Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Policy on Policy on Use of Seclusion

This policy is only applicable in Glencree Unit, in Newcastle Hospital, Co. Wicklow

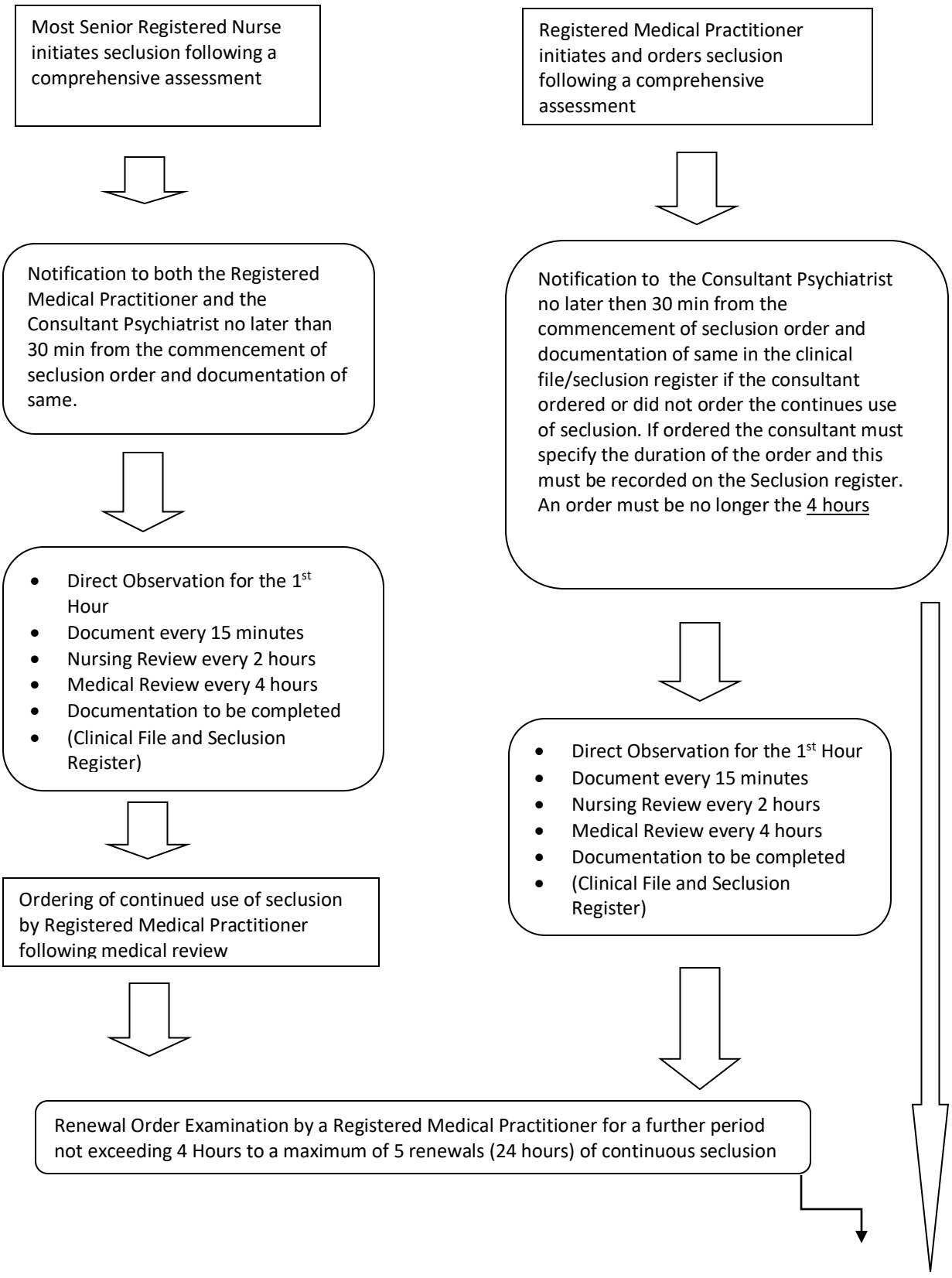
Policy ✓ Procedure ☐ Protocol ☐ Guideline ☐

Insert Service Name(s), Directorate and applicable Location(s):
Glencree Unit – Newcastle Hospital, Co Wicklow.

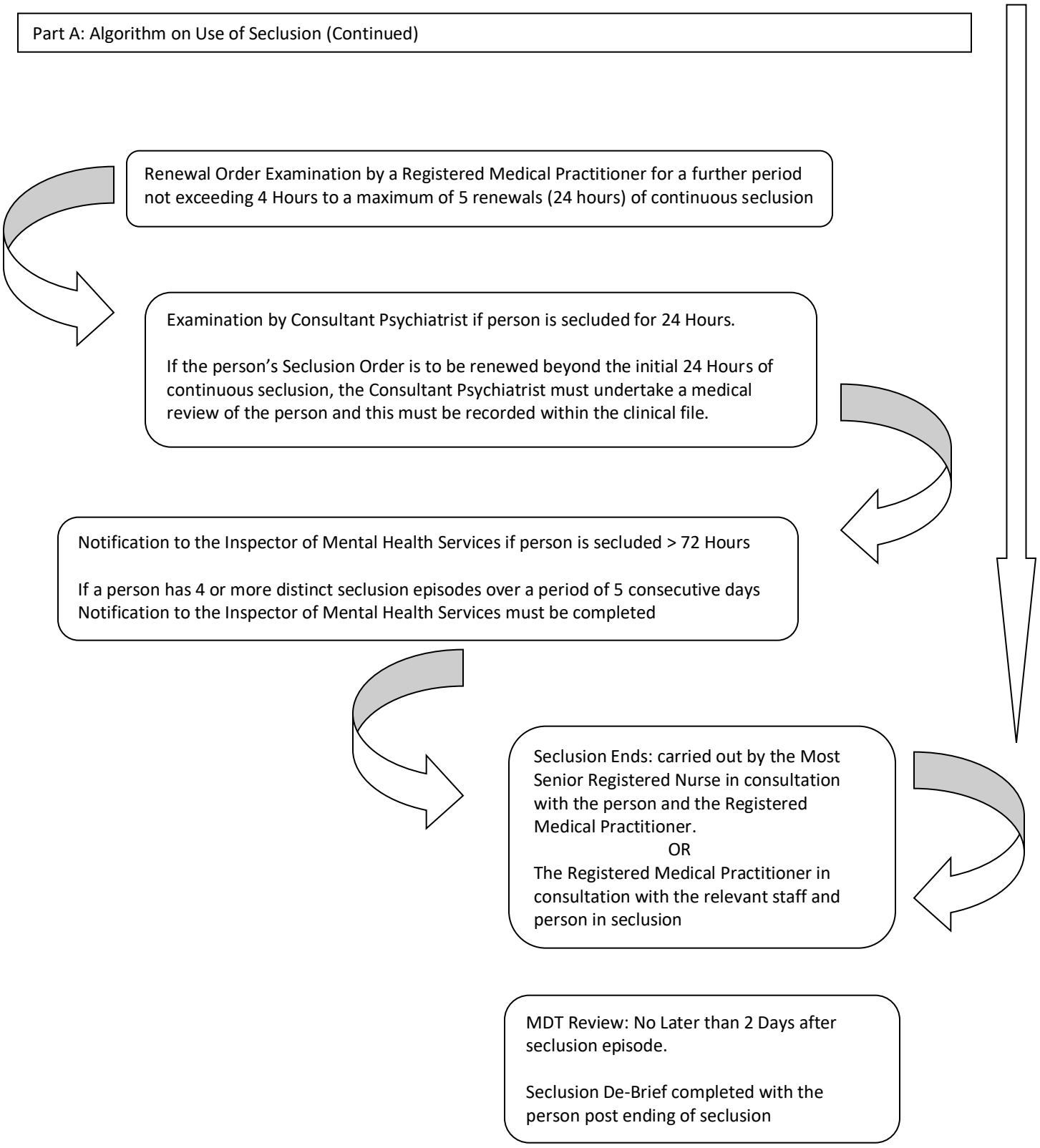
Title of PPPG Development Group:	HSE:CHE:MHS: Dublin South East and Wicklow Mental Health Services Policy Development Group
Approved by:	HSE:CHE:MHS: Dublin South East and Wicklow Mental Health Services Policy Approval Governance Group
Reference Number:	HSE/CHE/Use of Seclusion/V6
Version Number:	7
Publication Date:	20.03.2024
Date for revision:	January 2025
Electronic Location:	N/A

