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CORCAIGH CIARRAÍ
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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

St Michael's Unit

Policy on the Reduction of Restrictive Practices

Is this document a:

Policy [✓] Procedure [ ] Protocol [ ] Guideline [ ]

Cork Kerry Community Healthcare: Mental Health Services

Title of PPPG Development Group:	St Michael's Unit Policy Review Group
Approved by: Area Administrator: Area Director of Nursing: Clinical Director:	 Ms Therese Ahern _____ Date___/___/___ _Mr Ned Kelly _____ Date___/___/___ _Dr_Ruth Collins _____ Date___/___/___
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Contents

1. INITIATION:

1.1 Purpose:

1.1.1 St Michael's Unit aim to reduce and where possible eliminate the use of restrictive interventions.

1.1.2 It is the policy of St Michael's Unit to ensure that the rights of patients are not compromised unless it is necessary to prevent harm to patients or others.

1.1.3 The purpose of this policy is to prevent aggression and violence by ensuring a high standard of care and to assist patients to find more effective ways of dealing with their emotions.

1.1.4 This policy will clearly document how St Michael's Unit will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of physical restraint within the approved centres.

1.1.5 This policy will

- Outline leadership responsibilities
- Describe how data will be used to inform practice,
- Outline specific reduction tools in use,
- Outline the development of the workforce,
- Outline the use of post incident reviews to inform practice
- Outline the Steering group responsibilities

1.2 Scope of practice:

1.2.1 This policy applies to all staff working in St Michael's Unit

1.2.2 This Policy applies to all patients who are admitted to St Michael's Unit

1.2.3 Whilst it is recognised that there are additional restrictive practise this policy will focus on the reduction of restraint

1.2.4 Further iterations of the scope may be considered on reviewing this policy.

1.3 Objectives:

1.3.1 It is the objective of this policy that St Michael's Unit share a commitment to reducing and, where possible, eliminating restrictive interventions within St Michael's Unit.

1.3.2 It is the objective of this policy to comply with the European Convention on Human Rights.

1.3.3 The following principles apply in relation to St Michael's Unit

1.3.3.1 Reducing restrictive interventions is the responsibility of all staff in the approved centre

1.3.3.2 All key stakeholders – that is, people with a lived experience, carers, health service staff and management– have a role in the design and implementation of safe environments.

1.3.3.3 People with lived experience, their support networks and staff are treated with respect and dignity; their rights and responsibilities are central to promoting safety.

1.3.3.4 The service environment is organised to ensure the safety and wellbeing of people accessing the service, their support networks and staff.

1.3.3.5 Difficult and challenging behaviour is managed in ways that show decency, humanity and respect for individual rights while effectively managing risk.

1.3.3.6 Restrictive interventions are used as a last resort after all other less restrictive options reasonably available have been tried or considered and found to be unsuitable in the circumstances.

1.3.3.7 Programs of activity to reduce restrictive interventions require effective governance and ongoing monitoring of local action plans and processes to ensure effective implementation.

1.3.3.8 Recovery-oriented practice, trauma-informed care and supported decision making inform workforce practices and are necessary to prevent ward cultures that are experienced as either coercive or conflictual.

1.3.3.9 To ensure that violence and aggression is managed in line with the services values and best practice guidelines and that any restrictive practices are employed in a transparent, lawful and ethical manner on a 'last resort' basis.

