Management of Physical Restraint

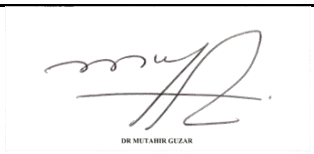
Cavan Monaghan Mental Health Services

Is this document a:

Policy √ **Procedure** ☐ **Protocol** ☐ **Guideline** ☐

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

Mental Health Services CH CDLMS, Cavan Monaghan Mental Health Services

Title of PPPG Development Group:	CMMHS PPPG Development Group
Approved by:	 Dr. Mutahir Gulzar, Executive Clinical Director On behalf of: Cavan Monaghan Mental Health Management Team Ms. Pauline Ackermann Nominated Approved Centre Registered Proprietor Cavan Monaghan Mental Health Service
Reference Number:	CMMHS/Cl/17/3
Version Number:	18
Publication Date:	February 2024
Date for revision:	January 2025
Electronic Location:	CMMHS Policy Portal

Version	Date Approved	List section numbers changed	Author
18	Feb 2024	1.153	Graham Malone

Contents

Part A: Algorithm

Registered nurse or registered medical practitioner initiates and orders physical restraint.
An order for physical restraint should last for a **maximum of 10 minutes**

- Consultant Psychiatrist notified of the episode of physical restraint as soon as is practicable
- The person should be continually assessed throughout the use of restraint to ensure the person's safety
- The staff member leading the use of physical restraint should ensure that other staff members:
- Protect and support the person's head and neck, where needed;
- Ensure that the person's airway and breathing are not compromised;
- Conduct observations, including vital clinical indicators such as the monitoring of pulse, respiration and complexion (with special attention for pallor/discolouration). These observations should be recorded and staff should be trained so that they are competent to interpret these vital signs; monitor and maintain effective communication with the person and; monitor the person's physical and psychological health for as long as clinically necessary after using physical restraint.
- A record of these observations should be recorded in the person's clinical file.

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

Renewal order - by a registered medical practitioner or the most senior registered nurse on duty in the unit/ward following a medical examination or nursing review, for a further period not exceeding 10 minutes (to a maximum of two renewals of continuous restraint - the continuous period of physical restraint should never be longer than 30 minutes).
The reasons for renewing the order, and the time that the nursing review or medical examination took place, should be clearly recorded in the person's clinical file.

Medical examination carried out by a registered medical practitioner no later than two hours after the start of an episode of physical restraint

Documentation to be completed

- The episode of physical restraint should be recorded in the person's clinical file.
- The relevant section of the "Clinical Practice Form for Physical Restraint" - completed by the person who initiated and ordered the use of physical restraint no later than three hours after the conclusion of the episode of physical restraint.
- Clinical Practice Form for Physical Restraint - signed by the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist within 24 hours.

Part B: PPPG Development Cycle

Initiation

Purpose

1.1 The Cavan Monaghan Mental Health Service (CMMHS) is committed to the best professional and evidence based practice in the professional management of aggression and violence.

1.2 The CMMHS is committed to respecting the human rights of the person to dignity, bodily integrity, privacy and autonomy during the management of a physical intervention, whilst taking into consideration the level of resident's clinical risk and safety.

1.3 This policy must be read and applied in conjunction with the Mental Health Commission (MHC) revised Code of Practice on the Use of Physical Restraint (2022) and the revised Rules Governing the Use of Mechanical Restraint in Approved Centres (2022).

1.4 A failure to implement or follow the Code of Practice and Rules in Approved Centres could be referred to during the course of legal proceedings.

Scope

1.5 This policy applies to all:

- Staff working in the CMMHS.
- Residents/service users involved in an incidence of aggression and/or violence.

Objectives(s)

1.6 To give guidance to managers and staff in the professional management of aggression and violence and the use of approved physical interventions. A reduction in work-related aggression and violence and the use of physical restraint, or an improvement in their manner of containment, can only be obtained if there is a clear commitment and co-operation between all levels and disciplines of staff.

1.7 To ensure staff Implement Standard Precautions for infection prevention and control with all patients at all times.

Outcome(s)

1.8 The aim of CMMHS is to minimise the potential for work related aggression and violence by ensuring the highest standards of care. If immediate threat of serious harm to persons occurs, then it is managed safely and effectively in such a way as to maintain both the safety of the residents and employees. The primary objective of the staff in relation to the management of unsafe behaviour must, at all times, be directed towards its prevention.

If preventative measures have failed, the primary objective of the employee will be directed towards maintaining the safety and wellbeing of the residents/service users involved in the aggressive or violent incident.

PPPG Development Group

(Appendix 1)

PPPG Governance Group

- CMMHS Area Management Team
- Quality Patient Safety Committee CMMHS
- PPPG Development Group CMMHS

Supporting Evidence

1.9 This policy must be read in conjunction with:

- CMMHS Risk management Policy
- CMMHS Risk Screen and Management Policy
- CMMHS Violence and Aggression Risk Assessment to Staff/Others Policy
- CMMHS Restraint Reduction Policy
- CMMHS Management of Mechanical Means of Bodily Restraint
- CMMHS Arm Protectors in the Management of Scratching, Biting & Pinching
- CMMHS Maintenance of Records Policy
- CMMHS Development Management and updating of Individual care and treatment Plan
- CMMHS Protocol for Personal Alarms and Emergency Response
- CMMHS Policy on Mandatory Training
- CMMHS Uniform Policy
- Safety, Health and Welfare at Work Act 2005.
- Seclusion and Restraint Reduction Strategy (MHC, 2014)
- Mental Health Act 2001
- MHC Quality Framework
- The MHC Judgement Support Framework
- HSE Best Practice Guidance for Mental Health Service
- MHC Rules & Codes of practice CMMHS
- Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting (V2), (2023).