Version	Date Approved	List section numbers changed	Author
V5			HSE:CHE:MHS: Dublin South East and Wicklow Mental Health Services Policy Development Group
V6		Revision throughout to reflect revised code of practice on the rules governing the use of seclusion issued pursuant to section 69 (2) of the Mental Health Act 2001-2018 .	HSE:CHE:MHS: Dublin South East and Wicklow Mental Health Services Policy Development Group
V7	QSEC Meeting held 20.03.2024	Page 8 to reflect 2023 MHC Inspectorate feedback	HSE:CHE:MHS: Dublin South East and Wicklow Mental Health Services Policy Development Group

Part A: Algorithm on Use of Seclusion



Part A: Algorithm on Use of Seclusion (Continued)



PART B: Policy Development Cycle

1. Policy Statement

This Policy provides guidance in relation to the use of Seclusion in Glencree Unit, in Newcastle Hospital within Community Healthcare East. It outlines that Seclusion will be used in a professional manner and is based within an ethical and legal framework. In this regard the seclusion of a person should be implemented only as a last resort when all other alternative interventions have been considered and where the resident poses an immediate threat of serious harm to self or others.

2. Purpose

The purpose of this Policy is to communicate legislative policy and best practice on the use of seclusion within the Approved Centre in Glencree unit. The purpose is to protect the safety, dignity and fundamental rights of the resident in adherence with the rules governing the use of seclusion made by the Mental Health Commission and in accordance with Section 69(2) of the Mental Health Act 2001.

3. Scope of the Policy

This policy applies to:

- **All registered nursing and medical personnel** working within Glencree Unit.
- All residents , that is , persons receiving care and treatment in Glencree Unit.

This is solely applicable to Glencree Unit, Newcastle Hospital, Greystones,Co. Wicklow, within Community Healthcare East.

4. Roles/ Responsibilities

It is the responsibility of the Registered Proprietor of the Approved Centre to have a written policy in relation to the rules governing the use of seclusion issued pursuant to section 69 (2) of the Mental Health Act 2001-2018 .
Staff must be competent in the care and management of persons receiving seclusion and must practice in accordance with their professional scope of practice guidelines.
It is the responsibility of all staff to be aware of, have read, implement and comply with this policy. This should be documented.

5. Definition:

Approved Centre
A "centre" means a hospital or other inpatient facility for the care and treatment of persons suffering from a mental illness or mental disorder .An "Approved 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.

Disengagement Techniques
A set of physical skills to help separate from an aggressor in a safe manner .They do not involve the use of restraint.

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

Clinical File
A record of the persons referral, assessment , care and treatment while in receipt of mental health services . This documentation must be stored in the one file .If all relevant information is not stored in the one file , the file must record where the other information is held.

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.

Consultant Psychiatrist
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 of Ireland.

Closed Circuit Television (CCTV)
Any monitoring device which captures a persons image, either for recording or live observation.

Continuous observation
Ongoing observation of the person by a registered nurse and registered medical practitioner , who is within sight and sound of the person at all times , which may include the use of electronic monitoring for e.g. CCTV

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

Dignity
The right of an individual to privacy, bodily integrity and autonomy, and to be treated with respect as a person in their own right.

Duty Consultant Psychiatrist
The consultant psychiatrist on the on call duty rota

Direct Observation
Ongoing observation of the person by a registered nurse who is within sight and sound of the seclusion room at all times, but is outside the seclusion room. The observation of a person via electronic monitoring (e.g) CCTV does not constitute "direct observation".

Examination
In relation to these rules an examination is carried out by a Registered Medical Practitioner or the Consultant Psychiatrist responsible for the care and treatment of the resident or the duty Consultant Psychiatrist of the process and content of thought, the mood and the behaviour of the person.

Individual Care Plan
A documented set of goals developed , regularly reviewed and updated by the persons multidisciplinary team so far as practicable in consultation with each person receiving care and treatment. The individual care plan must specify the treatment and care required which must be in accordance with best practice , must identify necessary resources and must specify appropriate goals for the person .For children , individual care plans must include educational requirements . The care plan is recorded within the one composite set of documentation.

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

Person centred
Focuses on the needs of the person, ensuring that the persons preferences, needs, and values guide clinical decisions or support, and providing care that is respectful and responsive to them.

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

Refractory clothing
Clothing specifically placed on residents, forcefully or otherwise, that is to be worn by persons in place of their normal clothes whilst in seclusion.

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

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.

Risk assessment
An assessment to guage risk in relation to a person, designed and recognised for use in mental health settings.

Trauma Informed Care
Trauma informed care is an approach which acknowledges that many people who experience mental health difficulties may have experienced some form of trauma in their life. A trauma – informed approach seeks to resist traumatising or re-traumatising persons using mental health services and staff.

Unsafe behaviour
When a person acts in such a way that they may injure themselves or others.

6. Principles

Principles underpinning the use of seclusion in accordance with the Mental Health Commission, 2009 issued pursuant to Section 69(2) of the Mental Health Act, 2001.The following general principles must underpin the use of seclusion at all times .These principles are informed by a rights based approach to mental health care and treatment. The following principles are applicable to Glencree Unit Approved Centre –Newcastle Hospital.

- The use of seclusion may increase the risk of trauma and may trigger symptoms of previous experiences of trauma. Therefore, it must only be used in rare and exceptional circumstances. Approved centres must recognise the inherent rights of a person to personal dignity and freedom in accordance with national and international human rights instruments and legislation.
- Information will be provided to the person which includes information about the person`s rights and the processes in place for the implementation and monitoring of restrictive practices in Newcastle Hospital
- As seclusion compromises a person's liberty, its use must be the safest and least restrictive option of last resort necessary to manage the immediate situation, be proportionate to the assessed risk, and employed for the shortest possible duration. Its use must only occur following reasonable attempts to use alternative means of de-escalation to enable the person to regain self-control.
- Communication with persons who are secluded must be clear, open and transparent, free of medical or legal jargon, and staff must communicate with empathy, compassion and care. Persons who have a sensory impairment may experience an increased level of trauma during seclusion and staff must address the additional communication needs of these persons.
- The views of family members, representatives and nominated support persons, must be taken into account, where appropriate.
- Cultural awareness and gender sensitivity must be taken into account at all times and must inform the approved centre's policies and procedures for the use of seclusion.
- Seclusion must be used in a professional manner and its use must be based within a legal and ethical framework.
- Any use of restrictive intervention may be traumatic for the person who experiences it. Appropriate emotional support must be provided to the person in the direct aftermath of the episode. Staff must also offer support. if appropriate , to other persons who may have witnessed the seclusion of the person.
- Staff involved in and witnessing physical restraint and /or seclusion will be offered support as appropriate by the shift coordinator.
- Services must be able to demonstrate that they are attempting to reduce the use of seclusion and mechanical means of bodily restraint, where

applicable. This includes considering all other interventions to manage a person's unsafe behaviour before deciding to use seclusion or mechanical means of bodily restraint.

