ANNUAL REPORT 2024

Department of Psychiatry, Portlaoise - Oversight and Review Committee for the Reduction of Seclusion and Physical & Enduring Mechanical Restraint

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Annual Report of the Department of Psychiatry, Portlaoise Multidisciplinary Review and Oversight Committee

January 2024 - December 2024

1.0 – Foreword

The Oversight and Review Committee for the Reduction of Seclusion and Physical and Enduring Mechanical Restraint are pleased to publish this second annual report. Since we commenced as an Oversight Committee in March 2023, we have undertaken a significant amount of work to include the following:

The Committee undertook a number of key tasks that included:

- Ongoing review and development of Terms of Reference of the Committee. Reviewed on 30th. July 2024 (Appendix 1)
- DOPP Reduction of Restrictive Practices Policy, March 2023, reviews on 14th. September 2024 (Appendix 2)
- Use of Physical Restraint Policy, 2024 (Appendix 3)
- Seclusion policy, published on 8th. February 2024 (Appendix 4)
- Policy of the Use of Mechanical Means of Bodily Restraint for Immediate Threat of Serious Harm to Self and Others, Approved February 2024 (Appendix 5)
- Review of each episode of Seclusion and Physical & Enduring Mechanical Restraint – monthly reviews.
- Organised and informed training to assist staff in the avoidance of and reduction in the need for Seclusion and Restraint

The aim of the committee over the year was to reduce the instances and need for the use of Seclusion or Restraint where possible. The Committee and all the staff at the Dept of Psychiatry collectively sought to achieve this through a continued recovery focused, trauma informed and human rights based approach to patient care. There was however an increase in the use of Physical Restraint from 36 episodes in 2023 (30 patients) to 55 in 2024 (36 patients). All episodes were audited with a 99% compliance rate with the Code of Practice on the use of Physical Restraint. There was also an increase in the use of Seclusion from 27 episodes in 2023 to 37 episodes in 2024. All episodes were audited with a 98% compliance rate with the Rules on the Use of Seclusion. The Committee and all the staff will continue to strive to reduce these figures to optimise patient outcomes.

This annual report has been accepted by:

Claire Donnelly, Registered Proprietor Nominee

2.0 - Background

The Dept of Psychiatry, Portlaoise Oversight and Review Committee for the reduction of Seclusion and Physical & Enduring Mechanical Restraint was set up in March 2023 pursuant to requirements of the Mental Health Act 2001-2018, September 2022.

This Approved Centre provides in-patient treatment for people suffering from mental illness. It comprises of a male and a female ward which can accommodate a combined total of 46 patients at any one time.

From January 1st 2024 to December 31st 2024, there were a total number of 661 admissions to the Approved Centre. There were 32 in-patients already on the unit on January 1st 2024.

This report is based on the following meetings of the Committee held on:

- Thursday 11th. January 2024
- Thursday 8th. February 2024
- Thursday 13th. March 2024
- Thursday 11th. April 2024
- Thursday 9th. May 2024
- Thursday 13th. June 2024
- Thursday 11th. July 2024
- Thursday 8th. August 2024
- No meeting in September 2024
- Thursday 10th. October 2024
- Thursday 14th. November 2024
- Thursday 12th. December 2024
- Thursday 9th. January 2025 (reviewed episodes of restraint and seclusion episodes during the month of December 2024)

3.0 – Committee Membership

Dr. Maurice Gervin, Executive Clinical Director/Professor Henry O' Connell, Consultant Psychiatrist

Tracy Quigley, A/DON

Roisin Fitzpatrick, CNM3

Helen Hanlon, Principal Social Worker (Chairperson)

Deirdre O'Connor, Mental Health Act Administrator (Minute taker)

Alex Anagnostaras, Senior Clinical Psychologist

Dr. Azmi, Medical Representative

Shaista Zaidi, Occupational Therapy Manager

Con Bourke, Nurse Practice Development Coordinator

4.0 – Relevant Documentation

- MHC Rules Governing the Use of Seclusion issued Pursuant to Section 69(2) of the Mental Health Act 2001 – 2018, September 2022
- MHC Code of Practice on the Use of Physical Restraint – Issued Pursuant to Section 33(3)(e) of the Mental Health Act 2001 – 2018, September 2022
- MHC Rules governing the use of Mechanical Means of Bodily Restraint – Issued Pursuant to Section 33(3)(e) of the Mental Health Act 2001 – 2018, September 2022

5.0 – Work of the Committee

The Committee undertook a number of key tasks that included:

- Ongoing review and development of Terms of Reference of the Committee. Reviewed on 30th. July 2024 (Appendix 1)
- DOPP Reduction of Restrictive Practices Policy, March 2023, reviewed on 14th. September 2024
- Use of Physical Restraint Policy, 2024
- Seclusion policy, updated on 8th. February 2024
- Policy of the Use of Mechanical Means of Bodily Restraint from Immediate Threat of Serious Harm to Self and Others, Approved February 2024.
- Review of each episode of Seclusion and Physical & Enduring Mechanical Restraint.
- Organised and informed training to assist staff in the avoidance of and reduction in the need for Seclusion and Restraint

6.0 – Review of Episodes of Enduring Mechanical Restraint (EMR) 2024

There were fewer than, or equal to, 5 episodes of Enduring Mechanical Restraint in use during 2024. Episodes of EMR were audited and deemed to be fully compliant with the revised Rules governing the use of Mechanical means of Bodily Restraint (Sept 2023). Each EMR was only used to address an identified need or risk and was only used when less restrictive measures were deemed unsuitable. A risk assessment of the safety and suitability of the mechanical restraint had been undertaken by the MDT and this specified the monitoring arrangements and frequency to be implemented during its use. A record of the monitoring arrangements was maintained in the clinical file. The episodes had been ordered by the treating Consultant Psychiatrist and were in use for the shortest possible timeframe.

7.0 – Review of Episodes of Seclusion - January – December 2024

Table 1. Breakdown of seclusion episodes in DOPP 2024

	Seclusion episodes 2024												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD total
No. of episodes	2	3	2	0	10	1	3	2	1	4	6	3	37
No. of Service Users secluded	2	3	2	0	8	1	3	2	1	1	3	3	29
No. of MDT reviews – within two days and five days	1	3	2	0	10	1	3	2	1	3	6	3	35
No. requiring renewals	2	3	2	0	6	0	3	2	1	4	6	3	32
No. notified to MHC	0	1	0	0	0	0	0	0	0	1	2	0	4
No. where refractory clothing was used	0	0	0	0	0	0	0	0	0	0	0	1	1
Any actions													

7.1 - Audit Findings for Seclusion:

In total, there were 37 episodes of seclusion involving 29 service users in 2024, up 10 on the 27 episodes of Seclusion in the DOPP in 2023. The shortest episode of Seclusion in 2024 was 2 hours and the longest episode of Seclusion was 112 hours. Compliance with Rules on the Use of Seclusion was on average 99%.

In relation to the 1% non-compliance the issues highlighted were as follows:

- The patient did not receive a MDT debrief following the episode of Seclusion within 2 working days.
- There were not 3 members of the MDT present for the 2 day debrief.
- The patient did not receive a MDT debrief following the episode of Seclusion within 5 working days.
- Patient had not signed the 5 day patient debrief or no reason given for same.
- Not all 3 members of the MDT were present for the 5 day debrief.

These issues have been addressed with the relevant clinical teams

Initiatives that may have contributed towards this reduction are

1. Changes to the environment were implemented over the reporting period in order to create a low stimulus environment. Further developments are planned to create a specific space that patients can use to self-regulate emotional distress and experience wellbeing. The use of this space will be incorporated into the enhanced learning that will be provided in the area of Reducing Restrictive Practices.
2. We have enhanced our learning by providing extra training in the area of reducing Restrictive Practices.
3. Culture change following introduction of new Rules and Codes by The Mental Health Commission.
4. Introduction of de-escalation boxes on both units.
5. Changes in who can initiate seclusion to most senior person.

7.2 - Learning:

1. Regardless of whether the patient is not available or declines to engage, the MDT meeting must still take place within 5 working days of the episode.

Action: Regardless whether the patient is not available or declines to engage, the MDT meeting must still take place within 5 working days of the episode.

2. Additional training to be put in place to support staff on issues relating to compliance.

Action: Four training dates in 2023 were provided on the revised Rules and Code of Practice. This will continue through 2024 with 5 further dates scheduled. Audit findings will be presented at Doctors training and across all nursing shift patterns.

8.0 – Review of Episodes of Physical Restraint January – December 2024:

Table 1. Breakdown of Physical Restraint episodes in DOPP 2024

Episodes of Physical Restraint 2024													
	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD total
No of episodes	7	5	3	0	11	1	3	2	5	4	10	4	55
No of Service Users involved	2	4	3	0	7	1	2	2	4	1	6	4	36

No of MDT reviews - within 2Days and Five Days	2	5	3	0	11	1	3	2	5	3	10	4	49

8.1 - Audit Findings for Physical Restraint:

There were 55 episodes of Physical Restraint during 2024 involving 36 service users.

(Table 2). This was 37.04% increase compared with 2023. Since Physical Restraint is often necessary to initiate seclusion, the frequency graph for restraint fluctuates per month over the two years in a manner similar to that for seclusion.

During 2024, the longest episode of physical restraint was 10 minutes and the shortest was for 1 minute. Compliance, on average, was 99%, Resultant learning and actions are detailed below.

The audit findings demonstrated the following:

- There were not 3 members of the MDT present at both the 3 & 5 day patient debriefs.
- The 2 & the 5 day MDT debriefs did not happen within the required timeframe.
- The Clinical Practice form was not signed by the consultant within 24hrs of the restraint episode.

8.2 - Learning:

Regardless of whether the patient is not available or declines to engage, the MDT meeting must still take place within 5 working days of the episode.

Action: Regardless whether the patient is not available or declines to engage, the MDT meeting must still take place within 5 working days of the episode.

Additional training has been put in place to support staff on issues relating to compliance to include

1. Recognising their personal responsibility in being responsive, compassionate and in providing support when people need it based on the person's free and informed consent.
2. Considerations to how staff can engage with patients in a way that avoids conflict. The Safewards Model (Bowers, 2014) is currently being implemented across both male and female wards.
3. Strengthening the understanding, use and monitoring of the 'least restrictive' principle and identify control measures that can ensure this principle is upheld.

4. Strengthening practices and de-briefings around intrusive practices particularly where staff are required to be present when patients are tending to personal care and in these circumstances that the measures applied are also subjected to the 'least restrictive' principle.
5. Alternatives to Restrictive Practice being actively considered and implemented such as Positive Behaviour Support/including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic factors.
6. Environmental triggers and changes to physical environment & less restrictive environment
7. Comfort Rooms being designed currently
8. Care Culture
9. Conflict Resolution
10. De-escalation
11. Debrief/Diffuse
12. Implementation of Safewards Messaging
13. Individualised plans to explore sensitivities and signs of distress
14. Creating a "saying yes" and "can-do" culture

Action: Four training dates in 2023 were provided on the revised Rules and Code of Practice. This will continue through 2024 with a further 5 dates scheduled. Audit findings will be presented at Doctors training and across all nursing shift patterns.

9.0 - Conclusion

On behalf of the Dept of Psychiatry, Portlaoise Oversight and Review Committee for the Reduction of Seclusion and Physical and Enduring Mechanical Restraint, I am pleased to publish our Annual Report for 2024.

I want to acknowledge the significant work undertaken by the Committee over the past two years in establishing the Terms of Reference for the group, policies to reduce the use of Seclusion and Physical & Enduring Mechanical Restraint, documentation and tools for recording episodes and reviewing all episodes of Seclusion, Physical Restraint and Enduring Mechanical Restraint.

