Donegal Mental Health Service Approved Centre

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

DONEGAL MENTAL HEALTH SERVICE

APPROVED CENTRE

POLICY DOCUMENT ON:

The Reduction of Restrictive Practice

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE National Template for developing PPPGs (2016)

REDUCTION OF RESTRICTIVE PRACTICE POLICY

Is this document a:

Policy [v] Procedure [ ] Protocol [ ] Guideline [ ]

CHO Area 1

Organisation: Donegal Mental Health Service

Location: Approved Centre (Department of Psychiatry), Letterkenny University Hospital

Title of PPPG Development Group:	Donegal Mental Health Services Policy Development and Review Group
Approved by:	Donegal Mental Health Services Approval Governance Group
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1	February 2023		DMHS (PDRG)
2	February 2024		DMHS (PDRG)

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1.0 INITIATION

1.1 Purpose

1.1.1 The use of restrictive practices and coercion in mental health services has long been debated. There's little evidence to show that they have any therapeutic benefits. Restrictive interventions can cause physical and psychological harm to patients and staff. Their use is associated with longer treatment times and can damage the recovery relationship with the patient. They are also found to cause moral distress for those tasked with using restrictive interventions. However a restrictive intervention may be necessary in some cases where there is an imminent risk to the person or others. Despite these rare occasions it is in the best interests of everyone receiving care and working in the Approved Centre that we work toward reducing these interventions. The purpose of this policy is to outline the importance of early recognition, a focus on de-escalation strategies and opportunity for learning to facilitate a reduction in the number of restrictive interventions used in the Approved Centre. The strategies are based on the best available evidence drawing on the WHO's (2019) 'Ending Seclusion and Restraint', research on the 'Safewards' principles and the focus on learning from the past through data collection and analysis (HIQA and MHC Standards 2017, Incident management Framework, The Quality Framework, Patient Safety Strategy 2019).

1.1.2 This policy applies to the use of Physical Restraint, Seclusion and Involuntary administration of medication. It does not apply to the use of bedrails, lap straps or therapeutic observations.

1.2 Scope

This policy applies to all partners involved in the delivery of mental health care and treatment within the department of psychiatry including:

1.2.1 Service users, families/carers, advocates

1.2.2 Staff in the Approved Centre,

1.2.3 Community Mental Health Teams,

1.2.4 Child and Adolescent Mental Health Teams,

1.2.5 Mental Health Services for Older Person

1.2.6 Mental Health and Learning disability

1.2.7 General Practitioners/ Primary Care Teams,

1.2.8 Advocacy services and outside agencies.

1.3 Objective(s)

1.3.1 To provide guidance to staff on strategies that can help to reduce restrictive practices in the Approved Centre.

1.3.2 To ensure that there is a proactive approach to reducing unsafe behaviour.

1.3.3 To set out clear governance and leadership in reducing restrictive practices and a strong commitment to learn from the past using data collected when Restrictive Interventions are necessary.

1.3.4 To reduce the use of restrictive practices collectively by 10% in 12 months through implementation of this policy.

1.4 Outcome(s)

1.4.1 To reduce the number of restrictive interventions used in the DMHS approved centre.

1.4.2 To prevent any unnecessary physical or psychological harm to patients, staff or visitors to the approved centre.

1.4.3 To improve safety culture.

1.4.4 To enhance the principles of the recovery model.

1.5 PPPG Development Group

1.5.1 See Appendix II for Membership of the PPPG Development Group Template.

1.5.2 See Appendix III for PPPG Conflict of Interest Declaration Form Template.

1.6 PPPG Governance Group

1.6.1 See Appendix IV for Membership of the Approval Governance Group.

1.7 Supporting Evidence

1.7.1 **List relevant legislation/PPPGs**

1.7.1.1 The Mental Health Act (2001)(Revised 2020)

1.7.1.2 M.H.C Revised Code of Practice on the use of physical restraint in Approved Centres (2010).

1.7.1.3 Children First Act 2015

1.7.1.4 National Consent Policy (2022)

1.7.1.5 Mental Health Commission Judgement Support Framework V5 (2020)

1.7.1.6 HSE Best Practice Guidance for Mental Health Services (2017)

1.7.1.7 NICE Guidelines: Violence and aggression: short-term management in mental health, health and community settings [NG10]