- **Restrictive practice review plan –This is under review**

7. Order for Seclusion.

The seclusion of any person must only be initiated by a **registered medical practitioner** or the **most senior registered nurse on duty** in the unit/ward.

Seclusion must only be initiated following as **comprehensive assessment** of the person as is practicable. This must include a risk assessment, the outcome of which must be recorded in the person's clinical file. A copy of the risk assessment must be made available to the Mental Health Commission on request.

The registered medical practitioner or registered nurse must record the matter in the clinical file and on the seclusion register.

Where seclusion is initiated by a registered nurse, **a registered medical practitioner must be notified of the seclusion episode** as soon as is practicable, and **no later than 30 minutes following the commencement of the episode.**

There must be a **medical examination** of the person by a registered medical practitioner as soon as is practicable and, in any event, **no later than two hours** after the commencement of the episode of seclusion. This must include an assessment and record of any physical, psychological and/or emotional trauma caused to the person as a result of the seclusion.

As soon as is practicable, and **no later than 30 minutes following the medical examination**, the registered medical practitioner must contact **the person's consultant psychiatrist** or the duty consultant psychiatrist to inform them of the episode of seclusion. The consultant psychiatrist must discontinue the use of seclusion unless they order its continued use.

The registered medical practitioner must record this consultation in the clinical file and indicate on the seclusion register that the consultant psychiatrist **ordered or did not order** the continued use of seclusion.

If the consultant psychiatrist orders the continued use of seclusion, they must advise the duration of the order. The registered medical practitioner must record this information on the seclusion register. **A seclusion order must not be made for a period of time longer than four hours from the commencement of the seclusion episode.**

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

The **consultant psychiatrist must undertake a medical examination of the person and sign the seclusion register within 24 hours of the commencement of the seclusion episode.** The examination must be recorded in the person's clinical file.

The person must be informed of the reasons for, likely duration of, and the circumstances which will lead to the discontinuation of seclusion, unless the provision of such information might be prejudicial to the person's mental health, well-being or emotional condition. If informed of the reasons, a record of this must 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 must be entered in the person's clinical file as soon as is practicable.

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

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

8. Dignity and Safety

Seclusion of a person with a known psycho-social/medical condition, in which close confinement would be contraindicated, must only be used when all alternative options have been implemented and proven unsuccessful and following an appropriate risk assessment.

The clothing worn in seclusion must respect the right of the person to dignity, bodily integrity and privacy. The person must be secluded in their own clothing. If, in exceptional circumstances, the decision is made to use any other clothing (e.g. tear-proof clothing, or other clothing that is not the person's), this must only occur following a specific and documented risk assessment which is regularly reviewed no less frequently than at each renewal order. If the person's own clothing is not worn, the reason must be documented in the person's individual care plan.

A person in seclusion must not have access to hazardous objects.

Bodily searches must only be undertaken in the most exceptional circumstances, following a risk assessment (the outcome of which must be recorded in the person's clinical file). Bodily searches must be undertaken in the presence of more than one staff member, and respect the right of the person to dignity, bodily integrity and privacy. Gender and cultural sensitivity and the preferences of the person must be respected when undertaking a bodily search.

All staff members involved in the use of seclusion must have undertaken appropriate training in accordance with the policy outlined in section 17.0 staff training.

9. The Monitoring of a person during seclusion

- A person placed in seclusion must be kept under direct observation by a registered nurse for the first hour following the initiation of a seclusion episode.
- After the first hour, a registered nurse must keep the person under continuous observation and be within sight and sound of the seclusion room. This observation may be completed in person or with CCTV (or other electronic monitoring).
- A written record of the person must be made by a registered nurse at least every 15 minutes. This must include a record of:
    - the person's level of distress;
    - the person's behaviour (what the person is doing and saying);
    - the person's level of awareness;
    - the person's physical health, especially with regard to breathing, pallor or cyanosis;
    - whether elimination/hygiene needs were met;

- Whether hydration/nutrition needs were met. If the person's unsafe behaviour has abated, the ending of the episode of seclusion must be considered.

- Following a risk assessment, a nursing review of the person in seclusion must take place every two hours, unless the risk assessment indicates that to do so would place the person or staff at a high risk of injury. During this review, a minimum of two staff members, one of whom must be a registered nurse who was not directly involved in the decision to seclude (where possible), will enter the seclusion room and assess the person to determine whether the episode of seclusion can be ended. This assessment and decision must be recorded.
- A medical examination must be carried out by a registered medical practitioner every four hours. This examination must take account of the records of the nursing observations and any previous medical examination(s). The decision to end or continue seclusion must be recorded.
- Where a person is sleeping, clinical judgement needs to be used as to whether it is appropriate to wake the person for a nursing review or medical examination. In such instances medical examinations may be suspended. Nursing reviews must continue every two hours. However, the nature of the nursing review may be such that the person is not woken. A registered medical practitioner must be on call to carry out a medical examination during the night, should the need arise.

- Upon commencement of an episode of seclusion, a Seclusion Care Plan for the person must be developed by a registered nurse.

  A Seclusion Care Plan must include as a minimum:
  - personal details;
  - known clinical needs (including mental and physical considerations);
  - how de-escalation strategies will continue to be used;
  - the person's preferences in relation to seclusion, where known (e.g. access to music or reading material while in the seclusion room), and take into account outcomes of any previous debrief with the person, if applicable;
  - recognising signs where the person's behaviour is no longer deemed an unmanageable risk towards themselves or others, e.g. evidence of tension reduction, improved communication etc.;
  - how potential risks may be managed;
  - reference to specific support plans for the person and details of how the person's mental health needs will continue to be met while in seclusion;
  - meeting of food/fluid needs;
  - meeting of needs in relation to personal hygiene/dressing;
  - meeting of elimination needs (with specific reference to how privacy and dignity will be managed);
  - medication reviews (in consultation with a registered medical practitioner);
  - monitoring of physical observations;
  - A strategy for ending seclusion; indicating the criteria required for this to be reached.

10. Renewal of Seclusion Orders

- A seclusion order may be renewed by an order made by a registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist following a medical examination, for a further period not exceeding four hours to a maximum **of five renewals (24 hours) of continuous seclusion.**
- If the person's seclusion order is to be renewed **beyond the initial 24 hours** of continuous seclusion, the **consultant psychiatrist responsible** for the care and treatment of the person **or** the **duty consultant psychiatrist** must undertake **a medical examination of the person**, and this must be recorded in the person's clinical file.
- If the person's seclusion order is to be renewed beyond 72 hours of continuous seclusion, the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist must undertake a medical examination of the person, and this must be recorded in the person's clinical file. Following the medical examination, the consultant psychiatrist must discontinue the use of seclusion unless they order its continued use.
- If a decision is made by the consultant psychiatrist responsible for the care and treatment of the person, or the duty consultant psychiatrist acting on their behalf, to continue to seclude a person for a total period exceeding 72 hours, the Mental Health Commission must be provided with additional information to include:
    - a record of the reasonable attempts and outcomes to use alternative means of calming and de-escalation to enable the person to regain self-control
    - the reasons why continued seclusion is ordered.

- **If a person has four or more distinct seclusion episodes over a period of five consecutive days, the Mental Health Commission must be provided with additional information, to include the following:**
    - **A record of the reasonable attempts and outcomes to use alternative means of calming and de-escalation to enable the person to regain self-control**
    - **The reasons why seclusion has been repeatedly ordered**

10. Ending Seclusion

Seclusion may be ended:

i. By a registered medical practitioner at any time following discussion with the person in seclusion and relevant nursing staff; or

ii. By the most senior registered nurse in the unit/ward, in consultation with the person in seclusion and a registered medical practitioner.