Occupational Infections for Healthcare workers

1.10 Infection Prevention and Control practice supported by appropriate use of PPE is important to minimise risk to patients of healthcare associated COVID-19. These measures are equally important in controlling exposure to occupational infections for healthcare workers (HCWs). Traditionally, a hierarchy of controls has been used. The hierarchy ranks controls according to their reliability and effectiveness and includes engineering controls, administrative controls, and ends with

personal protective equipment (PPE). In the context of risk of respiratory infection PPE adds an extra layer or protection in the context of scrupulous attention to hand hygiene, respiratory hygiene and cough etiquette and environmental hygiene.

- Appropriate PPE must be worn by staff identified using a risk assessment for the type of PPE to be worn
- Implement Standard Precautions for infection prevention and control with all patients at all times
- Maintain a physical distance of at least 1 metre (3 feet) but ideally 2 metres from individuals with respiratory symptoms (where possible)
- Clean your hands regularly as per WHO 5 moments
- Avoid touching your face
- Promote respiratory hygiene and cough etiquette which involves covering mouth and nose with a tissue when coughing and sneezing or coughing into the crook of an elbow, discarding used tissue into a waste bin and cleaning hands

Glossary of Terms and Definitions

(Appendix 2)

Development of PPPG

- List the questions (clinical/non-clinical)
- How can we prevent aggression and violence from occurring?
- If it does occur what is the best way of dealing with it?
- What are the legal and ethical considerations in the management of aggression and violence?
- How do we demonstrate compliance with the MHC code of practice on the use of physical restraint?
- How can we reduce incidents of physical restraint?
- What supports need to be put in place for the staff?

Describe the literature search strategy

1.11 This literature search strategy involved an electronic data base search using CINAHL and psychINFO. The keywords used to guide the search included: 'Aggression and Violence', 'physical restraint', 'debriefing', 'trauma', 'trauma informed care', 'Psychiatry', mental illness,' and 'restraint reduction.' The search was limited to full text and English language articles. Articles were restricted to those published in the past ten years to ensure a review of recent and up to date articles were used. An engine search of Mental Health Commission website, HSE publications, Mental Health Commission framework, and guideline publications was also completed.

Describe the process the PPPG development group used to formulate recommendations

- Convene a dedicated PPPG development group made up of members of the PPPG development group and certified PMCB Instructors

- Conduct a literature review of relevant and recent articles available.
- Research and review evidence best practice available through the literature.
- Review of existing policies and procedures available.
- Develop PPPG using HSE national Framework for Developing policies, Procedures, Protocols and Guidelines (2016).
- Seek Advice and Guidance from Quality and Patient Safety Manager.
- Participate in Audit Conduction in approved Centres.
- Review applicable recommendations arising from adverse incidents and ensure overseeing of any relevant learning by local Quality patient safety committee to disseminate across the Services.

Provide a summary of the evidence from the literature

1.12 The HSE recognises and accepts its responsibility in accordance with the Safety Health & Welfare at Work Act (2005) to provide, as far as practicable, the following conditions relating to the prevention and management of aggression and violence:

- Written guidelines in preventing and managing violence and aggression.
- A working environment, including adequate levels of staffing, conducive to the management of potential or actual aggression or violence.
- Information and training to staff handling potential or actual aggression or violence.
- Support to staff involved in aggressive or violent incidents.
- A system of monitoring and reviewing aggressive and violent incidents.

The Declaration of Human Rights (United Nations, 1948) and the European Convention of Human Rights (Council of Europe, 1956) are clear that the use of any force by one person over another must be justifiable. In the context of caring for individuals who may present actual or potential aggression, this duty remains absolute. In establishing the broad constraints of any such actions, the United Nations (1948) and the Council of Europe (1956) state: *"The restraint of a severely disturbed person is justified as long as the method of restraint does not involve inhumane or degrading treatment."*

Physical interventions are actions that should be used in RARE AND EXCEPTIONAL circumstances and only used in the best interests of the individual, and only when the individual poses an immediate threat of serious harm to him/herself or others, and all alternative interventions to manage the individual's unsafe behaviour have been considered, and exhausted.

Occurrences of work-related aggression and violence are a function of an interchange between the service user, service provider, interaction taking place and environmental factors. Effectively responding to the problem involves adequately and equitably addressing the concerns of all involved (Linking service to safety, 2008).

Detail resources necessary to implement the PPPG recommendations

- Major and minor capital funding.

- Purpose designed training room and equipment to accommodate didactic and physical practicum education and training in The Professional Management of Complex Behaviour (PMCB) which complies with infection control guidelines.
- Certified instructors in PMCB.
- Staff training in PMCB.
- Annual audits and reports on the use of physical restraint in approved centres.

Outline of PPPG steps/recommendations

1.13 Principles underpinning the use of physical restraint:

1. Approved centres should recognise the inherent rights of a person to personal dignity and freedom in accordance with national and international human rights instruments and legislation.

2. The use of physical restraint may increase the risk of trauma and may trigger symptoms of previous experiences of trauma. Therefore, it should only be used in rare and exceptional circumstances as an emergency measure.

3. Persons who are restrained should be treated with dignity and respect at all times, before, during and after the restraint.

4. Persons who are restrained should be fully informed and involved in all decisions regarding their care and treatment to include all matters relating to the use of physical restraint. The views of persons who are restrained should be listened to, taken into account and recorded.

5. As physical restraint compromises a person's liberty, its use should be the safest and least restrictive option of last resort necessary to manage the immediate situation, be proportionate to the assessed risk and employed for the shortest possible duration. Its use should only occur following reasonable attempts to use alternative means of de-escalation to enable the person to regain self-control.

6. Communication with persons who are restrained should be clear, open and transparent, free of medical or legal jargon, and staff should communicate with empathy, compassion and care. Persons who have a sensory impairment may experience an increased level of trauma during physical restraint and staff should address the additional communication needs of these persons.

