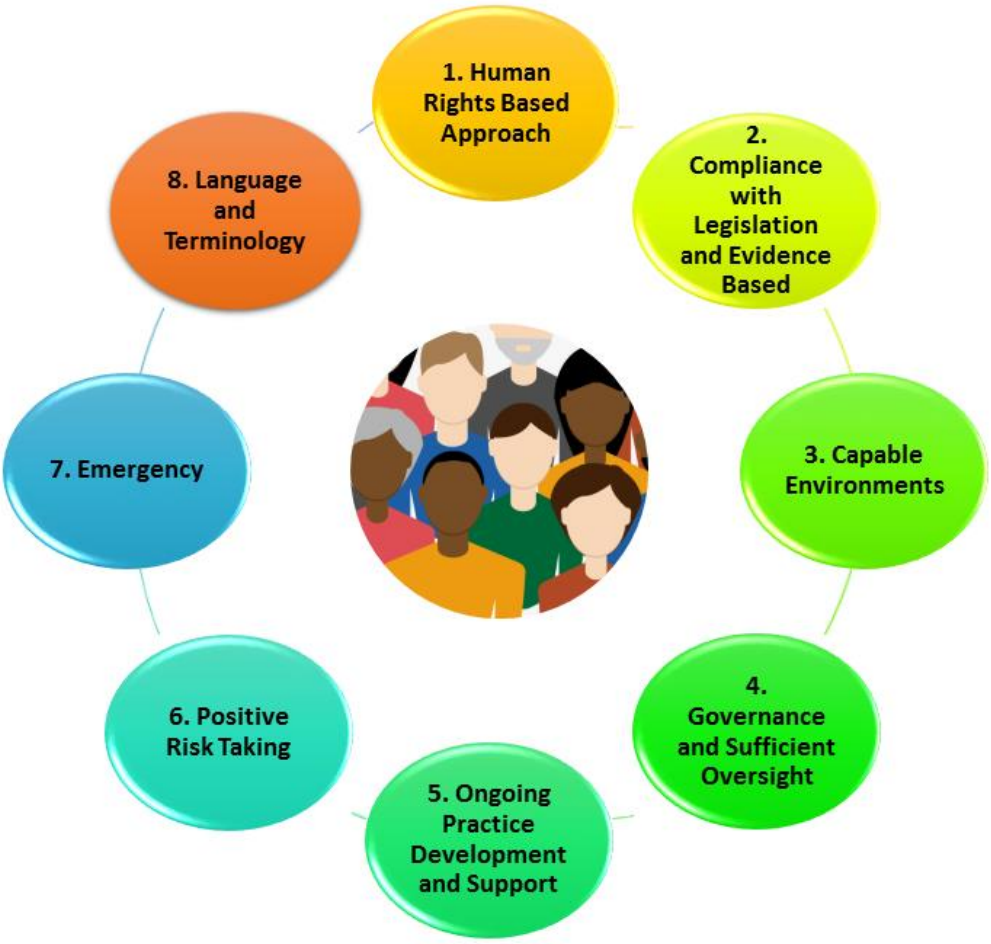
Office of the National Quality Improvement Office
Disability Services
Community Operations
Health Service Executive
Upper Park Road
Killarney Co. Kerry V93CH69
Email: disabilitiesqi@hse.ie

Preventing the Need for Restrictions

Guiding Principles



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Preventing the Need for Restriction Guiding Principles

Preamble: The use of a restriction in the provision of supports and services is a human rights issue and may also be a legal issue. Services have a responsibility to reduce imminent risk of harm, mitigate for a risk of harm and prevent, reduce and eliminate the use of restrictions. With good governance, risk can be reduced, safety maintained and restrictions made redundant.

While guidelines and policies for the use of Restrictions can be helpful in the short term, they run the risk of focusing on the better management of such interventions instead of facilitating the necessary paradigm shift required for a commitment to their prevention, reduction and elimination.

The research indicates the negative impact of restrictions for people as pain/ discomfort, injury, experienced as abuse and/or a form of punishment, human rights infringements, humiliation, traumatisation and negative emotions. There are also similar negative impacts for staff who use restrictions and for others who may witness and/or experience the negative side effects arising from sharing an environment or for the care and love they have for the person being supported.

Excellence in practice is dependent on each HSE and HSE funded agency, relevant government department and our subsequent legislation to evidence a commitment to safeguard individual's Human Rights through the non-use of restrictions when providing care and support where imminent risk of harm is present.

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1.0 Introduction:

These Guiding Principles are intended to support services when revising the local policies and procedures developed to meet the Schedule V requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for persons with disabilities) Regulations 2013 in respect of the Designated Centre; '*the use of restrictive procedures and physical, chemical and environmental restraint.'*

The Guiding Principles –
The set of Guiding Principles has been developed following an international literature review which was validate using the AGREE tool along with the preferences and views elicited from service users. These Guiding Principles reflect the key elements that should be incorporated in your local policy and procedure. The references which were used to identify these principles are attached to the end of the Guiding Principles document.

Impact Assessment (Appendix I) –
This Impact Assessment has been developed to assist services during the implementation of the revised local policy and procedure and is intended as a guide to provide a structure for measuring the impact of the revised policy in four key areas:

1. Stakeholder Perspective
2. Internal Business Processes Perspective
3. Learning and Growth Perspective
4. Financial Perspective

This tool should be used by the local policy and procedure development or steering group when the policy revision is close to completion. There is an action plan to record what needs to happen under each of the four headings to support the implementation of the policy.

Audit Tool (Appendix II) –
This document is intended to act as an audit tool when a service is revising their local policy and procedure. The purpose is to ensure that each of the questions in the audit tool is addressed in the local policy and procedure. This includes a question at the end of the audit tool to ensure that experts by experience or people who use the service have been involved in developing or reviewing the policy in a meaningful way.

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Verification of Literature using AGREE Tool (Appendix III) –
This document is included in the packet to assure services that the Guiding Principles were developed in a robust manner and that the literature was validated against this accredited tool (AGREE) as well as giving a synopsis of the engagement with service users. It is for information purposes.

2.0 Definitions:

There are multiple definitions in the literature on interventions and practices that meet the criterion of a restriction. For a full list of definitions used internationally see Appendix VIII International Definitions.

This document will use the term 'Restriction.' Definition: A restriction is any practice, strategy, intervention, inaction that has the effect of limiting, controlling, monitoring, preventing, impeding the movement, rights and/or freedom of a person to act voluntarily. Adapted from the Australian Government (2014) - *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.*

Restriction is an umbrella term for any act or inaction that restricts a person's voluntary/free movement. This may also be called restraint or restrictive practice.