1.7.1.8 DMHS Restraint Policy

1.7.1.9 DMHS Addendum to Use of Seclusion Policy due to Covid-19 (updated addendums are located in Approved Centre's Policy Folder and DMHS Policy Portal).

1.7.1.10 DMHS Therapeutic Observation Policy

1.7.1.11 DMHS Medication Policy

1.7.1.12 Mental Health Commission (2014) Seclusion and Restraint Reduction Strategy

1.7.1.13 European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment (2020) Report to the Government of Ireland on the visit to Ireland

1.7.1.14 Mental Health Commission (2006) Rules Governing the Use of Seclusion & Mechanical Means of Bodily Restraint, Ireland.

1.7.1.15 Mental Health Commission (2011) Addendum to the Rules Governing the Use of Seclusion & Mechanical Means of Bodily Restraint, Ireland.

1.7.1.16 DMHS Policy Document on The Administration of IM Medication Against Resistance

1.7.1.17 Health Service Executive (2020) Incident Management Framework

1.7.1.18 Health Service Executive(2019) Patient Safety Strategy 2019-2024

1.7.1.19 Mental Health Commission (2013) Quality Framework for Mental Health Services, Ireland.

1.7.1.20 Mental Health Commission (2022) The Use of Restrictive Practices in Approved Centres September 2022 Seclusion, Mechanical Restraint and Physical Restraint Activities Report 2021

1.7.1.21 Dept of Health (2021) Update on the Reform of the Mental Health Act 2001, Report of the Public Consultation Process

1.7.1.22 World Health Organisation (2019) Strategies to End Seclusion and Restraint, WHO Quality Rights specialized training

1.7.1.23 Health Information Quality Authority and the Mental Health Commission (2017) National Standards for the Conduct of Reviews of Patient Safety Incidents

1.7.1.24 Mental Health Commission (2020) Judgement Support Framework, Covid-19 Special Edition

1.8 Glossary of Terms

1.8.1 **Approved centre**: A hospital or other in-patient facility approved by the Mental Health Commission and registered by the Commission in compliance with Section 64(1) of the Mental Health Act (2001), for the care and treatment of persons suffering from mental illness or mental disorder.

1.8.2 **CRAM**: Client Risk Assessment and Management Tool

1.8.3 **Dignity**: The right of an individual to be treated with respect as a person in his or her own right.

1.8.4 **DMHS**: Donegal Mental Health Service.

1.8.5 **HSE**: Health Service Executive.

1.8.6 **Multi-Disciplinary Team (MDT)** is a group of health care workers who are members of different health care professions i.e.: psychiatrists, mental health nurses, psychologists, occupational therapists, advocacy groups and social workers.

1.8.7 **Privacy**: A culturally specific concept defying the degree of one's personal responsibility to others in regulating behaviour that is regarded as intrusive (Mosby 2021).

1.8.8 **Patient**: Refers to resident /service users admitted to the Approved Centre (Department of Psychiatry) receiving care and treatment, both Voluntary and Involuntary status.

1.8.9 **Seclusion**: The confinement and isolation of a patient under supervision, in an area which is away from other patients and prevents the patient from leaving due to the immediate necessity of containing severe behavioural disturbance which is likely to cause harm to themselves or others. (Mental Health Act Code of Practice, 26.103)

1.8.10 **Physical Restraint** refers to the use of physical by one or more persons for the purpose of preventing the free movement of a patient's body

1.8.11 **Involuntary administration of Medication** refers to the involuntary administration of intramuscular medication against a person's clear objection

1.8.12 **Therapeutic Management of Violence and Aggression (TMVA)**: Staff training in the prevention and management of violence (including breakaway techniques and team working) and training in alternative methods to physical restraint.

