DONEGAL MENTAL HEALTH SERVICE

APPROVED CENTRE

POLICY DOCUMENT

ON

THE USE OF PHYSICAL RESTRAINT

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE National Template for developing PPPGs (2016)

THE USE OF PHYSICAL RESTRAINT

Is this document a:

Policy [√] 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
Reference Number:	4.62
Version Number:	14
Publication Date:	May 2007
Date for revision:	Feb 2025
Electronic Location:	4.62

Version	Date Approved	List section numbers changed	Author
4	July 2014		DMHS (PDRG)
5	April 2015		DMHS (PDRG)
6	May 2016		DMHS (PDRG)
7	May 2017		DMHS (PDRG)
8	May 2018		DMHS (PDRG)
9	May 2019		DMHS (PDRG)
10	Feb 2020		DMHS (PDRG)
11	Feb 2021	Amended to fit in new format	DMHS (PDRG)
12	Feb 2022	Restraint Pathway updated to V3	DMHS (PDRG)
13	Feb 2023	Updated Code of Practice 2022	DMHS (PDRG)

14	Feb 2024	Restraint Pathway updated to V4	DMHS (PDRG)

This is a controlled document: While this document may be printed the electronic version posted on the website is the controlled copy and can only be guaranteed for 24 hours after downloading.

Table of Contents:

1.0 INITIATION 4

1.1 Purpose 4

1.2 Scope 4

1.3 Objective(s) 4

1.4 Outcome(s) 5

1.5 PPPG Development Group 5

1.6 PPPG Governance Group 5

1.7 Supporting Evidence 5

1.8 Glossary of Terms 6

2.0 OUTLINE OF PPPG STEPS AND RECOMMENDATIONS 9

2.1 Orders for Physical Restraint: 9

2.2 Using restrictive interventions NICE GUIDELINES 1.4.5 10

2.3 Patient's dignity and safety 11

2.4 Ending the use of Physical Restraint 12

2.5 Recording the use of Physical Restraint 13

2.6 In the event of the use of restraint of a child 17

3.0 GOVERNANCE AND APPROVAL 18

3.1 Outline formal governance arrangements 18

4.0 COMMUNICATION AND DISSEMINATION 18

4.1 Describe communication and dissemination plan 18

5.0 IMPLEMENTATION 19

5.1 Describe implementation plan listing barriers and /or facilitators 19

5.2 Describe any education/training required to implement the PPPG 19

5.3 Identify lead person(s) responsible for the Implementation of the PPPG: 19

5.4 Outline specific roles and responsibilities 19

6.0 MONITORING, AUDIT AND EVALUATION 20

6.1 Describe the plan and identify lead person(s) responsible for the following processes: 20

7.0 REVISION/UPDATE 20

7.1 Describe the procedure for the update of the PPPG 20

7.2 Identify the method for amending the PPPG if new evidence emerges 20

7.3 Complete version control update on the PPPG template cover sheet 20

8.0 REFERENCES 21

9.0 APPENDICES 21

Appendix I: Signature Sheet 22

Appendix II: Membership of the PPPG Development Group 23

Appendix III Conflict of Interest Declaration Form Template 24

Appendix IV Membership of the Approval Governance Group Error! Bookmark not defined.

Appendix V CRAM 1

Appendix VI Clinical Restraint Form 28

Appendix VII: DOP Restraint Pathway V3 29

Appendix VIII: MHC Leaflet on Code of Practice on Physical Restraint: 33

Appendix IX: Written Consent re sharing of patient information 35

1.0 INITIATION

1.1 Purpose

1.1.1 The Executive Clinical Director/Director of Nursing/CNM3/CNM2 or designated persons attached to the Approved Centre (Department of Psychiatry), shall endeavour to ensure that in the event of the physical restraint of a patient being initiated/ordered, it shall only be initiated/ordered by the specified persons at section (3.1) of the Mental Health Commission Revised Code of Practice on the Use of Physical Restraint (2022).

1.1.2 The Director of Nursing/Assistant Director of Nursing/CNM3/CNM2/Designated persons shall endeavour to ensure that staff will receive training in the use of physical restraint in compliance with section (8) Mental Health Commission Revised Code of Practice in the Use of Physical Restraint (2022) and in adherence to section 33 (3) of the Mental Health Act (2001).

1.1.3 The CNM3/CNM2 or designated persons shall endeavour to ensure, that only staff who have received training in the use of physical restraint will take part in the physical restraint of a patient if required to do so.

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 ensure that the use of physical restraint when used, is in compliance with best practice guidelines and legislation as outlined in Mental Health Commission's Code of Practice and only used in the best interests of the patient when they pose an immediate threat to themselves or others.

1.3.2 This aim of this policy is to ensure that all staff are aware of the proper procedures to follow in the event of physical restraint being initiated to deal with patient care to the highest standards.

1.3.3 This policy document also aims to protect the welfare of patients/residents by promoting high standards NICE guidelines (NG10, May 2015), "Violence and aggression: short-term management in mental health, health and community settings" provides clear guidance for the underpinning evidence of the development of this policy.

1.4 Outcome(s)

1.4.1 This policy provides the guidelines to safeguard both staff and patients by providing guidance to manage situations safely when restraint may be required and also endeavors to provide best practice in line with legislation and research.

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)

1.7.1.2 M.H.C Revised Code of Practice on the Use of Physical Restraint in Approved Centres (2022).

1.7.1.3 Children First Act 2015

1.7.1.4 National Consent Policy V1.3 (2019)

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 Seclusion Policy

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

1.8 Glossary of Terms

1.8.1 **Approved Centre**: A 'centre' means hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder. An 'approved centre' is a centre that is registered pursuant to the Mental Health Act 2001-2018. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the Mental Health Act 2001-2018.

1.8.2 **Child:** A person under 18 years of age other than a person who is or has been married.

1.8.3 **Clinical File:** A record of the person's referral, assessment, care and treatment while in receipt of mental health services. This documentation should be stored in the one file. If all relevant information is not stored in the one file, the file should record where the other information is held.

1.8.4 **Clinical Governance:** A system for improving the standard of clinical practice including clinical audit, education and training, research and development, risk management, clinical effectiveness and openness.

1.8.5 **Consultant Psychiatrist:** Means a Consultant Psychiatrist who is employed by the HSE or by an approved centre whose name is entered on the division of psychiatry or the division of child and adolescent psychiatry of the register of Medical Specialists maintained by the Medical Council.

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

1.8.7 **De-escalation**: use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. P.R.N. medication can be used as part of a de-escalation strategy but P.R.N medication used alone is not de-escalation.

1.8.8 **Dignity**: The right of an individual to privacy, bodily integrity and autonomy, and to be treated with respect as a person in his or her own right.

1.8.9 **Direct Supervision** shall mean being physically present, within sight and sound, to direct the physical restraint of a patient.