1.4 Outcome

1.4.1 Restrictive interventions will only be used as a "last resort".

1.4.2 There will be a focus on reducing and where possible eliminating restrictive practices.

1.5 Governance

1.5.1. St Michael's Unit Policy Group (Regulation: 29 Operating Policies & Procedures)

1.6 Glossary of terms and definitions

- **ADON**: Assistant Director of Nursing
- **Approved Centre**: A hospital or in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder, which is registered on the Register of Approved Centres in accordance with Section 63 of the Mental Health Act 2001
- **Area DON**: Area Director of Nursing
- **Audit**: Auditing is the on-site verification activity, such as inspection or examination, of a process or quality system, to ensure compliance to requirements. An audit can apply to an entire organisation or might be specific to a function, process, or production step
- Clinical Director
- Clinical Nurse Manager
- **ECD:** Executive Clinical Director
- **Key-Nurse**: a registered psychiatric nurse assigned to an individual patient.
- **MDT**: A Multi-Disciplinary Team MDT is a group of people from various disciplines (both clinical & non clinical) who work together to provide care/service within a specified area e.g. Doctor, nurse, administrative staff, Allied Health Professional etc
- **MHA:** Mental Health Act 2001.
- **MHC:** Mental Health Commission. The Commission is an independent body set up in 2002, to promote, encourage and foster high standards and good practices in the delivery of mental health services and to protect the interests of patients who are involuntarily admitted
- **NCHD:** Non Consultant Hospital Doctor
- **OT:** Occupational Therapist
- **PMCB:** Professional Management of Complex Behaviours in Clinical Practice.
- **Policy**: A written operational statement of intent which helps staff make appropriate decision and take actions, consistent with the aims of the service provider, and in the best interests of service users
- **Positive Behaviour Support (PBS)**: Positive behaviour support involves assessments that looks 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 the behaviour change as opposed to behaviour management.
- **PRN:** Abbreviation meaning "when necessary" (from the Latin "pro re nata"), for an occasion that has arisen, as circumstances require, as needed.
- **Procedure**: A written set of instructions that describe the approved and recommended steps for a particular act or sequence of acts

- **Process**: Series of goal-directed, inter-related activities, events, mechanisms or steps and communications which accomplish a service for a service user / client
- **Registered Proprietor**: The person whose name is entered in the register as the person carrying on the centre (S. 62, MHA 2001)
- **Representative**: An individual chosen by the patient who is being cared for (e.g. Next of Kin, friend, family member, advocate) or a legal professional appointed by the patient, statutory organisation or court to represent the patient
- **Restrictive interventions/restrictive practices**, the use of mechanical means of bodily restraint to prevent immediate threat to self or others, physical restraint and seclusion**.**
- **Physical restraint** is defined as "the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident's body when he or she poses an immediate threat of serious harm to self or others"
- **Risk**: The chance of something happening that will have an impact on objectives.
- **Seclusion** "the placing or leaving of a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving"
- **S/N**: Staff Nurse
- **SW**: Social Worker
- **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.

2. ROLES AND RESPONSIBILITIES

2.1. The **Registered Proprietor** has overall accountability for the use of physical restraint within St Michael's Unit.

2.2. The **Clinical Director** as the Registered Proprietor Nominee for purpose of reduction of restrictive practices is responsible for the approved centres reduction of physical restraint.

It is the responsibility of the Mental Health Act Administrator/ Nominated administrative personnel to maintain a database for each approved centre which will be used in to compile an annual report on the use of physical restraint used within the St Michael's Unit.

The database should contain the following information:

2.1.1. The total number of persons that the approved centre can accommodate at any one time.

2.1.2. The total number of persons that were admitted during the reporting period.

2.1.3. The total number of persons who were physically restrained and/or secluded during the reporting period.

2.1.4. The total number of episodes of physical restraint.

2.1.5. The shortest episode of physical restraint.

2.1.6. The longest episode of physical restraint (MHC 2022)

2.2. It is the responsibility of the **Registered Proprietor** to sign and publish an annual report on the use of physical restraint used within the service within 6 months of the end of year calendar on the appropriate website. This report should include:

2.2.1. Aggregate data that does not identify any individuals.

2.2.2. A statement about the effectiveness of the St Michael's Unit actions to eliminate, where possible, and reduce physical restraint

2.2.3. A statement about the St Michael's Unit compliance with the code of practice on the use of physical restraint

2.2.4. A statement about the compliance with the approved centre's own reduction policy.

2.2.5. The data as specified in 2.2.1

2.3. St Michael's Unit multidisciplinary Restraint Reduction working group are responsible for the over sight of physical restraint and where it is used

2.4. The Restraint Reduction working group are accountable to the Registered Proprietor Nominee.

2.5. It is the role and responsibility of the Restraint and Seclusion Reduction working group to meet quarterly to review each episode of physical restraint to:

2.5.1. Determine if there was compliance with the code of practice on the use of physical restraint for each episode of physical restraint reviewed.