Where seclusion is ended by a registered medical practitioner or the most senior registered nurse on duty in the unit/ward, the consultant psychiatrist responsible for the care and treatment of the person, or the duty consultant psychiatrist acting on their behalf, must be notified.

The person must be informed of the ending of an episode of seclusion.

Leaving seclusion for a toilet break, or for a medical examination does not constitute the end of an episode of seclusion.

The time, date and reason for ending seclusion must be recorded in the person's clinical file on the date seclusion is ended.

Where a person's representative has been informed of the person entering seclusion, the person's representative must be informed of the ending of the episode of seclusion as soon as is practicable. A record of this communication must be entered in the person's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the person's clinical file.

Any use of a restrictive intervention may be traumatic for the person who experiences it. Appropriate emotional support must be provided to the person in the direct aftermath of the episode. Staff must also offer support, if appropriate, to other persons who may have witnessed the seclusion of the person.This may also include the staff involved in the use of physical restraint and/or seclusion.

11.0 In Person Debrief Guide

An in-person debrief with the person who was secluded must follow every episode of seclusion.

This debrief must be person-centred and must:

- give the person the opportunity to discuss the seclusion with members of the multidisciplinary team involved in the person's care and treatment as part of a structured debrief process;
- **Occur within two working days (i.e. days other than Saturday/Sunday and bank holidays)** of the episode of seclusion unless it is the preference of the person who was secluded to have the debrief outside of this timeframe.
- The person's preferences regarding the timing of the debrief must be recorded;
- 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 must be maintained and recorded in the person's clinical file;
- Include a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future;
- **Include a discussion regarding the person's preferences in the event where a restrictive intervention is needed in the future e.g. preferences in relation to which restrictive intervention they would not like to be used;**
- Give the person the option of having their representative or their nominated support person attend the debrief with them, and, if the person's representative or nominated support person does not attend the debrief, a record of the reasons why this did not occur must be recorded in the person's clinical file.
- Where multiple episodes of seclusion occur within a 48-hour timeframe, these episodes may be reviewed during a single debrief.
- A record must be kept of the offer of the debriefing, whether it was accepted and the outcome.
- The person's individual care plan must be updated to reflect the outcome of the debrief, and in particular, the person's preferences in relation to restrictive interventions going forward.
- A record of all attendees who were present at the debrief must be maintained and be recorded in the person's clinical file.

12.0 MDT Review

Each episode of seclusion must 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 seclusion.

The review must include the following:

i. the identification of the trigger/antecedent events which contributed to the seclusion episode;
ii. a review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support;
iii. the identification of alternative de-escalation strategies to be used in future;
iv. the duration of the seclusion episode and whether this was for the shortest possible duration;
v. considerations of the outcomes of the person-centred debrief, if available; and
vi. An assessment of the factors in the physical environmental that may have contributed to the use of seclusion.

The multidisciplinary team review must be documented and must record actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person.

13.0 Recording of seclusion episodes

All uses of seclusion must be clearly recorded in the person's clinical file (Seclusion care plan) paying particular attention to level of containment / disengagement levels which have been used to seclude a person.

All uses of seclusion must be clearly recorded on the Register for Seclusion (see Appendix 2) in accordance with Rules 3.7, 3.8 and 3.10.

A copy of the Register must be placed in the person's clinical file and a copy must be available to the Mental Health Commission upon request.

14.0 Clinical Governance:

Seclusion must never be used:

i. to ameliorate operational difficulties including where there are staff shortages;
ii. as a punitive action;
iii. where mechanical means of bodily restraint is also in use;
iv. solely to protect property;
v. As a substitute for less restrictive interventions.

The approved centre must maintain a written record indicating that all staff involved in the use of seclusion have read and understand the policy. The record must be available to the Mental Health Commission upon request

The approved centre must review its policy on seclusion as required and, in any event, at least on an annual basis.

Every approved centre that uses, or permits the use of, seclusion must develop and implement **a reduction policy** which must be published on the Registered Proprietor's website.

This policy must:

i. clearly document how the approved centre aims to reduce or, where possible eliminate, the use of seclusion within the approved centre;

ii. 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;
iii. Clearly document how the approved centre will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of seclusion within the approved centre.

The Registered Proprietor has overall accountability for the reduction policy.

The Registered Proprietor must appoint a named senior manager who is responsible for the approved centre's reduction of seclusion

All information gathered regarding the use of seclusion must be held in the approved centre and used to compile an annual report on the use of seclusion at the approved centre. This report, which must be signed by the Registered Proprietor Nominee, must be made publicly available on the Registered Proprietor's website within six months of the end of the calendar year and be made available, upon request, to the public.

The annual report must contain:

i. aggregate data that must not identify any individuals;
ii. a statement about the effectiveness of the approved centre's actions to reduce or, where possible, eliminate the use of seclusion;
iii. a statement about the approved centre's compliance with the rules governing the use of seclusion;
iv. a statement about the compliance with the approved centre's own reduction policy; and
v. The data as specified in Appendix 3.

All approved centres must produce and publish an annual report on their use of seclusion.

Where seclusion has not been used in the relevant 12-month period, then points i and ii above must only be reported on.

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

i. determine if there was compliance with the rules governing the use of seclusion for each episode of seclusion reviewed;
ii. determine if there was compliance with the approved centre's own policies and procedures relating to seclusion;
iii. identify and document any areas for improvement;
iv. identify the actions, the persons responsible, and the timeframes for completion of any actions;

v. provide assurance to the Registered Proprietor Nominee that each use of seclusion was in accordance with the Mental Health Commission's Rules
vi. Produce a report following each meeting of the review and oversight committee.
    a. This report must be made available to staff who participate, or may participate, in seclusion, to promote on-going learning and awareness.
    b. This report must also be available to the Mental Health Commission upon request.

The Registered Proprietor has overall accountability for the use of seclusion in the approved centre.

15.0 CHILDREN

In addition to above which apply to all persons, the following rules apply in approved centres providing care and treatment for children. Children are particularly vulnerable to trauma and harm as a result of restrictive interventions. Seclusion can have particularly adverse implications for the emotional development of a child. These points must be taken into account in any decision to seclude a child.

Upon admission to an approved centre that uses seclusion as a restrictive intervention on children, a documented risk assessment must be carried out by a registered medical practitioner or registered nurse. This must show that careful consideration has been given to the potential effects of secluding a child or adolescent.

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

An approved centre secluding a child must ensure the child's parent or guardian is informed as soon as possible of the child's seclusion, and the circumstances which led to the child being secluded. The child's parent or guardian must also be informed when the episode of seclusion has ended.

An approved centre secluding a child must have in place child protection policies and procedures in line with relevant legislation and regulations made thereunder.

An approved centre secluding a child must have a policy and procedure in place addressing appropriate training for staff in relation to child protection

16.0 Health safety and welfare of Staff:

16.1. Staff de-briefing:

Debriefing should serve as a learning/support/supervision opportunity for staff to process restraint episodes and their associated feelings and actions. This forum should remain professionally focused with an appropriate referral arrangement for staff if indicated. Debriefing should explore how staff, individually and collectively, might avoid future occurrences by identifying the trigger/antecedent events which contributed to the occurrence and identifying alternative de-escalation strategies to be used in future. Debriefing should review events leading up to restraint, what worked well, and less so, and what alternatives might be tried in future. Its is the responsibility of the **person incharge of the unit** to ensure that staff de- briefing is completed with in the timeframe.

The two stages of staff debriefing:

1. Post-incident support (Immediately after the PR):

Post-incident support focuses on the immediate physical and emotional well-being of the people involved. Staff can 'check in' immediately or soon after an incident by reassuring, showing care, and genuinely listening to the staff's voice. This support can also include managing practicalities (e.g. any injuries), capturing key issues, and taking stock of the situation.