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

1.8.11 **Duty Consultant Psychiatrist**: The Consultant Psychiatrist on the on call duty rota.

1.8.12 **HSE**: Health Service Executive.

1.8.13 **Individual Care Plan**: A documented set of goals developed, regularly reviewed and updated by the person's multidisciplinary team, so far as practicable in consultation with

each person receiving care and treatment. The individual care plan should specify the treatment and care required which should be in accordance with best practice, should identify necessary resources and should specify appropriate goals for the person. For children, individual care plans should include education requirements. The care plan is recorded in the one composite set of documentation.

1.8.14 **Manual restraint** A skilled, hands-on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user.

1.8.15 **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.

1.8.16 **NIMS:** National Incidence Management Systems

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

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

1.8.19 **Person-Centred**: Person-centred focuses on the needs of the person; ensuring that the person's preferences, needs and values guide clinical decisions or support; and providing care that is respectful and responsive to them.

1.8.20 **Physical Restraint** shall be defined as "the use of physical force (by one or more persons) for the purpose of preventing the free movement of a patient/residents body when he/she poses an immediate threat of serious harm to self or others. Section (2.1) Mental Health Commission Revised Code of Practice on the use of physical restraint (2022).

1.8.21 **Policy:** Written statement that clearly indicates the position of the organisation on a given subject.

1.8.22 **Positive Behaviour Support:** Positive behavior support involves assessments that look beyond the behavior 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 behavior change as opposed to behavior management.

1.8.23 **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).

1.8.24 **Registered Medical Practitioner**: A person whose name appears on the General Register of Medical Practitioners.

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

1.8.26 **Rights-Based Approach:** Integrating human rights norms and principles in the design, implementation, monitoring and evaluation of policies and programmes. The principles of equality and freedom from discrimination are central.

1.8.27 **Risk Assessment**: An assessment to gauge risk in relation to the person, designed and recognized for use in mental health settings.

1.8.28 **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)

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

1.8.30 **Trauma-Informed Care:** acknowledges the need to understand a patient's life experiences in order to deliver effective care and has the potential to improve patient engagement, treatment adherence, health outcomes and provider and staff wellness.

2.0 OUTLINE OF PPPG STEPS AND RECOMMENDATIONS

2.1 Orders for Physical Restraint:

2.1.1 Physical restraint should only be initiated and ordered by registered medical practitioners, or registered nurses in accordance with the approved centre's policy on physical restraint.

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

2.1.3 The CNM3/CNM2/Designated Persons shall endeavour to ensure that staffing levels in the Approved Centre are at all times adequate in order to comply with TMVA training guidelines which advocates a minimum of two, but preferably three persons be available to deal with an incident which involves the use of physical restraint of a patient/ resident.

2.1.4 All episodes of physical restraint will be based on a risk assessment, and a risk assessment tool (CRAM) (Appendix V) will be completed as soon as is practicable in relation to each episode of physical restraint.

2.1.5 In the event of a crisis, risk management or a health and safety issue in the Approved Centre, assistance from security staff can be requested by the Clinical Nurse Manager or designated person in charge. Only in extreme circumstances should the security staff become directly involved in the physical restraint of a patient/resident. Where security are requested to provide assistance, they must work under the direction of Clinical Nurse Manager or designated person in charge.

2.1.6 Clinical Nurse Manager or designated person in charge must ensure that security staff have completed the Therapeutic Management of Violence and Aggression training (TMVA) before requesting assistance in managing a patient/resident who is the subject of physical restraint.

2.1.7 The relevant section of the clinical practice form shall, as soon as practicable be completed by the security staff (Appendix VI).

2.1.8 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.

2.1.9 As soon as is practicable, and no later than two hours after the start of an episode of physical restraint, a medical examination of the person by a registered medical practitioner 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.

2.1.10 An order of physical restraint should last for a maximum of 10 minutes.

2.1.11 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 reason for renewing the order, and the time that the nursing review or medical examination took place, should be clearly recorded in the persons clinical file.

2.1.12 The episode of physical restraint should be recorded in the person's clinical file.

2.1.13 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.

2.1.14 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.

2.1.15 The person should be informed of the reason 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, wellbeing 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 a soon as is practicable.

2.1.16 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.

2.1.17 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 person's clinical file.

2.1.18 The Registered Proprietor should notify the Mental Health Commission of the start time and date, and the end time and date of each episode of physical restraint in the format specified by the Mental Health Commission, and within the timeframes set by the Mental Health Commission.

2.1.19 The DOP Physical Restraint Pathway will be completed in full after each restraint (Appendix VII).

2.2 Using Restrictive Interventions (NICE GUIDELINES 1.4.5)

2.2.1 Restrictive intervention is used only 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. Continue to attempt de-escalation throughout a restrictive intervention.

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

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

2.2.3.1 are proportionate to the risk and potential seriousness of harm;

2.2.3.2 are the least restrictive option to meet the need;

2.2.3.3 are used for no longer than necessary;

2.2.3.4 take account of the patient's preferences, if known and it is possible to do so

2.2.3.5 take account of the patient's physical health, degree of frailty and developmental age.

2.2.4 Consider rapid tranquillisation or seclusion as alternatives to prolonged manual restraint (longer than 10 minutes) as per NICE Guideline 1.4.30.

2.3 **Patient's Dignity and Safety**

2.3.1 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.

2.3.2 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.

2.3.3 Where practicable, the person should have a staff member of the same gender present at all times during the episode of physical restraint.

2.3.4 All staff members involved in the use of physical restraint should have undertaken appropriate training in accordance with section (2.7.2) of this policy document.

2.3.5 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:

2.3.5.1 Protect and support the person's head and neck, where needed;

2.3.5.2 Ensure that the person's airway and breathing are not compromised;

2.3.5.3 Conduct observations, including vital clinical indicators such as the monitoring of pulse, reparation 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;

2.3.5.4 Monitor and maintain effective communication with the person;

2.3.5.5 Monitor the person's physical and psychological health for as long as clinically necessary after using physical restraint.

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

2.3.7 The level of force applied during physical restraint should be justifiable, appropriate, reasonable, and proportionate to the situation and minimal force should be applied. In the exceptional circumstances 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.

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

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

2.3.9.1 Neck holds

2.3.9.2 The application of weight to the person's chest or back;

2.3.9.3 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.

2.3.9.4 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.

2.3.10 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.

2.4 Ending the use of Physical Restraint

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

2.4.2 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.

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

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

2.4.3.2 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 preference regarding the timing of the debrief should be recorded;

2.4.3.3 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;

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

2.4.3.5 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.

2.4.3.6 Give the person the option of having their representation 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.

2.4.4 Where multiple episodes of physical restraint occur within a 48-hour timeframe, these episodes may be reviewed during a single debrief in accordance with point (2.4.3.2) of this policy.