2.5.2. Determine if there was compliance with the approved centre's own policies and procedures relating to physical restraint

2.5.3. Identify and document any areas for improvement.

2.5.4. Identify the actions, the persons responsible, and the timeframes for completion of any actions.

2.5.5. Provide assurance to the Registered Proprietor Nominee that each use of physical restraint was in accordance with the Mental Health Commission's Code of Practices and Rules.

2.5.6. 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.

2.5.7. It is the role and responsibility of the Restraint and Seclusion Reduction working group to oversee the implementation of this Physical Restraint Reduction Policy for St Michael's Unit.

3. **Responsibilities:**

3.1. The **Clinical Director** is responsible for ensuring that all medical staff have read, understood and can articulate the process within this policy.

3.2. The **Area DON** is responsible for ensuring that all nursing staff, healthcare assistants, multitask attendants and student nurses have read, understood and can articulate the process within this policy.

3.3. The **Area Principal Psychology Manager** is responsible for ensuring that all psychology staff and students have read, understood and can articulate the process within this policy.

3.4. The **Area SW Manager** is responsible for ensuring that all SW staff and students have read, understood and can articulate the process within this policy.

3.5. The **Area OT Manager** is responsible for ensuring that all OT staff and students have read, understood and can articulate the process within this policy.

3.6. The **Area Speech and Language Therapy Manager** is responsible for ensuring that all Speech and Language Therapy staff, and Speech and Language Therapists in Training have read, understood and can articulate the process outlined in this policy.

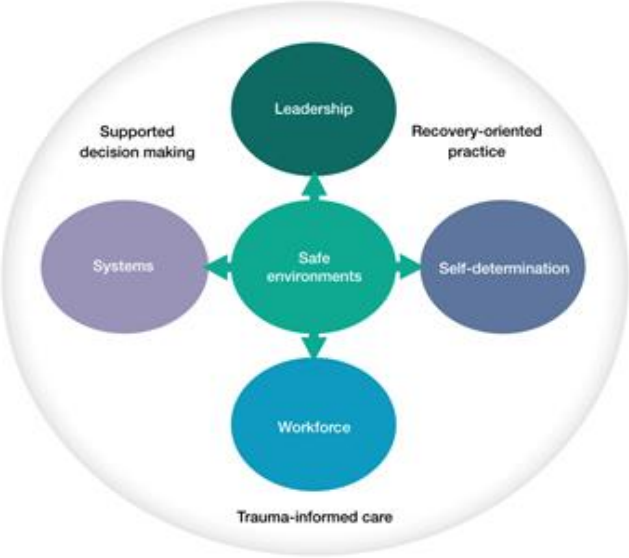
3.7. Professional Management of Complex Behaviours training is a mandatory requirement for **all staff**. Staff retain responsibility to ensure that they have up to date training by attending training and refreshers within the timeframes specified in the PMCB guidelines.

3.8. All **relevant staff** are responsible for reading this policy to understand it and be able to articulate the process within this policy, to sign the signature sheet and report any breaches in the policy to their Line Manager.

4. PROCEDURE AND PROCESS

4.1. St Michael's Unit aims to reduce and where possible eliminate the use of physical restraint through the following.
4.2. This will be achieved through the Reducing Restrictive Practices working group which meets quarterly.
4.3. This working group has oversight of physical restraint practices used within St Michael's Unit.
4.4. Data will be reviewed and analysed of each episode of physical restraint within St Michael's Unit
4.5. The eight interventions (as below) outlined within the Seclusion and Restraint Reduction Strategy (MHC 2014) will frame the work of the Restraint Reduction working group.

- Leadership
- Engagement
- Education
- Debriefing
- Data
- Environment
- Regulation
- Staffing.



4.6. Leadership

"Leadership refers to the support for, and the strong commitment to, seclusion and restraint reduction efforts" (MHC 2014). St Michael's Unit is committed to building a restraint minimised service and is leading this through the following:

4.6.1. The establishment of a Restrictive Practices working group to oversee and review the use of physical restraint within St Michael's Unit.
4.6.2. Reviewing the mission, vision and philosophy of care statements within the Approved Centres to include reduction of restraint as an explicit goal.
4.6.3. The inclusion of the restraint reduction plan as a standing item on MDT and senior management team meetings.
4.6.4. Networking with other mental health services to facilitate best practice and learning.
4.6.5. People with a lived experience, carers, health professionals and management all have a role in influencing initiatives to reduce restrictive interventions.
4.6.6. Leaders empower and focus on people's strengths, resources, skills and assets.
4.6.7. Leaders are aspirational and work towards a culture that is supportive of the least restrictive practices.
4.6.8. Leadership is demonstrated through language and behaviour, and by modelling the culture and practices the organisation is trying to achieve.

