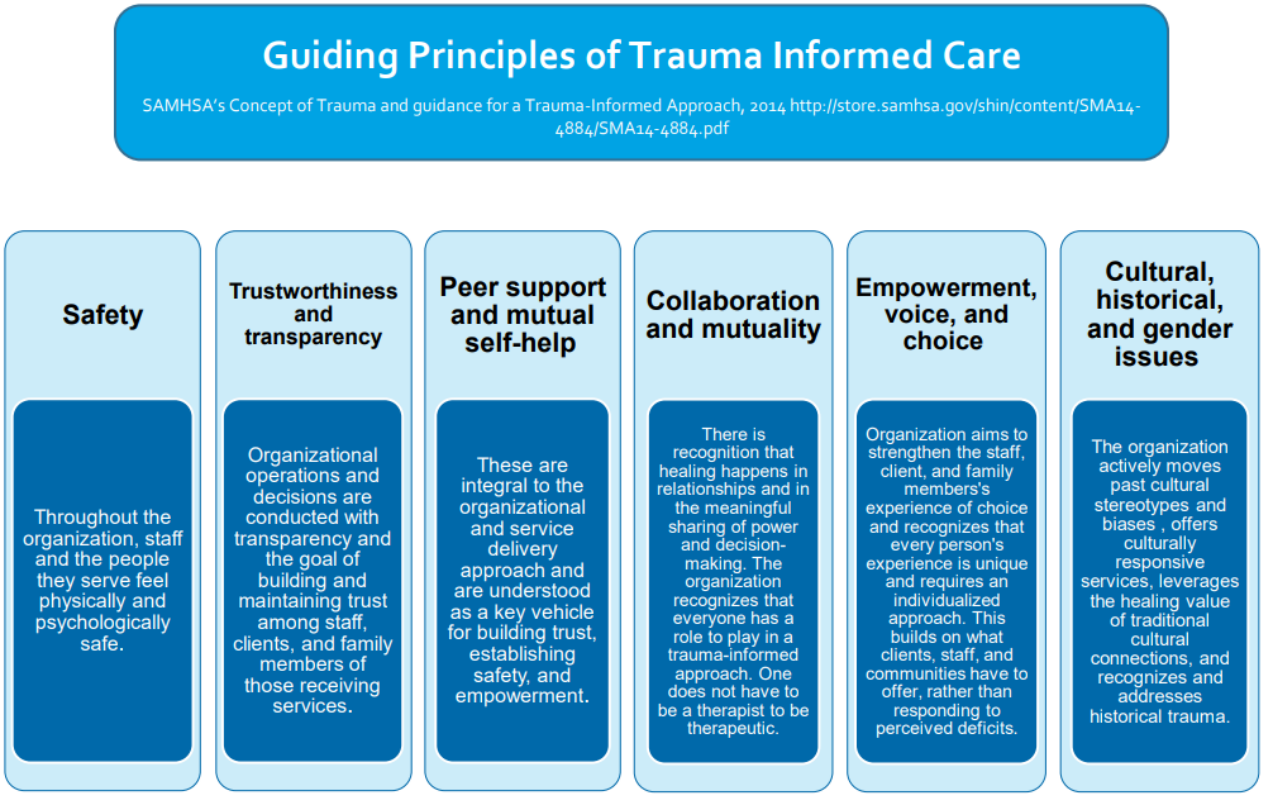
Clinical Practice MHC-PR- Number_____

Patient Identification Label
Name:
Address:
D.O.B.
Consultant:
Pay No.:

PHYSICAL RESTRAINT CHECK LIST/AUDIT TOOL.			
Physical restraint is based on the assessment of risk and is documented in the patient's clinical file.	☐ **Y**	☐ **N**	
Alternatives to Physical Restraint considered and documented in the patient's clinical file & the register **(Section 14)**.	☐ **Y**	☐ **N**	
Physical Restraint initiated by a registered medical practitioner, registered nurse or other MDT Member			
Designated member of staff leads physical restraint and continually monitors Patients head and airway.	☐ **Y**	☐ **N**	
Registered medical practitioner examines patient **no later than 2 hours** of initiation of episode of physical restraint (the medical examination is documented in patient's clinical file and **section 20** of the register) **NB The time of the examination is documented in the patient's clinical file**	☐ **Y**	☐ **N**	
Treating consultant /consultant on duty informed by the person initiating the restraint and a record of this is made in the patient's clinical file	☐ **Y**	☐ **N**	
Informing patient of Reasons for Physical Restraint			
Inform patient of reasons for and circumstances which will lead to the ending of physical restraint and document in patient's clinical file and their rights.	☐ **Y**	☐ **N**	
If patient is not informed document the reason why in patient's clinical file.	☐ **Y**	☐ **N**	☐ **N/A**
Informing patients representative Note the care plan should indicate the patient wishes			
If the patient wishes (as per their care plan) that their representative be informed of their physical restraint as soon as practicable and document in the patient's Clinical file and register **(section 16)**.	☐ **Y** ☐ **N** ☐		
If next of kin are not informed, document reason why in patient's clinical file.	☐ **Y**	☐ **N**	☐ **N/A**
Where the patients care plan indicates their wish **NOT** to inform their representative of their physical restraint it is recorded in patient's Clinical file.	☐ **Y**	☐ **N**	☐ **N/A**
Informing Parent/Guardian (child Physically Restrained)			
Parent/Guardian informed and document in child's clinical file.	☐ **Y**	☐ **N**	☐ **N/A**
Completion of Clinical Practice form			
Clinical practice form completed fully **(sections 1-17)**, **no later than 3 hours** after the conclusion of the episode of physical restraint.	☐ **Y**	☐ **N**	
Physical restraint episode documented in the patient's clinical file.	☐ **Y**	☐ **N**	
Clinical Practice form on Physical Restraint is signed by treating consultant/consultant on duty within **24 hours (section 18)**.	☐ **Y**	☐ **N**	
Ending of Physical Restraint			
Clinical Practice form completed with the date, time and who ended physical restraint **(section 19)**.	☐ **Y**	☐ **N**	
Completed clinical practice form placed in patient's clinical File.	☐ **Y**	☐ **N**	
Review of Physical Restraint episode			
Patient given the opportunity to participate in a debriefing of the episode of physical restraint with members of the MDT within **2 working days**	☐ **Y** ☐ **Declined**	☐ **N**	
Patient representative attended the debriefing	☐ **Y**	☐ **N**	☐ **N/A**
Review of episode of restraint by members of the MDT has been completed within **5 working days**.	☐ **Y**	☐ **N**	
Review of episode of restraint by members of the MDT is documented in the patient's clinical file and care plan updated.	☐ **Y**	☐ **N**	

Name_____ Signed _____ Date_____

40.0 Appendix 3: Trauma Informed Care Principles



41.0 Appendix 4: Safewards 10 interventions

The 10 Interventions

- **Mutual Expectation-**

  Listing out how we treat each other

- **Soft Words-**

  Respectful ways we talk to each other

- **Positive Words-**

  Positive handover of shifts. Listing service users' strengths

- **News Mitigation-**

  How we support each other receiving bad news

- **Reassurance-**

  Debriefing and supporting each other

- **Know each other-**

  Being transparent and sharing to help us get to know each other

- **Discharge Messages-**

  Messages of hope left by our service users on discharge

- **Calm Down Box-**

  Sensory calming items that service users can use

- **Mutual Help Meetings-**

  Checking in and coming together

- **Talk Down-**

42.0 Appendix 5: Positive behavioural support Strategies

- Develop a positive rapport
- Establish consistent routines
- Remain calm and respond positively during a behaviour
- Involve the person in discussing behaviour issues.

Positive behaviour support aims to identify and mitigate the triggers that generate behaviours and if done successfully it can reduce the chances of a behaviour occurring. Some of these strategies include;

- Avoid or minimize known triggers
- Use distraction or redirection away from the trigger
- Discuss these triggers with the person
- Work together on possible coping strategies
- Suggest and encourage these strategies when a trigger occurs.

43.0 Appendix 6: Sensory Modulation

Sensory modulation :

Guide for management of aggression in an Adult Acute Mental Health Unit:

Alternative options for the use of seclusion and physical restraint.

Anna Glynn (Senior OT AAMHU)

What is Sensory modulation?

It is the neurological regulation of response to sensory stimuli (Kinnealey et al., 2011). Problems with sensory processing can result from difficulties in how the nervous system receives, organises, and uses sensory information from the body and the physical environment. This is necessary for self-regulation, motor planning and skill development. Sensory processing refers to an individual's ability to take in information through the senses (touch, movement/balance, smell, taste, vision) and make a meaningful response (Brown & Nicholson, 2011).