2. Post-incident learning (Within 3 days after the PR) Applying the Gibbs' Reflective Model:

This focuses on learning about the PR event and how it can be reduced or avoided in the future. Because it aims to understand what happened and why it is a mixture of teaching and support. It should be carried out after a period of 'cool down' so that emotions can settle and people are in a better place to reflect.
Using Gibbs' Reflective Model (6 steps, see appendix 5) helps to identify strengths, areas for development, and actions taken to enhance your professional skills. Steps 1 - 3 relate to what happened during the experience and steps 4 - 6 focus on how you could improve on the experience and outcome in the future.

Debriefing should be recorded including follow-up plans or actions decided upon

16.2. staff well-being (The "ASSIST ME" model of staff support)

It is crucial to recognize the importance of line managers, peers, and colleagues offering their support to staff in the event of any incident.Being available for staff and knowing his/her story surrounding the event of physical restraint is crucial. Staff require a safe and confidential space to discuss the event and can find this therapeutic (See appendix 3, The "ASSIST ME" model of staff support).

17.0 Staff Training

All clinical staff will be made aware of the practice guidance in the prediction, prevention, and management of escalating behaviour by their line manager through the use of this policy.

All staff who participate, or may participate, in the use of physical restraint should have received the appropriate training PMCB (professional management of complex behaviour) in its use and in the related policies and procedures. PMCB provides training in line with contemporary person-centred, trauma-informed, and recovery-oriented best-practice.

a) All Clinical Staff working in Glencree Unit will receive training based on the identified needs of persons who are secluded and the areas to be addressed within the training programme , including training in:

i. Alternatives to seclusion;
ii. Trauma-informed care;
iii. Cultural competence;
iv. Human rights including the legal principles of restrictive interventions; the prevention and therapeutic management of violence and aggression (including "disengagement" and de-escalation techniques);
v. Positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic.

c) There is a team of appropriately qualified persons based within Glencree Unit to give the training.

d) The mandatory nature of training for those involved in seclusion.

17.1 Training in PMCB is required to be undertaken as follows;

- All Staff –4 -days of PMCB
- All Staff – 2 yearly Refresher (One-day disengagement)

A record of attendance at training should be maintained

Incorporated in the PMCB training to trainers is the underpinning principle of disengagement and containment of persons but also the active engagement in a dynamic risk assessment from point of admission utilising trauma informed care .

As part of the Seclusion **reduction policy** which will be operational parallel to the Approved Centres compliance with the rules governing the use of seclusion, the Approved Centre shall

i. clearly document how the approved centre aims to reduce and/or, where possible eliminate, the use of seclusion within the approved centre;
   a. identifying a committee focusing on restrictive practice whilst aiming to reduce the use of seclusiom
   b. Incorporate the philiosophy underpinning PMCB in the overall culture/practice change of managing complex behaviour
   c. Monitor the use of seclusion and use data collected to inform practice and target the reduction of its use .
   d. PMCB provides training in line with contemporary person-centred, trauma-informed, and recovery-oriented best-practice.As part of the delivery of PMCB to Approved Centre staff . The training plan will incorporate the data on seclusion together with the use of post incident reviews.

ii. address leadership and development of the workforce,through
   a. Induction processes
   b. The use of safety pause prioir to and following an episode of seclusion .
   c. The signposting of staff to support services available within Dublin South East and Wicklow Mental Health Services
      i. Such as Employee assistance programme
      ii. Coaching via identified HSE Coaches in DSE
      iii. Access to clinical supervision with DSE

iii. As part of the Care Planning process for persons whom are secluded staff will be encouraged via the PMCB to will provide positive behaviour support plans as a means of reducing or, where possible eliminating, the use of seclusion within the approved centre.

18.0 The Use of Closed Circuit Television (CCTV)

Where CCTV or other monitoring devices are installed in seclusion rooms their use is in addition to and does not replace the provisions of **Section 9 'The Monitoring of the Person during Seclusion'.**

Where CCTV or other monitoring devices are used, the approved centre must:

- Ensure viewing is restricted to designated personnel as per approved centre policy;
- Ensure that it is evident and clearly labelled;

- Ensure that it is incapable of recording, is incapable of storing a person's image in any format, and is incapable of transmitting images other than to the monitoring station being viewed by the staff member responsible for the care and treatment of the person;
- Stop using it if the person starts to act in a way which compromises the person's dignity;
- Have a clear written policy in relation to its use.
- Disclose its existence and usage of CCTV to;residents, persons representatives, Mental Health Commission during the inspection of the approved centre or at any time on request

19.0 SECLUSION FACILITIES –

Seclusion facilities must be furnished, maintained and cleaned in such a way that ensures the person's inherent right to personal dignity and ensures that the person's privacy is respected.

i. The construction of the seclusion room must be designed to withstand high levels of violence with the potential to damage the physical environment e.g. walls, windows, doors, locks.

ii. There must be no ligature points or electrical fixtures.

iii. There must be an anti-barricade door.

iv. The room must allow for staff to be able to clearly observe the person within the seclusion room.

v. Seclusion rooms must have externally controlled heating and air conditioning, which enables those observing the person to monitor the room temperature.

vi.The seclusion room must include limited furnishings which must include a pillow, mattress, and blanket or covering, all of which must meet current health and safety requirements.

vii. The room must be large enough to support the person and team of staff who may be required to use physical interventions during transition to seclusion.

viii. The person must have sight of a clock displaying the time, day and date.

ix. As far as is possible, the seclusion room must be in an area away from communal sitting rooms and sleeping accommodation, but not isolated.

In addition, the below requirements are applicable to all new seclusion facilities where construction is commenced after 1 January 2023: The following have not been implemented as of January 1st 2023 in Glencree Unit

The seclusion room must have a window which provides the person in seclusion with a clear view of the outdoor environment.

The seclusion room must not be visible to unauthorised persons from the outdoor environment.

The person who is secluded must have ready access to sanitary facilities and sanitary items (unless there is a clearly documented reason recorded in the Seclusion Care Plan).

All furniture and fittings in the seclusion room must be of such a design and quality as not to endanger the safety of the person in seclusion.

Seclusion facilities must not be used as bedrooms.

Bedrooms must not be used as seclusion facilities.

Subject to the outcome of a documented, suitable risk assessment, the person must be permitted periods of access to secure outside areas. A record of daily outdoor access must be maintained.

20.0 Revision & audit

A quarterly analysis must be completed to identify opportunities for improvement of physical restraint processes and for the effective implementation of physical restraint reduction strategy

It is the responsibility of Clinical Nurse Manager 3 to ensure that analysis and audit are completed and circulated with all relevant stakeholders within the timeframe.

An annual audit must be undertaken to determine compliance to the Seclusion policy to ensure they are being fully and effectively implemented and adhered to in clinical practice.

An Approved Centre must review its policy and procedure on the use of Seclusion as required but at minimum on an annual basis.

Incident reports shall be recorded for non-compliances identified in relation to the processes for the use Seclusion.

Analysis shall be completed to identify opportunities for improvement to the Process of seclusion.

All information gathered by the Approved Centre regarding the use of Seclusion must be used to compile an annual report on the use of Seclusion. This report must be available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.

Incident Summary reports are forwarded to the Mental Health Commission on a 6 monthly basis by administration of HSE CHE MHS .