4.7. Engagement

Recovery-oriented practice

4.7.1. Encourages self-determination and self-management of mental health and wellbeing.

4.7.2. Involves tailored, personalised and strengths-based care that is responsive to people's unique circumstances, needs and preferences.

4.7.3. Supports people to define their goals, wishes and aspirations

4.7.4. Holistically addresses factors that impact on people's wellbeing, such as housing, education and employment, and family and social relationships

4.7.5. Supports people's social inclusion, community participation and citizenship.

4.7.6. A recovery approach involves promoting people's choice, agency and self-management. To that end, a degree of risk tolerance in services becomes necessary.

4.7.7. Services can empower people – within a safe environment and within the parameters of their duty of care – to decide the level of risk they are prepared to take as part of their recovery journey (Department of Health 2011a).

4.7.8. Recovery-oriented practice emphasises hope, social inclusion, community participation, personal goal setting and self-management.

4.7.9. Practice is oriented towards supported decision making and working with people's expressed wishes and could include advance statements, enabling the person to retain legal capacity regardless of the level of support required.

4.7.10. A presumption of capacity is the foundation of supported decision making and people's capacity is supported and developed.

4.7.11. People are provided with the information and support they need to make decisions or participate in decision making as much as possible.

4.7.12. Services are aware of, and promptly respond to, people's needs in a timely manner.

4.7.13. Consider communication needs assessment by Speech and Language therapy if clinically appropriate.

4.8. Trauma Informed Care

Many people with a mental illness and within the mental health service workforce have experiences of trauma. The effects of these experiences can be multiple, varied, complex and enduring.

4.8.1. The use of restraint, or the precursory situation, can trigger new experiences of trauma. Trauma-informed mental healthcare is sensitive to and understanding of trauma-related behaviours that serve as coping and survival mechanisms for people with a lived experience.

4.8.2. Trauma-informed care involves the recognition of lived experience and the empowerment of consumers in decision making (Department of Health 2011)

4.8.3. All staff will be requested to compete the HSE Land module 'Becoming trauma aware an introduction to Psychological Trauma'.

4.8.4. Training in trauma-informed care will ensure that all staff have an awareness of trauma, are able to provide opportunities to collaborate, practice with consistency and continuity, build trust and prioritise safety for all patients (Isobel et al., 2021).

4.8.5. Consider sensory modulation and sensory attachment assessment by Occupational Therapy if clinically appropriate. (Callan Institute, 2016, Champayne, 2011 & 2014).

4.9. Positive Behaviour Support

4.9.1. Positive behaviour support planning tells us the best way to work with a person who shows behaviours of concern and gives us ways to improve the

quality of life for the person and does not just deal with behaviour, therefore it can add realistic goals for the person.

4.9.2. Positive behaviour support is implemented across the St Michael's Unit to create high quality care and support environments by incorporating functional, contextual and skills-based assessments when necessary.

4.9.3. Functional behavioural assessment to identify relationships between behaviour, antecedents and consequences will guide positive behaviour support. Where there are behaviours of more recent onset or marked changes in existing patterns of behaviour, the contributions of any significant changes in environment, physical or psychological health must be explored and appropriate interventions implemented.

4.9.4. The complexity and intensity of the assessment and any subsequent positive behavioural support plan will, however, vary with the complexity and intensity of the behavioural challenge.

4.9.5. Support in assessing and developing positive behavioural support plans will be provided by psychology as required. Assessment of more complex behaviours should always be multi-disciplinary.

4.9.6. Encourage staff to ask specific questions and event analysis for staff and patient self-awareness and analysis (Callan Institute, 2016). This may include modifications to the social and physical environment of the patient change of rooms, allow to sleep in, quiet meal times, approach of staff. Creation of safe space to meet client's circumstances.