This work highlighted a number of areas for improvement around the recording and review of episodes, continuous staff training, and the development of a Quiet Space and the introduction of bean bags & comfort boxes.

The data gathered by the audits and review show that, overall, there was an ?% increase in the use of Physical Restraints from 2023- 2024 (58.4% from 2021) and a ??% increase in the use of Seclusions from 2023 to 2024 (32.81% from 2021).

Helen Hanlon, Chairperson

10.0 Appendices

Appendix 1: Oversight and Review Committee for the Reduction of Physical Restraint/ Seclusion

TITLE: **Oversight and Review Committee for the Reduction of Physical Restraint/ Seclusion TOR**	**REFERENCE NO:**
AUTHOR: Oversight and Review Committee for the Reduction of Physical Restraint/ Seclusion	**REVISION NO:** 1
APPROVED BY: Laois/Offaly Senior Management Team	**DATE APPROVED: 31/07/2023**
REVIEW DATE: 30/07/2024	**Page** 10 of 178

Oversight and Review Committee for the Reduction of Physical Restraint/ Seclusion

Dept of Psychiatry in Portlaoise

Terms of Reference

1. Purpose

The purpose of the Oversight and Review Committee for the Reduction of Physical Restraint/ Seclusion at the Admissions Unit, Dept of Psychiatry in Portlaoise is to monitor and analyse every episode of physical restraint and seclusion in the centre and to provide assurance to the Registered Proprietor of the adherence to the Code of Practice on the Use of Physical Restraint (2022) and the Rules of Seclusion (2022).

2. Aim

The overall aim is to examine the use of physical restraint and seclusion in the unit, and to provide assurance that each episode complies with the Code of Practice/ Rules. In addition to this, the aim is to reduce the use of physical restraint and seclusion in the approved centre.

3. Governance

The Oversight and Review Committee for the Reduction of Physical Restraint is accountable to the Registered Proprietor's Nominee or Senior Manager who, in turn is accountable to the Registered Proprietor in respect of the actions of the committee.

Reports of the committee will be presented at the Laois/Offaly Senior Management Meeting on a monthly basis.

4. Objectives of the Committee

a) Develop and implement a reduction policy for the Approved Centre

b) For each episode of Physical Restraint:

- Determine if there was compliance with the code of practice on the use of physical restraint for each episode of physical restraint reviewed
- Determine if there was compliance with the approved centre's own policies and procedures relating to physical restraint.
- Identify and document any areas for improvement.
- Identify the actions, the persons responsible, and the timeframes for completion of any actions;
- Provide assurance to the Registered Proprietor Nominee that each use of physical restraint was in accordance with the Mental Health Commission's Code of Practice

c) For each episode of seclusion:

- Determine if there was compliance with the rules governing the use of seclusion for each episode of seclusion reviewed
- Determine if there was compliance with the approved centre's own policies and procedures relating to seclusion
- Identify and document any areas for improvement
- Identify the actions, the persons responsible, and the timeframes for completion of any actions
- Provide assurance to the Registered Proprietor Nominee that each use of seclusion was in accordance with the Mental Health Commission's Rules

d) Compile an annual report on the use of physical restraint and seclusion in the Approved Centre to contain:

- Aggregate data that should not identify any individuals;
- A statement about the effectiveness of the approved centre's actions to eliminate, where possible, and reduce physical restraint and seclusion
- A statement about the approved centre's compliance with the code of practice on the use of physical restraint and rules governing seclusion
- A statement about the compliance with the approved centre's own reduction policy
- The data as specified in Appendix 3 of the Code of Practice and the Rules governing Seclusion

5. Membership

Membership of the Oversight and Review Committee for the Reduction of Physical Restraint/ Seclusion:

- Registered Proprietor's Nominee/ Senior Manager - Helen Hanlon
- Consultant Psychiatrist x 1 – Dr. Gervin, ECD or his designate
- Assistant Director of Nursing, DOPP or designate – Tracey Quigley
- Clinical Nurse Manager 3, DOPP or designate– Roisin Fitzpatrick
- Clinical Nurse Manager 2, DOPP (when available)
- Staff Nurse, DOPP (when available)

- NCHD – Dr. Asmi Khalid
- Occupational Therapy Manager, Mental Health, Midlands or their nominee – Shaista Zaidi
- Principal Psychologist, Laois/Offaly or their nominee – Alex Anagnostaras
- Principal Social Worker Adult Mental Health Services, Laois, Offaly, Longford, Westmeath or their nominee – Helen Hanlon
- Mental Health Act Administrator, Laois/Offaly – Deirdre O' Connor
- Nurse Practice Development Co-Ordinator (Mental Health), HSE - Con Bourke
- QPS Advisor will be invited when new person is in post

6. **Ground Rules for Meetings**

- The committee will meet quarterly at a minimum to fulfill the Code of Practice on the Use of Physical Restraint and Rules governing Seclusion. In practice, it is envisaged that the committee will meet monthly – second Thursday of the month at 11am.
- The chair will be selected from within the membership and will be rotated
- Quorum equates to 50% of the membership plus 1.

7. **Agenda**

- The agenda will be prepared in advance by the chair and with the assistance of the MHAA.

- To include:

    - Approval and adoption of last meetings minutes
    - Review of each episode of restraint and seclusion since the last meeting
    - Trends analysis
    - Quality improvement
    - Additional training needs
    - Additional service needs

8. Review

- Terms of reference will be reviewed annually or more frequently if required and approved by the Laois/Offaly Senior Management Team

Appendix 2: Dept of Psychiatry Portlaoise- Reduction of Restrictive Practices Policy, March 2023

Laois/Offaly Mental Health Services

Dept of Psychiatry, Portlaoise, Co. Laois

Policy Title: Reduction of Restrictive Practices Policy

Document reference number	Draft	**Document developed by**	DOPP Oversight and Review Committee for the Reduction of Physical Restraint, Seclusion and Enduring Mechanical Restraint
Revision number	1	**Document approved by**	DOPP Approved Centre Governance Group
Approval date	14/9/2023	**Responsibility for implementation**	Designated ADON's, CNM's, Consultant Psychiatrist, NCHD's
Revision date	14/9/2024	**Responsibility for review and audit**	DOPP Oversight and Review Committee for the Reduction of Physical Restraint, Seclusion and Enduring Mechanical Restraint

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1.0 Policy Statement:

"Following on from a review in 2009, this document represents the second substantial review and update of the Rules.

There have been significant and progressive developments in mental health care in the intervening years.

International developments around human rights, the advancement of person-centred care, and evidence demonstrating that restrictive practices can have harmful physical and psychological consequences, have changed how these practices are viewed.

This policy document is informed by these developments and, in particular, emphasises the need for services to adopt a rights-based approach to mental health care. In particular this policy is informed by two key documents:

1. *The RCSI Research conducted by Dr. Christine Larkin (2022) also informed the MHC issued Code of Practice on the use of Physical Restraint and the rules governing seclusion and mechanical means of bodily restraint in inpatient Mental Health Services.*

2. *The WHO QualityRights initiative: building partnerships among psychiatrists, people with lived experience and other key stakeholders to improve the quality of mental healthcare.*

These Rules are being issued following an extensive stakeholder engagement process and consideration of national and international evidence and best practice.

The Mental Health Commission consulted with people who have experienced restrictive practices, as well as staff and clinicians in mental health services. (Copies of the Consultation Report and Evidence Review are available on the Mental Health Commission's website.)

The Mental Health Commission considers that these Rules will encourage continual efforts to avoid, reduce and, where possible, eliminate restrictive practices.

Each service provider will be required to demonstrate how they are achieving this.

The Rules emphasise the importance of strong governance and oversight mechanisms as key to successful reduction and elimination strategies.

Although the Rules aim to direct and inform practice, they do not purport to be all-encompassing and providers of mental health services have a duty to ensure that they regularly review and update policy and practice in this area.

The date of commencement of these Rules is 1 January 2023, following which, the Inspector of Mental Health Services will begin assessing compliance with the revised Rules.

The Mental Health Commission shall review these Rules as required in terms of any relevant case law and/or amending legislation, but no later than five years from the date of commencement of these Rules.

The preamble provides an explanation and context to the Rules Governing the Use of Seclusion. It is not part of the Rules."

This policy has been developed in line with the Revised Rules Governing the Use of Seclusion and Mechanical Restraint (as they apply to use of cot sides in the Maryborough Centre) (September 2022) and Code of Practice on the Use of Physical Restraint (September 2022), enacted January 1st 2023. Mechanical Means of Bodily Restraint are not used in the DOPP Approved Centre and there is limited use of cot sides in the Maryborough Centre.

2.0 Purpose

Following the initial review the service has revised the local Policies on Seclusion and Enduring Mechanical & Physical Restraint in line with these revisions and devised Seclusion and Enduring Mechanical & Physical Restraint documentation and Registers in line with the revisions. We will also modify our Seclusion Care Plan (SCP) in line with the revisions. We will develop a proforma for debriefing post Seclusion and Enduring Mechanical & Physical Restraint and for the Multidisciplinary (MDT) review to ensure that all the required components are captured. We will devise a flow diagram for behavioural analysis and Positive Behavioural Support Plans.

3.0 Scope

All members of the Multi-Disciplinary Team

4.0 Glossary of Terms and Definitions

- **SCP:** Seclusion Care Plan
- **MDT:** Multi-Disciplinary Team
- **RP:** Registered Proprietor
- **CD:** Clinical Director
- **Area DON:** Area Director of Nursing
- **ADON:** Assistant Director of Nursing
- **CNM 3:** Clinical Nurse Manager 3
- **QQS:** Quality and Patient Safety
- **ORC:** Oversight and Review Committee

5.0 Roles and Responsibilities

5.1 It is the responsibility of all staff to adhere to this Policy.

5.2 It is the responsibility of the ORC to ensure that this policy is reviewed triennially or at any time if there is a change of practice.

5.3 It is the responsibility of individual line managers to ensure that all staff in their Department are aware of this policy and that work practices are in line with the policy.

5.4 All staff must demonstrate that they have read and have understand the processes of this policy by signing the signature log attached to the front of the Policies and Procedures Manual.

6.0 Procedure

A Multidisciplinary Oversight Committee has been established to analyse in detail every episode of seclusion and physical restraint. The committee is meeting monthly to fulfil the functions as outlined in the revisions:

i. Determine if there was compliance with the rules governing the use of seclusion and physical restraint for each episode of seclusion and enduring mechanical & physical restraint reviewed;

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

iii. Identify and document any areas for improvement;

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

v. provide assurance to the RP (or their nominee) that each use of seclusion and enduring mechanical & physical restraint was in accordance with the Mental Health Commission's Rules;

The Committee is also overseeing the formulation of this Reduction Policy.

Given that "The Rules emphasise the importance of strong governance and oversight mechanisms as key to successful reduction and elimination strategies", we have strong governance and oversight of Restrictive Practices in the current governance structure in addition to this Oversight Committee;

1. We will explore having weekly reports on use of restrictive practices (including searches, restraint and seclusion) to the CD, Area DON and RP to ensure regular feedback and oversight and early capture of any changes in trends.

2. The Nursing Management Team, ADON and CNM 3 are located in the approved centre to ensure strong governance within the centre. All episodes of seclusion are reviewed with ward staff by the ADON on duty on a daily basis.

3. Audits of each episode of Restrictive Practices are included in the QPS report and are presented monthly to the Laois/Offaly Senior Management Team and the DOPP Approved Centre Governance Group. They are also now presented monthly to the DOPP Oversight Committee and there is a full review of each episode in detail as per the revised Rules and Code of Practice is conducted.