Restrictive practices are defined as 'the intentional restriction of a person's voluntary movement or behaviour'. *S.I. 367 of 2013 The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013*

HIQA refined the definitions of a restrictive practice in April 2016 as follows:
A Restrictive Practice: is a practice that*:*

- limits an individual's movement, activity or function
- interferes with an individual's ability to acquire positive reinforcement
- results in the loss of objects or activities that an individual values or
- requires an individual to engage in a behaviour/action that the individual would not engage in given freedom of choice.
  (*Source – HIQA - Guidance for Designated Centres Restraint Procedures April 2016)*

Some examples of restrictions are: physical, mechanical, medication used as a restriction, environmental and psycho-social. Some restrictions can be easily identified – locked doors, physical restraint; others are more subtle – only allowing a person to watch television for a certain length of time for example. (See appendix VIII)

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Area of concern of imminent risk of serious harm: any conditions or practices or situations which are such that a danger or risk exists which could reasonably be expected to cause death or serious physical/psychological harm to an individual(s) immediately or before the imminence of such danger/risk can be reduced or eliminated. For example, falling out of bed; choking; eating non-edibles; leaving home without adequate support; to participate in a medical procedure; physical harm to self or another; postural/positioning for breathing etc.

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3.0 Preventing the need for Restriction - Guiding Principles

The National Guiding Principles Group, under the auspices of the National Quality Improvement Office, HSE Disability Operations, has identified eight (8) guiding principles to assist organisations in developing and revising local policies and procedures for the prevention, reduction, elimination and under very limited circumstances the use of restriction(s)

Guiding Principles:

1. Services practice a Human Rights Model (HRM): Supporting persons to live lives of their choosing informed by human rights.

1.1 Human Rights Model underpins all supports to a person. A HRM is delivered through a Human Rights Based Approach which has five core principles (PANEL) (HIQA uses FREDA, which can also be applied.)

a. **Participation**-everyone is entitled to active participation in decision-making processes which shape their lives and affect the enjoyment of their rights. They must know what their rights are, be supported to understand them if necessary and have the opportunity to influence decisions affecting them.

b. **Accountability** – Those responsible (duty bearers) for respecting, protecting and fulfilling human rights must be accountable for their actions or their failures to act. There should be effective strategies in place to identify rights infringements and remedies in place when human rights breaches occur. This includes advocating with the person.

c. **Non-discrimination and equality** – all individuals are entitled to their rights without discrimination of any kind. A HRBA requires that laws and practices guarantee full and equal enjoyment of human rights to vulnerable groups on the same basis as anyone else. In order to achieve this, these groups may require a special focus. All types of discrimination should be prohibited, prevented and eliminated.

d. **Empowerment** – everyone is entitled to claim and exercise their rights. Individuals (to include family, carers and staff) must be educated about their rights, equipped with the necessary skills to claim them and participate in the development of policies which affect their lives. This represents a shift from models which see people as being in need or as passive recipients of charity, but instead views them as people empowered to claim their rights.

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e. **Legality** – Human rights must be at the heart of policymaking and service delivery. Approaches should be in line with the legal rights set out in Irish and international laws. This includes identifying and naming the rights that the person may not be supported to exercise or that may be restricted.

1.2 The rights and voice of each person are recognised: A complete, dynamic profile of the person's communication strengths and needs should be gathered and communication supports based on this assessment, for example a Communication Passport, be put in place in line with the organisation's communication policy. All staff should be trained and/or advised on the person's communication needs. The voice of the person must be central to the co-development of their care and support. This includes access to an advocate and/or second opinion from an independent person if required.

1.3 A person centred approach is evidenced for each adult; and a child centred, family centred approach is evidenced for children in the resultant policy. Persons who access and use services (together with their families as appropriate) are equal partners in planning, developing and monitoring their care and support to make sure it meets their needs. The strengths, capabilities, and unique circumstances and needs of each person and/or their families (as appropriate) are recognised and included in person centred, child and family centred, care and support plans.

1.4 Effective, evidence based an ethical care and support, acknowledges the importance of a capable and responsive environment (for example-where the person lives, who they live with, relationships they have, what activities they engage in and the skills of the people who provide their support, how they access clinical support etc.) on a person's well-being and stress. If an environment is unable or incapable of meeting a person's needs, this is identified together with the person and advocacy is accessed, as required. A plan (business plan, for example DSMAT), to build a better service or refer to an alternative service where the person's needs and concerns can be met, may be required. If there is a risk to the person or other people the Safeguarding Policy and the complaints policy is referenced and adhered to.

1.5 Quality of Life Outcomes define effective care and support: This includes supports to enable each person to improve their quality of life, for example by supporting the person to have:

- Meaningful and enduring relationships (which includes intimate relationships);
- A place to call home, (living with people who love and care about them and who they love and care about.);

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- Meaningful and socially valued roles; for example, employment; skills for independence etc.;
- Fun, joy, pleasure and love;
- Effective ways to communicate, to exercise choice, power and control;
- On-going education, support and advocacy opportunities (for self, citizen advocacy, disability activist organisation participation for example);
- Skills and supports to be safe and healthy, to maximise feelings of well-being, value and worth;
- Opportunities for personal development and reflection; for example, coping skills for resilience, problem solving, communication skills (expressive and receptive), self-awareness, psychological therapy, etc.
  HSE approved NDA Nine Outcomes can also be used here.

2. Compliance with current legislation, national policy, research and human rights framework, and any relevant future amendments to support persons to live according to their will and preference.

Each service's policy will reference relevant legislation, national policy and research: see Appendix IV.

3. A Service Evidences a 'capable environment' approach.

The 11 characteristics of a capable environment involve a systemic, theoretically-driven approach in which the focus is on improving the quality of care and support especially in those areas known to be associated with risk of imminent harm. These 11 characteristics share two defining features. Firstly, they produce positive outcomes for individuals and their supporters such as enhanced quality of life. Secondly, they can prevent the risk of imminent harm from occurring. The 11 characteristics are as follows:

Every Individual is:

1. Supported with positive social interactions;
2. Supported in rich communication environments where their communication skills and communication support needs are consistently recognised and responded to and where communication is considered in all areas of the person's life;
3. Supported to participate in meaningful activity, using skilled support that provides enough support to ensure success;

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4. Supported consistently in predictable environments and given support to understand and predict events; with personalised routines and activities.
5. Supported to develop and maintain relationships with family and friends;
6. Offered choice and experiences which lead to more meaningful choices which are supported to be clearly communicated;
7. Supported to try new experiences, develop skills and increase independence;
8. Supported in dignified ways to care for and look after themselves and their health; (physical, emotional, sexual and spiritual)
9. Supported in acceptable physical (home like, work like, leisure) environments;
10. Supported by skilled and mindful carers who have the skills to lead all aspects of capable practice; which includes quality of life and area(s) of concern of imminent risk of harm(if applicable);
11. Capable environments receive sufficient and timely government funding to provide individualised person centred supports as needed throughout the person's lifespan talking into account changing needs and are rights based in their provision of services. Advocacy and business plans can support this.

(McGill et al., in press)

Where there is evidence that a capable environment does not exist, a case may be made for a Disability Supports Management Application Tool (DSMAT) to be completed.