4.10. Community Meetings

4.10.1. Patients will have regular opportunities and a forum to discuss their experience of the ward with the team. This can enable patients to begin to talk to staff about violence and aggression, and how staff respond to it, in a managed and safe way.

4.11. Use of Person Centred-Care Principles:

4.11.1. Being person-centred means affording people dignity, respect and compassion, whether service user or provider.

4.11.2. Being person-centred means the person is a partner in their own health care, and the health and wellbeing of the person is the focus of care, not their illness or conditions.

4.11.3. Being person-centred means offering co-ordinated care, support or treatment across multiple episodes of treatment, care and therapy over time and across services.

4.11.4. Being person-centred means offering personalised health and social care, support or treatment, for example by incorporation of the person's family/significant other, knowledge, values, beliefs and cultural backgrounds into the planning and delivery of care

4.11.5. Being person-centred means being enabling where systems and services are oriented towards supporting persons to recognise and build upon their own strengths, preferences and goals, to achieve their full potential.

4.11.6. A person-centred health and social care system supports the person to make informed decisions about, and successfully manage, their own health and social care at the level they choose, including choices about when to let others act on their behalf.

4.11.7. Being person-centred means collaboration between the person, their family/significant other and staff to influence policy and service design and development, and be partners in evaluation.

4.11.8. Achieving a person-centred culture requires a change in behaviour and mind-set supported by a system that puts the person at its heart.

4.11.9. Being person-centred means a whole system approach to health and social care that values people, innovation, learning and teamwork throughout the organisation and demonstrates appreciation and respect for the unique contribution that people make regardless of position or status.

4.11.10. Consider utilisation of communication passports or communication profile, MDT summaries documents to assist with getting to know client and triggers for challenging behaviour (Shellenberger & Williams 1996, Moore, 2008).

4.12. Education.

4.12.1. All staff must attend Professional Management in Complex Behaviour (PMCB) mandatory training every 2 years. Within this training staff learn de-escalation skills.

4.12.2. Professional Management of Complex Behaviours training is a mandatory requirement for **all staff**. Staff retain responsibility to ensure that they have up to date training by attending training and refreshers within the timeframes specified in the PMCB guidelines

4.13. De-escalation techniques include:

4.13.1. Being empathic. Try not to judge or discount the feelings of the patient. Whether or not you think their feelings are justified, those feelings are real to the other person. Pay attention and acknowledge their distress.

4.13.2. Clarify messages. Listen for the real message. Ask reflective questions and use both silence and paraphrase to clarify their feelings.

4.13.3. Be aware of your body position. Standing at an angle, off to the side is less likely to escalate the.

4.13.4. Permit verbal venting when possible. Allow the person to release as much energy as possible by venting verbally.

4.13.5. Where appropriate set and enforce reasonable limits. If the patient becomes dysregulated, defensive, or disruptive, state limits and directives clearly and concisely. When setting limits, offer choices to the patient

4.13.6. Keep your nonverbal cues nonthreatening. The more a patient feels out control, the less likely they are to listen to actual words. More attention is paid to your nonverbal communication. Be aware of your gestures, facial expressions, movements, and tone of voice.

4.13.7. Tone of Voice-special emphasis should be placed on tone of voice. Modelling behaviour by staff, repetition of client words, deep breaths, open statements of curiosity rather than direction can be utilised effectively (Pearce, 2017).

4.13.8. Avoid overreacting. Remain calm, rational, and professional. Your response will directly affect the behaviour.

- Consider use of low stimulus room/ relaxation rooms/ identified quiet areas within the Approved Centres name to support a person who is displaying unsafe behaviour to regain self-control.
- Providing low stimulus environment throughout ward can be helpful, and if not, rooms in proximity to main ward such as quiet rooms are beneficial.
- Use physical interventions only as a **last resort.** Use the least restrictive method of intervention possible. Physical techniques should be used only when individuals are a danger to themselves or others. Physical interventions should be used only by Competent and trained staff. There is inherent risk with any physical intervention

4.14. Understanding and working with risk:

4.14.1. Comprehensive clinical risk assessment and active management of that risk requires a skilled and engaged workforce focused on providing the best care possible.

4.14.2. Reducing restrictive interventions requires balancing the clinical risk assessment, patient choices and duty of care.