4. We will provide comfort boxes for use by service users who may be triggered or experiencing trauma in an attempt to de-escalate and prevent aggressive incidents occurring.
5. Each episode of seclusion and restraint, the patient debriefing and the follow on MDT meetings is audited and presented at the DOPP Oversight Committee and feedback is sent to the clinical team where indicated.

A key aspect of the reduction strategy will be the learning emerging from the positive behavioural support plans which includes analysis of underlying precipitants or causes leading to episodes and alternative strategies that can be deployed to avoid future episodes. There will also be a focus on more generalised strategies that emerge from trend analysis of episodes by the DOPP Oversight Committee and insights and evidence based strategies emerging from the Restrictive Practice Group. Learning will be disseminated through the educational channels described above and effects monitored by the continuous audit cycle.

7.0 Training

All staff involved in Seclusion and Physical Restraint will participate in the following training:

- Mental Health Act 2001- HSELanD
- Changes to the Rules and Code of Practice on Restrictive Practices - HSELanD
- Changes to Rules on Seclusion - HSELanD
- Changes to Code of Practice on Physical Restraint - HSELanD

- Changes to the Rules on Mechanical Restraint - HSELanD
- Therapeutic Management of Violence and Aggression (TMVA)
- Management of Actual or Potential Aggression (MAPA)
- Training on Revision to the Rules and Codes of Practice relating to Seclusion, Physical Restrain and Mechanical Restraint, covering Human Rights, Legal Principles, Trauma Informed Care, Alternatives to restrictive practices, early indicators and triggers, Cultural Competence – provided in person by External Trainer Ms. Amelia Cox)

8.0 Method used to review operation of Standard Operating Procedures

DOPP Oversight and Review Committee for the reduction of physical restraint/seclusion/enduring mechanical restraint

9.0 Frequency of Review

Review at each meeting

Appendix 3: Dept of Psychiatry, Portlaoise- Use of Physical Restraint Policy

Policy Title: Use of Physical Restraint

Department of Psychiatry, Laois/ Offaly MHS, CHO 8

Document reference number	DOP081	Document developed by	Policy Group DOPP
Revision number	4	Document approved by	Approved Centre Group
Approval date	February 2024	Responsibility for implementation	Designated ADON's CNMs, Consultant Psychiatrist , NCI-ID's
Revision date	February 2025	Responsibility for review and audit	Designated ADONs Working Group on Judgemental Support

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Policy Statement

The Department Of Psychiatry advocates the use of strategies to prevent aggression and violence occurring focused on early recognition, prevention and de-escalation but acknowledges that an individual's behaviour may escalate to a point where physical restraint becomes necessary to protect the person, staff or others from significant injury or harm.

2.0: Glossary of Terms

APPROVED CENTRE A “centre” means a hospital or other inpatient facility for the care and treatment of persons suffering from mental illness or mental disorder. An “approved centre” is a centre that is registered pursuant to the Mental Health Act 2001-2018. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the Mental Health Act 2001-2018.
BREAKAWAY TECHNIQUES A set of physical skills to help separate or break away from an aggressor in a safe manner. They do not involve the use of restraint.
CHILD A person under 18 years of age other than a person who is or has been married.
CLINICAL FILE A record of the person’s referral, assessment, care and treatment while in receipt of mental health services. This documentation should be stored in the one file. If all relevant information is not stored in the one fie, the file should record where the other information is held. **CLINICAL GOVERNANCE** A system for improving the standard of clinical practice including clinical audit, education and training, research and development, risk management, clinical effectiveness and openness. **CONSULTANT PSYCHIATRIST** means a consultant psychiatrist who is employed by the HSE or by an approved centre or a person whose name is entered on the division of psychiatry or the division of child and adolescent psychiatry of the Register of Medical Specialists maintained by the Medical Council.
DE-ESCALATION The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression.

DIGNITY The right of an individual to privacy, bodily integrity and autonomy, and to be treated with respect as a person in their own right. **DUTY CONSULTANT PSYCHIATRIST** The consultant psychiatrist on the on-call duty rota. 5 Mental Health Commission | 2022 Code of Practice on the Use of Physical Restraint

INDIVIDUAL CARE PLAN A documented set of goals developed, regularly reviewed and updated by the person's multidisciplinary team, so far as practicable in consultation with each person receiving care and treatment. The individual care plan should specify the treatment and care required which should be in accordance with best practice, should identify necessary resources and should specify appropriate goals for the person. For children, individual care plans should include education requirements. The care plan is recorded in the one composite set of documentation. **PERSON** All references to 'person' in this document should be taken to mean a voluntary or involuntary patient or resident, as defined in the 2001 Act.

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

POLICY Written statement that clearly indicates the position of the organisation on a given subject.

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

REGISTERED MEDICAL PRACTITIONER A person whose name appears on the General Register of Medical Practitioners.

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

RIGHTS-BASED APPROACH Integrating human rights norms and principles in the design, implementation, monitoring and evaluation of policies and programmes. The principles of equality and freedom from discrimination are central.

RISK ASSESSMENT An assessment to gauge risk in relation to the person, designed and recognised for use in mental health settings.

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

3.0 Definition of Physical Restraint

Physical Restraint: "the use of physical force (by one or more persons) for the purpose of preventing the free movement of a person's body when the person poses an immediate threat of serious harm to self or others.

4.0 ORDERS FOR PHYSICAL RESTRAINT

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

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

4.3The consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist should be notified of the physical restraint order as soon as is practicable, and this should be recorded in the person's clinical file.

4.4 As soon as is practicable, and no later than two hours after the start of an episode of physical restraint, a medical examination of the person by a registered medical practitioner should take place. This should include an assessment of any physical impacts of the restraint episode on the person, as well as a record of any psychological and/or emotional trauma caused to the person as a result of the restraint.

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

4.6 An episode of physical restraint may be extended by a renewal order made by a registered medical practitioner or the most senior registered nurse on duty in the unit/ward following a medical examination or nursing review, for a further period not exceeding 10 minutes - to a maximum of two renewals of continuous restraint. The continuous period of physical restraint should never be longer than 30 minutes. The reasons for renewing the order, and the time that the nursing review or medical examination took place, should be clearly recorded in the person's clinical file.

4.7 The episode of physical restraint should be recorded in the person's clinical file. The relevant section of the "Clinical Practice Form for Physical Restraint" should also be completed by the person who initiated and ordered the use of physical restraint as soon as is practicable and no later than three hours after the conclusion of the episode of physical restraint. The Clinical Practice Form for Physical Restraint should also be signed by the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist as soon as is practicable and in any event within 24 hours.

4.8 The person should be informed of the reasons for, and the circumstances which will lead to the discontinuation of, physical restraint unless the provision of such information might be prejudicial to the person's mental health, well-being or emotional condition. If informed of the reasons, a record of this should be recorded in the person's clinical file as soon as is practicable. In the event that this communication does not occur, a record explaining why it has not occurred should be entered in the person's clinical file as soon as is practicable.

4.9 As soon as is practicable, and if it is the person's wish in accordance with their individual care plan, the person's representative should be informed of the person's restraint and a record of this communication should be placed in the person's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred should be entered in the person's clinical file. Where it is the person's wish in accordance with their individual care plan that the person's representative is not to be informed of the person's restraint, no such

communication should occur outside the course of that necessary to fulfil legal and professional requirements. This should be recorded in the person's clinical file.

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

5.0 DIGNITY AND SAFETY

5.1 Staff involved in the use of physical restraint should be aware of, and have taken into account, any relevant entries in the person's individual care plan, pertaining to the person's specific requirements or needs in relation to the use of physical restraint.

5.2 It should be assumed that any person who is restrained may have a past history of trauma and/or abuse. Therefore, the principles of trauma-informed care should underpin the use of restraint on a person.

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

5.4 All staff members involved in the use of physical restraint should have undertaken appropriate training in accordance with the policy.

5.5 The person should be continually assessed throughout the use of restraint to ensure the person's safety.
The staff member leading the use of physical restraint should ensure that other staff members
1. Protect and support the person's head and neck, where needed
2. Ensure that the person's airway and breathing are not compromised
3. Conduct observations, including vital clinical indicators such as the monitoring of pulse, respiration and complexion (with special attention for pallor/discolouration)
4. Monitor and maintain effective communication with the person
5. Monitor the person's physical and psychological health for as long as clinically necessary after using physical restraint. A record of these observations should be recorded in the person's clinical file.

5.6 The level of force applied during physical restraint should be justifiable, appropriate, reasonable, and proportionate to the situation and minimal force should be applied. In the exceptional circumstance where it is considered necessary to use physical restraint on persons who are physically unwell, frail, physically disabled, pregnant or obese, the procedure should be approached with extreme caution and care.

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

5.8 The following present a very high risk of harm to the person and should be avoided neck holds and the application of weight to the person's chest or back. The use of physical restraint that interferes with the person's airway, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen, or obstructing the mouth or nose. The use of physical restraint in a way that interferes with the person's ability to communicate, for example by obstructing the eyes, ears or mouth.

5.9 Use of physical restraint involving the person in the "prone", face down position is only permitted in the most exceptional of circumstances by staff who have received appropriate and specific training in its safe use. A record of the use of prone restraint should be entered in the person's clinical file.

6.0 ENDING THE USE OF PHYSICAL RESTRAINT

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

6.2 The time, date, and reason for ending the physical restraint should be recorded in the person's clinical file on the date that the physical restraint ends.

6.3 An in-person debrief with the person who was restrained should follow every episode of physical restraint. This debrief should be person-centred and should give the person the opportunity to discuss the physical restraint with members of the multidisciplinary team involved in the person's care and treatment as part of a structured debrief process. Occur within two working days (i.e. days other than Saturday/Sunday and bank holidays) of the episode of physical restraint unless it is the preference of the person who was restrained to have the de-brief outside of this timeframe. The person's preferences regarding the timing of the de-brief should be recorded; iii. Respect the decision of the person not to participate in a de-brief, if that is their wish.

If the person declines to participate in the debrief, a record of this should be maintained and recorded in the person's clinical file

The two day MDT debrief should include a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future and include a discussion regarding the person's preferences in the event where a restrictive intervention is needed in the future for example preferences in relation to which restrictive intervention they would not like to be used.

Give the person the option of having their representative or their nominated support person attend the debrief with them, and, if the person's representative or nominated support person does not attend the debrief, a record of the reasons why this did not occur should be recorded in the person's clinical file.

6.4 Where multiple episodes of physical restraint occur within a 48-hour timeframe, these episodes may be reviewed during a single debrief.

6.5 A record should be kept of the offer of the debriefing, whether it was accepted and the outcome. The person's individual care plan should be updated to reflect the outcome of the

debrief, and in particular, the person's preferences in relation to restrictive interventions going forward.

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

6.7 Any use of a restrictive intervention may be traumatic for the person who experiences it. Appropriate emotional support should be provided to the person in the direct aftermath of the episode. Staff should also offer support, if appropriate, to other persons who may have witnessed the restraint of the person.

7.0 RECORDING THE USE OF PHYSICAL RESTRAINT

7.1 All uses of physical restraint should be clearly recorded in the person's clinical file.
7.2 All uses of physical restraint should be clearly recorded on the Clinical Practice Form for Physical Restraint.
7.3 The completed form should be placed in the person's clinical file and a copy should be available to the Mental Health Commission on request.

8.0 CLINICAL GOVERNANCE

8.1 Physical restraint should never be used to ameliorate operational difficulties including where there are staff shortages or as a punitive action. Physical Restraint should never be used solely to protect property or as a substitute for other less restrictive interventions.