4. Governance and Sufficient oversight: A Service evidences the four stages for care and support for an area of concern of imminent risk of harm: (see Appendix V for more information)

Stage 1: Identification and Assessment of the area of concern is evidenced and completed by suitably qualified professionals.

i. Identify the area of concern. This can occur using the risk assessment matrix.
ii. Except in an emergency, a full assessment of a person is then performed and recorded, prior to the support plan being recommended.
iii. Review the care and support in place for the individual in the context of the area of concern. Complete and /or Review assessment reports and any plans written that are pertinent to the concern. These reports may include but are not limited to cognitive/sensory/cultural factors/functional

assessment/Behaviour Support plan /environmental profile/ behavioural/life history/cultural needs /story/ psychosocial/ health/medical/mental health.

iv. Document the non-restriction options which have been explored / trialled before considering the use of a restriction.
v. Include the individual and those who support them in the process as appropriate.
vi. Include at a minimum 2 disciplines (healthcare professionals) pertinent to the area of concern of imminent risk of harm in the assessment and decision making process;
vii. If other non-restriction options have been exhausted, a time limited restriction option may be considered, list other non-restriction options, don't be limited by the circumstances a person currently has.
viii. Before a restriction is authorised check psychological and medical vulnerabilities, history of trauma or abuse, sensory issues, culturally safe practices for example.
ix. Information on a restriction is given to the individual and the process undertaken to include the person, their will and preference and involvement in the decision making process, which includes their consent is documented and evidenced.
x. Any restriction employed should be the least restrictive option, time limited and based on the findings from previous steps and not used frequently or used so often it becomes a planned treatment.
xi. Any restriction recommended as part of a care and support plan for an area of concern of imminent risk of harm is also reviewed by a Human Rights Committee (or equivalent oversight committee) to ensure due process (if an emergency arises resulting in the use of a restriction this information is shared with the MDT(or interdisciplinary group of suitably qualified healthcare professionals) as soon as possible and with the services Human Rights Committee)

- Note: Restriction(s) should never be used :
  - To force a person's cooperation or compliance;
  - as an organisational convenience;
  - to compensate for limited staff and /or skill;
  - due to limited resources
  - as a result of inappropriate/incapable environments,
  - without proper assessment, governance and due process;
  - as a form of abuse.

Should any of these occur an adult Safeguarding concern should be raised in relation to an adult via the HSE Adult Safeguarding Policy or a Children's First notification made to TUSLA in relation to a child. All staff members should be aware

of the possibility that an inappropriate restriction may be considered a form of abuse under the HSE Adult Safeguarding Policy. Staff members should also be aware of their responsibility to respond appropriately and to raise an inappropriate use of a restriction as a safeguarding concern to their line manager and their Designated Officer. TUSLA and the HSE Safeguarding and Protection Teams are also available for advice and guidance.

Stage 2: The development of the Plan, to include the process of decision making and consent:

If the plan includes the use of a restriction this is recommended by an Interdisciplinary team, with the practice/intervention clearly labelled as a restriction; and the process undertaken to assist the person in this decision and consent is described and documented. At least one member of the interdisciplinary team is competent in supporting the area of concern of imminent risk of harm; for example, if behavioural support needs are required a practitioner with expertise in Behaviour Support may be required. (It is recognised that a court/legal requirement for a restriction may occur, but again this should occur as part of an interdisciplinary team approach). Autonomy, and the individual's will and preference should be evidenced in the decision making process. Consent is time limited and a review date is specified. A plan with a restriction must also include a methodology (plan) to reduce and remove the restriction (aka as a rights reinstatement plan) while also mitigating against the risk of imminent serious harm occurring. Consideration of the impact (physical/psychological) of a restriction or the use of a restriction on others living in the same environment will also need to be evidenced, for example a locked door, witnessing physical restraint; assigned seating as this may result in a third party experiencing a restriction or a safeguarding concern.

Stage 3: The implementation of the plan is supported and evidenced and the correct notification has occurred.

i. Support for the team implementing the plan is assessed and support is provided, for example in training, supervision and mentoring.
ii. Ensure that if a restriction is recommended that it is used as per the written protocol, recorded, monitored (and notified see next section) and the area of concern is regularly reviewed with the aim of reducing or eliminating it the use of the restriction in the context of mitigating for the imminent risk of harm.

iii. Ensure debriefing and review after each occurrence of an imminent risk of harm, which may also include a review of the use of a restriction. This should include the individual, staff members and any others impacted by the occurrence of the area of concern of imminent risk of harm and the use of a restriction (if applicable).

Stage 4: Evaluation

i. Each plan for an area of concern of imminent risk of harm (with or without the use of a restriction) must be reviewed by the healthcare professionals who (and/or the interdisciplinary team) who authorised the plan of care and support and if applicable the use of a restriction at a minimum once every 6 months or more frequently as required.
ii. The plan should evidence a reduction in the risk of imminent harm and if applicable, in the use of a restriction.
iii. Use data (continuous evaluation, interview, documentation, and observation) for audit and to inform process from the individual and other relevant parties.
iv. Appropriate documentation is available to evidence good practice.
v. Fulfil service requirements through internal governance structures e.g. oversight committee where data is collected and analysed to evidence a commitment to the prevention, reduction and elimination of a risk of imminent harm and use of restriction(s). (for example a Human Rights Committee, a Positive Practices Committee, Risk and Governance of Safety Committee, Ethics and Practice etc.) The oversight committee's work can involve:
    - the provision of education,
    - mentoring and practice support to staff member(s) around individual cases;
    - mitigating for risk;
    - engages in discussion and problem-solving;
    - being available to provide advice regarding best practice,
    - policy and standards.
vi. Fulfil statutory requirements by submitting the required documentation to HIQA and any other external monitoring group.

5. Ongoing practice development and support.

A service evidences structures and processes for education, mentoring, consultation, reflective practice, debriefing and training on how best to support the area of concern of risk of imminent serious harm while also evidencing a commitment to the prevention, reduction and elimination and in very limited

circumstances the use of a restriction with all stakeholders. (for example with the individuals they support, family members, staff to include healthcare professional(s), MDT members etc.)

6. Positive Risk Taking: A Service evidences a commitment to positive risk taking.

Individuals supported are afforded the 'dignity of risk'. It is recognised that as an individual leads a more independent life, the risk associated with the activities in which they are involved in is likely to increase. Robust risk management policies and procedures ensure individuals are protected yet supported by staff and families to make decisions about the level of risk they wish to take, to develop skills to manage their risks, and to take responsibility for risks. A step by step approach is practiced (which may include skills development, environmental adaptations, education etc.) to enable an individual to gradually build the skills to partake in different tasks, activities and experiences as they wish to.

7. Emergency: Imminent risk of serious harm

The support and response provided in an emergency should always ensure the safety of the individual, staff and others; occur within a caring and supportive relationship, with an understanding of the area of concern of imminent risk of harm where possible and evidence a commitment to the non-use of a restriction, aversive or punitive means.

8. Language and terminology

i. Restriction and Restraint are human rights issues. Avoid euphemisms when describing restrictions.
ii. Policies and Procedures should be accessible, jargon free, and written in Plain English.
iii. Materials and technology are used and adapted to best meet the person's needs and abilities to understand the information.
iv. Communication partners are suitably trained qualified professionals who value and adapt to a person's communication style and are competent to use a variety of communication approaches, as appropriate to the person.