7. The views of family members, representatives and nominated support persons, should be taken into account, where appropriate.

8. Cultural awareness and gender sensitivity should be taken into account at all times.

9. Physical restraint should be used in a professional manner and its use should be based within a legal and ethical framework.

10. The least restrictive option should first be considered in dealing with a potential or actual unsafe situation.

11. The use of physical restraint should be proportional and minimal force should be applied for the minimum amount of time which is strictly necessary to prevent immediate and serious harm to the resident or others.

1.14 Outline Specific Roles and Responsibilities:

1) The Registered proprietor has overall accountability for the use of physical restraint in the approved centre.

2) The Registered proprietor should notify the MHC of the start time, date and end time and date of each episode of physical restraint in the format specified by the MHC and within the timeframes set by the MHC.

3) Where restraint was not initiated and ordered by a medical practitioner, the registered medical practitioner (RMO) must be notified by the person who initiated the use of physical restraint as soon as is practicable.

4) As soon as is practicable, and no later than **2 hours** after the start of an episode of physical restraint, a medical examination of the person by a RMO should take place. This should include an assessment of any physical impacts of the restraint episode on the person, as well as a record of any psychological and/or emotional trauma caused to the person as a result of the restraint.

5) The NCHD must notify the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist should be notified of the physical restraint order as soon as is practicable, and this should be recorded in the person's clinical file.

6) A record of the examination must be entered in the resident's clinical file by the registered medical practitioner.

7) The relevant section of the Clinical Practice Form for Physical Restraint should also be completed by the person who initiated and ordered the use of physical restraint as soon as is practicable and no later than **3 hours** after the conclusion of the episode of physical restraint.

8) The CNM2 is responsible for designating a member of staff as responsible for coordinating the episode of physical restraint. The team 'co-ordinator' should be outside of the physical restraint to calmly communicate with the resident if required, instruct the team if required, record the time, seek additional resources if required and continually risk assess the occurrence.

9) The CNM2 is responsible for designating a member of staff as responsible for leading the physical intervention team and for monitoring the head and airway of the resident during an episode of physical restraint.

10) The staff member responsible for leading the physical intervention team must inform the resident of the reasons for and the circumstances which will lead to the discontinuation of physical restraint unless the provision of such information might be prejudicial to the person's mental health, well-being or emotional condition. If informed of the reasons, a record of this should be recorded in the person's clinical file as soon as is practicable. In the event that this communication does not occur, a record explaining why it has not occurred should be entered in the person's clinical file as soon as is practicable.

11) The CNM2 must ensure that as soon as is practicable, and if it is the person's wish in accordance with their individual care plan, the person's representative should be informed of the person's restraint and a record of this communication should be placed in the person's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred should be entered in the person's clinical file. Where it is the person's wish in accordance with their individual care plan that the person's representative is not to be informed of the person's restraint, no such communication should occur outside the course of that necessary to fulfil legal and professional requirements. This should be recorded in the resident's clinical file.

12) In the event that this communication does not occur, a record explaining why it has not occurred must be entered on the resident's clinical file.

13) The CNM2 must ensure that where the resident has capacity and does not consent to informing his/her next of kin or representative of his/her restraint, no such communication must occur outside the course of that necessary to fulfil legal and professional requirements. This must be recorded in the resident's clinical file.

14) The CNM2 must ensure that a restraint, involving the resident in the 'prone', face down, position, which, "is permitted in exceptional circumstances by staff who have received appropriate training" (MHC, 2022), that a record of the use of this prone restraint must be entered in the resident's clinical file.

15) The CNM2 must ensure that:
16) A full detailed account of the incident must be recorded in the resident's clinical file,
17) All sections of the clinical practice form are fully completed
18) The incident reporting form is completed.

19) The Clinical Practice Form for Physical Restraint should also be signed by the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist as soon as is practicable and in any event within 24 hours.

20) The MDT are responsible for ensuring that each episode of physical restraint is reviewed by members of the MDT involved in the person's care and treatment and documented in the person's clinical file as soon as is practicable and in any event, no later than five working days (i.e. days other than Saturday/Sunday and bank holidays) after the episode of restraint.

Use and orders for physical restraint:

1.15 Physical restraint should only be initiated and ordered by registered medical practitioners, or registered nurses.

The order should confirm that there are no other less restrictive ways available to manage the person's presentation.

The consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist should be notified of the physical restraint order as soon as is practicable, and this should be recorded in the person's clinical file.

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

An episode of physical restraint may be extended by a renewal order made by a registered medical practitioner or the most senior registered nurse on duty in the unit/ward following a medical examination or nursing review, for a further period not exceeding **10 minutes** - to a maximum of two renewals of continuous restraint. The continuous period of physical restraint should never be longer than 30 minutes. The reasons for renewing the order, and the time that the nursing review or medical examination took place should be clearly recorded in the person's clinical file.

a. The episode of physical restraint should be recorded in the person's clinical file.
b. The relevant section of the "Clinical Practice Form for Physical Restraint" should also be completed by the person who initiated and ordered the use of physical restraint as soon as is practicable and no later than three hours after the conclusion of the episode of physical restraint.
c. The Clinical Practice Form for Physical Restraint should also be signed by the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist as soon as is practicable and in any event within 24 hours.

Physical interventions are used in a professional manner and are based within an ethical and legal framework.

Physical interventions are used in settings where the safety of residents, staff and visitors is regarded as being essential and equal.

Use of physical restraint is based on the CMMHS Violence and Aggression Risk Assessment to Staff/Others.

The use of physical restraint is based on best available evidence and contemporary practice.

Cultural awareness and gender sensitivity are demonstrated when considering the use of and when using physical restraint.

Special consideration must be given to a child resident, older residents and residents with an intellectual disability in accordance with The Code of Practice on the Use Physical Restraint in Approved Centres (2022) and the Code of Practice for persons working in Mental Health Services with People with Intellectual Disabilities (2009).