8.2 The Department of Psychiatry has a written policy in relation to the use of physical restraint which should include sections which identify: Mental Health Commission | 2022 12 Code of Practice on the Use of Physical Restraint

1. The provision of information to the person which should include information about the person's rights, presented in accessible language and format
2. Who may initiate and who may carry out physical restraint

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

The Department of Psychiatry will maintain a written record indicating that all staff involved in physical restraint have read and understand the policy. The record should be available to the Mental Health Commission upon request.

4. The Policy will review its policy on physical restraint as required and, in any event, at least on an annual basis.

8.3 Each episode of physical restraint should be reviewed by members of the multidisciplinary team involved in the person's care and treatment and documented in the person's clinical file as soon as is practicable and, in any event, no later than five working days (i.e. days other than Saturday/Sunday and bank holidays) after the episode of restraint.

The review should include the following the identification of the trigger/antecedent events which contributed to the restraint episode, a review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support. It should include the identification of alternative de-escalation strategies to be used in future and the duration of the restraint episode and whether this was for the shortest possible duration, considerations of the outcomes of the person-centred debrief, if available; and an assessment of the factors in the physical environment that may have contributed to the use of restraint.

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

8.5 Every approved centre that uses, or permits the use of, physical restraint, should develop and implement a reduction policy which should be published on the Registered Proprietor's website. This policy should clearly document how the approved centre aims to reduce, or where possible eliminate, the use of physical restraint within the approved centre. It should address leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice and Clearly document how the approved centre will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of physical restraint within the approved centre. 13 Mental Health Commission | 2022 Code of Practice on the Use of Physical Restraint

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

8.7 All information gathered regarding the use of physical restraint should be held in the approved centre and used to compile an annual report on the use of physical restraint at the approved centre. This report, which should be signed by the Registered Proprietor Nominee, should be made publicly available on the Registered Proprietor's website within six months of the end of the calendar year and available, upon request, to the public.
The annual report should contain the aggregate data that should not identify any individuals, it should contain a statement about the effectiveness of the approved centre's actions to eliminate, where possible, and reduce physical restraint. It should include a statement about the approved centre's compliance with the code of practice on the use of physical restraint and a statement about the compliance with the approved centre's own reduction policy.
All approved centres should produce and publish an annual report on the use of physical restraint.

8.8 A multidisciplinary review and oversight committee, which is accountable to the Registered Proprietor Nominee, should be established at each approved centre to analyse in detail every episode of physical restraint. The committee should meet at least quarterly and should determine if there was compliance with the code of practice on the use of physical restraint for each episode of physical restraint reviewed. The Group will determine if there was compliance with the approved centre's own policies and procedures relating to physical restraint. Identify and document any areas for improvement and identify the actions, the persons responsible, and

the timeframes for completion of any actions. The Group will provide assurance to the Registered Proprietor Nominee that each use of physical restraint was in accordance with the Mental Health Commission's Code of Practice. A report will be produced 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.

8.9 The Registered Proprietor has overall accountability for the use of physical restraint in the approved centre. Mental Health Commission | 2022 14 Code of Practice on the Use of Physical Restraint

9. STAFF TRAINING

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

9.2 The areas to be addressed within the training programme, which should include training:
1. The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques)
2. Alternatives to physical restraint
3. Trauma-informed care
4. Cultural competence
5. Human rights, including the legal principles of restrictive interventions
6. Positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic
7. The monitoring of the safety of the person during and after the physical restraint. The identification of appropriately qualified person(s) to give the training; and the mandatory nature of training for those involved in physical restraint.

9.3 The appropriate person identified by Laois / Offaly Mental Health Service to provide the training needs identified in the Code of Practice on the use of Physical Restraint is Ms. Amelia Cox.
9.4 A record of attendance at training should be maintained.

10.0 CHILDREN

Children are particularly vulnerable to trauma and harm as a result of restrictive interventions. Physical restraint can have particularly adverse implications for the emotional development of a child. In addition, the size and physical vulnerability of children and young people should be taken into account when considering physical restraint. Physical restraint should be used with extreme caution when it involves children and young people because in most cases their musculoskeletal systems are immature which elevates the risk of injury. In addition to sections 3-8 which apply to all persons, the following considerations apply to children being provided care and treatment in approved centres: 15 Mental Health Commission | 2022 Code of Practice on the Use of Physical Restraint

10.1 Upon admission to an approved centre that uses physical restraint on children, a documented risk assessment should be carried out by a registered medical practitioner or registered nurse. This should show that careful consideration has been given to the potential effects of restraining a child or adolescent, having regard to the physical status and emotional development of the child, and their particular vulnerability to trauma and harm as a result of restrictive interventions. The outcome of the risk assessment should determine if physical restraint can be safely used or not.

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

10.3 An approved centre physically restraining a child should ensure the child's parent or guardian is informed as soon as possible of the child's physical restraint and the circumstances which led to the child being physically restrained. The child's parent or guardian should also be informed when the episode of physical restraint has ended.

10.4 An approved centre physically restraining a child should have in place child protection policies and procedures in line with relevant legislation and regulations made thereunder.
10.5 An approved centre physically restraining a child should have a policy and procedures in place addressing appropriate training for staff in relation to child protection

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Portlaoise
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R32 RW61

ANNUAL REPORT

Department of Psychiatry, Portlaoise - Oversight and Review Committee for the Reduction of Seclusion and Physical & Enduring Mechanical Restraint

Index

Please complete all sections sign*

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HSE Midlands Louth Meath
Community Healthcare Organisation CHO 8
Dept. of Psychiatry MRHP
Portlaoise
Co. Laois
R32 RW6

1. Physical Restraint Checklist

Name:_____

DOB: ____/____/____

Patient Hospital Number:_____

Affix Patient Label Here

- ☐ NCHD contacted.
- ☐ Consultant Psychiatrist contacted.
- ☐ Physical restraint clinical practice form completed.
- ☐ Physical exam completed by NCHD within two hours?

☐ Has the staff member leading the use of restraint ensured the following:

- Protect and support the patients head and neck ☐
- Patients airways and breathing are not compromised ☐
- Monitor and maintain effective communication with the patient. ☐

Conduct observations including vital Clinical Indicators:

- Monitoring of Pulse ☐
- Respirations ☐
- Complexion (Pallor/Discolouration) ☐

- ☐ Monitor the patient's physical and psychological health following restraint.
- ☐ Record all these observations in the patients Clinical File.
- ☐ Notification of Consultant Psychiatrist documented in Clinical File.
- ☐ Next of kin informed (with consent) and recorded.
- ☐ If next of kin not contacted reasons why documented.
- ☐ ADON / CNM 3 informed and recorded.
- ☐ Is the Physical Restraint initiation documented in Clinical File
- ☐ Incident Report form completed and recorded in chart.
- ☐ All episodes of Physical Restraint will need to be notified to the MHC

All above documented in clinical file.

Nurses Signature: _____ Date: ____/____/____

2. CLINICAL PRACTICE
FORM FOR PHYSICAL RESTRAINT

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

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

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

11 (c) Who assisted with the physical restraint:

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

Signed: _____

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

Signed: _____

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

Signed: _____

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

Signed:

12. Details of what each member of staff named above was doing during the episode of physical restraint:

13. Why is physical restraint being ordered/renewed?

Immediate threat of serious harm to self ■

Actual harm caused to self ■

Immediate threat of serious harm to others ■

Actual harm caused to others ■

Transfer to seclusion room ■

To administer medication/treatment (excluding nasogastric feeding) ■

To administer nasogastric feeding ■

Other (please specify) ■ _____

Please provide further details on the above:

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

Verbal Intervention ■ Medication offered / administered ■

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

Other (please specify) ■ _____

Please provide further details on the above:

15. Type of physical restraint used:

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

Please provide further details

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

Yes ■ No ■

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

17. Order:

I _____ have assessed _____ on

Date: ____/_____/_____ at ____ hrs ____ mins and I order the use of physical

restraint from Date: ___/_____/_____ at ____ hrs ____ mins for up to a

maximum of ____minutes

Name (print): _____ Signed: _____

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

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

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

Duty consultant psychiatrist ■

Name (print): _____ Signed: _____

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

19. Physical restraint ended ■ Physical restraint renewed* ■

Who ended/renewed physical restraint:

Name (print): _____ Signed: _____

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

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

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

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

Yes ■ No* ■

If yes, please complete the following:

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

_____

Date and time of medical examination:

Date: ____/____/_____ at ____hrs ____mins

*If no, please provide further details:

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

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

If yes, please provide further details:

22. Steps taken to ensure compliance with the rules of the use of physical restraint in terms of maintaining person's dignity and safety throughout the process?
23. Outline the circumstances that led to the Physical Restraint

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3. Physical Examination

Service User ID label :

PHYSICAL EXAMINATION FOLLOWING A PHYSICAL RESTRAINT

PHYSICAL OBSERVATIONS (To be completed by admitting doctor or nurse):

Drug Screen:

Height: _____m **Blood Pressure:** _____ **Resp. Rate:** _____resp/min
Weight: _____kg **Heart Rate:** _____bpm **Blood Sugar** *(if relevant)* _____
BMI: _____ **Temperature:** _____°C **Urinalysis:** _____
Waist: _____cm **Oxygen Saturation:** ____% **HCG:** _____

Name (Print): _____ **Signed:** _____

THIS SECTION TO BE COMPLETED BY ADMITTING/TREATING DOCTOR: PHYSICAL EXAMINATION

Consent: ☐ Service user declined.
☐ Verbal consent obtained.

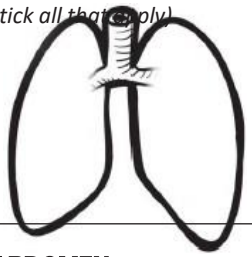
Chaperone: ☐ Chaperone used (same gender as service user)

Allergies: _____

Vaccinations (if relevant): _____

RESPIRATORY:

(tick all that apply)



- ☐ Chest Clear
- ☐ Equal Air Entry
- ☐ No Wheeze
- ☐ No crepitations
- ☐ Other:

CARDIOVASCULAR:

(tick all that apply)

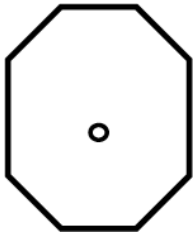
- ☐ Warm & Peripherally well perfused
- ☐ Normal Sinus Rhythm
- ☐ Normal Heart Sounds
- ☐ Other:

ECG:

(tick all that apply)

- ☐ Declined / Unable to Answer
- ☐ Not needed
- ☐ Day team to do.
- ☐ Done. Results:

ABDOMEN:



- ☐ Soft, non-tender
- ☐ No guarding
- ☐ No organomegaly
- ☐ Normal bowel sounds
- ☐ Other:

_____
_____

NEUROLOGICAL:

(tick all that apply)

- ☐ Cranial Nerves Intact
- ☐ Power 5/5 throughout upper & lower limbs
- ☐ Normal reflexes
- ☐ Normal sensation
- ☐ Other/Comments: _____

Any Relevant Medical History

_____

_____

_____

Any Relevant Family Medical History:

_____

_____

_____

How would you describe your physical health?

_____

_____

_____

Do you wish to tell me about any physical problems including any pain you may be experiencing?