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APPENDIX I - Impact Assessment:

The purpose of an impact assessment is to 'assist leaders to fully understand the extent and complicity of the change' and will ensure that an integrated approach to managing the change is adopted (McAuliffe *et al.*, 2006). The Balanced Score Card provides a structure for measuring Impact (Kaplan & Norton, 1993). It has 4 key areas and as the name suggests we need to keep a balanced approach to all four. We also need to pay attention to how these interact with each other- for example training and education for staff may be a requirement to introduce something new- how does that impact on finances?

- **Stakeholder Perspective:** This perspective is about how the Policy will impact on stakeholders.

- **Internal Business Processes Perspective:** This perspective ensures the stability and sound operation of your business. What systems/ structures/ referrals/ recording do you need to change or introduce to fully implement this policy?

- **Learning and Growth Perspective:** This perspective consists of training and improvements required for the workforce to implement the policy. It ensures that your employees have the skills to implement the policy. This area also considers the need for data relating to the implementation of a policy- do you need records of how the policy is implemented, eg- the number of referrals to a department, the number of staff who have been trained? Do you need an audit tool?

- **Financial Perspective:** This perspective indicates whether your Policy impacts on the bottom line. Not for profit companies consider the financial perspective last. This however is often a challenging area in public service and requires attention before a policy is 'launched' into a system that is not financially able to support its implementation/ sustainment.

There are a series of questions for each of the four areas of the Balanced Score Card that should be considered by a Policy Steering Group/ Policy Development Group when the policy is close to completion. There is an action plan to record what needs to happen under each of the four headings to support the implementation of the policy.

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Disability Services
Community Operations
Health Service Executive
Upper Park Road
Killarney Co. Kerry V93CH69
Email: disabilitiesqi@hse.ie

1: Stakeholders; who does the policy impact on? What level of impact is there? How do we engage with the stakeholders to maximise the positive impact of the policy and minimise the perceived negative impact of the Policy?

Name of Stakeholder	**How much are they affected? High/Med/Low**	**How much influence do they have on the implementation of the policy? High/Med/Low**	**Do we have a plan to engage with/ inform this stakeholder about the policy?**
Service Users			
Families			
Clinical staff			
Frontline staff			
Local Managers/ PIC's			
Senior Managers/ Regional Managers			
CHO Disability Managers			
National Disability Team			
HIQA			
Voluntary Agencies			
Other agencies / service providers			

Actions required relating to stakeholders:

1.

2.

3.

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2: Internal Processes: How will this Policy impact on internal processes?

Operations Management: delivering services to service users:

Is there a current practice/ procedure that needs to change?

Do we have a governance structure to support the implementation of the policy?

Do we need to develop/ update assessment process associated with this policy?

Is there a new/ updated referral pathway required?

Do all staff know how to access information/ training/ support to implement the policy?

Do we have a review process in place for the policy?

Do we need resources (eg- new equipment/ access to computers, access to documents/ etc)

Regulatory Requirements – Does this Policy support compliance with a set of regulations?

What will the impact be on the compliance levels?

Does it have an impact on GDPR compliance?

Does it have an impact on Assisted Decision Making (Capacity Act)

Does it support compliance with the Health Act?

Does it support the introduction of New Directions for Day Services?

Are there other regulatory implications? (eg- Health and Safety Legislation, Safeguarding Policy requirements,

Are there regulatory risks associated with implementing the policy?

Actions required relating to internal processes:

1.

2.

3.

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3: Learning and Growth: How will this Policy impact on learning and growth needs in the organisation?

Data: Is there accurate, timely and complete information available to make management decisions?

What data is available and what data is required?

Can we leverage the data we have to support the implementation of this policy?

What data will help us to report on the implementation of this policy?

Training: Are education and training interventions required?

Do we have a training provider who will provide training?

Have we considered how many staff will need training and education?

Can we record staff training and include it in HR records?

Are there 'backfill' costs for staff to attend the training?

Is it going to be 'mandatory' training?

Can we do some online elements?

Is the training based on the Policy?

HR/IR: Are there IR/ HR issues to be dealt with?

Are there role specific HR implications?

Do job descriptions need to be updated?

Do we need to engage with representative bodies/unions/professional bodies?

Are the management team clear about the processes for implementing this policy and their role in it?

Do we have a HR process to manage people who do not implement the policy?

Do we need new posts to support this policy? Do we have agreement that these posts can be filled?

Actions required relating to Learning and Growth:

1.

2.

3.

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3: Finances: How will the implementation of this Policy impact on Finances?

Have we considered the financial implications associated with the policy?

Consider: staffing, new equipment, training, new data collection systems, computers/ hardware/software/

Where will the costs be located: Locally? Regionally? Organisationally? Nationally?

Is there an agreement in place to fund the implementation of the policy?

If funding is not available are we going to do it anyway? – is this sustainable?

Do we need to pilot it and examine the cost of implementation before a wider role out?

Are there risks associated with finances?

Actions required relating to Finances:

1.

2.

3.

References (For Impact Assessment Tool):

Kaplan, R. and Norton, D. (1993). Putting the Balanced Scorecard to Work. [online] Harvard Business Review. Available at: https://scanmail.trustwave.com/?c=6600&d=mtOP3Hd_PgUW7QSSAIx5Gk_RqyLJQxm3v95eDITWTQ&s=343&u=https%3a%2f%2fhbr%2eorg%2f1993%2f09%2fputting-the-balanced-scorecard-to-work [Accessed 8 Jan. 2018].

McAuliffe, E. *et al.* (2006) *Guiding change in the Irish health system*. Report. Health Service Executive (HSE). Available at: http://www.lenus.ie/hse/handle/10147/78553 (Accessed: 8 February 2018

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Community Operations
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APPENDIX II – Audit Tool

Organisations/ Local Communication Policy Audit Tool: Preventing the Need for Restriction

Guiding Principles to be included in 'Preventing the Need for Restriction' Policy	Yes/ No	Action Required
Does the policy define what restrictions are?		
Does the policy set out how the person will be supported to make choices in how they are supported?		
Does the policy set out how the person will be supported to live a life of their choosing informed by a Human Rights Model and a Human Rights Based Approach?		
Does the policy provide guidance on how to ensure a person's voice is heard?		
Does the policy comply with the most current legislation, national policy and research and human rights framework?		
Does the policy evidence a "capable environment" approach?		
Does the policy provide clear guidance on governance and oversight measures?		
Does the policy define "an area of concern of imminent risk of harm"?		
Does the policy identify the four stages for care and support for an area of concern of imminent risk of harm?		
Does the policy support ongoing practice, education and support for staff?		
Does the policy support positive risk taking?		
Does the policy identify the priorities in an emergency: imminent risk of serious harm?		
Does the policy use accessible language and terminology, free from jargon?		
Does the policy give guidance on suitable communication supports depending on the person's needs?		
Have experts by experience or people who use the service been involved in developing or reviewing the policy in a meaningful way?		