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Revision History Sheet:

Document Control No. - (Revision No.)	
Section	Changes Made

16

Appendix 1 Clinical Practice form for the use of physical restraint

CLINICAL PRACTICE FORM FOR PHYSICAL RESTRAINT

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

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

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

Mental Health Comission | 2022 Code of Practice on the Use of Physical Restraint

11 (c) Who assisted with the physical restraint: Name (print): _____ Job title (print): _____ Signed: _____ Name (print): _____ Job title (print): _____ Signed: _____ Name (print): _____ Job title (print): _____ Signed: _____ Name (print): _____ Job title (print): _____ Signed:
12. Details of what each member of staff named above was doing during the episode of physical restraint:
13. Why is physical restraint being ordered/renewed? Immediate threat of serious harm to self ☐ Actual harm caused to self ☐ Immediate threat of serious harm to others ☐ Actual harm caused to others ☐ Transfer to seclusion room ☐ To administer medication/treatment (excluding nasogastric feeding) ☐ To administer nasogastric feeding ☐ Other (please specify) ☐ _____ *Please provide further details on the above:*

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

Verbal Intervention ☐ Medication offered / administered ☐

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

Other (please specify) ☐ _____

Please provide further details on the above:

15. Type of physical restraint used:

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

Please provide further details

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

Yes ☐ No ☐

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

17. Order:

I _____ have assessed _____ on

Date: ____/____/_____ at ____ hrs ____ mins and I order the use of physical restraint from Date: ____/____/_____ at ____ hrs ____ mins for up to a maximum of ____minutes

Name (print): _____ Signed: _____

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

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

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

Duty consultant psychiatrist ☐

Name (print): _____ Signed: _____

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

19. Physical restraint ended ☐ Physical restraint renewed* ☐

Who ended/renewed physical restraint:

Name (print): _____ Signed: _____

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

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

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

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

Yes ☐ No* ☐

If yes, please complete the following:

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

_____

Date and time of medical examination:

Date: ____/____/_____ at ____hrs ____mins

*If no, please provide further details:

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

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

If yes, please provide further details:

Appendix 2 : Register for Seclusion

SECTION 69 - REGISTER FOR SECLUSION

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

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

Seclusion Details

8. Seclusion Order Type: First seclusion order ☐ Renewal order* ☐

As per Rule 3.8, a seclusion order shall last for a maximum of four hours. A renewal order must be made if it is necessary to renew the episode of seclusion beyond four hours.

If **renewal order, please complete sections 9-10, 12 and 23-25 only. 23 is applicable to renewal orders only.*

9. Date seclusion episode commenced:	**10. Time seclusion episode commenced:**
_____/_____/_____ (dd/mm/yyyy)	____:____ (24hr clock e.g. 2.41pm is written as 14.41)

11. Who initiated seclusion:

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

Signed: _____

12. Why is seclusion being ordered or 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 ☐
Other (please specify) ☐ _____

Please provide further details on the above:

13: Did the medical examination of the person take place within two hours of the commencement of the seclusion episode?

Yes ☐ No ☐

If yes, please complete the following:

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

_____

Date and time of medical examination:

Date: ____/____/_____ at ____hrs ____mins

Date and time that the consultant psychiatrist was contacted following the medical examination:

Date: ____/____/_____ at ____hrs ____mins

**If no*, please provide further details:*

14. Alternative means of de-escalation attempted prior to the use of seclusion:

Verbal Intervention ☐ Medication offered/administered ☐
Time Out/One to One Nursing/Observation ☐ Physical restraint ☐
No alternatives attempted ☐

Other (please specify) ☐ _____

Please provide further details on the above:

15. Was the person secluded in their own clothing?

Yes ☐ No ☐

If no, please explain the reasons why this did not occur and what clothing was provided to the person:

16. Was a seclusion care plan developed and implemented for the person?

Yes ☐ No ☐

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

17. Was the person's representative informed of the person's seclusion?

Yes ☐ No ☐

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

Use of physical restraint/mechanical means of bodily restraint for immediate threat to self or others

18. Was mechanical means of bodily restraint used?

Yes ☐ No ☐

If yes, complete the Register for Mechanical Means of Bodily Restraint for Immediate Threat to Self or Others

19. Was physical restraint used?

Yes ☐ No ☐

If yes, complete the Clinical Practice Form for Physical Restraint

Initiation of seclusion by the most senior registered nurse in the unit/ward or a registered medical practitioner

20. Initiation:

Initiation of seclusion by the **most senior registered nurse** in the unit/ward **or a registered medical practitioner**:

If seclusion is initiated by the most senior registered nurse on duty in the unit/ward, or a registered medical practitioner, they must complete this section.

I _____ have assessed/examined _____ on

Date: ____/____/_____ at ____ hrs ____ mins and I initiated the use of seclusion from

Date: ____/____/_____ at ____ hrs ____ mins

Name (print): _____ Signed: _____

21. Order:

To be completed by the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist

I _____ have been informed of the outcome of the medical examination of _____ on Date: ____/____/____ at ____hrs ___mins and I order/do not order the use of seclusion from Date: ____/____/____ at ____ hrs ____ mins for no later than ____hrs ___mins

Name (print): _____ Signed: _____

Date: ____/____/_____ at ____hrs ____mins

Initiation of seclusion by a consultant psychiatrist:

22. Initiation and Order:

I _____ have assessed/examined _____ on Date: ____/____/____ at ____hrs ___mins and I initiated and ordered the use of seclusion from Date: ____/____/____ at ____ hrs ____ mins for no later than ____hrs ___mins

Name (print): _____ Signed: _____

Renewing/Ending Seclusion

Applicable to a renewal order only:

23. The seclusion order has been renewed and ordered under the supervision of the:

Please tick as appropriate and sign below:

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

Duty consultant psychiatrist ☐

Name (print): _____ Signed: _____

Date: ____/____/_____ at ____hrs ____mins

24. Seclusion ended ☐ Seclusion renewed* ☐

Who ended or renewed seclusion:

Name (print): _____ Signed: _____

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

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

** If seclusion is renewed, a new entry on the Register for Seclusion and an Order must be completed.*

To be completed by the person who ended/renewed seclusion

25. Did the seclusion episode result in any injury to the person?

Yes ☐ No ☐

If yes, please provide further details:

Appendix III:

The "Assist Me" model of staff support

	Action	**Example**
A	Acknowledge with empathy the incident that has occurred and the impact on the member of staff. Assess the impact of the incident on the member of staff and on their ability to continue normal work .	"I came to see you as soon as I heard what happened. This must be very difficult for you" "How are you doing?" "How are you coping?" "How are you feeling right now" "Are you ok to be here?"
S	Sorry - express regret for their experience	"I am so sorry that this has happened. Sometimes despite our best efforts things can go wrong". "I am so sorry that you have had this experience and for the distress this is causing you".
S	Story – allow time and space for the member of staff to talk about what happened and how they are feeling - using active listening skills. Demonstrate your understanding of their story through the feedback process Share personal experiences, as appropriate	"You may find it helpful to talk about how you are feeling right now" "Would you like go for a cup of coffee and we can have a chat about what happened?" "What I'm hearing from you is…. Is that correct? Is there anything else you want to tell me or talk about?" "Can I tell you about an experience of my own, how I felt and what I found helped me at that time?"
I	Inquire – encourage questions Information – provide answers/information	"What questions do you have that I can perhaps help you with?" "Is there anything I can help you with at this time?" "Would it help if I told you what happens next and what you can expect in relation to the management of this incident?"

S	**Supports Solutions**	**(a) Informal emotional support:** "My door is open for you. I will be checking in with you regularly to see how you are doing if that is okay with you. In the meantime if you do wish to talk about this or discuss anything with me please come and see me or give me a call. Can I arrange for someone to collect you from work?" **(b) Formal emotional support:** • Assess any immediate needs, discuss with the member of staff and arrange, with their knowledge and consent, a referral to the relevant support services, as required. • Provide information on the supports provided by the HSE Employee Assistance Programme (EAP) which can be accessed by managers and staff e.g. counselling, crisis intervention and Critical Incident Stress Management (CISM) response. • Discuss the benefits of CISM and organise, with the consent of the staff member, one to one or team CISM response as soon as is practical. Click here to access further information on CISM. • Consider referral to the HSE Occupational Health Department for additional support, as required. • Provide staff support information leaflets/ brochures, and signpost to the HSE Workplace Health and Wellbeing Unit website here. Contact the EAP national phone number on 0818 327 327 to speak to someone who can help. This service includes access to internal EAP services and external 24/7 counselling support.