1.8.13 **Restrictive Practice** Is making someone do something they don't want to do or stopping someone doing something they want to do.

1.8.14 **Restrictive Intervention** Are deliberate acts on the part of other person(s) that restrict a patients movement, liberty and/or freedom to act independently in order to : take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is taken, and end or reduce significantly the danger to the patient or others

1.8.15 **PRN Medication** Medication taken pro re nata: the medication is not regularly scheduled but is taken when needed.

1.8.16 **TRP** Therapeutic Recovery Programme

1.8.17 **Therapeutic Observation** A closer level of observation prescribed to engage the patient positively to reduce risk and prevent harm, can be within arms-length, eyesight or scheduled 20 minute checks.

1.8.18 **De-escalation** is an approach which engages and establishes a collaborative relationship with the key people involved in a conflict in order to resolve or diffuse the situation. De-escalation applies effective communication techniques to these situations (WHO 2019)

1.8.19 **Unsafe Behavior** When a Patient acts in such a way that they may injure themselves or others.

2.0 OUTLINE OF PPPG STEPS AND RECOMMENDATIONS

2.1 Proactive Approach to Managing Unsafe Behaviour

2.1.1 Patient engagement:

2.1.1.1 On Admission the Patient will be adequately orientated to the assessment unit; the assessment unit provides a lower stimulus area for new admissions. The Assessment unit has the same facilities as the open unit i.e. therapeutic recovery programmes, access to a garden and a primary nurse. The assessment unit provides a settling in period away from the hustle and bustle of the busy open ward. It enhances the "getting to know" aspect of the therapeutic rapport.

2.1.1.2 The patient will receive information about the ward. This includes:

2.1.1.2.1 Treatment expectations e.g. physical observations, medication and team review.

2.1.1.2.2 Meal times/menu.

2.1.1.2.3 Ward routine.

2.1.1.2.4 Therapeutic recovery programmes.

2.1.1.2.5 Visiting times/procedure.

2.1.1.2.6 Advocacy service.

2.1.1.2.7 Peer support services.

2.1.1.3 The Patient is an active participant in their individual care plan. Their preferences are recorded and revised at the patient's request. The patient signs and is offered a copy of their care plan.

2.1.1.4 The patient and family/carers, with the patients consent, are an active participant in the risk assessment and management plan. Collateral history from family or carers may help ascertain triggers or idiosyncrasies to unsafe behaviour.

2.1.1.4.1 Where it is identified that a patient is at risk for unsafe behaviour. The risk management strategies identified in the CRAM should be communicated at hand over/safety pause.

2.1.2 **Care Provision**

2.1.2.1 Patients will be allocated a primary nurse each day. The primary nurse will spend one to one time with the patient each day. This ensures the patient has the opportunity to discuss their treatment and raise any concerns. The primary nurse will introduce themselves to the patient daily and the primary nurse's name will be displayed on the whiteboard in the appropriate office.

2.1.2.2 A community meeting held each Monday provides the patient the opportunity to request specific groups they would like to attend in the week ahead. The therapeutic recovery programmes will run in the activity room daily at 10:00 and 14:00. With an emphasis on stress management, discharge planning and groups on identifying triggers and devising safety plans.

2.1.2.3 The ward environment will be well maintained, bright and spacious. Various rooms will be accessible to facilitate quiet spaces away from noise or crowds. The relaxation room is accessible for sensory based activities e.g. relaxation, music, guided progressive muscle relaxation.

2.1.2.4 The Garden area is accessible and regularly maintained. Patients are encouraged to attended any activities that are scheduled outdoors e.g. walks, gardening, light exercise.