2.4.5 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 preference in relation to restrictive interventions going forward.

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

2.4.7 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 person's who may have witnessed the restraint of the person.

2.5 Recording the use of Physical Restraint

2.5.1 The CNM2/CNM1 or designated person shall ensure that where the use of physical restraint has been initiated/ordered the person's treating Consultant Psychiatrist/Duty Consultant Psychiatrist shall be notified as soon as possible by the person who initiated the restraint, and this shall be recorded in the patient's clinical file in compliance with section (6.1) of the M.H.C Revised Code of Practice 2022.

2.5.2 The relevant section of the clinical practice form shall, as soon as practicable be completed by the person who initiated the episode of restraint, but no later than three hours following the episode.

2.5.3 This clinical practice form shall also be signed by the sector Consultant /duty Consultant as soon as is practical, but in any event not later than 24 hours, and a copy of the relevant form is then filed in the patients/residents medical file, in compliance with section (3.7) of the M.H.C (Revised Code of Practice on the Use of Physical Restraint 2022) and a copy should be available to the Mental Health Commission on request.

2.5.4 In the event of any injury to a patient or member of staff a NIMs incident form should be completed.

2.6 **Clinical Governance**

2.6.1 Physical restraint should never be used:

2.6.1.1 To resolve operational difficulties including where there are staff shortages;

2.6.1.2 As a punitive action;

2.6.1.3 Solely to protect property;

2.6.1.4 As a substitute for other less restrictive interventions.

2.6.2 Each Approved Centre should have a written policy in relation to the use of physical restraint which should include sections which identify;

2.6.2.1 The provision of information to the person which should include information about the person's rights, presented in accessible language and format;

2.6.2.2 Who may initiate and who may carry out physical restraint;

2.6.2.3 The safety, safeguarding and risk management arrangements that should be followed during any episode of physical restraint.

2.6.3 The Approved Centre should maintain a written record indicating that all staff involved in physical restraint have read and understood the policy. The record should be available to the Mental Health Commission upon request.

2.6.4 The Approved Centre should review its policy on physical restraint and update as required or at least on an annual basis.

2.6.5 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;

2.6.5.1 The identification of the trigger/antecedent events which contributed to the restraint episode;

2.6.5.2 A review of any missed opportunities for earlier intervention, in line with the principles of positive behavior support;

2.6.5.3 The identification of alternative de-escalation strategies to be used in future;

2.6.5.4 The duration of the restraint episode and whether this was for the shortest possible duration;

2.6.5.5 Considerations of the outcomes of the person-centred debrief, if available;

2.6.5.6 An assessment of the factors in the physical environment that may have contributed to the use of restraint.

2.6.6 The multidisciplinary team review should be documented and the actions decided upon recorded. Plans to eliminate, or reduce, restrictive interventions for the person should be followed up on.

2.6.7 Every approved centre that uses, or permits the use of, physical restraint, should develop and implement a reduction policy which should be published on the Registered Proprietor's website. This policy should:

2.6.7.1 clearly document how the approved centre aims to reduce, or where possible eliminate, the use of physical restraint within the approved centre;

2.6.7.2 address leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice; and

2.6.7.3 Clearly document how the approved centre will provide positive behavior support as a means of reducing or, where possible eliminating, the use of physical restraint within the approved centre.

2.6.8 The Registered Proprietor has overall accountability for the reduction policy. The Registered Proprietor should appoint a named senior manager who is responsible for the approved centre's reduction of physical restraint.

2.6.9 All information gathered regarding the use of physical restraint should be held in the Approved Centre and used to compile an annual report on the use of physical restraint at the Approved Centre. This report, which should be signed by the Registered Proprietor Nominee, should be made publicly available on the Registered Proprietor's website within six months of the end of the calendar year and available, upon request, to the public. The annual report should contain:

2.6.9.1 Aggregate data that should not identify any individuals;

2.6.9.2 A statement about the effectiveness of the Approved Centre's actions to eliminate, where possible, and reduce physical restraint;

2.6.9.3 A statement about the Approved Centre's compliance with the code of practice and the use of physical restraint;

2.6.9.4 A statement about the compliance with the Approved Centre's own reduction policy;

2.6.9.5 The data as specified in Appendix 3 (MHC Code of Practice 2022).

All Approved Centres should produce and publish an annual report on the use of physical restraint. Where physical restraint has not been used in the relevant 12-month period, then points 2.6.9.1 and 2.6.9.2 should only be reported on.

2.6.10 A multidisciplinary review and oversight committee, which is accountable to the Registered Proprietor Nominee, should be established at each Approved Centre to analyse in detail every episode of physical restraint. The committee should meet at least quarterly and should;

2.6.10.1 Determine if there was compliance with the Code of Practice on the use of physical restraint for each episode of physical restraint reviewed;

2.6.10.2 Determine if there was compliance with the Approved Centre's own policies and procedures relating to physical restraint;

2.6.10.3 Identify and document any areas for improvement;

2.6.10.4 Identify the actions, the person's responsible, and the timeframes for completion of any actions;

2.6.10.5 Provide assurance to the Registered Proprietor Nominee that each use of physical restraint was in accordance with the Mental Health Commission's Code of Practice;

2.6.10.6 Produce a report following each meeting of the review and oversight committee. This report should be made available to staff who participate, or may participate, in physical restraint, to promote on-going learning and awareness. This report should also be available to the Mental Health Commission upon request.

2.6.11 The Registered Proprietor has overall accountability for the use of physical restraint in the Approved Centre.

2.7 Staff Training

2.7.1 All staff who participate, or may participate, in the use of physical restraint should have received the appropriate training in its use and in the related policies and procedures.

2.7.2 Approved Centre's that use physical restraint should implement a policy and have procedures in place for the training of all staff involved in physical restraint. This policy should include, but is not limited to, the following:

2.7.2.1 Who will receive training based on the identified needs of staff and person's who are restrained;

2.7.2.2 The areas to be addressed within the training programme, which should include training in:

2.7.2.2.1 The prevention and Therapeutic Management of Violence and Aggression (TMVA), including 'breakaway' and 'de-escalation techniques;

2.7.2.2.2 Alternatives to physical restraint;

2.7.2.2.3 Trauma-informed care;

2.7.2.2.4 Cultural competence;

2.7.2.2.5 Human rights, including the legal principles of restrictive interventions;

2.7.2.2.6 Positive behavior support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional or somatic;

2.7.2.2.7 The monitoring of the safety of the person during and after the physical restraint.

2.7.2.3 The identification of appropriately qualified person(s) to give the training;

2.7.2.4 The mandatory nature of training for those involved in physical restraint.

2.7.3 A record of attendance at training should be maintained.

2.8 In the event of the use of restraint of a child

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 which apply to all persons, the following considerations apply to children being provided care and treatment in Approved Centres (as per Revised Code of Practice on the use of Physical Restraint in Approved Centres, 2022):

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

2.8.2 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.