		(c) Practical Support: • Provide an opportunity for the member of staff to take time out from their normal work, if required. Staff should be involved in and have input to any decision made regarding the same. Many staff find it more helpful to remain at work. Allocation to different duties may benefit initially if it is practical to do so. • Provide practical support and information in relation to the incident review process and how the staff member might assist/ contribute to this process. e.g. encourage the member of staff to write up their recollection of the incident as soon as possible for their own record. Ensure that they are kept updated and involved in the incident review/open disclosure process. • Provide information and support in relation to communicating with the patient/service user following the incident and preparing for open disclosure discussions. • Ensure that they are encouraged to provide their insight into the steps being taken to try to reduce the risk of a recurrence of the incident. • Establish the learning from the incident, at individual and organisational level and provide on-going support.
T	Travel – providing continued support and reassurance going forward and throughout the incident review/open disclosure process	"I am here to support you." "I will assist you in any way I can"

M	Maintain contact Monitor progress Moving forward	Ensure that there is continued contact with the staff member to prevent feelings of isolation. Continually monitor and assess the staff member's response to the incident and their response to any interventions. Provide guidance and support on their return to normal work.
E	End – reaching a stage of closure from the event. Evaluate	Establish when the staff member has reached a stage of closure from the incident as it is important at this stage not to keep re-opening the incident with them. Leave your door open to them if they should require any further assistance. Review the support provided with the staff member involved. Consider feedback and establish any learning which may benefit other staff.

Appendix 4:

CHE MHS Physical restraint reduction strategy:

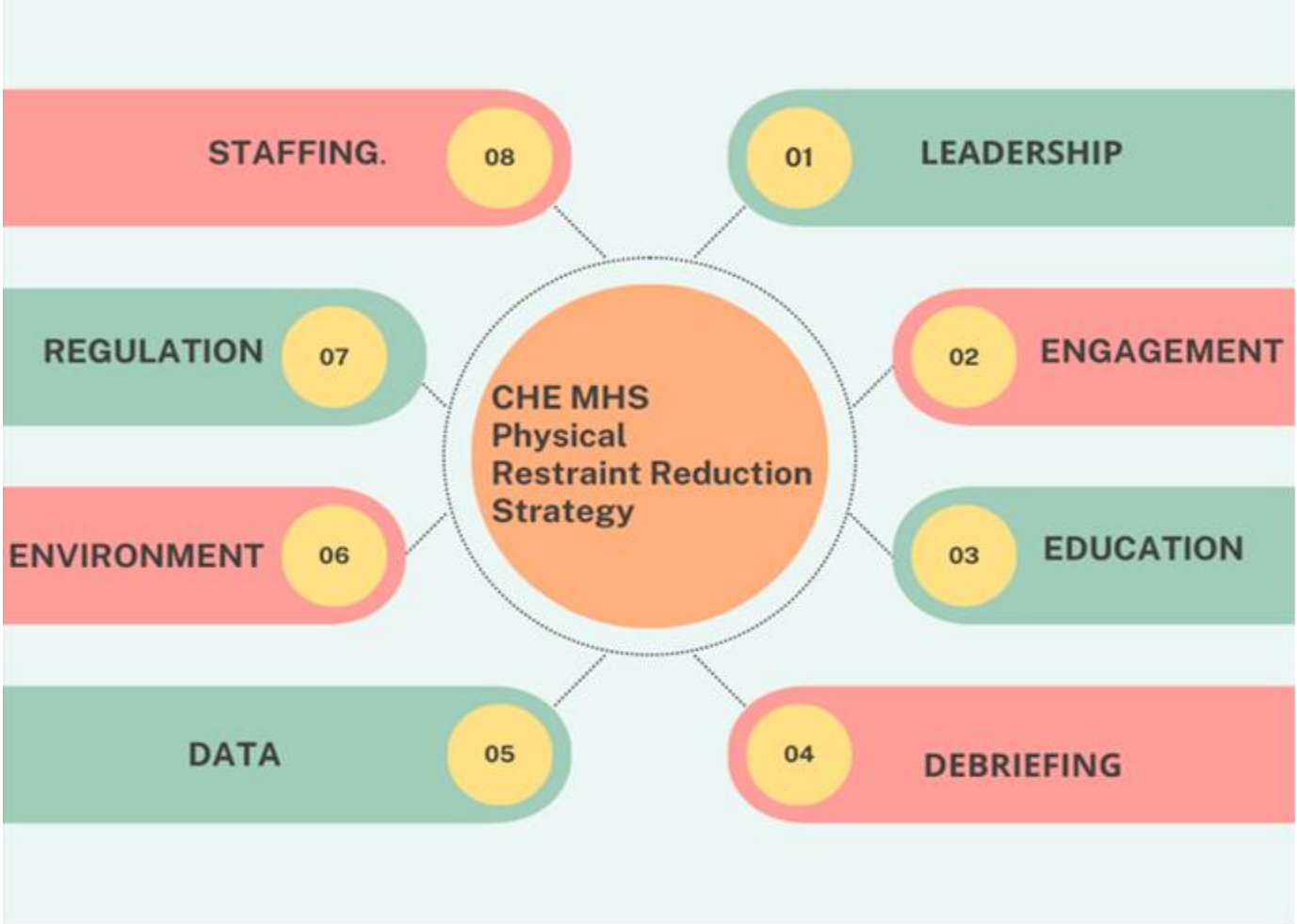
The development of restrictive physical interventions (RPI) to manage challenging behaviours based upon control and restraint during the 1980s and 1990s led to widespread professional disquiet and campaigning to improve the policies, training and application of physical techniques. This included the promotion of a value base within which physical techniques should be used. This value base may be summarised as any use of physical interventions must be in the person's best interests, 'least restrictive' and used as the last resort following preventive strategies. The last resort principle implies that services should be able to demonstrate support plans to prevent or reduce the frequency and/or restrictiveness of PI used in individual cases. This stargegy proposes that adopting explicit policies and practice to reduce restrictive PI is likely to be more effective in improving quality of support as opposed to solely managing PI use.

Literature review:

Whilst little is known about what might be the 'right' levels of RPI use, it is known that RPI is used commonly in response to challenging behaviour and often associated with other restrictive responses to challenging behaviours, including seclusion, multi and frequent 'as required' psychotropic medication use (Emerson et al., 2000; Harris, 2002; McGill et al., 2008, In Press). Moreover, the series of actions and reactions surrounding RPI use is associated with injury/harm to the participants, staff and service users. Injury, both physical (Spreat et al., 1986; Hill & Spreat 1987; Harris et al., 1996) and/or emotional (Sequeira & Halstead, 2001; Murphy et al., 1996) may be experienced. In the latter two studies service users described their experience of being subject to RPI. Themes that emerged were overwhelmingly negative, with pain, anxiety and mental distress, anger, and the perception that the staff were experiencing anger, hatred and feelings of enjoyment during the interventions. Two subsequent papers have examined the responses of staff and service users to the same RPI event. Staff involved experienced similar negative, emotions and thoughts (Hawkins et al., 2005; Fish & Culshaw, 2005). In the latter study, conducted in a medium secure unit, staff reported feeling upset and guilty following the use of restraint and that this use was always as the 'last resort'. However, from the client perspective this was not the case. McIntyre Undercover (November 1999) showed graphically how the use of RPI can become part of abusive and restrictive care environments.