_____

_____

_____

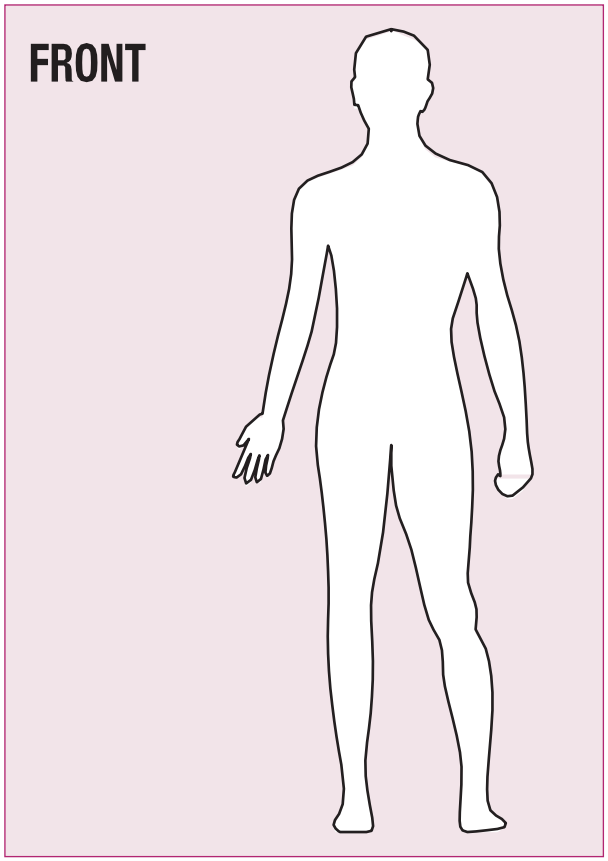
How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

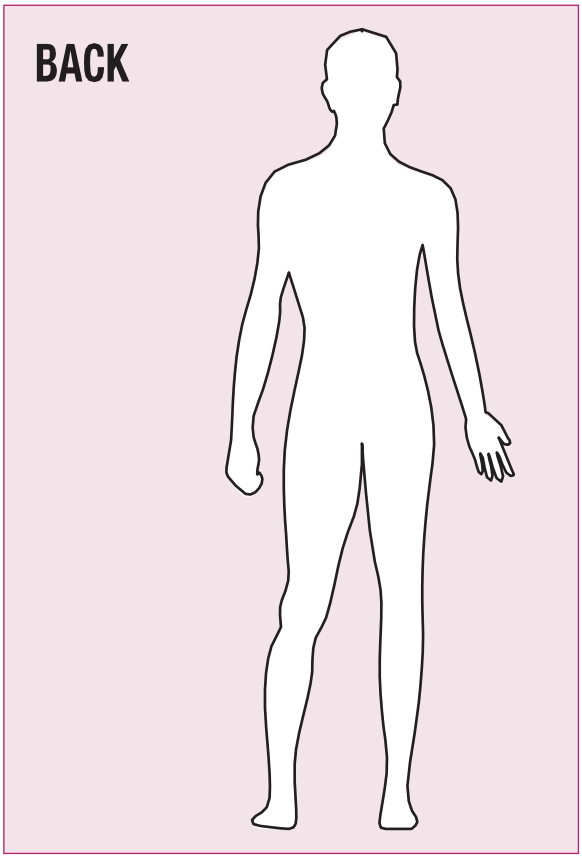
_____

_____

_____

Please mark on diagram any abnormalities, areas of bruising, skin cyanosis, skin condition including pressure sores, wounds, rashes, puncture marks, and self harm, OR please tick (☐) if no abnormalities detected ☐





General Appearance:

_____

_____

_____

Name of Doctor (Print): _____ MCRN No: _____

Signed: _____

Date & Time: _____

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4. Ending of the Physical Restraint Episode

Post Restraint Checklist

Has the patient been informed regarding the ending of physical restraint? ☐

Has the post physical examination been completed? ☐

Has the following people been notified of the ending of the seclusion episode?

- **CNM 2** ☐
- **CNM 3** ☐
- **Duty ADON or ADON On-Call** ☐
- **Duty Consultant or On-Call Consultant** ☐
- **Patients N.O.K (Only if consent is given)** ☐

Has the MHC been notified of the ending of the restraint episode? ☐

Has the need of seclusion been resolved in the patient ICP? ☐

Has the patients debriefing tool being completed by the Key nurse or MDT Member within two working days? ☐

Has the Multidisciplinary team reviewed the episode of physical restraint within five working days? ☐

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5. Patient Debriefing

Completed by the Multidisciplinary Team Following Episode of Physical Restraint Within Two Working Days.

Consultant Psychiatrist: _____ **Social Worker: _____**

NCHD: _____ **Occupational Ther: _____**

Nurse: _____ **Psychologist: _____**

Any Other Member: _____

Patient / Resident's Name: _____ **DOB: ____/____/____**

Patient / Resident's ID Number: _____ **Date: ____/____/____** **Time: _____**

Q1. Would you like to discuss your recent episode of Physical Restraint? Yes ☐ No ☐
If not has it been recorded in the clinical file if the person does not wish to participate in the debrief

_____

_____

_____

Q2. What is your understanding of why you were physically restrained?

_____

_____

_____

Q3. Is there anything that could have helped you to prevent the incident occurring?

_____

_____

_____

Q4. In your estimation, was length of time you were Physically Restrained appropriate?
Yes ☐ No ☐ (✓ One)

Q5. Do you think the Physical Restraint could have ended sooner? Yes ☐ No ☐ (✓ One)
If yes what would have ended it sooner?

_____

_____

Q6. Did you find this intervention helpful? Yes ☐ No ☐ (✓ One)
If not helpful, can you explain why?

_____

Q7. How do you feel you were treated during this episode? **E.g.** With **Dignity** and **Respect**
Comment:

_____

_____

_____

Q8. What could you and the staff have done to make it easier for you after you were Restrained?

_____

_____

_____

Q9. If this was required in the future, do you have a preference with alternative de-escalation strategies that could avoid another Physical Restraint episode?

_____

_____

_____

Q10. Do you think your episode of restraint could have been managed differently?

_____

_____

_____

Signature: _____ (MDT member / Key worker)

Signature: _____ (Patient / Resident)

Debriefing is deferred due to the Patient's / Resident's mental / clinical state.

For Review again in 24 Hours. Next debriefing Date: ____/____/____

For Review again in 24 Hours. Next debriefing Date: ____/____/____

For Review again in 24 Hours. Next debriefing Date: ____/____/____

Signature: _____ Date: ____/____/____

MHC INFORMATION BOOKLET ON SECLUSION GIVEN TO RESIDENT: Yes □ No □

IF NO, PLEASE STATE REASON:

_____

_____

_____

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LAOIS OFFALY MENTAL HEALTH SERVICES
HSE Midlands Louth Meath
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6. MULTIDISCIPLINARY REVIEW
FOLLOWING ENDING OF A PHYSICAL RESTRAINT EPISODE
Within Five Working Days.

Consultant Psychiatrist: _____ **Social Worker:** _____

NCHD: _____ **Occupational Ther:** _____

Nurse**:** _____ **Psychologist:** _____

Any Other Member: _____

Patient / Resident's Name: _____ **DOB:** ____/____/____

Date: ____/____/____ **Time:** _____

Q1. Identify any triggers which may have contributed to the Physical Restraint Episode.

_____

_____

_____

Q2. Review any missed opportunities for earlier intervention in line with the principles of positive behaviour support i.e. Inclusion, Choice, participation and equality of opportunity.

_____

_____

_____

Q3. Alternative de-escalation strategies discussed that could avoid a Physical Restraint Episode in the future.

_____

_____

_____

Q4. Was the Physical Restraint Episode the shortest possible duration for this person with evidence in the Seclusion Core Care plan?

_____

_____

_____

Q5. Considerations of the outcomes of the person centred debrief if possible.

_____

_____

_____

Q6. Identify if there were any factors in the physical environment that may have contributed to the Physical Restraint Episode.

_____

_____

_____

Signature: _____ (MDT member / Key worker)

Signature: _____ (Patient / Resident)

Debriefing is deferred due to the Patient's / Resident's mental / clinical state.

For Review again in 24 Hours. Next debriefing Date: ____/____/____

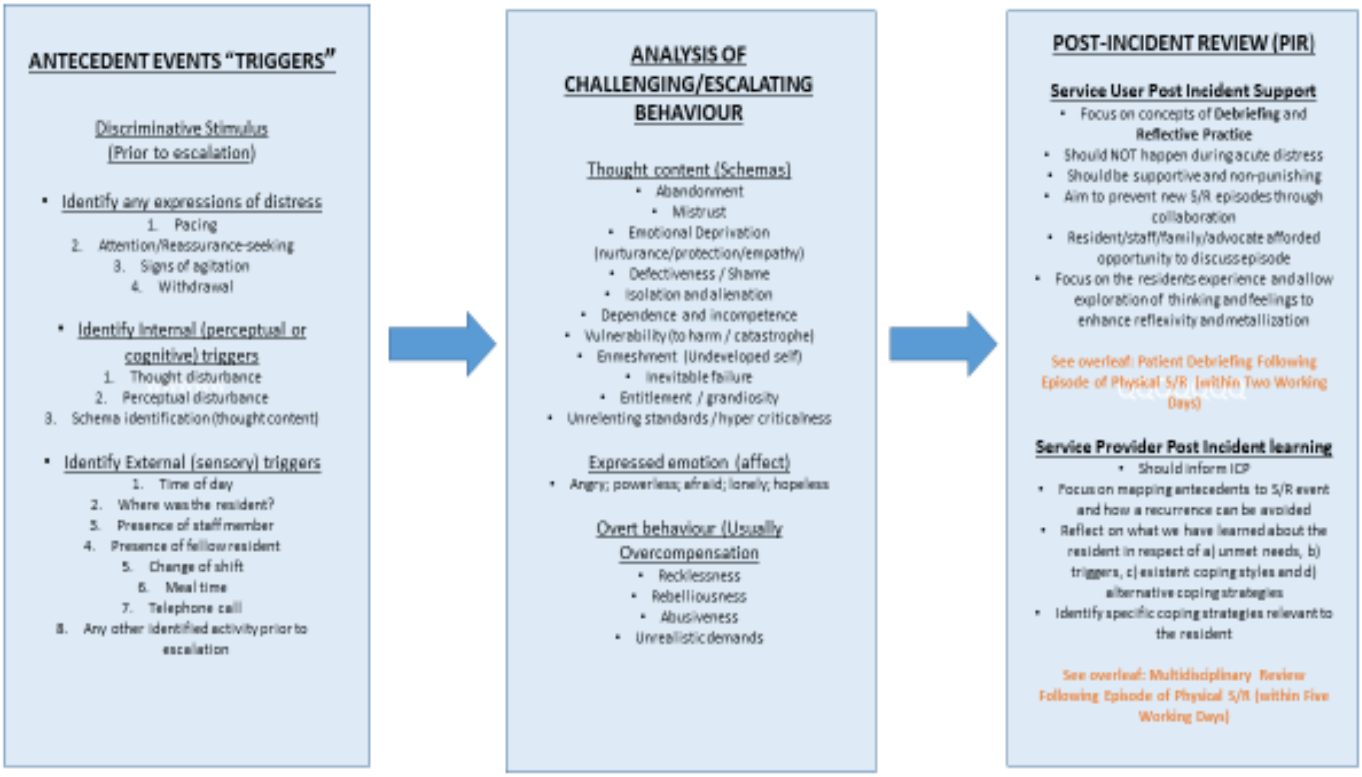
For Review again in 24 Hours. Next debriefing Date: ____/____/____

For Review again in 24 Hours. Next debriefing Date: ____/____/____

Signature: _____ (MDT member / Key worker)

Signature: _____ (Patient / Resident)

MULTIDISCIPLINARY POSITIVE BEHAVIOURAL SUPPORT PLAN FOLLOWING SECLUSION/RESTRAINT (S/R)



Appendix 4: Dept of Psychiatry, Portlaoise- Seclusion Policy v2, January 2024

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Policy Title: Seclusion

Approved Centre: Department of Psychiatry Portlaoise

Is this document a:

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

Laois Offaly Adult Mental Health Approved Centre Department of Psychiatry

Title of PPPG Development Group:	Department of Psychiatry Policy Development and Review Group
Reference Number:	DOP 080
Version Number:	2
Publication Date:	08/02/2024
Date for revision:	08/02/2025
Electronic Location:	

Version	Date Approved	List section numbers changed	Author
2	08/02/2024	Appendix 2 Seclusion Pack, Section 9	DOPP PPPG Committee Group

PPPG Title: Seclusion Policy; PPPG Reference Number DOP080; Version No. 2 Approval Date 08/02/2024 Revision Date 08/02/2025 Approved Centre: DOPP

Table of Contents

1.0 DEFINITION OF SECLUSION:

For the purposes of these rules, Seclusion is defined as “the placing or leaving of a person in any room, at any time, day or night, such that the person is prevented from leaving the room by any means’

1.1 Possible alternatives to Seclusion:

Agreed prevention strategies/ Crisis Plan/ Care Plan (ICP)

Quiet space/ Bedroom/ Low Stimulus

Implementation of Safewards

Distraction

Exercise

Meaningful Activity

De-escalation/ Coaching

Medication

1:1 Nursing

2.0 INITIATION:

Purpose:

To ensure that where patients need to be placed in a seclusion facility, the care and management of the patient is managed strictly in accordance with the ‘Rules Governing the Use of Seclusion’ updated by the Mental Health Commission in January 2023.