2.8.3 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.

2.8.4 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.

2.8.5 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.

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.

5.0 IMPLEMENTATION

5.1 Describe implementation plan listing barriers and /or facilitators

5.1.1 None.

5.2 Describe any education/training required to implement the PPPG

5.2.1 All staff must be up-to-date with the Therapeutic and Management of Violence training (TMV).

5.2.2 The areas to be addressed within the training programme, include training in the prevention and management of violence (including 'breakaway' techniques and team working) and training in alternatives to physical restraint.

5.2.3 All members of the MDT working in the Approved Centre will have completed mandatory training in Child First Guidelines, have a knowledge of the Childcare Act (1981) and the Children Act (2001).

5.2.4 The training is mandatory and will be refreshed every two years.

5.2.5 The training will be provided by appropriately qualified persons.

5.2.6 A record of attendance at training will be maintained in the Approved Centre. A personal training record will be retained post successful completion of TMVA Training for each staff member.

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

5.2.8 All staff will read the policy on seclusion along with this policy.

5.2.9 Staff will sign policy log to say that they have read 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.

5.4 Outline specific roles and responsibilities

5.4.1 The Registered Proprietor has the responsibility of ensuring the Approved Centre has written policy on the guidance of Use of Physical Restraint.

5.4.2 It is the responsibility of all staff to read and adhere to this policy.

5.4.3 All staff involved in the care of the patient must continually reassess the use of Physical Restraint in line with legislation and best practice guidelines.

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 The Use of Physical Restraint within the Approved Centre is continuously monitored and improved upon.

6.1.3 **Audit**

6.1.2.1. Audit of policy implementation to ensure compliance with legislation and Code of Practice and NICE Guidelines must be completed by DOP management.

6.1.2.1 This policy shall be reviewed at any point and at minimum every year in compliance with the Mental Health Commission Code of Practice on the Use of Physical Restraint in Approved Centres (2022).

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.

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 I update on the PPPG template cover sheet.

8.0 REFERENCES

Attorney General (2001) Mental Health Act. Dublin: Government of Ireland. Revised (2020).

Judgement Support Framework, version 5.1 (2020)

Mental Health Act Code of Practice Department of Health April 2015, The Stationary Office. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Mental Health Commission, Code of Practice on the Use of Physical Restraint (2022), Dublin.

Menschner,C. & Maul, A.(2016) Key Ingredients for Successful Trauma-Informed Care Implementation, Centre for Health Care Strategies. Available at: https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

Mosby (2021) Dictionary of Medicines, Nursing & Health Professions, 11th Edition, ISBN: 9780323639149

Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint Issued Pursuant to Section 69(2) of the Mental Health Act, 2001 (2010)

Violence and aggression: short-term management in mental health, health and community settings, NICE guideline [NG10] Published date: 28 May 2015. Available at: https://www.nice.org.uk/guidance/ng10/chapter/1-Recommendations#using-restrictive-interventions-in-inpatient-psychiatric-settings-2

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: CRAM

Appendix VI Clinical Restraint Form

Appendix VII: DOP Restraint Pathway V3

Appendix VIII: MHC Leaflet on Code of Practice on Physical Restraint

Appendix IX: Written Consent re: sharing of patient information

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: J McCardle
Area Director of Nursing	Date: 17/1/24
Dr. Colin O'Donnell	Sign: [signature]
Clinical Director	Date: 2/4/24.
Pauline Ackermann	Sign: Pauline Ackermann
Registered Proprietor General Manager	Date: 12/2/2024

Appendix V CRAM

CLINICAL RISK ASSESSMENT FORM

Location: APPROVED CENTRE Consultant: Initial Date Of Completion :____________ Addressogram

Participants/clinician:

Prioritise & Rank Order Most Relevant Risks- RISK TO SELF ☐ RISK TO OTHERS☐ VULNERABILITY☐ SELF-NEGLECT☐

Rank order	IDENTIFIED RISK	Description of Evidence (& source) of specific, relevant, past behaviours Indicating Risk
	Protective Factors	
	Management plan	

Information re-risk discussed with service user: Yes ☐ No ☐ If no reason;

Clinician completing: ________________ Print Name: ______________Discipline/& Reg No.: _______________Date__________

CLINICAL RISK ASSESSMENT UPDATES

Consultant: **Update/Review Date:** ________________ **Addressogram**

Participants/clinician:

Updates to Relevant Priority Risks (as above) - RISK TO SELF ☐ RISK TO OTHERS☐ VULNERABILITY☐ SELF-NEGLECT☐

Rank order	IDENTIFIED RISK	Description of any new information/ evidence Indicating Risk UPDATE as REQUIRED
	Any Changes to management plan	

Clinician completing: ________________ **Print Name:** ______________ **Discipline/& Reg No.:** _______________ **Date** __________

Rank order	IDENTIFIED RISK	Description of any new information/ evidence Indicating Risk UPDATE as REQUIRED
	Any Changes to management plan	

Clinician completing: ________________ **Print Name:** ______________ **Discipline/& Reg No.:** _______________ **Date** __________

CLINICAL RISK ASSESSMENT UPDATES

Consultant: **Update/Review Date:** ________________ **Addressogram**

Participants/clinician:

Updates to Relevant Priority Risks (as above) - RISK TO SELF ☐ RISK TO OTHERS☐ VULNERABILITY☐ SELF-NEGLECT☐

Rank order	IDENTIFIED RISK	Description of any new information/ evidence Indicating Risk UPDATE as REQUIRED
	Any Changes to management plan	

Clinician completing: ________________ **Print Name:** ______________ **Discipline/& Reg No.:** _______________ **Date** _________

Rank order	IDENTIFIED RISK	Description of any new information/ evidence Indicating Risk UPDATE as REQUIRED
	Any Changes to management plan	

Clinician completing: ________________ **Print Name:** ______________ **Discipline/& Reg No.:** _______________ **Date** _________

CLINICAL RISK ASSESSMENT UPDATES

Consultant: **Update/Review Date:** ________________ **Addressogram**

Participants/clinician:

Updates to Relevant Priority Risks (as above) - RISK TO SELF ☐ RISK TO OTHERS☐ VULNERABILITY☐ SELF-NEGLECT☐

Rank order	IDENTIFIED RISK	Description of any new information/ evidence Indicating Risk UPDATE as REQUIRED
	Any Changes to management plan	

Clinician completing: ________________ **Print Name:** ______________**Discipline/& Reg No.:** _______________**Date**_________

Rank order	IDENTIFIED RISK	Description of any new information/ evidence Indicating Risk UPDATE as REQUIRED
	Any Changes to management plan	