Special consideration must be given when restraining residents who are known to have experienced physical or sexual abuse.

Special consideration must be given to residents who are obese, pregnant, under the influence of intoxicants and residents with underlying medical and physical conditions.

Special consideration must be given to residents trained in the use of combat, military, police and the martial arts.

The management of the presenting risk must not exceed the available resources and/or capability of staff present, to deal with a situation safely. In the event of this not being the case, contingency plans should be considered, e.g. consult with Senior Nurse, Gardaí involvement, locking or opening of doors.

It is generally considered to be unsafe for anybody to try to restrain another person on their own. If you are alone in a difficult situation, you should try to escape from the situation and summon assistance verbally or by the alarm system.

Dignity and safety

1.16 Staff involved in the use of physical restraint should be aware of and have taken into account any relevant entries in the person's individual care plan, pertaining to the person's specific requirements or needs in relation to the use of physical restraint.

It should be assumed that any person who is restrained may have a past history of trauma and/or abuse. Therefore, the principles of trauma-informed care should underpin the use of restraint on a person.

The person must have a staff member of the same gender present at all times during the episode of physical restraint.

All staff members involved in the use of physical restraint should have undertaken appropriate training in Professional Management of Complex Behaviour (PMCB).

The person should be continually assessed throughout the use of restraint to ensure the person's safety. Approved centres should ensure that physical restraint is only undertaken by staff who work closely together as a team, understand each other's roles and have a clearly defined lead. The staff member leading the use of physical restraint should ensure that other staff members:

- protect and support the person's head and neck, where needed;
- ensure that the person's airway and breathing are not compromised;
- Conduct observations, including vital clinical indicators such as the monitoring of pulse, respiration and complexion (with special attention for pallor/discolouration). These observations should be recorded and staff should be trained so that they are competent to interpret these vital signs;
- monitor and maintain effective communication with the person
- Monitor the person's physical and psychological health for as long as clinically necessary after using physical restraint.

A record of these observations should be recorded in the person's clinical file.

The level of force applied during physical restraint should be justifiable, reasonable, and proportionate to the situation and minimal force should be applied. In the exceptional circumstance where it is considered necessary to use physical restraint on persons who are physically unwell, frail, physically disabled, pregnant or obese, the procedure should be approached with extreme caution and care.

The use of holds that have the potential to inflict pain are prohibited.

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

- neck holds,
- the application of weight to the person's chest or back,
- the use of physical restraint that interferes with the person's airway, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen, or obstructing the mouth or nose,
- the use of physical restraint in a way that interferes with the person's ability to communicate, for example by obstructing the eyes, ears or mouth.

Use of physical restraint involving the person in the “prone”, face down position is only permitted in the most exceptional of circumstances by staff who have received appropriate and specific training in its safe use. A record of the use of prone restraint should be entered in the person’s clinical file.

Methods of Physical Restraint:

1.17 Any form of physical restraint requires that the 'duty of care' afforded to residents is not compromised, and that it takes into account the safety and well-being of everyone involved.

Physical restraint requires the safe restriction of a person’s movement in an effort to avoid immediate and serious harm to self or others.

The CMMHS permit the use of the following training in the management of aggression and violence:

Professional Management of Complex Behaviour (PMCB).
Within this programme, three different levels of restraint are defined:

Level 1 refers to a technique that may be used as a physical intervention to safely engage and de-escalate a resident who may be or may become distressed, anxious, mildly agitated or becoming verbally aggressive. The technique is used to provide reassurance and support for the resident. It allows staff to safely engage and disengage from the resident if the situation escalates.

Level 2 technique is the lowest level of physical restraint applied when the resident’s aggressive behaviour escalates and poses an immediate danger to self or others. The movements of the resident’s arms are limited to protect the resident, staff or others. The resident can still avail of movements considered to be safe by staff.

Level 3 technique is the highest level of restriction and is only applied when the resident becomes aggressive and physically aroused, where he/she poses an immediate and imminent danger to self or others. The movements of the resident’s arm are fully restricted.

Footnote: If Level One is the only level utilised/required, it does not indicate an immediate threat of serious harm to self or others and thus does not come under the definition of a physical restraint as per the Revised Code of Practice (2022) and therefore it is not required to be recorded in the Clinical Practice Form prescribed by the MHC. However, as any clinical intervention, it is required to be recorded in the resident’s clinical file and reported to the multi-

disciplinary team responsible for the care and treatment of the resident.

Implementing Physical Restraint:

1.18 When using physical restraint methods, the following guidelines should be remembered;

1) Staff involved in the use of physical restraint should be aware of and have considered any relevant entries in the resident's care and treatment plan, pertaining to his or her specific requirements/needs in relation to the use of physical restraint. This may include "advance directives".

2) Where practicable, the resident should have a same sex member of staff present at all times during the episode of physical restraint.

3) Make a visual check for weapons.

4) Nominate staff members to assist and allocate each a specific task.

5) Fewer well-briefed staff are likely to be more effective than large numbers of staff holding in an unorganised fashion.

6) Aim to manage arms (head and legs if necessary) swiftly and safely.

7) Protect the head from harm and maintain the airway.

8) Restraint involving the resident in the 'prone', face down position is permitted in exceptional circumstances by staff who have received appropriate training. A record of the use of prone restraint must be entered in the resident's clinical file.

9) The resident must be continually assessed throughout the use of restraint to ensure his/her safety.

10) Continually explain the reason for restraint to the resident, likely duration of and the circumstances which will lead to the discontinuation of the restraint and encourage their co- operation and voluntary control as soon as possible.

11) Wherever possible, staff should remove their own personal items of risk (e.g. jewelry and ties) prior to becoming involved in the physical restraint of a person. This will help to reduce the risk of damage and injury occurring.