For example auditory hallucinations may impact on self-concept, emotional regulation, attention, problem solving, behaviour control, skill performance, and the capacity to develop and maintain interpersonal relationships. In adults they may negatively impact on occupations, sense of self and occupational performance skills (parenting, working, home management, social and leisure activities) (AOTA, 2011; Brown & Nicholson, 2011; Champagne 2011). Interventions include activities or modalities offering specific types and amounts of sensation, at strategic times of use, for therapeutic purposes. Examples offered in the table below:

Research to support the use of sensory strategies in a Mental Health setting to reduce the use of seclusion:

Champagne and Stromberg (2004) examined the sensory approaches used in an inpatient psychiatric setting as an alternative to seclusion and restraint. It was found that 89% of the sensory room sessions had a positive effect. During the year of implementation the facility's rates of seclusion and restraint decreased by 54%. Sivak (2012) found that following the introduction of comfort rooms (similar to sensory rooms/modulation) in a mental health facility, positive outcomes were noted with decreased rates of assaults as well as zero use of seclusion and mechanical restraints. Chalmers et al. (2012) showed a significant reduction in patient distress levels when using sensory modulation strategies. Novak (2012) found that a sensory room was an effective intervention to lessen distress and aggressive behaviour in an inpatient setting. Lloyd et al. (2014) completed 2 sensory modulation studies: In study 1, they found that most patients had a marked reduction in disturbance after using sensory modulation. In study 2, they found that frequency of seclusion dropped dramatically in the unit that introduced sensory modulation but rose slightly in the unit that did not have access to sensory modulation. Sutton, et al. (2013) suggested that sensory approaches have a valuable role in regulating emotion and that they improve the options in managing aggression. Bjorkdahl et al. (2016) reported an increase in patients' self-confidence, emotional self-care, and well-being with the use of sensory rooms in psychiatric care. Wiglesworth and Farnworth (2016) identified a decrease in stress with the use of a sensory room in an inpatient setting. Reed (2017) found patients did not exhibit acting out behaviours within 24 hours post sensory intervention.

A sensory programme is meant to help calm versus alert the senses. The goal of a sensory modulation programme is to provide patients the opportunity for self-regulation of emotions and learning new coping skills to de-escalate aggressive behaviours. A sensory programme is intended to help patients who are becoming escalated in behaviour (i.e. increased agitation and defensive behaviours: including questioning authority, refusal, verbal venting, and intimidation) in order to help them calm and regulate their own emotions. Sensory modulation and sensory rooms are deliberately intended to be sensory calming with the goal of crisis de-escalation and/or prevention (Champagne, 2015).

Weighted Blankets (WB):

Prescribed only by OT staff.

A review of literature found the use of weighted blankets to be effective and safe in reducing the signs and symptoms of anxiety. Numerous quantitative and qualitative studies showed that a multitude of physiological symptoms and self-reported levels of anxiety were consistently reduced after use of a weighted blanket (Eron et al, 2020).

Trauma-informed care is a national mental health initiative promoting a model of care and advocates for the offering of interventions that are empathic, empowering, client-centered, nurturing, sensory supportive and do not contribute to re-traumatization (DOH Sharing the Vision, 2020; NETI, 2003, 2009; Van der Kolk, 2006, 2014). WBs are particularly promising in the area of trauma-informed care because they can be used to help foster self-care, self-nurturance, rest/sleep, and stabilization.

The aim of using the weighted blanket is to provide a patient with a sustained deep pressure sensation to their body to aid them in maintaining a calm and alert state, reduce their arousal level and for their sensory proprioceptive system be more organised to function. Parasympathetic nervous system (PNS) influences the "rest and digest" and polyvagal responses which aids social engagement and the ability to participate in meaningful life roles (Boucsein, 1992; Porges, 1992).

Advice for use:

Prescribed only by OT staff.

The following is the recommended protocol for using the weighted blanket with a person. If a person objects to wearing the blanket, the blanket can be placed on their lap when sitting.

If they continue to object to this, please remove the blanket and contact the Occupational Therapist as soon as possible.

The person should not be forced to wear the blanket or have it on their bed if they are uncomfortable with it. Consent is required.

It is recommended that any applied weighted object to the body is no more than 10% of body weight, to ensure that the weight is not putting an excessive strain on the body.

Place the blanket on a person for 10 minutes approximately every 2 hours. This is to help the person's sensory proprioceptive system to register the blanket and help the effects last.