4.14.3. Creating a safe environment requires staff to reconcile flexibility and responsiveness and people's unique circumstances and preferences with appropriate risk-management obligations.

4.14.4. Working with risk requires:

4.14.4.1. Transparency and an openness with the person about risks

4.14.4.2. Clarity about practitioner roles and associated responsibilities

4.14.4.3. Supportive teams with whom duty of care and dignity of the patient can be discussed

4.14.4.4. A safe authorising environment within the health service's governance structures, where open and non-blaming dialogue can occur on the best interests and duty of care

4.14.4.5. Clear protocols and development opportunities for front-line staff to implement strategies that support de-escalation and effective engagement with the patient and their carer

4.14.4.6. Supporting staff to do their job well.

5 Children and Young people

Young people 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 young person. In addition, the size and physical vulnerability of young people should be taken into account when considering physical restraint. Physical restraint should be used with extreme caution when it involves young people because in most cases their musculoskeletal systems are immature which elevates the risk of injury.

5.1. Considerations with regards restrictive interventions with a Young person

5.1.1. On admission a documented risk assessment must be carried out by a registered medical practitioner and/or registered nurse which will have careful consideration to the potential effects of restraining a young person. It will consider,

5.1.1.1. the physical status of the young person

5.1.1.2. the emotional development of the young person

5.1.1.3. If there is a particular vulnerability to trauma and harm that may be caused as a result of restrictive interventions.

5.1.2. The outcome of the risk assessment will determine if physical restraint can be safely used or not. This determination will be clearly documented in the young person's ICP.

5.2. Restrictive interventions are not therapeutic:

5.2.1. Restrictive interventions are management strategies and are not regarded as primary treatment techniques.

5.3. Debriefing.

5.3.1. Debriefing is made available for all individuals who have experienced physical restraint. Family/Significant others may attend with the patient (unless clinically contra-indicated).

5.3.2. Provide post-event debriefing for all to emphasise the importance of a no-blame culture.

5.3.3. Patient debriefs can assist in reminding all staff of the impact of violence, aggression and restraint on the individual. This can lead to improved relationships with patients.

5.3.4. Staff debriefs will take place in peer meetings and with their line-manager.

5.4. Use of Data to Inform Practice

5.4.1. Data serves as a source of clinical and organisational learning, supporting the reduction of physical restraint (MHC 2014).

5.4.2. Data is collected by the Mental Health Act Administrator/ or nominated admin personnel in compliance with the Mental Health Commission Codes of Practice for Physical Restraint (2022)

5.4.3. It is the responsibility of the Reducing Restrictive Practices working group to review this data quarterly to monitor the progress and achievement of the reduction strategy and publish a report.

5.4.4. Regular auditing to ensure compliance with all MHC Rules and Codes of Practice.

5.4.5. Data should be utilised to inform staff education and training to improve practice

6. Environment.

6.1. Develop treatment environments that reduce stress, anxiety and conflict and enable the early identification of issues.

6.2. Develop strategies that support patients and families to stay informed.

6.3. Address environmental factors that impact restrictive interventions. This may include providing space and privacy for people

6.3.1. Consider the potential impact of the following on patients: time of day for ward appointments/ programme, ward rounds, medication times, time of alarm testing

6.3.2. Consider factors such as visiting times, expected attendance at appointments, number of people present at ward rounds, access to possessions, privacy and comfort.

6.3.3. Consider reduced sleep, ward round, visitors, change of medication/s, staff changeovers as these may have a cumulative effect and lead to challenging behaviour.

6.3.4. Consider noise level, temperature, hunger, lack of privacy, physical proximity of others – personal space, access to garden/outdoor spaces, financial worries, impact of family and/or social circumstances.

6.4. For service users with specific communication needs staff can employ individualised support strategies to reduce distress or frustration. These strategies will be included in the ICP. Assessment/advice from Speech and Language Therapy may be sought as appropriate.

7. Regulation.

7.1. Mental Health Commission is responsible for regulation of all approved centres.

7.2. Policies and procedures provide clear guidance and direction to prevent and manage escalation, and enable people with a lived experience, their support people and staff to work together.

7.3. Systems reflect the organisation's core values, including openness and reflective practice to reduce restrictive interventions.