Organisation of Physical Restraint:

1.19 Ideally, one staff member should be nominated by the nurse-in-charge, to coordinate the whole situation and utilise resources to meet all of the needs of the incident.

When the team of staff involved in the physical restraint of a resident has assembled; the member of staff who is monitoring the head and airway should assume the role of 'team leader'. All other staff in that team should then take instruction from the team leader.

Ask all other staff/people who are not involved in the situation to leave the immediate vicinity in order to maintain the privacy and dignity of the resident.

The use of physical restraint may be ended at any time by the person responsible for leading the physical restraint of the resident and monitoring the head and airway of the resident.

Ending the physical restraint

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

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

Recording the use of Physical Restraint:

1.21 A full detailed account of the incident must be recorded as soon as is practicable in the resident's clinical file, clinical practice form and an incident reporting form completed.

The relevant section of the "Clinical Practice Form for Physical Restraint" must be completed by the person who initiated and ordered the use of physical restraint as soon as is practicable and no later than 3 hours after the episode of physical restraint.

The MHA administrator/ADON are responsible for ensuring the restraint is recorded on the CIS platform of the MHC within 72hrs of the restraint occurring.

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

Debriefing

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

1) Give the person the opportunity to discuss the physical restraint with members of the multidisciplinary team involved in the person's care and treatment as part of a structured debrief process;

2) Occur within two working days (i.e. days other than Saturday/Sunday and bank holidays) of the episode of physical restraint unless it is the preference of the person who was restrained to have the debrief outside of this timeframe. The person's preferences regarding the timing of the debrief should be recorded;

3) Respect the decision of the person not to participate in a debrief, if that is their wish. If the person declines to participate in the debrief, a record of this should be maintained and recorded in the person's clinical file;

4) Include a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future;

5) Include a discussion regarding the person's preferences in the event where a restrictive intervention is needed in the future for example preferences in relation to which restrictive intervention they would not like to be used;

6) Give the person the option of having their representative or their nominated support person attend the debrief with them, and, if the person's representative or nominated support person does not attend the debrief, a record of the reasons why this did not occur should be recorded in the person's clinical file.

7) Where multiple episodes of physical restraint occur within a 48-hour timeframe, these episodes may be reviewed during a single debrief.

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

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

10) Any use of a restrictive intervention may be traumatic for the person who experiences it. Appropriate emotional support should be provided to the person in the direct aftermath of the episode. Staff should also offer support, if appropriate to other persons who may have witnessed the restraint of the person.

Children

1.23 Children are particularly vulnerable to trauma and harm as a result of restrictive interventions. Physical restraint can have particularly adverse implications for the emotional development of a child. In addition, the size and physical vulnerability of children and young people should be taken into account when considering physical restraint. Physical restraint should be used with extreme caution when it involves children and young people because in most cases their musculoskeletal systems are immature which elevates the risk of injury.

In addition to sections 3-8 (MHC Code of Practice) which apply to all persons, the following considerations apply to children being provided care and treatment in approved centres:

1) Upon admission to an approved centre that uses physical restraint on children, a documented risk assessment should be carried out by a registered medical practitioner or registered nurse. This should show that careful consideration has been given to the potential effects of restraining a child or adolescent, having regard to the physical status and emotional development of the child, and their particular vulnerability to trauma and harm as a result of restrictive interventions.

2) The outcome of the risk assessment should determine if physical restraint can be safely used or not.

3) Children should have the reasons for, and the circumstances which will lead to the discontinuation of restraint, explained in a way that the child can understand and in a format that is appropriate to their age. A record should be maintained of this communication and clearly outline how it met the child's individual communication needs.

4) An approved centre physically restraining a child should ensure the child's parent or guardian is informed as soon as possible of the child's physical restraint and the

circumstances which led to the child being physically restrained. The child's parent or guardian should also be informed when the episode of physical restraint has ended.

5) An approved centre physically restraining a child should have in place child protection policies and procedures in line with relevant legislation and regulations made thereunder.

6) An approved centre physically restraining a child should have a policy and procedures in place addressing appropriate training for staff in relation to child protection.

7) All uses of physical restraint should be clearly recorded in the child's clinical file.

8) All uses of physical restraint should be clearly recorded on the Clinical Practice Form for Physical Restraint in accordance with Provision 1.5.3

Working in the Community:

1.24 It is generally considered to be unsafe for anybody to try to restrain another person on their own. If you are alone in a difficult situation, you should try to escape from the situation and summon assistance.

Staff working in the community should have the local Gardaí station telephone numbers on their mobile phones, in order that they may summon help and should have arrangements in place as per Lone Working Policy.

Any member of staff finding themselves alone and is assaulted by a resident or another person, must use the most appropriate means available to defend themselves, this is a matter of personal judgement in the given circumstances. If possible and practicable the member of staff should leave the danger area and summon assistance.

All staff should attended training in PMCB which would assist in managing this situation.

Any situation requiring the physical restraint of a resident in an approved centre or a resident in a community service must be recorded on an incident report form and documented in the resident's clinical file.

Following any incident of restraint or assault the resident should be reviewed by members of the multi-disciplinary team as soon as is practicable and a decision made on his/her future management including an up to date risk assessment and risk management plan.

Action after an Incident

1.25 Most incidents of physical restraint in the work place cause little or no physical injury. But an incident can leave an individual traumatised.

The HSE will support any member of staff who has either been a victim of attack or who has lent assistance during a violent incident. Support will be offered by the HSE in the event of a complaint or legal action arising against a member of staff involved in a violent incident. Staff should use their own legal advisor, professional association or trade union where there is a particular need for legal advice. However a member of staff without access to such representation should seek advice from their line manager.

Following a violent incident the appropriate manager must ensure that an opportunity to discuss the incident should be available for all personnel involved or to individual members as soon as is practicable after the incident and where requested follow-up support made available.