2.1.2.5 Patients will have access to individual activities in the activity room, the resources will be checked regularly by staff and replenished by management when required.

2.1.2.6 The MDT are supportive and empathetic when breaking bad news to a patient e.g. delayed discharge.

2.1.2.6.1 The primary nurse will follow up with the patient following bad news and offer support.

2.1.2.7 Staff should use the REFLECT strategy to promote a "can do" culture see appendix VI.

2.1.2.8 Feedback is sought from the patients on discharge. This is designed to highlight any areas for improvement relating to care, treatment and the environment.

2.1.2.8.1 See Appendix VIII

2.1.3 **Early Recognition:**

2.1.3.1 While the use of the assessment unit lends itself to establishing a therapeutic rapport and getting to know the patient. Staff must recognise that some patients may perceive this to be containment and may trigger agitation. The assessment unit nurse must escalate these concerns early with the Nurse in Charge and take action to alleviate any distress e.g. relocation to open ward if appropriate.

2.1.3.2 Staff will be visible in the main areas of the ward throughout the day. This ensures early recognition of escalation and to also provide a feeling of ease to patients feeling anxious about the environment.

2.1.3.3 Recognising triggering behaviours and distress:

2.1.3.3.1 restlessness

2.1.3.3.2 agitation

2.1.3.3.3 pacing

2.1.3.3.4 shortness of breath or rapid breathing

2.1.3.3.5 sweating

2.1.3.3.6 clenched teeth

2.1.3.3.7 crying

2.1.3.3.8 wringing hands

2.1.3.3.9 rocking

2.1.3.3.10 withdrawal

2.1.3.3.11 prolonged eye contact

2.1.3.3.12 increased volume of speech

2.1.3.3.13 aggression,

2.1.3.3.14 threatening harm.

2.1.3.3.15 If these physical symptoms of distress are observed by staff they will endeavour to intervene promptly to avoid further escalation: Below are a list of de-escalation tips from the WHO (2019) and should be used in conjunction with the de-escalation aspects of TMVA training.

2.1.3.3.15.1 Avoid enclosed spaces (e.g. small rooms) to make sure that the person does not feel trapped, cornered or confined.

2.1.3.3.15.2 Try to engage with the person. Inform the person that you wish to support them and will not do anything against their will or anything to harm them.

2.1.3.3.15.3 Do not use language that can be perceived as provocative, humiliating and condescending. Be polite and respectful at all times.

2.1.3.3.15.4 Talk to the person with the appropriate degree of formality, depending on your knowledge of the person.

2.1.3.3.15.5 Do not rush the person. Give them time and space to process what is being said and to respond.

2.1.3.3.15.6 Try to understand the reason behind the person's distress and try to understand what the person needs and wants. Ask the person directly what they expect and what you can do.

2.1.3.3.15.7 Ask the person what they would find helpful and try to offer some options and choices.

2.1.3.3.15.8 Do not dismiss what the person is saying just because you disagree. Even if you do not agree, try to find areas on which you can agree. If you are unable to agree on anything, then agree to disagree.

2.1.3.3.16 Facilitate access to people that the person knows and trusts.

2.1.3.3.17 Once the difficult moment has passed, try to explore with the person what has happened.

2.1.3.4 If escalation was prevented it's important to document what strategy was helpful in the situation.

2.1.3.5 Other Strategies include; offering one to one time if safe to do so.

2.1.3.6 Offering review by team or on call doctor.

2.1.3.7 Encouraging contact with family or relevant persons.

2.1.3.8 Offer support in a low stimulus area.

2.2 Reactive Approaches/Opportunities for Learning

2.2.1 When a Restrictive Intervention is Assessed as Necessary Staff Must:

2.2.1.1.1 Seek the patients consent where applicable before using a restrictive intervention. This may not always be achievable.

2.2.1.1.2 Ensure dignity and respect for the patient through communication and privacy.

2.2.1.1.3 Provide the patient the opportunity to air their views when it is safe to do so and at the earliest opportunity. This is recorded in the patient file.