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Upper Park Road
Killarney Co. Kerry V93CH69
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APPENDIX III – AGREE TOOL

HSE Disabilities - Operations
National Quality Improvement Subgroup:
Guiding Principles Subgroup

Preparation for validation of research - adapted from Agree Checklist[1]
To be used by working groups to document and present research undertaken in developing a policy for review by the Expert Group within the Guiding Principles Group

Title of SET OF GUIDING PRINCIPLES: Preventing the Need for Restriction

DOMAIN 1: Scope and Purpose

1.1. The purpose of this set of Guiding Principles is:

1. To define best practice in relation to 'Preventing the need for Restriction' with adults with a disability
2. To provide a support to services when developing or revising their local policies Preventing the Need for Restriction (Restrictive Practices Schedule V no.6, Health Care Act 2007, Regulations 2013) to ensure they are in line with best practice**.**

NOTE - During the course of development and due to ongoing findings in the literature, it was agreed to change the title of the Guiding Principles to – *Preventing the Need for Restrictions* – it is hoped that this will also influence a change in culture with regards to restrictions.

1.2. The scope of this set of Guiding Principles is:

1.2.1. Describe the population (staff, people who use services etc.) to whom the set of Guiding Principles *will apply*

This policy applies to all:

- Staff
- Volunteers
- Students on placement

involved in supporting adults with a disability in HSE provided and HSE funded day and residential services. This also includes adults with a dual diagnosis of intellectual disability and another diagnosis (e.g. physical disability / sensory disability, autism spectrum disorder, mental health diagnosis etc.).

1.2.2. Outside the scope of the set of Guiding Principles *– who does this* set of Guiding Principles not *apply to?*

This set of Guiding Principles does not apply to services:

- *Supporting children with a disability.*

[1] Agree Enterprise Website – Appraisal of guidelines, research and evaluation

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1.3. OBJECTIVES

Report the overall objective(s) of the set of Guiding Principles *:*

- To provide a set of Guiding Principles that can be used to support the development of Restrictive Practices local policies where they do not exist.
- To provide a benchmarking tool for services where Restrictive Practices policies do exist to allow the existing policy to be reviewed to bring them in line with best practice.

1.4. OUTCOMES:

The Outcomes of the Implementation of the Restrictive Practices Guiding Principles are:

- Promote supportive environments free from restraints for adults with disabilities.
- Decreased use of restrictive practices by staff, but where used are respectful of the person and based on the individual's needs and preferences.
- Improved staff knowledge and skills to safeguard individual's rights through the non-use of restrictive practices.
- Improved staff's understanding about the importance of implementing rights based restrictive practices.

1.5. QUESTIONS

Report the policy questions – SPIDER questions (Sample, Phenomenon of interest, Design, Evaluation, Research Type) covered by the set of Guiding Principles, particularly for the key recommendations:

The Preventing the Need for Restriction Guiding Principles are based on three Clinical Questions and a research strategy for each was developed:

1. What are effective ways to eliminate or decrease use of restrictive practices for adults with disabilities?:
S: adults with disabilities
Pi: elimination/decrease of restrictive practices
D: N/A
E: experiences
R: qualitative/quantitative

2. How does a rights based approach support the reduction of restrictive practices?
S: adults with disabilities
Pi: rights based approach
D: N/A
E: experiences
R: qualitative/quantitative

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3. What is the role of frontline staff and multidisciplinary team in providing restrictive practices?
S: staff, MDT.
Pi: role of staff and MDT
D: N/A
E: experiences
R: qualitative

DOMAIN 2: STAKEHOLDER INVOLVEMENT

2.1 GROUP MEMBERSHIP

Report all individuals who were involved in the development process. This may include members of the steering group, the research team involved in selecting and reviewing/rating the evidence and individuals involved in formulating the final recommendations.

The working group is comprised of:

1. Marie Kehoe-O'Sullivan, National Quality Improvement Office, HSE Disabilities (Chair)
2. Nicole Lam, Research Officer, National QI Office, HSE Disabilities
3. Ruth Connolly, Psychologist, Muiriosa
4. Maeve Whyte, CNM2 PIC, St Christophers
5. Kirsi Salo, Assistant Director, Inspire Wellbeing
6. Ann Nally, Western Care
7. Janette Tyrrell, Psychiatrist, St. Michael's House
8. Niamh Mulryan, Psychiatrist, Daughters of Charity Disability Support Services
9. Mary O'Connor, NMPDU Tullamore
10. Niamh McGoldrick, Risk Manager, QPS CHO 7
11. Clare Egan, Quality Partner, Cheshire
12. Mayra Orrillo, CNM2 PIC, Cheeverstown
13. Stephanie Kilrane, Quality and Risk, CRC
14. Angela Colgan, CNS Behaviour, Stewarts Care
15. Asim Sheik, Human Rights Specialist, UCD (consultation)
16. Marian Murphy, Training and Development Manager, Western Care
17. Caoimhe Gleeson, ADM lead, HSE
18. Dr. Suzanne Timmons, Clinical Lead, Dementia, HSE
19. Dr. Brian McClean, Senior Clinical Psychologist, Acquired Brain Injury Ireland
20. Maria Walls, PhD candidate, NUIG
21. Elizabeth McGrattan, Practice Development Coordinator, Peamount
22. Caroline Dench, Callan Institute Coordinator, Saint John of Gods
23. Tara Molloy, Quality and Standards Manager, St Michael's House
24. Maria Elena Costa, Human Rights Division, CRC
25. Aoife Sweeney, Senior Occupational Therapist, St John of Gods
26. Catherine Jackman, Principal Clinical Psychologist, Cheeverstown
27. Padraig Manning, HSE librarian
28. Gary Brennan, National Development Manager, Prader-Willi Syndrome Association of Ireland

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2.2 TARGET POPULATION PREFERENCES AND VIEWS

Report how the views and preferences of the target population were sought /considered and what the resulting outcomes were.

Two service user consultations took place in two different services. Both sessions were facilitated by staff that knew the service users well. Service users were asked questions that were developed by the working group. Below is a summary of the questions and answers found in both services.

1. What is your idea of a good life?
    - Chatting to and seeing friends
    - Independence and getting around, want to be on their own
    - Being educated and gaining more knowledge
    - Social and sport events BUT unable to do a lot of things due to lack of drivers. Would like to see their friends more often.
    - Go on the bus and go shopping in town
    - Living with family
    - Independence, having a job to earn money and go on holidays

2. What happens if you can't have a good life?
    - Ask staff and family, talk to friends
    - Stand up and speak out
    - Go mad if they (staff or other people) don't listen to them
    - Service users were very aware of the chain of command, named their key worker, the manager and then the CEO as staff to approach if they wanted to escalate a concern
    - Feel stuck in the house
    - Ask friends for advice
    - 5 out of 7 have made a formal complaint before

3. How do people react if they are upset?
    - Cry, scream, shout
    - Throwing things
    - Temper tantrums
    - Banging things
    - "get angry"

How can others help?

- They ask each other what's wrong
- Friends help one another
- Talk and calm them down
- They want staff to be calm as well, tell them they are their friend.
- Regular staff know their unique and individual needs
- A few indicated preference for regular staff as opposed to agency/new staff who "talk to the manager, not you", they don't listen as much. Some were ambivalent and trusted any staff member.