Scope:

All members of the Multidisciplinary Team.

2.3 Objective(s):

The main responsibility of the Standards and Quality Assurance Division is to work closely with all relevant stakeholders to ensure that high standards and best practices are achieved in Ireland's Mental Health services. The implementation and maintenance of high standards is for the benefit of all involved in the Mental Health services but particularly service users.

The purpose of this policy is to ensure that the Mental Health Commission Rules on Seclusion, which are based on best practice, are adhered to as per Mental Health Commission recommendations.

2.4 PPPG Development Group:

See Appendix III for Membership of the PPPG Development Group Template.

2.5 PPPG Governance Group:

See Appendix IV for Membership of the Catchment Management Group.

2.6 Supporting Evidence:

2.6.1 Related PPPG

DOP081 Use of Physical Restraint

2.7 Glossary of Terms and Definitions:

APPROVED CENTRE **A "centre" means a hospital or other inpatient facility for the care and treatment of persons suffering from mental illness or mental disorder. An "approved centre" is a centre that is registered pursuant to the Mental Health Act 2001-2018. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the Mental Health Act 2001-2018.**

BREAKAWAY TECHNIQUES **A set of physical skills to help separate or break away from an aggressor in a safe manner. They do not involve the use of restraint. CHILD A person under 18 years of age other than a person who is or has been married. CLINICAL FILE A record of the person's referral, assessment, care and treatment while in receipt of mental health services. This documentation must be stored in the one fie. If all relevant information is not stored in the one file, the file must record where the other information is held.**

CLINICAL GOVERNANCE **A system for improving the standard of clinical practice including clinical audit, education and training, research and development, risk management, clinical effectiveness and openness.**

CLOSED CIRCUIT TELEVISION (CCTV) **Any monitoring device which captures a person's image, either for recording or live observation.**

CONSULTANT PSYCHIATRIST **means a consultant psychiatrist who is employed by the HSE or by an approved centre or a person whose name is entered on the division of psychiatry or the division of child and adolescent psychiatry of the Register of Medical Specialists maintained by the Medical Council.**

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

DE-ESCALATION **The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. 5 Mental Health Commission | 2022 Rules Governing the Use of Seclusion**

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

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

DUTY CONSULTANT PSYCHIATRIST **The consultant psychiatrist on the on-call duty rota.**

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

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

POLICY **written statement that clearly indicates the position of the organisation on a given subject.**

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

REGISTERED MEDICAL PRACTITIONER **A person whose name appears on the General Register of Medical Practitioners.**

REPRESENTATIVE **An individual chosen by the person who is being cared for (e.g. friend, family member, advocate) or a legal professional appointed by the person, statutory organisation or court to represent the person. Mental Health Commission | 2022 6 Rules Governing the Use of Seclusion**

RIGHTS-BASED APPROACH **Integrating human rights norms and principles in the design, implementation, monitoring and evaluation of policies and programmes. The principles of equality and freedom from discrimination are central.**

RISK ASSESSMENT **An assessment to gauge risk in relation to the person, designed and recognised for use in mental health settings.**

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

3.0 PPPG STEPS:

Use of Seclusion

Orders for Seclusion (Appendix I)

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

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

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

3.1.3 Where the Seclusion is initiated by the most senior nurse on duty a registered medical practitioner must be notified of the seclusion episode as soon as is practicable and no later than 30 minutes following the commencement of the episode.

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

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

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

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

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

3.1.9 A Seclusion Order under these rules shall remain in force for a maximum period of 4 hours from the time of its making and then shall expire.

3.1.10 The authorisation to seclude must only be made following an examination of the patient concerned by the Registered Medical Practitioner, where such an examination is practicable. A record of the examination must be entered into the patient's clinical file.

3.1.11 In an emergency situation the following applies:-

a) Seclusion may be initiated by the most Senior Registered Nurse on Duty. When seclusion is initiated a "Seclusion Care Plan" must commence immediately (Appendix II).

b) If the most Senior Nurse on duty initiates seclusion, a Registered Medical Practitioner must be notified within 30minutes of the initiation of seclusion.

c) The relevant sections of the Seclusion Register relating to the details surrounding seclusion must be completed by the Registered Medical Practitioner or Registered Nurse who initiated the seclusion.

d) As soon as is practicable, and no later than 2 hours after the commencement of seclusion, a Registered Medical Practitioner under the supervision of the Consultant Psychiatrist responsible for the care and treatment of the patient or the duty Consultant Psychiatrist, must authorise seclusion in writing.

e) If the Registered Medical Practitioner, under the supervision of either the Consultant Psychiatrist responsible for the care and treatment of the patient or the duty Consultant Psychiatrist, is not satisfied that secluding the patient is warranted he or she will discontinue seclusion following discussion with the nursing staff and complete the relevant section of the Seclusion Register.

3.1.12 the patient must be informed of the reasons for and the likely duration of the period of seclusion, unless the provision of such information might be prejudicial to the patient's mental health, well-being or emotional condition. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the patient's clinical file.

3.1.13 a) As soon as is practicable, and with the patient's consent, the patient's next of kin or representative must be informed of the patient's seclusion and a record of this communication must be entered in the patient's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the patient's clinical file.

b) Where the patient lacks capacity and cannot consent, the patient's next of kin or representative must be informed of the patient's seclusion and a record of this communication must be entered in the patient's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the patient's clinical file.

3.2 Patient Dignity and Safety:

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

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

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

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

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

3.3 The Monitoring of a patient during seclusion:

3.3.1 A person placed in seclusion must be kept under direct observation by a registered nurse for the first hour following the initiation of a seclusion episode.

3.3.2 After the first hour, a registered nurse must keep the person under continuous observation and be within sight and sound of the seclusion room. This observation may be completed in person or with CCTV (or other electronic monitoring).

3.3.3 A written record of the person must be made by a registered nurse at least every 15 minutes.

This must include a record of: 1. the person's level of distress; 2. the person's behaviour (what the person is doing and saying); 3. The person's level of awareness; 4. The person's physical health, especially with regard to breathing, pallor or cyanosis; 5. Whether elimination/hygiene needs were met; and 6. Whether hydration/nutrition needs were met. If the person's unsafe behaviour has abated, the ending of the episode of seclusion must be considered.

3.3.4 Following a risk assessment, a nursing review of the person in seclusion must take place every two hours, unless the risk assessment indicates that to do so would place the person or staff at a high risk of injury. During this review, a minimum of two staff members, one of whom must be a

registered nurse who was not directly involved in the decision to seclude (where possible), will enter the seclusion room and assess the person to determine whether the e episode of seclusion can be ended. This assessment and decision must be recorded.

3.3.5 Where a person is sleeping, clinical judgement needs to be used as to whether it is appropriate to wake the person for a nursing review or medical examination. In such instances medical examinations may be suspended. Nursing reviews must continue every two hours. However, the nature of the nursing review may be such that the person is not woken. A registered medical practitioner must be on call to carry out a medical examination during the night, should the need arise.

3.3.6 Upon commencement of an episode of seclusion, a Seclusion Care Plan for the person must be developed by a registered nurse. A Seclusion Care Plan must include as a minimum:

1. Personal details

2. Known clinical needs (including mental and physical considerations)

3. How de-escalation strategies will continue to be used

4. the person's preferences in relation to seclusion, where known (e.g. access to music or reading material while in the seclusion room), and take into account outcomes of any previous debrief with the person, if applicable; 13 Mental Health Commission | 2022 Rules Governing the Use of Seclusion v. recognising signs where the person's behaviour is no longer deemed an unmanageable risk towards themselves or others, e.g. evidence of tension reduction, improved communication etc.

5. How potential risks may be managed

6. Reference to specific support plans for the person and details of how the person's mental health needs will continue to be met while in seclusion

7. Meeting of food/fluid needs

8. Meeting of needs in relation to personal hygiene/dressing

9. Medication reviews (in consultation with a registered medical practitioner)

10. Monitoring of physical observations

11 a strategy for ending seclusion; indicating the criteria required for this to be reached.

3.3.7 Where a patient is sleeping, clinical judgement needs to be used as to whether it is appropriate to wake the patient for a nursing or medical review. In such instances medical reviews may be suspended, nursing reviews must continue every 2 hours, however the nature of the nursing review will be such that the patient is not woken. A Registered Medical Practitioner must be on call to carry out a medical review during the night, should the need arise.

Renewal of Seclusion Orders:

The period referred to in Rule (2.6) may be extended by Order made by the Registered Medical Practitioner under the supervision of the Consultant Psychiatrist responsible for the care and treatment of the patient or duty Consultant Psychiatrist following an examination, for a further period not exceeding 8 hours to a maximum of 2 renewals (24 hours) of continuous seclusion.

If a patient's Seclusion Order is to be renewed after 24 hours continuous seclusion, the Consultant Psychiatrist responsible for the care and treatment of the patient or the duty Consultant Psychiatrist must examine the patient.

If a decision is made by the Consultant Psychiatrist responsible for the care and treatment of the patient concerned, or the duty Consultant Psychiatrist acting on his or her behalf, to continue to seclude a patient for a total period exceeding 72 hours, the Inspector of Mental Health Services and/or the Mental Health Commission must be notified in writing and included must be the following:

a) The range of therapeutic options considered

b) The reasons why continued seclusion is ordered

Ending Seclusion:

3.5.1 Seclusion may be ended at any time by the Registered Nurse in charge, in consultation with a Registered Medical Practitioner, following discussion with the patient.

A Registered Medical Practitioner may end seclusion on his or her own authority following discussion with the nursing staff in the Approved Centre.

The patient is informed of the ending of an episode of seclusion.

The reason for ending seclusion must be recorded in the patient's clinical file. Following seclusion, the patient concerned must be afforded the opportunity to discuss the episode with the Multi-disciplinary Team involved in his or her care and treatment and recorded in the Seclusion Care Plan.

The requirement for a Multi-disciplinary Team Patient De-Brief review will be held within two working days following the episode of Seclusion.

The Requirement for a Multi- disciplinary Team Review will be held within five working days following the episode of Seclusion.

3.6 Seclusion Facilities:

Seclusion facilities must provide access to adequate toilet/washing facilities. Leaving the seclusion room solely to use toilet/washing facilities shall not be considered as ending seclusion.

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

Seclusion facilities must be placed away from the unit's living/recreation areas.