2.2.1.1.4 The CMN in charge will debrief the staff involved to aid reflection and focus on any new learning.

2.2.1.1.5 An MDT debrief will be held within 5 working days of the restrictive intervention. This will be documented in the clinical file and any new learning will be added to the ICP/ Risk assessment. The details of the updated ICP/CRAM must adequately communicated to those who need to know. The MDT will give due attention to the patients preferences regarding the debrief to avoid the patient feeling objectified. The patient can bring an advocate/peer support worker/family member to the debrief.

2.2.2 Information gathered regarding the use of Restrictive Practices will be held in the Approved Centre and used to compile an annual report on the use of Restrictive Practices in the Approved Centre. This report will be available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.

2.2.3 The data will be analysed, checking for patterns such as time of day, location, day of the week, days since admission, age and gender. This data will be anonymized and stored securely for review. See appendix VII for sample data entry.

2.2.3.1 Management will use the data to prioritise resources during periods found to be correlated with the use of restrictive interventions.

2.3 **Using Restrictive Interventions NICE GUIDELINES 1.4.5**

2.3.1 Restrictive interventions are only used if de-escalation and other preventive strategies, including p.r.n. medication, have failed and there is potential for harm to the patient or other people if no action is taken. Staff should continue to attempt de-escalation throughout a restrictive intervention.

2.3.2 Restrictive interventions are not to be used to punish, inflict pain, suffering or humiliation, or establish dominance.

2.3.3 Ensure that the techniques and methods used to restrict a service user:

2.3.3.1 Are proportionate to the risk and potential seriousness of harm.

2.3.3.2 Are the least restrictive option to meet the need.

2.3.3.3 Are used for no longer than necessary.

2.3.3.4 Take into account the patient's preferences, if known and it is possible to do so.

2.3.3.5 Take into account the patient's physical health, known history of trauma, degree of frailty and developmental age.

2.3.4 See the local Seclusion, Restraint and Administration of I.M. Medication Against Resistance policies for specific details regarding the procedure for using Seclusion, Restraint and Involuntary administration of IM medication.

2.4 **The Use of Closed Circuit Television (CCTV)**

2.4.1 Where CCTV or other monitoring devices are used, the Approved Centre must:

Ensure viewing is restricted to designated personnel as per Approved Centre policy;

2.4.1.1 Ensure that it is evident and clearly labeled.

2.4.1.2 Ensure that it is incapable of recording and is incapable of storing a patient's image on a tape, disc, hard drive or in any other form and is incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the patient.

2.4.1.3 Stop using it if a patient starts to act in a way which comprises his or her dignity.

2.4.2 There is a clear written DMHS Use of CCTV policy in relation to the use of live stream CCTV in seclusion.

3.0 GOVERNANCE AND APPROVAL

3.1 Outline formal governance arrangements

After completion by the DOP policy group, policy is then forwarded to governance group (individuals who have final approval of PPPG)

3.1.1 Refer to Appendix IV for Membership of the Approval Governance Group.

4.0 COMMUNICATION AND DISSEMINATION

4.1 Describe communication and dissemination plan

4.1.1 This policy is available through the DMHS Policy portal which is accessible to and signed by all staff

4.1.2 Policy will also be available in the policies folder located on the DOP for quick reference

4.1.3 Managers must ensure that staff under their supervision have read and understood the policies

4.1.4 All new staff as part of their induction will be directed to the policy folders to read and sign that they have understood the policy.

5.0 IMPLEMENTATION

5.1 Describe Implementation Plan Listing Barriers and /or Facilitators

5.1.1 Barriers to the initial implementation of this policy include:

5.1.1.1 Ensuring appropriate and timely dissemination of the policy to all staff across DMHS that work in the approved centre on a permanent or flexible basis.