4. Do you know what rights are?
    - Friends/social life
    - Privacy – no one in their room
    - Voting, passport, travelling – citizenship
    - Education
    - Accessibility: wheelchairs, ramps sign language.
    - One individual highlighted that their home is not accessible to their friend, whose wheelchair cannot fit through the front door.
    - Safety and feeling safe in own home
    - Ramp outside one individual's home is uneven and their chair gets stuck.

5. Is it ok for a staff to take away a right to keep others and the individual safe?
    - No one's rights should be taken away
    - But staff need to be there sometimes to support individuals, e.g to use the toilet
    - If someone is upset on the bus they should still be allowed out in town instead of returning home and stopping the trip. They should try and calm them down, relax, and find out alternative ways to support them.
    - Bringing someone out of the room is ok if they hurt someone else and others are frightened. If others rights are infringed upon, it is ok to take it away.
    - Conflicting opinions on seclusion, only okay if someone else is hurt
    - What is more important: safety or rights? 4 said safety was more important than rights, 3 said rights were more important.

DOMAIN 3: RIGOUR OF DEVELOPMENT

3.1 SEARCH METHODS

Report details of the strategy used to search for evidence:

A review of Gray Literature was conducted, including restrictive practices policies in existence in Disability Services in Ireland, as well as an international literature search.

A primary literature search was conducted using PICO and key words that were suggested by group members, yielding 45 articles. However, the group felt a more qualitative perspective, especially from a Human rights based approach was needed and a secondary search was completed using the SPIDER questions. A total of 31 articles were identified as relevant from the SPIDER search, with 6 already found from the first search. The two literature searches were conducted by the HSE librarian including a full search of CINAHL, MEDLINE, SOCINDEX and EBSCO DISCOVERY.

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Disability Services
Community Operations
Health Service Executive
Upper Park Road
Killarney Co. Kerry V93CH69
Email: disabilitiesqi@hse.ie

3.2 EVIDENCE SELECTION CRITERIA

Report the criteria used to select (i.e., include and exclude) the evidence. Provide rationale, where appropriate:

The primary literature review excluded articles that were not relevant, one due to the focus on children others that were too clinical, short, or opinion based.

3.3 STRENGTHS & LIMITATIONS OF THE EVIDENCE

Describe the strengths and limitations of the evidence. Consider from the perspective of the individual studies and the body of evidence aggregated across all the studies.

Key questions to answer:

3.3.1 Are the results valid?

The literature review did identify systematic reviews and meta analysis in relation to restrictive practices for adults with a disability. It was not difficult to analysis the validity of smaller scale studies.

The literature identifies the various types of restrictive practices (mechanical, physical, chemical/medical, and seclusion) that are used in disability services. There is a divergence in the literature between those who suggest that restrictive practices are a “necessary evil” versus those who believe in the complete elimination of restrictive practices. However, most literature agree on the following: firstly, the minimization and reduction of restrictive practices, secondly, that they should be used as a last resort, and thirdly, it should be the least restrictive application (Luiselli, 2009). Evidence suggests the reduction of harm and use of restrictive practices when there is planned use (rather than emergency application) of restrictive practices. When it is planned and discussed with individuals, in some cases individuals feel calm when restraint (Cusack et al., 2018).

Human rights based approach and ethics are vital when considering the application of restrictive practices. The individual should be at the centre of planning and if rights are restricted at any stage, there should be efforts made to reinstate the right. The severity of restrictive practices in certain instances can lead to death, a reality that is acknowledged by many authors (Ferleger, 2008). Restrictive practices have notable traumatic impact, including physical and psychological harm on individuals, staff, and family (Griffith, Hutchinson and Hastings, 2013). Individuals report feeling distressed, dehumanised, fearful and re-traumatised (Wilson, Rae and Ray, 2017). Staff often feel guilty and not well-trained enough to respond to individuals. Family members feel torn about the use of chemical restraint as they feel that it may have had a positive effect on behavior but that it should be used in conjunction with environmental and other forms of supports. Families also felt that language is important when discussing chemical restraint; it is a form of restrictive practice when it is prescribed to alter an individual’s behavior (Edwards, et al., 2017). Furthermore, Tyrer et al. (2008) question the efficacy and ethics of using chemical restraint for individuals with a

disability who are classified as having challenging behaviours but do not have a proper diagnostic status. Psychotropics such as anti-psychotics, sedatives, tranquilizers, anti depressants, and mood stabilizers have been used as PRN medication but as part of a long term plan. This is despite the lack of evidence to support the effectiveness of medication in preventing challenging behaviours. Results from Tyrer et al's randomized controlled trial suggests that using either the medicine or placebo had little effect on behaviours and overall quality of life, but that aggressive behaviours decreased in both.

Focusing on the strengths and environmental needs of the individual is an approach that many focus on other than restrictive practices to intervene or prevent the need for restraints. The will and preferences of the individual should be reflected in their plan, which should record that their voice has been heard. Approaches should be non-punitive, practical and strengths based (Kalke, Glanton and Cristalli, 2007; Petti, Somers and Sims, 2003). Any intervention can be considered an instructional and learning moment rather than viewing an individual's behaviour as challenging. Person-centred approach to mitigating restricted practices should include strategies for skills and resiliency building, self-control, promote choice, environmental modification (Baker and Bissmire, 2000; Luiselli, 2009; Matson and Boisjoli, 2009). As supported by the human rights based approach, an individual's quality of life and level of social inclusion is considered an important preventative strategy. This includes participation in meaningful activities and social networks (Rigby, 2012; Sturmey, 2009), and self-determination (Van der Meulen et al., 2018). The literature also highlights the importance of emotional well-being for the individual. Service users value a close relationship with staff who can co-design a plan to seek alternative coping strategies which will allow them to safely express their anger, frustration or sadness without being labeled as challenging, a risk, or a problem (Stirling and McHugh, 1997). Alternative approaches to restrictive practices include mindfulness (Rickard, Chan and Merriman, 2013), gentle teaching or natural therapeutic holding (Stirling, 1998), Good Lives Model – which is very similar to a strengths based approach (Sustere and Tarpey, 2019), recovery-focused care (Barr, Wynaden and Heslop, 2019), Positive Alternatives to Restraint and Seclusion or PARS (Wisdom et al., 2015).

Organisational change is necessary to the reduction, minimization and elimination of restrictive practices. This requires a commitment to strong systems level oversight with clear policies governing restrictive practices, ongoing observations, staff training and reflection (Williams and Grossett, 2011). Policies and practices should be data informed and regularly reviewed to accurately reflect the experiences of individuals and allow for planned contingencies. Larue et al. (2018) and Wisdom et al. (2015) in particular highlight the factors that contribute to the reduction in seclusion and restraint. It was identified that a cohesive staff cohort, positive organizational culture, capacity and time for reflection and de-briefing, personalized relational interventions in care plan and trusting relationships between individuals and staff were contributors to the reduction in restrictive practices. Training that fosters a deeper understanding of behaviours, risks, understanding trauma, sensory modulation, and individualised calming plans were

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Disability Services
Community Operations
Health Service Executive
Upper Park Road
Killarney Co. Kerry V93CH69
Email: disabilitiesqi@hse.ie

also important interventions. This is supported by Webber, Richardson and Lambrick's (2014) study which suggests the importance of a positive organizational culture that does not condone seclusion results in less restraint. They also highlight that staff should acknowledge power imbalances of the relationship between the individual and staff, especially when restrictive practices are used.