Clinician completing: ________________ **Print Name:** ______________**Discipline/& Reg No.:** _______________**Date**_________

CLINICAL RISK ASSESSMENT UPDATES

Consultant: **Update/Review Date:** ________________ **Addressogram**

Participants/clinician:

Updates to Relevant Priority Risks (as above) - RISK TO SELF ☐ RISK TO OTHERS☐ VULNERABILITY☐ SELF-NEGLECT☐

Rank order	IDENTIFIED RISK	Description of any new information/ evidence Indicating Risk UPDATE as REQUIRED
	Any Changes to management plan	

Clinician completing: ________________ **Print Name:** ______________**Discipline/& Reg No.:** _______________**Date**_________

Rank order	IDENTIFIED RISK	Description of any new information/ evidence Indicating Risk UPDATE as REQUIRED
	Any Changes to management plan	

Clinician completing: ________________ **Print Name:** ______________**Discipline/& Reg No.:** _______________**Date**_________

CLINICAL RISK ASSESSMENT UPDATES

Consultant: **Update/Review Date:** ________________ **Addressogram**

Participants/clinician:

Updates to Relevant Priority Risks (as above) - RISK TO SELF ❑ RISK TO OTHERS❑ VULNERABILITY❑ SELF-NEGLECT❑

Rank order	IDENTIFIED RISK	Description of any new information/ evidence Indicating Risk UPDATE as REQUIRED
	Any Changes to management plan	

Clinician completing: ________________ **Print Name:** ______________**Discipline/& Reg No.:** _______________**Date**__________

Rank order	IDENTIFIED RISK	Description of any new information/ evidence Indicating Risk UPDATE as REQUIRED
	Any Changes to management plan	

Clinician completing: ________________ **Print Name:** ______________**Discipline/& Reg**

GUIDANCE/PROMPTS FOR COMPLETING CRAM2 FOR APPROVED Centre from – UPDATED February 2020

GUIDANCE FOR COMPLETING FORM **GOAL-**the CRAM 2 aims to record risks with specific examples in one place in the file so that the most relevant information needed for clinical decisions (or use of a structured formal risk assessment tool) can be easily & quickly accessed. -It may be useful to refer to the psychiatric inpatient interview/ scan nurse interviews completed on the resident to help answer prompts	Please note that the following information **DOES NOT** need to be reproduced on this form-as it is available elsewhere in the file. 1. Presentation 2. Psychiatric history, 3. Psychiatric evaluation & diagnoses I.e., this form is not intended to be an Integrated Care plan (ICP)-refer to ICP for information on presentation 4. refer to Mental State Evaluation for diagnosis etc
PROMPTS the following are suggested prompts to guide staff to record relevant specific information that supports any risks identified–**not all prompts will be relevant to every case**	**NOTE- if a relevant NIMS incident arises this can be recorded in the update section**
RISK OF SUICIDE & SELF-HARM	
A) Suicidal Behavior 5. evidence that the person has taken steps towards completing suicide 6. Behaviour (e.g., cutting, hanging, OD et cetera) 7. ascertain the following 8. Previous suicide attempts 9. number of times they have attempted 10. methods they have used 11. evidence previous attempts were planned 12. events leading up to previous attempts 13. Regrets 14. Attitude to previous attempt, beliefs about if there was a different outcome	**B) Suicidal ideation** 15. Person currently has suicidal thoughts 16. they've had these thoughts for days/weeks/months 17. frequency of thoughts 18. the resident themselves attributes their suicidal behaviour/thoughts to (e.g. bereavement, financial, physical or relationship) 19. the resident has thoughts of suicide in the past 20. the resident didn't act on the suicidal thoughts because....... **C) Current risk** 21. the resident has expressed a plan to suicide – 22. The person may try to abscond 23. the resident can access a specified lethal means (e.g. rope, gun, or tablets
D) Deliberate Self-Harm 24. **THE RESIDENT** 25. has been self-harming (days, weeks, months, years) 26. self-harms by 27. 's frequency of self-harming (daily, weekly, monthly, other 28. identifies the triggers for self-harming e.g. strong emotions) 29. there is a history of self-harm in the family 30. the resident reports their friends self-harm 31. the resident reports a reason for self-harming (e.g. response to emotional pain & with no intention of suicide)	**Deliberate Self-Harm (continued)** 32. **THE RESIDENT** 33. starves self/binge eats/makes themselves vomit 34. presented to GP/A&E after most recent occurrence 35. attended themselves/was brought by a specified person 36. has presented to a GP/A&E with DSH injuries a specified number of times 37. still feels like harming themselves S) **HOPELESSNESS** 38. **THE RESIDENT** 39. is looking forward hopefully to the future or is not 40. can state how they are going to get through the problems they are facing

	41. can see a point where the problems get resolved without self-harm or suicide
E) Other risk factors 42. the resident feels social isolation/alienation/estrangement from family close friends 43. the resident has a Relative/friend who attempted/completed suicide 44. **Reasons for living (PROTECTIVE FACTORS)** 45. the resident has at least one significant person they can relate to 46. Supportive family relationships 47. spirituality / belief system	**F) Reasons for living (PROTECTIVE FACTORS continued) THE RESIDENT** 48. has skills & resilience to deal with difficult situations 49. good physical health 50. willingness to seek help / treatment 51. economic security 52. good level of confidence 53. community & social integration 54. responsibility for children 55. belief that suicide is wrong 56. Fear of death. 57. help seeking behaviour (e.g. calling helpline/ GP)
RISK OF VIOLENCE-	**SPECIFIC QUESTIONS**
G) Violent behaviour present <u>If yes</u> then, 58. the violence appeared to be triggered by… 59. the violence was triggered by… 60. Violence was directed at (e.g. family member, partner, stranger, acquaintance or friend 61. the violence specifically took the form of **E**.g. punching, slapping, kicking, head-butting et cetera 62. the resident was reported (by whom) to use a weapon (state type) or something as a weapon during the incident 63. the assault lasted… 64. The assault ended when… (E.g. the resident stop being violent, or they were stopped by others	**G) Violent behaviour present (continued)** 65. the Garda said the resident has criminal record involving violence/public disorder offences 66. The resident explained their violent behaviour/thoughts as arising e.g. bereavement, financial, revenge/retaliation, physical or relationship 67. the resident may pose a risk of violence to others because… 68. The risk might be imminent because… 69. The resident might pose a risk to children because… **If yes is the answer to any of the above- is the risk imminent** 70. The resident might be at risk of violence from someone else because… 71. The person may try to abscond
<u>H) Vulnerability</u> there is evidence of the following 72. learning difficulty, 73. dementia, 74. neurological difficulties 75. infectious disease)? ❑ 76. There has been a recent negative life event a. bereavement, b. relationship breakdown, c. financial worries)	**<u>H) Vulnerability (continued)</u>** 77. there is evidence of recent victimization e.g. a. assault (specify), b. sexual/domestic abuse (specify), c. victim of crime such as burglary 78. The person may try to abscond 79. There are other health & safety issues
I) Risk of Self-Neglect 80. Recent or previous poor nutrition	83. unable to cook/feed self 84. unable to wash/dress self