Sensory Modulation suggestions: where possible alongside the use of the sensory room

Proprioceptive • Weighted blanket • Resistive had-squeeze equipment • Use of therapy ball • Use of weighted ball activities • Dance/yoga/tai chi	Vestibular • Rocking chair • Glider rocker • Therapy ball activities • Swinging • Dance/yoga/tai chi • Getting in and out of beanbag chair
Tactile • Loofahs • Sitting in a bean bag • Self-massage tools • Weighted therapy tools • Fleece blankets/pillowcases • Microwaveable hot packs • Manicure • Hand/face lotion • Chew/ crunchy foods • Vibration	Auditory • Guided imagery CDs • Various types of music – fast/slow pace • Stereo or personal audio system • Musical instruments • Flowing rock/waterfall
Visual • Bubble lamp • Wall murals/various pictures • Bubbles • Glitter wands • Various lights/lighting • Computer use • Coloured sunglasses	Olfaction • Scented bath/body wash • Scented lotions/balms • Aromatherapy (100% essential oils) • Lemon • Spices • Eucalyptus • Candles • Herbal teas
Gustatory • Carrot sticks • Celery sticks • Pretzels • Sour lollies • Gummy bears • Fruit snacks • Ice blocks/frozen fruit bars • Ice • Biting on a lemon • Chewy foods • Strong mints • Herbal teas • Lollipops • Trail mix • Yoghurt	

Occupational Therapy Recommendations for Use of a Weighted Blanket

Name of Patient	
Date of Birth	
Name of Occupational Therapist Recommending the WB	
Date	

It is recommended that a weighted blanket be used with this person, for a trial period.

The aim of using the weighted blanket is to provide this person with a sustained deep pressure sensation to their body to aid them in maintaining a calm and alert state, reduce their arousal level and for their sensory proprioceptive system to be more organised to function.

The following is the recommended protocol for using the weighted blanket with a person. If a person objects to wearing the blanket, the blanket can be placed on their lap when sitting.

If they continue to object to this, please remove the blanket and contact the Occupational Therapist as soon as possible.

The person should not be forced to wear the blanket or have it on their bed if they are uncomfortable with it. Consent is required.

Protocol for Weighted Blanket

Blanket
It is recommended that any applied weighted object to the body is no more than 10% of body weight, to ensure that the weight is not putting an excessive strain on the body.

Application
The weighted blanket if needed should be placed on the person by staff. If agreed prior with the person the weighted blanket could be placed on the bed when the person is asleep.

When - Activity
The weighted blanket could also be placed on the person when they are seated: on the lap or draped around themselves.
It should not be used when he is engaging in movement activities.
This is because the blanket aims to calm the person, movement is exciting to the sensory system, and the effects are reduced if he is moving around with weighted blanket.
It is ok if they walk in the room for a brief time when the blanket is on.
Encourage them to stay sitting and provide them with activities to engage in at the table.

When - Time Frame
The **weighted blanket should be left on the person for initially 10 minutes at a time**, then after a week, or gradually over a few days build up to 15 minutes.
After a period of having the blanket on for 15 minutes at a time, it can be gradually increased again up to 20 minutes, but should not be left on for longer than 20 minutes or the effectiveness will be reduced.

Occupational Therapy Recommendations for Use of a Weighted Blanket

Name of Patient	
Date of Birth	
Name of Occupational Therapist Recommending the WB	
Date	

- Place the blanket on the person for initially 10 minutes approximately every 2 hours. This is to help the person's sensory proprioceptive system to register the blanket and help the effects last.
- Try putting the blanket on the person before times of transition, e.g. for 10 minutes on before into dining room and before their break time.
- Select regular times for the person to wear the blanket, so they can become familiar and more comfortable with it as part of their sensory toolbox routine.
- As this is a new experience for the person, it would be very useful if it could be noted how they are reacting to the weighted blanket and if it has any impact on him, especially on their attention, arousal levels and their behaviours.

44.0 Review History:

PPG-GRMHS-CLN-20 Physical Restraint and the management of aggression and violence.	
Section	**Changes Made**
	Document changed to comply with the Revised Code of Practice on the use of Physical Restraint (MHC 2022)
6.4.1 c)	New point added
6.5.1 c)	New point added
7.12	Added "Where a female is being restrained and where practical there should be a female member of staff present."
11.8 g)	New point added
11.8 h)	Added "..emotional.."
11.18 a)	Added "..if they wish,"
11.18 d)	Added "..if they wish,"
11.18	Added "**NOTE: this information should be in accessible language and format. The Mental Health Commission information leaflet: "What you need to know about the Code of Practice on Physical Restraint" may be used."**
12.1	Deleted "..or other members of the multi-disciplinary team".
12.2	New point added.
12.7	Added "..medical.."
12.2	Deleted "..the to.."