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

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

There must be no ligature points or electrical fixtures. iii. There must be an anti-barricade door.

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

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

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

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

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

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

Recording of Seclusion Episodes:

All uses of seclusion must be clearly recorded in the patient's clinical file, in the "Seclusion Care Plan". (Appendix II)

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

Clinical Governance:

Each episode of seclusion must be reviewed by the Multi-disciplinary Team involved in the patient's care and treatment and documented in the patient's clinical file as soon as is practicable and in any event no later than 2 normal working days and 5 working days (i.e. days other than Saturday/Sunday & bank holidays). (Appendix II)

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

3.9 The Use of Closed Circuit Television (CCTV):

3.9.1 ***Where CCTV or other monitoring devices are installed in seclusion rooms their use is an addition to and does not replace the provision of rule 4.1 'Monitoring of a Patient during Seclusion'***

Any use of CCTV or other monitoring device must:-

Ensure viewing is restricted to designated personnel as per Approved Centre Policy.

b) Be evident and clearly labelled.

c) Be incapable of recording and be incapable of storing a patient's image on tape, disc, hard drive or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the Nurse responsible for the Health and welfare of the patient.

d) Must not be used if a patient starts to act in a way which compromises his or her dignity.

e) Have a clear written Policy in relation to its use.

Approved Centres must ensure that they disclose the existence and usage of these cameras to patients and/or their representatives and the Inspector of Mental Health Services and/or the Mental Health Commission during the inspection of the Approved Centre or at any time on request.

3.10 Child Patients:

In addition, the following rules apply in Approved Centres providing care and treatment for children.

3.10.1 An Approved Centre secluding a child must ensure the child's parent or guardian is informed as soon as possible of the child's seclusion.

3.10.2 An Approved Centre secluding a child must have in place Child Protection Policies and Procedures in line with relevant Legislation and Regulations made there under.

3.10.3 An Approved Centre secluding a child must have a Policy and Procedure in place addressing appropriate training for staff in relation to child protection.

3.11 Local Standard Operating Procedure:

3.11.1 The patient should be taken to the seclusion room by an appropriate number of staff bearing in mind the safety of both the patient and the staff but this number should never be less than two.

Where a patient requires to be restrained the restraint process must be managed in accordance with the Approved Centre Restraint Policy Document Policy No. DOP081

Where considered necessary the patient's day clothing must be removed following a risk assessment. If this is the case, appropriate clothing will be provided to maintain the dignity and safety of the patient. **The use of refractory gowns is as a last resort and should be governed by the individual needs of the patient.**

Nursing staff should ensure that the patient does not retain any articles that may cause harm i.e. lighters, nail files, matches, pyjama cords, plastic bags etc. It is advisable to remove any dentures or other prosthesis, particularly if the patient is to be or has been sedated.

The CNM 2/Nurse in charge must make every effort to explain to the patient the reason why seclusion is being used. However disturbed the patient may be, always explain to him/her:-

The reasons why seclusion is being used.

The circumstances under which seclusion will be discontinued.

Medical and Nursing staff must make a record of the seclusion in the "Seclusion Care Plan", giving clear reasons as to why seclusion is being used. The record must include specific details of the circumstances, behaviour, incident or symptoms, which led up to the use of seclusion. (Appendix II).

The CNM 2/Nurse in charge shall assign a designated nurse to manage the patient's care whilst in seclusion.

The assigned nurse shall check the patient every 15 minutes and make a record of same in the ***Record of Seclusion Observation Sheet***, included in the "Seclusion Care Plan" (Appendix II). This provides the CNM 2/Nurse in charge with a written record of the patient's behaviour and status while in Seclusion. **Camera monitoring, where in place does not replace this requirement.**

If a patient needs to return to Seclusion, then the patient may be returned to seclusion for the period of time for which it was prescribed that remains outstanding.

If the patient then requires any additional Seclusion then he/she should be reviewed by a Doctor and an additional period of Seclusion prescribed.

The Nurse in Charge should refer to the ***Record of Seclusion Observation Sheet*** as a basis for continuing/discontinuing Seclusion. As a general measure where there have been four consecutive 15 minute periods of appropriate behaviour discontinuation of Seclusion may be considered in consultation with the Registered Medical Practitioner.

During seclusion the patient's care continues as per Care Plan. The assigned nurse must ensure that a written record of his/her observations of the patient's mental/physical status during the period of seclusion are made at least once in every two-hour period in the Nursing Care Plan. (Appendix II).

Review:

The patient should be reviewed by a Consultant Psychiatrist at least once every 24 Hours while in seclusion. In addition, depending on the patient's clinical presentation the patient should be reviewed as often as clinically appropriate by the team NCHD/duty NCHD in consultation with the CNM 2/Nurse in charge on the unit. (Appendix II).

As soon as the seclusion is judged to have achieved its aim seclusion should end.

Following seclusion, the seclusion period should be discussed by the staff with the patient in the two day de brief and the five day review by the Multi- Disciplinary Team in order to

highlight the reason why seclusion was used. This allows an opportunity to re-establish a therapeutic relationship with the patient (Appendix II).

It is the responsibility of the Nurse in Charge of the unit to ensure that ***The Register of Seclusion*** is retained in the unit for inspection by the Inspectorate of Mental Health Services and the patient's Care Plan & ***Record of Seclusion Observation Sheets*** are retained in the patient's Clinical Records (Appendix II).

Only rooms designated as seclusion facilities should be used for seclusion. Seclusion rooms should,

Be appropriately heated and ventilated.

Have facilities that ensure all areas of the room are visible.

Have the door opening outwards and should be opened by the standard hospital key.

Afford privacy to the patient other than when under observation by staff.

Be checked thoroughly for their safety prior to the patient entering the room.

Have an appropriate viewing panel fitted which allows for adequate observation of the Patient while in seclusion.

3.13 Psychological Tasks:

Nursing staff should strive to,

(A) Continue to verbally communicate with the patient while continually reassessing the patient's mental and physical status.

(B) Repeatedly explain the reasons for seclusion to the patient and also the circumstances/behaviour, which will permit seclusion to be discontinued.

(C) Strive to engage with and maintain therapeutic rapport with the patient.

(D) Use verbal prompts to calm and reassure the patient.

(E) Check for effects and side effects of medication.

3.14 Physiological Observations:

The nurse must attend to observations and personal needs in the form of:

4 hourly observations of vital signs.

Hourly fluid assessment unless contra indicated.

1 to 2 hourly toilet accesses.

Access to bathing and oral hygiene.

All of the above is included in the “Seclusion Care Plan”. (Appendix II).

4.0 Clinical Governance

Seclusion must never be used:

1. To ameliorate operational difficulties including where there are staff shortages

2. As a punitive action

3. Where mechanical means of bodily restraint is also in use

4. Solely to protect property; v. as a substitute for less restrictive interventions.

4.2 a) Each approved centre must have a written policy in relation to the use of seclusion which must include sections which identify: 1. who may initiate, and who may carry out, seclusion 2. The provision of information to the person which must include information about the person’s rights, presented in accessible language and format 3. The safety, safeguarding and risk management arrangements that must be followed during any episode of seclusion.

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

(c) The approved centre must review its policy on seclusion as required and, in any event, at least on an annual basis. 17 Mental Health Commission | 2022 Rules Governing the Use of Seclusion

4.3 Each episode of seclusion must be reviewed by members of the multidisciplinary team involved in the person’s care and treatment and documented in the person’s clinical file as soon as is practicable and, in any event, no later than five working days (i.e. days other than Saturday/Sunday and bank holidays) after the episode of seclusion.

The review must include the the identification of the trigger/antecedent events which contributed to the seclusion episode and a review of any missed opportunities for earlier

intervention, in line with the principles of positive behaviour support. It must also include identification of alternative de-escalation strategies to be used in future, the duration of the seclusion episode and whether this was for the shortest possible duration and the considerations of the outcomes of the person-centred debrief, if available; and an assessment of the factors in the physical environmental that may have contributed to the use of seclusion.

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

4.5 Every approved centre that uses, or permits the use of, seclusion must develop and implement a reduction policy which must be published on the Registered Proprietor's website. This policy must: i. clearly document how the approved centre aims to reduce or, where possible eliminate, the use of seclusion within the approved centre; ii. address leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice; iii. Clearly document how the approved centre will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of seclusion within the approved centre. 4.6 The Registered Proprietor has overall accountability for the reduction policy. The Registered Proprietor must appoint a named senior manager who is responsible for the approved centre's reduction of seclusion.

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

1. Aggregate data that must not identify any individuals

2. A statement about the effectiveness of the approved centre's actions to reduce or, where possible, eliminate the use of seclusion

3. Statement about the approved centre's compliance with the rules governing the use of seclusion; Mental Health Commission | 2022 18 Rules Governing the Use of Seclusion

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

5. The data as specified in Appendix 3. All approved centres must produce and publish an annual report on their use of seclusion. Where seclusion has not been used in the relevant 12-month period, then points 1 and 2 above must only be reported on.

4.8 A multidisciplinary review and oversight committee, which is accountable to the Registered Proprietor Nominee, must be established at each approved centre to analyse in detail every episode of seclusion. The committee must meet at least quarterly and must determine if there was compliance with the rules governing the use of seclusion for each episode of seclusion reviewed. It should also determine if there was compliance with the approved centre's own policies and procedures relating to seclusion and Identify and document any areas for improvement. The Group must also look and Identify the actions, the persons responsible, and the timeframes for completion of any actions and provide assurance to the Registered Proprietor Nominee that each use of seclusion was in accordance with the Mental Health Commission's Rules. This group must also compile a report following each meeting of the review and oversight committee. This report must be made available to staff who participate, or may participate, in seclusion, to promote on-going learning and awareness. This report must also be available to the Mental Health Commission upon request.

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

5.0 COMMUNICATION AND DISEMINATION:

5.1 Communication and dissemination is achieved through an Internal Memorandum from the Area Director of Nursing to the Clinical Director, Hospital Administrator, Mental Health Act Administrator, Heads of Discipline, Assistant Director of Nursing and Clinical Nurse Managers outlining that the Policy has been updated and placed in the Policy and Procedure Manual. This Memorandum will request the recipient to ensure that all staff are informed the updated PPPG has been placed in the Manual, and to inform staff that it is a requirement of the Mental Health Commission to read and complete the Signature Sheet located at the back of this PPPG. Additionally they must complete an attached 'Acknowledgement of Receipt Form' and return to the Nursing Office for record purposes.

6.0 IMPLEMENTATION:

6.2 Roles and Responsibilities:

6.2.1 **It is the responsibility of all staff to adhere to this Policy.**

6.2.2 It is the responsibility of the CMT to ensure that this Policy is reviewed annually or at any time if there is a change of practice.

6.2.3 It is the responsibility of individual Line Managers to ensure that all staff in their Department are aware of this Policy and that work practices are in line with the Policy.

6.2.4 Staff Training

6.2.4.1 All staff must demonstrate that they have read and have understood the processes of this Policy by signing the signature log located at the back of this PPPG.

7.0 STAFF TRAINING

7.1 All staff who participate, or may participate, in the use of seclusion must have received the appropriate training in its use and in the related policies and procedures.

7.2 Each approved centre that uses seclusion must implement a policy and have procedures in place for the training of all staff involved in seclusion. This policy must include, but is not limited to, the following

(a) Who will receive training based on the identified needs of persons who are secluded and staff

(b)The areas to be addressed within the training programme, including training in

1. Alternatives to seclusion

2. Trauma-informed care

3. Cultural competence

4. Human rights including the legal principles of restrictive interventions

5. The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques); 19 Mental Health Commission | 2022 Rules Governing the Use of Seclusion

6. Positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic.

7. The identification of appropriately qualified person(s) to give the training

8. The mandatory nature of training for those involved in seclusion.

7.3The appropriate person identified by Laois / Offaly Mental Health Service to provide the training needs identified in the Rules on the use of Seclusion is Ms. Amelia Cox.