81. poor personal hygiene; 82. poor physical health	85. poor or non-compliance with medication. 86. Mental health symptoms where they impact on risk e.g. specific depressive symptoms, paranoia et cetera
MANAGEMENT- PLAN	
L) <u>Recommendations</u> 87. to keep the resident/other people safe on the ward, the following should happen… 88. To keep the resident/other people safe outside the ward, the following should happen…	89. Specific aspects of the residents behaviour/presentation that should be observed as part of ongoing assessment of risk 90. The assessment been included in the resident's' file to assist development of the Integrated Care Plan (ICP) 91. Specifics about leave should be stated clearly, e.g. length, whether accompanied, whether local or other

Appendix VI Clinical Practice Form for Physical Restraint 2023

Person's Details	
1.First Name:	**2.Surname:**
3. Date of Birth:	**4. Gender: Male ☐ Female ☐ Other ☐**
5.Persons Medical Record Number: PCN	
Location	
6.Approved Centre Name:	**7.Unit/Ward Name:**
Physical Restraint Details	
8. Physical Restraint Order Type **First Restraint Order ☐ First Renewal Order ☐ Second Renewal Order ☐** **As per provision 3.5,** a physical restraint order should last for a maximum of 10 minutes. A renewal order should be made if it is necessary to renew the episode of physical restraint beyond 10 minutes **(MAX 2 renewals = 30 mins)**	
9. Date Restraint Commenced _ _/_ _/_ _ _ _	**10. Time Restraint commenced: _ _ : _ _ 24 hr clock**
11a. Who initiated and ordered physical restraint: Name (print) ____________ Job Title (print)____________ Signed: ____________ **11b. Who led the physical restraint episode in accordance with provision 4.5:** Name (print) ____________ Job Title (print)____________ Signed: ____________ **11c. Who assisted with the physical restraint:** Name (print) ____________ Job Title (print)____________ Signed: ____________ Name (print) ____________ Job Title (print)____________ Signed: ____________ Name (print) ____________ Job Title (print)____________ Signed: ____________ Name (print) ____________ Job Title (print)____________ Signed: ____________	
12. Details of what each member of staff named above was doing during the episode of physical restraint:	
13. Why is physical restraint being ordered/renewed? Immediate threat of serious harm to self ☐ Actual harm caused to self ☐ Immediate threat of serious harm to others ☐ Actual harm caused to others ☐ Transfer to seclusion room ☐ To administer medication/treatment (excluding nasogastric feeding) ☐ To administer nasogastric feeding ☐ Other (please specify) ☐ *Please provide further details on the above:*	

14. Alternative means of de-escalation attempted prior to the use of physical restraint:
Verbal intervention ☐ Medication offered/administered ☐
Time out/One to One Nursing/ Seclusion ☐ No alternatives attempted ☐
Other (please specify) ☐ ____
Please provide further details on the above:

15. Type of Physical Restraint used:
Prone ☐
Supine ☐
Side ☐
Upright ☐
Other (please specify ☐ ______________________________________
Please provide further details:

16. Was the person's representative informed of the person's physical restraint?
Yes ☐ **No** ☐
If no, please explain the reasons why this did not occur:

17. Order: I ________________________ have assessed ______________________________ on
Date: ____/____/____ at ____hr ___min and I order the use of physical restraint from
Date: ____/____/____ at ____ hr ____ min for up to a maximum of ______ minutes.
Name (print): _________________________ Signed: ___________________________________
Date: ____/____/______ at ____hr ____min

18. Physical restraint has been ordered under the supervision of the:
Please tick as appropriate and sign below:
Consultant psychiatrist responsible for the care and treatment of the person ☐
Duty Consultant Psychiatrist ☐
Name (print) _________________________________ Signed: ____
Date: ___/___/ _____ at ___hr ___min (24 hour clock)

19. Physical Restraint ended ☐ **Physical restraint renewed*** ☐
Who ended or renewed physical restraint:
Name (print): _________________________ Signed: _____________________________________
Date physical restraint ended / renewed: ____/____/______ (dd/mm/yyyy)
Time physical restraint ended / renewed: ____ : ____ (24 hr clock e.g. 2.41pm is written as 14.41)
* *If Physical restraint is renewed, a new Clinical Practice form and order should be completed.*

20. Did the medical examination of the person take place within two hours of the commencement of the restraint episode?
Yes ☐ No ☐
If yes, please complete the following:
Name of the registered medical practitioner who conducted the medical examination:

____

Date: ___ / ___ / ______ at ____ hr ____ min
If no provide further details:

21. To be completed by the person who ended/renewed physical restraint
Did the physical restraint episode result in any injury to the person? Yes ☐ No ☐
If yes, please provide further details:

Appendix VII: DOP Restraint Pathway V5

Department of Psychiatry, Letterkenny University Hospital

Date: ___/___/______ Time: ___:___

Clinical Practice Form Completed: Yes ☐ No ☐

Donegal Mental Health Service

PHYSICAL RESTRAINT PATHWAY

This pathway has been developed in conjunction with the following:
Codes of Practice on the use of Physical Restraint
Mental Health Act 2001 Section 33 (3) (e)
Updated September 2022 and
DMHS Policy on Physical Restraint

This form must be completed in full.
Please ensure that this physical restraint pathway is filed in chronological order in the clinical notes section of the chart.

Donegal Mental Health Services August 2023 Version 5

PATIENT DETAILS

PATIENT DETAILS (Please affix patient label) **Gender: Male ☐ Female ☐ Other ☐**

NAME OF TREATING CONSULTANT: ______________________________

DATE & TIME RESTRAINT INITIATED: ______________________________

DATE & TIME RESTRAINT ENDED: ______________________________
PHYSICAL RESTRAINT ORDER CAN LAST MAXIMUM 10 MINUTES
RENEWAL ORDER REQUIRED: Yes ☐ No ☐ TIME: ________
2 RENEWAL ORDERS TO A MAXIMUM TIME 30 MINUTES
CONSULTANT/ON-CALL CONSULTANT NOTIFIED: Yes ☐ No ☐ TIME: ________

NCHD NOTIFIED: Yes ☐ No ☐ TIME: ________

NCHD ATTENDED: Yes ☐ No ☐ TIME: ________

CLINICAL PRACTICE FORM FOR CLINICAL RESTRAINT Yes ☐ No ☐ (SECTION 33(3) (E) MHA 2001)

Restraint Details

An order for physical restraint should last for a maximum of 10 minutes, this may be extended by a renewal order for a further 10 minutes to a maximum of two renewals for a maximum of 30 minutes.