3.3.2 Are the results applicable to the population group?
The evidence used to develop this Guiding Principle relates specifically to the use of restrictive practices for adults with disabilities.

3.4 FORMULATION OF RECOMMENDATIONS

3.4.1 What are the recommendations?
The set of Guiding Principles are attached as a separate document.
3.4.2 Describe the methods used to formulate the recommendations and how final decisions were reached. Specify any areas of disagreement and the methods used to resolve them:
Recommendations were drafted by members of the working group and discussed with stakeholders.

3.5 CONSIDERATION OF BENEFITS AND HARMS

Report the benefits, side effects, and risks that were considered when formulating the recommendations: (may not be required)

3.6 EXTERNAL REVIEW

Report the methodology used to conduct the external review: (discussion points only)
This set of Guiding Principles will be reviewed by the National HSE Guiding Principles Group (chaired by Marie Kehoe-O'Sullivan)

3.7 COMPETING INTERESTS

Confirmation that full group has completed a Declaration of Interest form: ***Yes****/ No*

Any other information to bring to the attention of the Subgroup:

For Further Discussion and Consideration: .

- Meeting with HIQA and DoH to influence terminology changes in no. 6 of the Schedule V policies "the use of restrictive procedures and physical, chemical and environmental restraint
- Need for training of staff and regulatory inspectors

Signed: Marie Kehoe-O'Sullivan Date: July 9th, 2021
Lead for Working Group

Office of the National Quality Improvement Office
Disability Services
Community Operations
Health Service Executive
Upper Park Road
Killarney Co. Kerry V93CH69
Email: disabilitiesqi@hse.ie

APPENDIX IV – EXAMPLES OF RELEVANT LEGISLATION, POLICIES AND RESEARCH

- United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)
- European Commission for Human Rights (ECHR).
- Assisted Decision Making Act (ADM)
- Health Act 2007
- HSE relevant policies, for example, Equality and Human Rights; Safeguarding Policy, Open Disclosure, National Consent Policy etc.
- Time to Move on from Congregated Settings: A Strategy for Community Inclusion
- New Directions Personal Support Services for Adults with Disabilities
- Guidance documents from HSE National Quality Improvement Office, HSE Disability Operations; for example behavioural support etc.
- National Standards for Residential Services for Children and Adults with Disabilities
- Guidance on Promoting a care environment that is free from a restriction practice (HIQA) March 2019
- Towards a Restraint Free Environment in Nursing Homes, Department of Health, published at: 10 March 2011, Last updated 12 July 2019
- Policy on the use of physical restraints in designated residential care units for older people 2010 HSE
- Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities)
- Health Information and Quality Authority – Guidance for Designated Centres – Restraint Procedures
- Health Service Executive – Policy on the Use of Physical Restraints in Designated Residential Care Units for Older People
- Association of Occupational Therapists of Ireland – Best Practice Guidelines for Occupational Therapists: A restriction Practices and People with Intellectual Disabilities
- Irish Nurses Organisation – Guidelines on the Use of Restraint in the Care of the Older Person
- Self-Assessment Questionnaire – A restriction Practice Thematic Programme (March 2019)
- A restriction Practice Thematic Programme Quality Improvement Plan (March 2019)
- Assessment Judgement Framework for Thematic Inspections of A restriction Practices (March 2019)

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Community Operations
Health Service Executive
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Killarney Co. Kerry V93CH69
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- National Standards for Residential Care Settings for Older People in Ireland, 2016.
- Guidance on a Human Rights-based Approach in Health and Social Care Services HIQA, Safeguarding Ireland
- Guidance for Designated centres A restriction Procedures November 2013 HIQA
- Assisted Decision Making (Capacity) Act (2015). Note: Guidance from the Decision Support Service is awaited regarding how and when this act will be fully implemented. This policy will be reviewed at that point to take account of any relevant changes in policy and procedure required.
- Committee on the Rights of the Child, 2007, re UN Convention on the rights of the child, Art 37a

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Community Operations
Health Service Executive
Upper Park Road
Killarney Co. Kerry V93CH69
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APPENDIX V: Commonly noted areas of concern of imminent risk of harm and the Relevant Health Care Professionals who can assist

Area of Concern of Imminent Risk of Harm	Postural and Mobility	Medical	Access	Emotional & Behavioural support needs
Examples of what might need to be supported:	Falling when; Sitting, walking, sleeping, standing, bending, steps, running,	Medical intervention/support that is seen as essential: Routine medical procedures (phlebotomy) Drop seizures; Post-surgery care; medical intervention (catheter for example); Mental health needs; swallowing/ eating; diet; breathing	Access to; Household harmful items/substances; cleaning supplies/knives/window openings/doors opening to outdoors; rooms/ offices; to personal items (e.g. mobile phone/money)	Harm to self/others; Emotional Distress
Health care professionals with expertise in these areas are (with Interdisciplinary working recommended.)	Occupational Therapist Physical Therapist Behaviour Support practitioner (e.g. Psychologist, Behaviour Specialist, CNS in Behaviour)	GP, Consultant Nurse, Speech and Language Therapist, Physical Therapist, Psychiatry/MHID team Behaviour Support practitioner	Occupational Therapist Behaviour Support practitioner	Behaviour Support practitioner Psychology (therapies); Psychiatry/MHID team OT, Social Care, Nurse, Social Worker

Note: remember a minimum of 2 healthcare professionals should always be involved in providing care and support to an individual presenting with an area of concern of imminent risk of harm where a restriction is being considered as part of their care and support.

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Community Operations
Health Service Executive
Upper Park Road
Killarney Co. Kerry V93CH69
Email: disabilitiesqi@hse.ie

APPENDIX VI - UNCRPD

Articles of the United Nations Convention on the Rights of Persons with Disabilities

1. Purpose
2. Definitions
3. General principles
4. General obligations
5. Equality and non-discrimination
6. Women with disabilities
7. Children with disabilities
8. Awareness-raising
9. Accessibility
10. Right to life
11. Situations of risk and humanitarian emergencies
12. Equal recognition before the law
13. Access to justice
14. Liberty and security of person
15. Freedom of torture or cruel, inhuman or degrading treatment or punishment
16. Freedom from exploitation, violence and abuse
17. Protecting the integrity of the person
18. Liberty of movement and nationality
19. Living independently and being included in the community
20. Personal mobility
21. Freedom of expression and opinion, and access to information
22. Respect for privacy
23. Respect for home and the family
24. Education
25. Health
26. Habilitation and rehabilitation
27. Work and employment
28. Adequate standard of living and social protection
29. Participation in political and public life
30. Participation in cultural life, recreation, leisure and sport
31. Statistics and data collection
32. International cooperation
33. National implementation and monitoring
34. Committee on the Rights on Persons with Disabilities
35. Reports by State Parties
36. Consideration of reports
37. Cooperation between States Parties and the Committee
38. Relationship of the Committee with other bodies
39. Report of the Committee
40. Conference of States Parties
41. Depositary
42. Signature
43. Consent to be bound
44. Regional integration organizations
45. Entry into force
46. Reservations
47. Amendments
48. Denunciation
49. Accessible format
50. Authentic texts