5.1.1.2 The time required for collecting and analyzing data relating to the use of restrictive practices.

5.1.1.3 Providing feedback to frontline staff regarding patterns of incidents of restrictive practice.

5.2 Describe any Education/Training Required to Implement the PPPG

5.2.1 All staff must be up to date with their training in the Therapeutic Management of Violence and Aggression programme (TMVA). The training is mandatory and will be refreshed every two years.

5.2.2 The areas to be addressed within the training programme, include training in alternatives to physical restraint. Increased focus on de-escalation and maintaining a therapeutic milieu. Safe breakaway and physical restraint techniques. The training will be provided by appropriately qualified persons.

5.2.3 All staff must have up to date training in Basic Life Support (BLS).

All members of the MDT working in the Approved Centre can access training on Communication and Management of Violence and Aggression in the Work Place via HSEland.

5.2.4 Trauma Informed Care courses can be accessed via the CMNE Donegal.

5.2.5 A record of attendance at training will be maintained in the Approved Centre.

5.2.6 All staff will read the policy on restraint, seclusion and administration of IM Medication against resistance along with this policy.

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

5.3.1 Managers at all levels are responsible for the implementation of this policy within their area. This includes:

5.3.1.1 Ensuring staff have read and understood the policy.

5.3.1.2 That new staff are orientated to the policy folders/ online portal during their induction.

5.3.1.3 That the environment is well maintained and conducive to recovery.

5.3.1.4 That adequate resources are available to facilitate the running of the Therapeutic Recovery Programmes.

5.3.1.5 That Restrictive practices are audited and new learning is disseminated to all relevant staff.

5.3.1.6 Anonymized data is collected following all episodes of Restrictive Practices to discuss at the governance meeting every 2 months.

5.3.1.7 That staff are debriefed following restrictive interventions to aid reflection and new learning.

5.3.2 Managers will adopt a supportive and corrective stance on implementing aspects of this policy.

5.4 Outline specific roles and responsibilities

5.4.1 It is the responsibility of the Registered Proprietor to ensure that staff are aware of the Reduction of Restrictive Practice Policy.

5.4.2 Staff will ensure they understand the documentation and have signed to demonstrate this.

5.4.3 It is the responsibility of the registered proprietor or designated person to maintain a record of this communication with staff.

5.4.4 Senior management of the Approved Centre are responsible for sourcing any new training that will facilitate a reduction in the use of Restrictive Practices. This may

include targeted training for staff or identifying staff to champion evidence based strategies for reducing restrictive practices.

5.4.5 Management of the Approved Centre are responsible for facilitating staff to attend necessary training.

5.4.6 All Staff have the responsibility to conduct themselves in a respectful manner, using empathetic, recovery orientated and supportive language.

6.0 MONITORING, AUDIT AND EVALUATION

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

6.1.1 **Monitoring**

6.1.2 Management of the approved centre will oversee the implementation of this policy on a daily basis. Managers will provide support and guidance for frontline staff in implementing aspects of this policy.

6.1.3 **Audit**

6.1.2.1. Episodes of restrictive practice will be audited to ensure compliance with this policy on reduction. Non-compliance with this policy will be managed using an incident management framework.

6.1.4 **Evaluation**:

6.1.3.1 Findings will have to be presented to DOP governance group and forwarded to Quality, Safety and Risk group and Area Management team as appropriate

7.0 REVISION/UPDATE

7.1 Describe the procedure for the update of the PPPG

7.1.1 Policy will be reviewed by the date outlined and updated by the DMHS PPPG group as required but at a minimum every year

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

7.2.1 Policy will be amended by the DMHS PPPG group should new evidence/information arise

7.3 Complete version control update on the PPPG template cover sheet

7.3.1 Any change made shall be entered into Version control on the PPPG cover sheet

8.0 REFERENCES

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9.0 APPENDICES

Appendix I Signature Sheet

Appendix II Membership of the PPPG Development Group Template

Appendix III Conflict of Interest Declaration Form Template

Appendix IV Membership of the Approval Governance Group Template

Appendix V: Restrictive Practice Audit

Appendix VI: R.E.F.L.E.C.T. tool

Appendix VII: Data compilation sheet

Appendix VIII: Patient Evaluation

Appendix I: Signature Sheet

I have read, understand and agree to adhere to this Policy, Procedure, Protocol or Guideline:

Print Name	Signature	Area of Work	Date

Appendix II: Membership of the PPPG Development Group

Please list all members of the development group (and title) involved in the development of the document.