Reason for Restraint: (Nursing) i.e. Circumstances leading to Restraint

Date & Time:

Signed: ______________________ **Discipline:** ________________

**Alternatives to Physical Restraint Attempted

Verbal De-escalation ☐ Medication offered/Administered ☐

Time out/One to One Nursing/Seclusion ☐

No alternatives ☐ Other (Please Specify):

____

Patient Dignity and Safety:

Gender Balance Maintained: Yes ☐ No ☐

Safe Environment Maintained: Yes ☐ No ☐

All Staff TMV trained: Yes ☐ No ☐

Was special consideration given to the resident who is known to have experienced physical or sexual abuse? Yes ☐ No ☐

Was the patient informed of reason(s) for the restraint? Yes ☐ No ☐

If No, Reason: ______________________________

Was the patient informed of the likely duration of Restraint? Yes ☐ No ☐

If No, Reason: ______________________________

Was the patient informed of the circumstances which would lead to the discontinuation of Restraint?

Yes ☐ No ☐

If No, Reason: ______________________________

Had the patient any specific requirements or "Advance Directives" in relation to the use of Restraint?

Yes ☐ No ☐

If Yes, give details: ______________________________

Was special consideration given to the patient with a known psychosocial/ medical condition, in which close confinement/physical contact would be contraindicated? Yes ☐ No ☐

Was patient consent obtained to contact their Next of Kin? Yes ☐ No ☐

If No, Reason: ______________________________

Was the patient's Next of Kin contacted (patient must give consent) Yes ☐ No ☐

If No, Reason: ______________________________

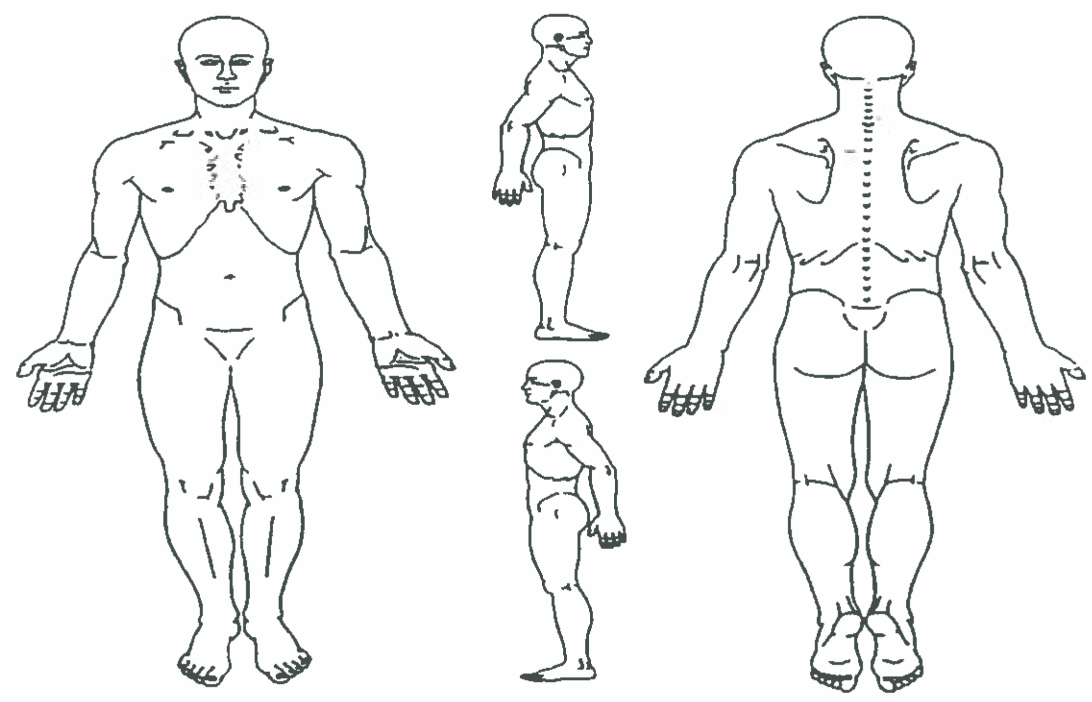
Who initiated and ordered the Physical Restraint?

Name:	Title:	Signature

Who assisted with the Physical Restraint and give details of what each member of the team was responsible for? **If team members changed during the restraint, please give details:**

Name (Block Capitals):	Title:	Responsible for:	Changed with

Description of restraint holds used:
Prone
Supine
Side
Upright
Other (Please Specify)
Further details
Who was responsible for monitoring the residents AIRWAY: Name: ____________ Title: ____________
Was the resident continually monitored and assessed for the duration of the restraint? Yes ☐ No ☐
Give a brief account of the how the Physical Restraint ended:
Post Restraint Physical completed at Time (24hour clock) __:__ By: Name: ______________________ Title:______________________ Was Post Restraint Physical completed within **2** hours: Yes ☐ No ☐ If no, please explain __ If Yes, Name of NCHD who conducted the medical examination BLOCK CAPITALS: ______________________



Respiratory Examination	CVS Examination

B/P **Pulse** **Temp** **Resp**

Observations

Signed (NCHD) ______________________________**Date** ____/____/_________ **Time** _____:_____

Risk assessment Reviewed and Updated: Yes ☐ No ☐
If No, Reason: ____

Was the resident given the opportunity to discuss the episode of Physical Restraint post episode? Please give details: ____
____
If No, please give details: ____
____

Physical Restraint Pathway completed by:

Name:___________________ Title:___________________ Date: __/__/____ Time: ___:___

Note: Clinical Practice form for Physical restraint must be completed by the person who initiated and ordered the use of physical restraint as soon as possible but in any case no later than 3 hours from the time the restraint ended.

De-Brief within 2 working Days:

A de-brief was offered to the person within 2 working days Yes ☐ No ☐ N/A ☐

The person is informed of the right to refuse de-brief Yes ☐ No ☐ N/A ☐

The person is informed of the right to take a representative to the de-brief and if this person does not attend reasons are documented in the notes Yes ☐ No ☐ N/A ☐

The de-brief included a discussion about alternative strategies which could avoid future restraints, and what restrictive practices they would prefer Yes ☐ No ☐ N/A ☐

The medical notes have a records of all attendees at the de-brief Yes ☐ No ☐ N/A ☐

The de-brief takes account of alternative preferences of the person Yes ☐ No ☐ N/A ☐

The de-brief takes account of any trauma in the person's past Yes ☐ No ☐ N/A ☐

The de-brief takes account of cultural differences Yes ☐ No ☐ N/A ☐

The de-brief takes account of Human rights legislation Yes ☐ No ☐ N/A ☐

Positive behavioural supports are discussed going forward Yes ☐ No ☐ N/A ☐

MDT Review within 5 working Days:

The **MDT review of the restraint reminder** is entered in the Ward Diary to be carried forward each day until completed. Yes ☐ No ☐

Appendix VIII: MHC Leaflet on Code of Practice on Physical Restraint:

What else does the Code say about physical restraint?