1.26 **Care of resident:**

- Maintain a safe level of nursing and medical staff to control, contain and observe the situation until the risk is clearly over. Occasions may arise during a restraint, where it is required to disengage from the restraint and then re-engage.
- The decision to disengage and re-engage must be made by the team leader of the restraint.
- Communicate with other staff so that they are aware of the potential risks.
- Implement and record any amendments to the resident's care and treatment plan subject to the outcome of the medical review.

1.27 **Care of Staff**

- Arrange for treatment of physical injuries if required.
- Arrange to take over urgent tasks if required.
- Arrange to contact the colleague's manager to report the incident.
- Provide reassurance and support.
- Facilitate the colleague with time and space to talk about the incident (but recognise that some prefer not to talk about it).
- Make arrangements for the safe transport home for the colleague.

1.28 **The Manager's role:**

- Coordinate the post incident review.
- Review the facts of the incident with all those involved and ensure that these are recorded on an incident report form. Where appropriate, get the resident's perceptions as well.

- Review what was carried out well and what might need to be done differently if there was a recurrence.

- Informing the victim of an assault and their right to make a complaint and to make a report to the Gardaí. Support should be provided to the victim if they wish to follow this process.

- Discuss with the person(s) involved in the incident whether they require time off work (a few hours, a few days).

- If appropriate, consult Occupational Health, Risk Management or Health and Safety Advisor.

- If appropriate, consult with PMCB Instructor for advice on interventions and future management issues.

- Depending on the severity of the outcome of the incident, inform the Director of Nursing and the Executive Clinical Director at home if out of hours.

- Implement any long-term measures which could prevent a recurrence of such an incident.

1.29 **Key questions to be considered include:**

- What was happening, i.e. what were the trigger factors and what had heightened the resident's arousal or hostility?
- What were people doing or saying?
- Where were they standing?
- Who was present?
- How were they feeling?
- What happened during the incident?
- What did people do to try and resolve it?
- What are the outcomes?
- What happened after the incident?

Situations Involving Weapons:

1.30 Wherever possible if faced with a resident who is threatening with a weapon, staff should try to confine that resident and the risk of harm that they present to a specific area away from others.

Staff within CMMHS have not received training on how to physically disarm a resident who has/is threatening to harm self/others with a weapon. Consequently, they would be accepting undue risk to themselves and to the resident if they were to try to disarm such a person using force.

The CMMHS does not expect any member of staff to undertake a task that they are not properly trained or equipped for therefore if weapons are involved staff should seek advice appropriate to the

circumstances by contacting the Senior Nurse, Consultant, or member of the Gardaí.

Training and Support

1.31 Staff must attend the PMCB training (Appendix 3) appropriate to their needs in their place of work and attend refresher courses within a minimum of a one year period.

Physical intervention skills are designed to help staff deal in a professional, trauma informed manner when confronted by an aggressive, hostile individual assisting staff to take control/manage a situation where that individual poses an immediate threat of serious harm to self or others.

The physical intervention skills/training provide a framework for organising roles, thoughts and actions in a crisis.

The physical intervention skills/training provide/teach the best available practical techniques for dealing with aggressive and challenging behaviour.

The physical intervention skills/training are trauma informed in their approach to the management of aggressive and violent behaviour, highlighting at all times the importance of good communication skills.

The PMCB training programme includes training in:

- The prevention and therapeutic management of violence and aggression (including “breakaway” and de-escalation techniques);
- Alternatives to physical restraint;
- Trauma-informed care;
- Cultural competence;
- Human rights, including the legal principles of restrictive interventions;
- Positive behaviour support including the identification of causes or triggers of the person’s behaviours including social, environmental, cognitive, emotional, or somatic;
- The monitoring of the safety of the person during and after the physical restraint.

(a) The service will undertake ongoing monitoring of restraints and outcomes of restraint and implement appropriate measures to address training gaps if identified.

(b) All PMCB training must be provided by certified PMCB Instructors. The Instructors require re-certification on a 2 yearly basis.

Clinical Governance

1.32 Physical restraint should never be used:

- To ameliorate operational difficulties including where there are staff shortages;
- As a punitive action;
- Solely to protect property;
- As a substitute for other less restrictive interventions

1.33 Each episode of physical restraint should be reviewed by members of the multidisciplinary team involved in the person's care and treatment and documented in the person's clinical file as soon as is practicable and, in any event, no later than five working days (i.e. days other than Saturday/Sunday and bank holidays) after the episode of restraint. The review should include the following:

- The identification of the trigger/antecedent events which contributed to the restraint episode.
- A review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support;
- The identification of alternative de-escalation strategies to be used in future;
- The duration of the restraint episode and whether this was for the shortest possible duration;
- An assessment of the factors in the physical environment that may have contributed to the use of restraint.
- The multidisciplinary team review should be documented and should record actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person.

1.34 A multidisciplinary review and oversight committee, which is accountable to the Registered Proprietor, should be established in each approved centre to analyse in detail every episode of physical restraint. The committee should meet at least quarterly and should:

- Determine if there was compliance with the code of practice on the use of physical restraint for each episode of physical restraint reviewed;
- Determine if there was compliance with the approved centres own policies and procedures relating to physical restraint;
- Identify and document any areas for improvement;
- Identify the actions, the persons responsible, and the timeframes for completion of any actions;
- Produce a report following each meeting of the review and oversight committee. This report should be made available to staff who participate, or may participate in physical restraint to promote on-going learning and awareness. This report should

also be available to the Mental Health Commission upon request.

Governance and Approval

1.35 Outline formal governance arrangements

- Area Management Team CMMHS
- Quality Patient Safety Group CMMHS
- PPPG Development Group CMMHS

List method for assessing the PPPG in meeting the standards outlined in the HSE National Framework for developing PPPGs

1.36 The HSE National Framework for Developing Policy, Procedure, Protocol and Guidelines (2016) was used to develop this policy.