Clinical Director Dr O'Donnell **Chairperson** Charlotte Coyle **A.D.O.N Approved Centre** Psychologist Emmet Murray Senior Occupational Therapist Aisling Quah Social Worker Team Leader Angela Strain Quality & Risk Mairead McGrory CNM3 Staff Nurse Ann Kelly Social Worker Siobhan Kelly Occupational Therapist Karen Quinn	

Appendix III Conflict of Interest Declaration Form Template

CONFLICT OF INTEREST DECLARATION

This must be completed by each member of the PPPG Development Group as applicable

Title of PPPG being considered:

_____

Please circle the statement that relates to you

1. I declare that I DO NOT have any conflicts of interest.

2. I declare that I DO have a conflict of interest.

Details of conflict (Please refer to specific PPPG)

_____

_____

_____

_____

_____

_____

(Append additional pages to this statement if required)

Signature

Printed name

Registration number (if applicable)

Date

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act. Data will be processed only to ensure that committee members act in the best interests of the committee. The information provided will not be used for any other purpose.

A person who is covered by this PPPG is required to furnish a statement, in writing, of:

(i) The interests of the person, and

(ii) The interests, of which the person has actual knowledge, of his or her spouse or civil partner or a child of the person or of his or her spouse which could materially influence the person in, or in relation to, the performance of the person's official functions by reason of the fact that such performance could so affect those interests as to confer on, or withhold from, the person, or the spouse or civil partner or child, a substantial benefit.

Appendix IV Membership of the Approval Governance Group

John McCardle — Sign: Jm'Cardle
Area Director of Nursing — Date: 17/1/24

Dr. Colin O'Donnell — Sign: Nicholl
Clinical Director — Date: 21/1/24

Pauline Ackermann — Sign: Pauline Ackermann
Registered Proprietor
General Manager — Date: 12/2/2024

Appendix V Restrictive Practice Audit

On __/__/____ in the Approved Centre Letterkenny,

Evidence of Compliance with RRP Policy:

		Yes	No	Comments
1	Other interventions such as distraction/de-escalation were utilised without desired effect and evidenced in the clinical notes.			
2	The patient's consent was sought, were applicable and documented in the clinical file.			
3	The patients preferences (recorded in the ICP, Risk assessment, Individualised Behaviour Support Plan) were given due regard prior to the Restrictive intervention.			
4	The patient was given the opportunity to air their feelings at the earliest opportunity after the restrictive intervention (with their nurse, this is separate to the MDT debrief) and is recorded in the clinical file			
5	The ICP, Risk Assessment and/or Individualised Behaviour Support Plan is updated after the restrictive intervention. This should record suspected/known triggers in an attempt to abate in the future			
6	The patient had a MDT debrief with 72 hours and this is recorded in the clinical file			
7	Staff involved had a team debrief after the restrictive intervention to reflect on the incident and discuss potential learning for the future			
8	The relevant post restrictive intervention physical observations were complied with			
9	The relevant team members/on call services/family members were made aware and this was documented in the clinical file			
10	All relevant documentation is completed correctly e.g. clinical practice forms, pathways, NIMS.			

Action Plan:

Findings:	Action Plan to improve areas of non-compliance:	Person responsible:	Completion Date:

Signed: _____ Discipline:_____ Date: _____

Signed: _____ Discipline:_____ Date: _____