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Health Service Executive
Upper Park Road
Killarney Co. Kerry V93CH69
Email: disabilitiesqi@hse.ie

Office of the National Quality Improvement Office
Disability Services
Community Operations
Health Service Executive
Upper Park Road
Killarney Co. Kerry V93CH69
Email: disabilitiesqi@hse.ie

APPENDIX VII – Sample of National and International Definitions

Meanings of Terms associated with Restrictions					
Term	**Meaning/Notes**	**Definition**	**Reference**	**Examples**	**Human Rights**
Restriction	An umbrella term for any act or inaction that restricts a person's free movement; some of which are listed here. May also be called restraint or restrictive practice.	A restriction is any practice, strategy, intervention, inaction that has the effect of limiting, controlling, monitoring, preventing, impeding the movement, rights and/or freedom of a person to act voluntarily.	Adapted from the Australian Government (2014). National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.	Physical Mechanical Medication Environmental Psycho-Social Human Rights	Restrictions impact on Human Rights as outlined in the Convention on the Rights of Persons with Disabilities. (UNCRPD)
Medication used as a restriction	Terminology referring to medication as 'chemicals' is stigmatising as this term is not used when applied to the general population. Referring to medication as such implies that it is somehow different when taken by a person with an intellectual disability, further deepening discrimination. It may even insinuate that their symptoms are not genuine or that distress deserves punishment or subjugation rather than healing. The use of medication for disciplinary or staff convenience is never acceptable as it infringes an individual's rights. The use of medication to treat an underlying condition, enable treatment is not a restriction.	The use of medication to control or modify an individual's behaviour when no medically identified conditions are being treated, or where the treatment is not necessary for the condition or the intended effect of the drug is to sedate the individual for convenience or disciplinary purposes.	https://www.hiqa.ie/sites/default/files/2017-01/Guidance-on-restraint-procedures.pdf	Use of psychotropic medications in the absence of a mental health diagnosis; The over-medication or misuse of medication The long term use of medication without a review to reduce the use of medication for the purposes of behaviour management Libido or menstruation suppression	

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Physical Restriction	The use of direct physical force applied by a person to restrict movement of another person. Prone restraint is a high risk physical restriction and should not be used in Services for Disability or the Elderly.	"Physical restraint refers to any direct physical contact where the intention is to prevent, restrict or subdue movement of the body (or part of the body) of another person"	The Mental Act Code of Practice, Department of Health, 2015, p. 295).	Physical holds; Disengagements Clinical holds	
Mechanical Restriction	The use of a device, piece of equipment or item placed on or adjacent to a person to limit, control, impede, prevent a person's movement. It does not include the use of devices for therapeutic purposes. For example, purposes may include the use of a device to assist a person with functional activities, as part of occupational therapy, or to allow for safe transportation. However if these items are not used as prescribed they could constitute a mechanical restriction. For example putting the brakes on a person's wheelchair to prevent them from self-propelling.	The use of a mechanical device, material or equipment attached or adjacent to an individual's body that the individual cannot easily remove that restricts their freedom of movement or normal access to their body. Ref.?		E.g. Hoists; Lap belts; Cot sides; Wheelchairs; Angel guards; Bumpers/ wedges; Ankle/hip/ Wrist guards; Deep seated chairs; E.g. Helmets Splints; arm/wrist cuffs;	
Environmental Restriction	The use of physical barriers to prevent, limit, control a person's access, movement and choice.	'is any action or inaction that restricts a person's free access to all parts of their environment, including items and activities. as in, preventing, limiting or controlling a person's use of their environment, to include the items in it, activities available to them and the spaces inside and outside this same environment.	https://www.facs.nsw.gov.au/__data/assets/pdf_file/0010/636949/Restrictive-Practices-Resources-environmental-restraint-guidance.pdf https://restraintreductionnetwork.org/wp-content/uploads/2016/11/A-national-	Locked doors, locked cupboards, locked rooms, locked fridges, items out of reach, access to personal items controlled e.g. mobile phone, cigarettes, alcohol, monitoring/tracking devices – GPS, sensor alarms/pads,	

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			measure-of-environmental-restraint-final-report-20-June-2019.pdf	CCTV, clothing,	
Psycho-Social Restriction	The use of verbal interactions which might reasonably be construed by the person to whom they are directed as intimidating or potentially abusive and/or threats of social or other sanctions which rely on eliciting fear to control, prevent, limit or impede a person's actions.	Psycho-social restraint is the use of "power-control" strategies, where one person exerts control over another, using verbal or non-verbal means.	Adapted from the Office of the Senior Practitioner (OSP) State of Victoria NSW Australia	Told not to move or to speak; to sit down; treating adults like they are children.	
Civic Restriction	The absence of support to enable a person to exercise, access and realise their civic duties and responsibilities on an equal basis with others.			Restrictions in voting, religious activities; independent advocacy; finances restrictions in institutional care Impeding rights to Legal representation; housing ; individualised budgets/ appropriate funding	
Human Rights Restrictions	Action or inaction resulting in an individual's ability to exercise a human right, for example, overly risk-averse, for example prevents a person from partaking in an activity that might involve a level of risk. For example, night clubbing; canoeing; having a relationship, drinking alcohol etc. or in-active in honoring and upholding an				

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	individual's human rights. For example, right to religious expression; right to marry, right to privacy;				
Seclusion	Seclusion has a legal definition under the Mental Health Act (2001). It is prohibited in services for Disability and the Elderly. Seclusion means the sole confinement of a person with a disability in a room or physical space at any hour of the day or night where voluntary exit is prevented. This would fall under environmental restrictions although it is often referred to euphemistically as "time out" rather than seclusion in disability services.	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." (Mental Health Act, 2001)	Mental Health Commission Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint https://www.mhcirl.ie/File/Revised_Rules_SecMR.pdf		
Safeguarding	Safeguarding refers to structures, processes and procedures put in place by a service to ensure individuals' supported are free from abuse and harm.	'All adults have a right to be safe and to live a life free from abuse. Safeguarding means putting measures in place to promote and protect people's human rights and their health and well-being while empowering people to protect themselves. It is fundamental to high-quality health and social care.' HSE 2019.	HSE Adult Safeguarding Policy 2019 (Draft). This policy will be implemented in line with the future health sector wide policy produced by the Department of Health. The HSE policy has been developed aligned to the principles of the National Standards for Adult Safeguarding[6]	Restrictions outlined above may meet the safeguarding definition; for example; limiting access to person's own finances; controlled access to the kitchen; prevented from having a mobile phone; bedtime assigned; Safeguarding HSE 2019	