Attach any copyright/permission sought

1.37 No copyright/permission required.

Insert Approved PPPG Checklist

1.38 (Appendix 4)

Communication and Dissemination

1.39 The completed policy is submitted to the Quality Patient Safety Committee CMMHS.

The complete policy is submitted to the area management group and the Registered proprietor of the approved centre for approval and signed off. It is then uploaded to the CMMHS policy portal for staff to indicate that they have read and understood the PPPG.

Implementation

1.40 The Registered proprietor will ensure the policy is brought to the attention of all staff under their remit.

The PPPG development group is responsible for ensuring the policy is available for relevant staff to read.

All clinical staff working within the approved centre are responsible for providing evidence that they have read and understood the policy and that they can articulate the processes relating to the management of physical restraint.

Describe any education/training required to implement the PPPG

1.41 A proposed PMCB training and education programme has been designed by the PMCB instructors for CMMHS and its employees to meet their mandatory obligations under the SHWWA (2005) to safely and effectively manage aggression and violence specific to their workplaces.

A 12 month PMCB refresher training and education programme based on site and service specific training needs analysis has been designed by the PMCB instructors for CMMHS and its employees to meet their mandatory obligations under the SHWWA 2005.

The PMCB instructors must maintain their recertification and registration as and when required.

Identify lead person(s) responsible for the Implementation of the PPPG

1.42 Quality Patient Safety Committee are responsible for developing and reviewing the service and care provision risk management register, including risk identification, risk assessment and risk treatment.

Quality Patient Safety Committee is responsible for reviewing the physical restraint audits, reports and the associated risk assessments.

Quality Patient Safety Committee will make recommendations to the Area Mental Health Management Team.

The Area Mental Health Management Team is responsible for seeking the resources required to enable appropriate action to be taken in the light of the risk management priorities identified in the physical restraint audits, reports and risk assessments.

Monitoring, Audit and Evaluation

1.43 Describe the plan and identify lead person(s) responsible for the following processes:

Monitoring:

Quality Patient Safety Committee are responsible for developing and reviewing the service and care provision risk management register, including risk identification, risk assessment and risk treatment.

There must be on going daily monitoring by all staff taking into account patient profiles, environmental issues, staffing and risk assessments.

Audit:

Inpatient Service Managers/ADON should satisfy themselves that physical restraint audits are undertaken quarterly in the approved centres and ensure that any agreed recommendations have been implemented and communicated appropriately.

Evaluation:

Annual physical restraint reports must be carried out by appropriately trained staff in conjunction with the ADON of approved centre.

Revision/Update:

The CMMHS physical restraint policy should be revised every year in line with the MHC Judgement Framework Version 6 (2024).

Identify the method for amending the PPPG if new evidence emerges:

1.44 The PPPG development group will amend this PPPG if any new evidence emerges.

References

1. An Bord Altranais (1997) Guidelines to Nurses and Midwives on the Management of Violence/Challenging Behaviour
2. Bonner, G. (2002) Trauma for all: a pilot study of the subjective experience of physical restraint for mental health in patients and staff in the UK. Vol 9(4), pg 465-473.
3. Bonner, G. (2007) The psychological impact of aggression on nursing. Vol 16(1), pg 810-814
4. Bjorkly, S. (2006) Psychological theories of aggression: Principles and application to practice. pg 27-46.
5. Code of Practice Guidance for Persons working in Mental Health Services with people with Intellectual Disabilities (MHC 2009)
6. Code of Practice on the Use of Physical Restraint (MHC, 2022)
7. Concise Dictionary of Law (1992), Oxford University Press, Oxford
8. Council of Europe (1953) European Convention for the Protection of Human Rights, Article 3.
9. Government of Ireland (2015). *Assisted Decision Making (Capacity) Act 2015*, Dublin: S17/2016.
10. Government of Ireland (2001) Mental Health Act.
11. Government of Ireland (2005) Health Safety and Welfare at Work Act,
12. HSE Dublin North East. (2014) Policy on Management of Work-related aggression and violence
13. Haimowitz, S., Huckshorn, K.A., (2006) Restraint and Seclusion – A Risk Management Guide.
14. Huckshorn, K.A. (2013). Reducing seclusion and restraint use in mental health settings: A phenomenological study of hospital leader and staff experiences. Dissertation Research.
15. Isobel S (2015) 'Because That's the Way Its Always Been Done': Reviewing the Nurse-Initiated Rules in a Mental Health Unit as a step toward Trauma Informed Care, Issues in Mental Health Nursing. 36(4), pg 272-278.
16. Mental Health Commission (2022) Revised Code of Practice on the Use of Physical Restraint in Approved Centres.
17. McKenna, K. (2004) Study of work-related violence. North Eastern Health Board, Kells.
18. McKenna, K. (2008) Linking Service to Safety: Together creating Safer Places of service. Health Service Executive Ireland.
19. Mental Health Commission (2008) Seclusion and Restraint Reduction Strategy. Dublin. Mental Health Commission.

20. The Maudsley (1994)Preventing & Managing Violence, Policy & Guidelines for Practice
21. United Nations (1991) UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, Principle 9.

Appendix

Appendix 1 **PPPG Development Group (subgroup)**

Graham Malone, Sallyann Mackarel, Angela Deery, Kim McLaren, Sean Byrne.

Appendix 2 **Glossary of Terms and Definitions**

Breakaway Techniques (disengagement skills) A set of physical skills to help separate or breakaway from an aggressor in a safe manner. They do not involve the use of restraint

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

Person All references to 'person' in this document should be taken to mean a voluntary or involuntary patient or resident, as defined in the 2001 Act.

Physical restraint is defined as the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident's body when he or she poses an immediate threat of serious harm to self or others. (Mental Health Commission 2009).