7.4. Reporting, monitoring and evaluation are core components of health service systems and contribute to building the knowledge base of effective strategies that reduce restrictive interventions.

8. Staffing.

8.1. Reducing restrictive interventions requires an interdisciplinary partnership committed to sustained effort.

8.2. Healthy teams are built on individual and collective skill sets.
8.3. A skilled workforce is resourced and supported.
8.4. Competence in, and commitment to, recovery-oriented practice and a focus on supported decision making and self-determination are key features of the interdisciplinary team
8.5. Roles are clear and accountable.
8.6. There is recognition of trauma and its impact on people with a lived experience, carers and staff.
8.7. The health service is a safe environment where governance arrangements support and enable open dialogue best interests and duty of care.
8.8. The environment values learning and authorises and fosters open disclosure.
8.9. The organisation is committed to continuous learning and quality improvement.

9. IMPLEMENTATION PLAN

9.1. Once approved by the Policy Review Team, all staff will be informed of the St Michael's Unit policy.
9.2. A copy of the policy will be available in policy file and any previous versions relating to this policy will be removed and retained as per the HSE guidelines and legislative requirements and the St Michael's Units own processes
9.3. All relevant staff are expected to read and sign a signature sheet to say they have read and understood this policy.
9.4. This policy should be read in conjunction with the Restraint policy and the guideline on the use of PMCB

10. TRAINING AND EDUCATION

10.1. All Staff must be trained in PMCB, as this is a mandatory requirement.
10.2. Refresher training must be completed within 24 months.
10.3. PMCB training is provided to staff by certified PMCB instructors in CKCH.
10.4. A record of staff attendance at training is maintained and these are available to the inspector of mental health services and/or the Mental Health Commission upon request.
10.5. All HSE staff (permanent, temporary, agency, locum or visiting), students and volunteers irrespective of role or grade have completed Children First Training, this is a mandatory requirement
10.6. All staff will be aware of their responsibility under Trust in Care policy
10.7. All clinical staff to undertake Mental Health commission developed e learning resources

All staff will be requested to compete the HSE Land module 'Becoming trauma aware an introduction to Psychological Trauma'.

HSELAND modules include:

- Module 1: Changes to the Rules and Code of Practice on Restrictive Practices
- Module 2: Changes to the Rules governing seclusion.
- Module 3: Changes to the Code of Practice on Physical Restraint

11. AUDIT AND MONITORING

11.1. All information gathered regarding the use of physical restraint is held in the Approved Centre and used to compile an annual report on the use of physical restraint at the approved centre. This report is available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request. This report, which will be signed by the Registered Proprietor Nominee, will 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. It will include the following information:

11.2. Aggregate data that must not identify any individuals.

- A statement about the effectiveness of the approved centres actions to eliminate, where possible, and reduce restraint
- a statement about the approved centres compliance with rules governing the use of restraint
- The data as specified in appendix 1
- Where physical restraint has not been used in the relevant 12-month period, then i) and ii) above will only be reported on.

11.3. Each individual episode of physical restraint will be audited and reviewed at the quarterly Reducing Restrictive practices working group at the approved centre

11.4. Incident Reports are to be completed where non compliances are identified in relation to the processes for the use of physical restraint.

11.5. Areas of non-compliance will be analysed by the local audit group and Reduction of Restrictive Practices Working Group, an action plan to address any issues will be developed.

11.6. A report will be issued to the Quality and Safety Committee.

11.7. This policy will be reviewed every 3 years or where new evidence, research or guidance comes to light (MHC, 2022).

12. REFERENCE:

- HSE (2018) *Policy on Management of Work-Related Aggression & Violence*, Available at: https://www.hse.ie/eng/staff/safetywellbeing/healthsafetyand%20wellbeing/policy%20on%20the%20prevention%20and%20management%20of%20work .
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Appendix 1

Data that is required to be published as part of the Approved Centre's annual report on the use of physical restraint

The total number of persons that the approved centre can accommodate at any one time*
The total number of persons that were admitted during the reporting period*
The total number of persons who were physically restrained during the reporting period*
The total number of episodes of physical restraint
The shortest episode of physical restraint
The longest episode of physical restraint

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