Apart from the inherent physical risks, significant psychological distress has also been associated with involvement in, or witnessing of, these measures. Service users have reported feelings of anger, abandonment, depression, despondency and re-enactment of previous traumas. Personnel similarly have reported feelings of intense fear, stress, ambivalence, guilt and disappointment that situations were not resolved in a more benign fashion .

Reduction Strategy



- Engage staff at all levels in relation to the restraint reduction strategy and provide opportunities for staff at all levels to participate in the development of the service specific restraint reduction plan.
- Monitor progress on actions specified in restraint reduction plans and allocate responsibility to someone
- to evaluate progression of specified goals.
- Include the progress of the restraint reduction plan as a standing item on the agenda of multidisciplinary team meetings.
- Develop a safe and accessible process for staff and others to provide comments, ideas, recommendations, concerns, to the wider team members regarding the reduction project.
- Utilise networking between mental health services to facilitate the sharing of best practice by including restraint reduction on the agenda of regional and/or national forums.

2. Engagement:

- Upon admission, orient service users and their families to the approved centre and the care and treatment programme.

- Implement a structured risk assessment with an evidence base in reducing use of seclusion and restraint.

- Ensure that staff interaction with service users is in compliance with the Rules and Code of practice related to service user monitoring during episodes of seclusion and/or restraint.

- Emphasis on patient-centeredness and the importance of service user and family involvement in care and treatment planning.

- Communications with service users and families is respectful of their needs and situations.

- Make use of objective service user satisfaction surveys which are undertaken by persons external to the centre, to inform decision making.

3. Training and education:

    - Services has implement a restraint reduction training programme , PMCB , since 2021.

    - Require attendance at training and consider classification of training as mandatory for all multidisciplinary staff working within approved centres

    - Require new staff to attend training during orientation and monitor congruence

    - Include learning informed by debriefings and data analysis in future training.

    - HSELand training programme on COP restrictive practice.

    - Combine coaching and supervision with training in order to ensure transfer of learning to practice.

4. Debriefing:

- Service User:

  As required by the MHC Rules and Code of Practice, service users should be debriefed following an episode of restraint. Specifically, the service user must be afforded the opportunity to discuss the episode with members of the multi-disciplinary team involved in his or her care and treatment.

- Staff:

  It is equally important that staff members have the opportunity to debrief following episodes of seclusion and/or restraint. While the opportunities for reflective learning is the core of staff debriefing, it also provides a safe and supportive environment in which staff can work through issues and/or feelings that may have emerged during an episode. The focus must be on supportive enhancement of professional practice, and that staff are aware of the organisational support mechanisms in place should an issue cause personal distress.

- The Organisation:

The third component of debriefing is the organisational review which may identify either preventive or remedial quality improvements. Occurrences are reviewed to identify measures which might prevent re-occurrence, or broader improvements which are necessary across the service. Conduct a formal review of each episode of restraint after the debriefing of the service user/advocate and staff member. ındividualised treatment plans should incorporate interventions that have been found to be effective in reducing the need for seclusion and restraint.

5. <u>Data collection and analysis :</u>

All approved centres will at a minimum record both unit specific and centre-wide data including the:

- Number of episodes of physical restraint used each month
- Number of administrations of involuntary medication used each month
- Number of service users physically restrained each month
- Number of service users administered involuntary medication each month.
- Service user injury rates during restraint episodes each month
- Staff injury rates sustained during restraint episodes each month
- Staff injury rates caused by service users during violent episodes each month
- Staff involved in occurrences
- Adverse events, both unit specific and centre-wide

Ensure compliance with all MHC Codes of practice related to the recording of data on the use of physical restraint.

Ensure data on the use of these interventions is submitted to the Mental Health Commission within the time frame.

Examine the feasibility of collecting additional data on restraint to include:

- Use of alternative strategies to replace seclusion and restraint;
- Themes and outcomes of debriefings.

Make data routinely available to staff and multidisciplinary teams so that they can measure the effects of their efforts to reduce the use of restraint.

Benchmark data collected in your service with that collected on restraint in other approved centres where appropriate.

6. **Physical and care environment:**

- Ensure that décor is warm with appropriate use of colour, furnishings and plants.
- Ensure a clear and full view of ward space where service users interact with each other.
- Ensure that all signage, including unit rules, is written in person-friendly positive language.
- Ensure the environment furnishings balance comfort with safety.
- Ensure furnishings are in a good state of repair.
- Arrange furniture to facilitate service user and staff interaction.
- Use sound-reducing materials, such as carpeting and ceiling tiles, to reduce noise in living areas where appropriate.
- Ensure seclusion rooms balance needs for safety with privacy, e.g. by minimising blind corners.
- Ensure seclusion rooms have appropriate and adequate temperature controls to promote a calming environment.
- Ensure seclusion rooms have adjustable soft lighting and consider soothing effects, including clouds and blue sky.
- Ensure seclusion rooms minimise isolation and provide visual orientation, including natural lighting and environmental cues (for example, being aware of the time).
- Examine the feasibility of removing seclusion rooms and replacing them with comfortable rooms for quiet time to assist service users should they need to practice "self-calming", thereby reducing the restrictive intervention.

7. **Regulation:**

- Ensure full compliance with all requirements of the Code of Practice on the Use of Physical Restraint in Approved Centres.

- Each approved centre shall have a policy which explicitly addresses the:
  o Use of physical interventions
  o Administration of involuntary of intramuscular or intravenous medication against the individual's clear objection.

- Each approved centre will ensure that all polices on the use of physical restraint are current, fully compliant with the relevant MHC Rules and Codes of Practice, and explicit as to the efforts in place to reduce the use of seclusion and restraint.

8. Staffing:

Appendix 5: the Gibbs' Reflective Model:

Step 1 – Description

- This should be a brief description of the experience or event to set the scene and give context.

Step 2 – Feelings

- Consider what you were thinking and how you felt before the experience.
- How did you feel during the experience?
- How did you feel after the experience?
- This is another short descriptive step, rather than being analytical.
- Description
- Feeling
- Analysis Evaluation
- Conclusion
- Action Plan

Step 3 – Evaluation

- Evaluation looks objectively at both positive and negative aspects of the experience.
- Describe key elements that went particularly well.
- Was there anything that did not go well or did not work?
- If appropriate, you can include what others did or did not do well.

Step 4 – Analysis

- Analysis attempts to explain why the experience was positive or negative and should form the
- largest section of your reflection. Take into account points made in the previous steps and identify
- any factors which helped you e.g. previous experiences, carrying out research or consulting with
- others. Consider your role in the experience and how you contributed to the success of this
- experience?
- If things did not go to plan, why do you think this was e.g. lack of preparation or external factors
- beyond your control?
- It can be useful to consider other people who were involved in the experience. Did they have
- similar views or reactions to you? If not, why do you think that was the case?

Step 5 – Conclusion

- Focus on what you have learned.
- Are there any skills you developed as a result of the experience? If so, how would you apply them in
- future experiences or situations?
- Are there areas of knowledge or particular skills you now need to develop?
- Is there anything you would do differently in the future? Try to give specific examples.

Step 6 – Action Plan

- What specific actions can you now take to build on your knowledge or skills?
- You could include any training that would benefit you (formal or otherwise), as well as identifying
- sources of information or support (people or resources)

Appendix 6:
Policy Governance –Executive Approval:

Policy Governance:

Ratified at the QSEC Meeting:
Date of meeting 20.03.2024 (record of ratification in minutes of meeting)

Executive Approval:

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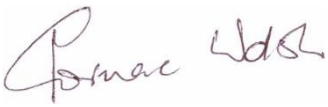
Dr Larkin Feeney
Executive Clinical Director
Community Healthcare East



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Cormac Walsh
Area Director of Nursing
Community Healthcare East

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Martina Behan,
General Manager,
Community Healthcare East