Physical Intervention refers to all interventions employed for the purpose of managing potential or actual work related aggression and violence, but excludes the functional physical contacts customarily involved in care delivery.

PMCB Professional Management of Complex Behaviour.

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

PPE refers to the personal protective equipment worn by staff.

Resident is a person receiving care and treatment in an approved centre. (Mental Health Commission 2009).

Service User refers to all recipients of services, including patients, clients, relatives, friends, concerned others and those accompanying recipients of services. The terms

patient and service user are also used in the report without any intended differentiation. (Linking Service to Safety, 2008)

Trauma Informed Care Trauma-informed care is 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.

Weapon is defined as "Any object that is made, adapted or intended to be used to cause physical injury to a person." (Concise Dictionary of Law Oxford University Press, Oxford, 1992)

Work-related aggression and violence is defined as, “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 to Safety, 2008)

Appendix 3.

Category 1 Staff: Applies to all employees in the Cavan Monaghan Mental Health Services who are exposed to the potential of aggression and violence in the workplace, but do not partake in the application of physical restraint within the Approved Centres under the Mental Health Act 2001 section 69 and 33(3)(e), Mental Health Commission (2022) codes of practice, rules and regulations.

Category 2 Staff: Applies to all clinical staff who partake in the application of physical restraint only in seated and standing positions within an Approved Centre under the Mental Health Act 2001 section 33(3)(e), Mental Health Commission (2022) codes of practice.

Category 3 Staff: Applies to all clinical staff who partake in the application all physical restraints including prone and supine restraints within an Approved Centre; under the Mental Health Act 2001 section 69 and 33(3) (e), Mental Health Commission (2009) codes of practice, rules and regulations.

Appendix 4 Approved PPPG Checklist

Standards for developing Clinical PPPG	Checklist
Stage 1 Initiation	
The decision making approach relating to the type of PPPG guidance required (policy, procedure, protocol, guideline), coverage of the PPPG (national, regional, local) and applicable settings are described.	✓
Synergies/co-operations are maximised across departments/organisations (Hospitals/Hospital Groups/Community Healthcare Organisations (CHO)/National Ambulance Service (NAS)), to avoid duplication and to optimise value for money and use of staff time and expertise.	✓
The scope of the PPPG is clearly described, specifying what is included and what lies outside the scope of the PPPG.	✓
The target users and the population/patient group to whom the PPPG is meant to apply are specifically described.	✓
The views and preferences of the target population have been sought and taken into consideration (as required).	✓
The overall objective(s) of the PPPGs are specifically described.	✓
The potential for improved health is described (e.g. clinical effectiveness, patient safety, quality improvement, health outcomes, quality of life, quality of care).	✓
Stakeholder identification and involvement: The PPPG Development Group includes individuals from all relevant stakeholders, staff and professional groups.	✓
Conflict of interest statements from all members of the PPPG Development Group are documented, with a description of mitigating actions if relevant.	✓
The PPPG is informed by the identified needs and priorities of service users and stakeholders.	✓
There is service user/lay representation on PPPG Development Group (as required).	✓
Information and support is available for staff on the development of evidence-based clinical practice guidance.	✓

Stage 2 Development	Checklist
The clinical question(s) covered by the PPPG are specifically described.	✓

Systematic methods used to search for evidence are documented (for PPPGs which are adapted/adopted from international guidance, their methodology is appraised and documented).	✓
Critical appraisal/analysis of evidence using validated tools is documented (the strengths, limitations and methodological quality of the body of evidence are clearly described).	✓
The health benefits, side effects and risks have been considered and documented in formulating the PPPG.	✓
There is an explicit link between the PPPG and the supporting evidence.	✓
PPPG guidance/recommendations are specific and unambiguous.	✓
The potential resource implications of developing and implementing the PPPG are identified e.g. equipment, education/training, staff time and research.	✓
There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care.	✓
Budget impact is documented (resources required).	✓
Education and training is provided for staff on the development and implementation of evidence-based clinical practice guidance (as appropriate).	✓
Three additional standards are applicable for a small number of more complex PPPGs: Cost effectiveness analysis is documented. A systematic literature review has been undertaken. Health Technology Assessment (HTA) has been undertaken.	✓
Stage 3 Governance and Approval	**Checklist**
Formal governance arrangements for PPPGs at local, regional and national level are established and documented.	✓
The PPPG has been reviewed by independent experts prior to publication (as required).	✓
Copyright and permissions are sought and documented.	✓
Stage 4 Communication and Dissemination	Checklist
A communication plan is developed to ensure effective communication and collaboration with all stakeholders throughout all stages.	✓
Plan and procedure for dissemination of the PPPG is described.	✓
The PPPG is easily accessible by all users e.g. PPPG repository.	✓
Stage 5 Implementation	Checklist
Written implementation plan is provided with timelines, identification of responsible persons/units and integration into service planning process.	✓
Barriers and facilitators for implementation are identified, and aligned with implementation levers.	✓
Education and training is provided for staff on the development and implementation of evidence-based PPPG (as required).	✓
There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care.	✓
Stage 6 Monitoring, Audit, Evaluation	✓ Checklist

Process for monitoring and continuous improvement is documented.	✓
Audit criteria and audit process/plan are specified.	✓
Process for evaluation of implementation and (clinical) effectiveness is specified.	✓
Stage 7 Revision/Update	✓ Checklist
Documented process for revisions/updating and review, including timeframe is provided.	✓
Documented process for version control is provided.	✓

I confirm that the above Standards have been met in developing the following:
Title of PPPG: Use of Physical Restraint Policy

Name of Person(s) signing off on the PPPG Checklist:

Name: Graham Malone **Title: Clinical Nurse Manager 3**	**Signature:**  **Date:** 11/12/2023

<u>This signed PPPG Checklist must accompany the final PPPG document in order for the PPPG to be approved</u>