The Code of Practice also states the following:

- If staff decide to restrain you, they should consider any needs relating to physical restraint that you have told them about.
- If possible, a staff member of the same gender should be present when you are being restrained.
- Staff should avoid using neck holds or weight on your chest, back or rib-cage. Staff should also make sure that they don't cover your eyes, mouth or ears when they are restraining you.
- Every time you are restrained, staff should keep good records.
- Staff should never use physical restraint as a punishment, or because there are difficulties in the approved centre, such as not enough staff on duty.

Do all approved centres use physical restraint?

No. Some approved centres have a policy of not using physical restraint. Ask your care team if they use physical restraint in your hospital.

Who we are

The Mental Health Commission was set up under the Mental Health Act 2001. We have two important jobs:

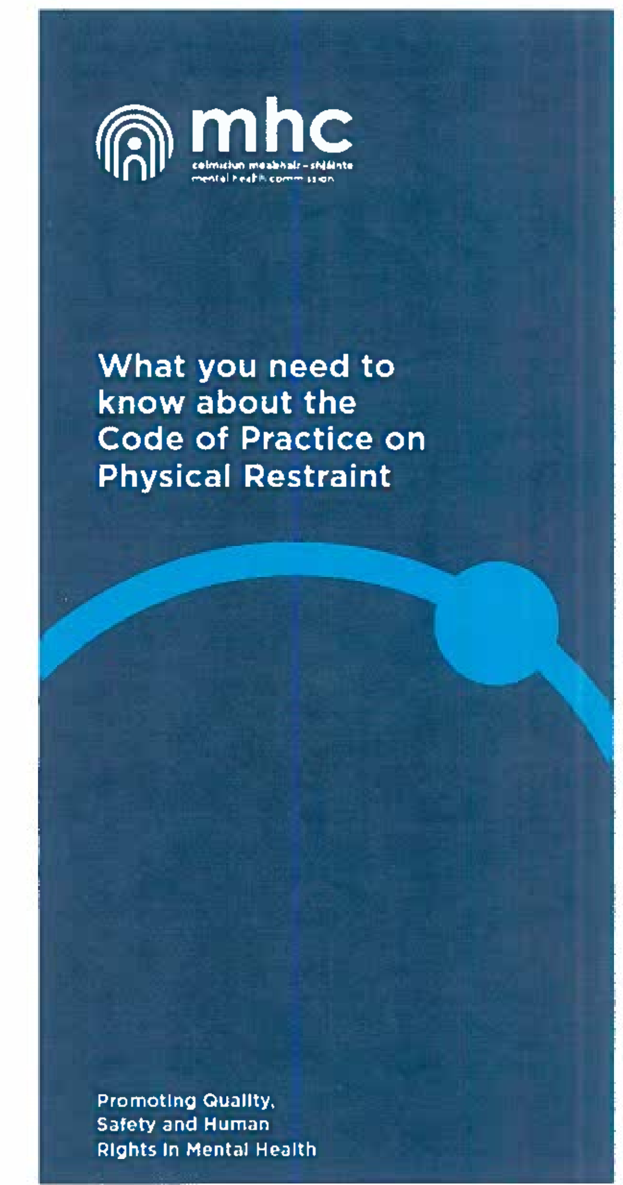
- to make sure that mental health services maintain high standards and good practices, and
- to take all reasonable steps to protect the interests of people detained in approved centres.

For more information

You can ask for a printed copy of the Code of Practice on Physical Restraint from the hospital staff, or you can view the code of practice on the Mental Health Commission's **website: www.mhcirl.ie**

You can also ask the Mental Health Commission to email a copy of the rules to you by contacting **info@mhcirl.ie**

Please note: This leaflet is only a guide to the Code of Practice on Physical Restraint. It is not a legal interpretation and it does not give a full description of the Code of Practice. Please do not rely on it for advice.



When you use mental health services in Ireland, your rights and interests are protected by the Mental Health Act 2001-2018. All staff who give you care and treatment must follow this law. The Act allows the Mental Health Commission to prepare codes of practice for mental health services. A code of practice is a guide to the best way of doing things.

We have produced a Code of Practice on Physical Restraint that your care team should follow if they decide to physically restrain you while you are receiving care and treatment in an approved centre. An approved centre is a hospital or in-patient service that is registered by the Mental Health Commission. In this leaflet, we aim to answer your questions about the Code of Practice.

What is physical restraint?

Physical restraint is when one or more people use physical force to prevent you from moving your body freely if you pose an immediate threat of serious harm to yourself or others.

When can staff use physical restraint?

The Code of Practice on Physical Restraint states that staff should only use physical restraint when no other option will work. They should use it only if it prevents you from harming yourself or others.

Who does the Code of Practice on Physical Restraint apply to?

The Code of Practice applies to people who receive care and treatment for a mental illness in an approved centre. All staff involved in physically restraining a person should follow it. The Inspector of Mental Health Services checks this.

Who can physically restrain me?

Only a doctor or nurse can start physical restraint.

How long can I be physically restrained for?

You should only be restrained for as long as is needed to stop you harming yourself or others. This means that restraint should end when you are no longer a serious threat to yourself or others.

You can only be restrained for a maximum of 10 minutes at first. After 10 minutes, a doctor or nurse should review you and may decide that you still need to be restrained. They should then make a renewal order that allows you to be restrained for up to another 10 minutes. They need to make a new renewal order for any further 10-minute period of physical restraint. The maximum time that you can be restrained for is 30 minutes.

What information will I get if I am physically restrained?

If you are physically restrained, staff should tell you:

- why you are being restrained, and
- what needs to happen before physical restraint will end.

You might not get this information if a staff member feels that it may make your condition worse.

Who will be told about my physical restraint?

If you agree, the staff will contact your representative to tell them you are being restrained. This might be a family member, friend, or advocate, for example.

How does physical restraint end?

Staff will end physical restraint when a doctor or nurse decides that you are no longer a serious threat to yourself or others. Afterwards, they should give you the chance to discuss your restraint with members of your team if you want to. You are allowed to bring a support person with you to this discussion

Appendix IX: Written Consent re sharing of patient information

Do you give consent to your Consultant Psychiatrist or any member of the Multidisciplinary team authorised by him/her, to discuss your treatment with the following persons

Yes ☐ No ☐

Name:________________ Name:________________ Name:________________

Relationship:__________ Relationship:__________ Relationship:__________

3