7.4 A record of attendance at training must be maintained.

7.5 Mandatory training must be delivered every 12 months at a minimum

8.0 MONITORING, AUDIT AND EVALUATON:-

8.1 This Policy will be reviewed and updated as required or annually by the Policy Development and Review Group.

8.2 Audit by CNM3 after every episode of seclusion in the Department of Psychiatry.

9.0 REFERENCES:

(A) Attorney General (2001) Mental Health Act. Dublin. Government of Ireland.

(B) Gaskin, C.J., Elsom, S.J., and Happell, B. (2007) Interventions for reducing the use of seclusion in psychiatric facilities Review of the literature. British Journal of Psychiatry. 191. 298-303.

(C) Mental Health Commission (2022) Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint. Dublin. Mental Health Commission.

(D) Mental Health Commission (2022) Judgement Support Framework. Dublin: Mental Health Commission.

10.0 APPENDICES:

Appendix I: Guidelines for Recording Episodes of Seclusion

Appendix II: Seclusion Documentation Pack including the positive behavioural support plan.

Appendix III: Membership of the Approval Catchment Management Team Template

Appendix IV: Signature Sheets

Appendix I

Guidelines to Recording Episodes of Seclusion

Approved Centre guidelines to recording episodes of seclusion.

In recording observations Nursing and Medical Staff must be cognitive that care and management of the patient is managed strictly in accordance with the Rules Governing the Use of Seclusion 2023, as laid down by the Mental Health Commission and in conjunction with the Approved Centre Policy on the "Use of Seclusion". ". These rules are outlined in the Seclusion Care plan and must be adhered to. (Appendix II)

In particular please note the following sections of our local policy:

1.3 The duration of seclusion must be for the ***minimum period of time*** necessary to prevent immediate and serious harm to self or others.

3.3 (e) the seclusion order under these rules shall remain in force for ***a maximum period of 4 hours*** from the time of its making and shall then expire.

5.1 (a) A patient in seclusion must be in direct observation by a registered nurse for the first hour following initiation of a seclusion episode.

5.2 A written record of the patient in seclusion must be made at least every 15 minutes. The patients level of distress and his /her behaviour must be recorded and if the patient's unsafe behaviour has abated his/her release from seclusion must be considered.

5.3 Following a risk assessment, a nursing review of the patient in seclusion must take place every 2 hours, unless to do so would place the patient or staff at a high risk of injury. During this review a minimum of 2 staff members, one of whom must be a registered nurse, will enter the seclusion room and directly observe the patient to consider whether the episode of seclusion can be ended.

5.4 An initial medical review must be carried out by a registered medical practitioner after 2 hours and 4 hours thereafter.

5.5 Where a patient is sleeping, clinical judgement needs to be used as to whether it is appropriate to wake the patient for a nursing or medical review. In such instances medical reviews may be suspended. Nursing reviews must continue every 2 hours, however the nature of the nursing review will be such that the patient is not woken. A registered medical practitioner must be on call to carry out a medical review during the night, should the need arise.

Observations recorded on the Record of Seclusion Sheet should, in the interests of best practice, be fully explained within the nursing and medical notes as appropriate

Appendix II

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

LAOIS OFFALY MENTAL HEALTH SERVICES

HSE Midlands Louth Meath

Community Healthcare Organisation CHO 8

Dept. of Psychiatry MRHP

Portlaoise

Co. Laois

R32 RW61

Tel: (05786) 96396

Fax: (05786) 96416

ANNUAL REPORT

Department of Psychiatry, Portlaoise - Oversight and Review Committee for the Reduction of Seclusion and Physical & Enduring Mechanical Restraint

Index

*****Please complete all sections sign*****

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

LAOIS OFFALY MENTAL HEALTH SERVICES

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Seclusion Checklist

Name:_____

DOB: ____/____/____

Patient Hospital Number:_____

Affix Patient Label Here

First-hour direct observation.

Refractory gown used / own clothes ticked in Seclusion Register.

Has the patient been informed of the following:

Reason for use of Seclusion; ☐

Likely duration of Seclusion; ☐

☐

Behaviours which lead to an end of seclusion;

Was the use of refractory clothing assessed? ☐

NCHD contacted.

Seclusion register updated.

Physical restraint register completed if used.

Physical exam completed by NCHD within two hours?

Risk Assessment (Pre & Post Seclusion).

Notification of Consultant Psychiatrist documented in chart. ☐

Next of kin informed (with consent) and recorded. ☐

If next of kin not contacted reasons why documented. ☐

ADON / CNM 3 manager informed and recorded. ☐

ICP updated (to reflect seclusion episode) *N.B. = New Need. ☐

Is the seclusion initiation documented in Clinical File (CF). ☐

Observation sheet (15 Minute Records) completed. ☐

Incident Report form completed and recorded in chart. ☐

Administration of medication recorded (if indicated). ☐

Seclusion Information Leaflet given to patient. ☐

All episodes of Seclusion will need to be notified to the MHC ☐

All above documented in clinical file.

Nurses Signature: _____ Date: ____/____/____

Note: Medical Examination must take place no later than 2 hours after start of physical restraint episode.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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R32 RW61

Tel: (05786) 96396

Fax: (05786) 96416

Seclusion Care Plan

Name: _____ DOB: _____ Ward: _____

Date Seclusion Commenced: _____

Time Seclusion Commenced: _____

Was Physical Restraint Required? Yes/No If Yes:

Was Physical Restraint Form Completed? ☐

If yes, complete Physical Restraint Checklist ☐

Was the relevant NCHD notified? Yes/No

Name of NCHD notified: _____

Time NCHD notified: _____

Name of person who notified NCHD: _____

Did the patient have a physical medical examination by the NCHD within a timeframe of no more than two hours of the episode of restraint? Yes/No

If no, please give reason as to why:

Date Seclusion Ended: _____ Time Seclusion Ended: _____

Patient Status

Voluntary ☐

Involuntary ☐

Ward of Court ☐

Change of Patients Status: Yes/No If Yes, please specify:

Seclusion Risk Assessment Form

Name:_____ ___	The following criteria are devised to assist clinicians in the formulation and management of risk. Y – Yes, risk present. N – No, no risk. U – Unknown, it is Not possible to rate at present.

Address:_____ _____ ____ **DOB:**_____**DOA:** _____	***Where a risk is assessed insert a √***

Risk Determination

A: ABSCONDING RISK	**Y**	**N**	**U**	**S: SUICIDE RISK (brief risk screen)**	**Y**	**N**	**U**
Expressing desire to leave/not come into hospital				*History of previous suicide attempt*			
Pacing/watching doors				*Current thoughts or plan that indicate risk*			
Active addictions (detoxing/craving) – strong desire take alcohol or non prescribed drugs				*Current problems with alcohol or substance abuse*			
Currently impulsive (dis-inhibited erratic)				*An expression of concern from others about suicide*			
History of impulsivity, defiance, non compliance, boundary breaking behaviour				*History of repeated self-harm*			
Previously absconded from (any) hospital				**F: FALLS RISK**			
Current suspiciousness re the hospital or staff especially command hallucinations				*Significant past history of falls*			
Expressing dissatisfaction with care/treatment				*Hypotension*			
Current social stressors increasing absconding risk				*Muscle rigidity*			
Risk of wandering – mobile and confused				*Visual impairment*			
V: VIOLENCE RISK (brief risk screen)				*Ataxia*			
Current thoughts plans or symptoms indicating risk				*An expression of concern from others about the risk of falls*			
Significant past history of violence				*Current behaviour suggesting there is a risk*			
Current behaviour with alcohol or substance abuse							
O: OTHER RISKS							

	Y	N	U		Y	N	U
Risk of self neglect				*Risk of exploitation*			
Risk of non compliance with treatment plan				*Risk to children*			

Place the appropriate heading A, S, F, O or V within the risk category rated most appropriate following clinical assessment

Risk	**Category**	**Time**	**Date**	**Assessor**	**Grade**
High – *imminent risk of harm/injury to self or others*					
Medium – *background risk but no imminent risk*					
Low – *no evidence of risk of harm to self or others*					

Risk Management Summary & Risk Management Plan

This assessment forms part of the overall mental health assessment/ care plan. It is not an exhaustive list of risk factors, but does give an initial indicator of potential sources of risk and the risk management responses are contained in the care plan section of this patient document. Where specific risk issues are identified the assessment is discussed with the MDT members and further assessment /actions are documented as required. On-going monitoring and review of risk factors forms part of the overall ICP evaluations.

Give details of positive risks identified and protective factors / strengths and assess remaining risk

Identified risks are carried forward to care plan with management and follow up documented

Seclusion Observation		**When the risk assessment is completed the assessor should rate the level of observation necessary to maintain an appropriate therapeutic environment. Please tick *√*** **Special nursing observations can only be initiated following consultation with the Treating/On-Call Consultant Psychiatrist**
Special Observation		
High Observation, Nurse supervision always		
General Observation Circulate freely on the ward		

Name: _____Signed: _____ Discipline: _____

Date: _____ Time: _____

INDIVIDUALISED CARE PLAN

_____ (Name) has been placed in seclusion on the _____ (date) at _____

Hrs, due to _____

_____

in order to maintain his/her safety and that of other residents and staff.

Goals

To nurse _____(name) in a safe and supportive environment in order to minimise the risk to self and others.

To allow _____(name) to gain a degree of mental health well-being in order to enable him/her to be among the general ward population.

Plan

Ensure the completion of the appropriate parts of the seclusion register for each stage of seclusion and make any relevant notes in the patient's clinical records

Direct observation must remain in place for the first hour following commencement of seclusion. A qualified nurse must remain within sight and sound of the room at all times.

Continuous observation remains in place for the duration of the seclusion period and may include video or other electronic monitoring device i.e. CCTV and must be carried out by a registered psychiatric nurse.

These observations should ascertain whether or not the patient is unduly distressed and whether behaviour has subsided to such a level that termination of seclusion could be considered. Those observations must be recorded on the seclusion record forms at least every fifteen minutes.

Not less than once in every 2 hours, a Nursing Review must take place. It will include nurses entering the seclusion room to carry out an assessment of the patient.

Where seclusion is initiated by the most senior registered nurse on duty, a registered medical practitioner must be notified of the seclusion episode no later than 30minutes following the commencement of the episode.

Not less than once in every two hours, a Medical Review must take place which includes an assessment of the patient's ongoing mental and physical health and emotional trauma caused to the person as a result of the seclusion following the commencement of seclusion episode.

A Medical Examination must be carried out by a registered medical practitioner every four hours thereafter.

No later than 30minutes following there medical examination the registered medical practitioner must contact the persons Consultant Psychiatrist or the duty consultant psychiatrist to inform them of the episode of seclusion. The consultant psychiatrist must discontinue the use of seclusion unless they order its continued use.

The Registered Medical Practitioner must record this consultation in the clinical file and indicate on the seclusion register that the consultant psychiatrist ordered or did not order the continued use of seclusion.

If the Consultant Psychiatrist orders the use of seclusion, they must advice the duration of the order. The Registered Medical Practitioner must record this information on the seclusion register. A seclusion order must not be made for a period of time longer than four hours from the commencement of the seclusion episode.

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

Once in every 24 hour period, a Consultant Psychiatrist review must be carried out to review the need to continue seclusion and includes an assessment of the patient's ongoing mental and physical state.

A debrief by the Multidisciplinary team must be carried out for each period of seclusion by the team responsible for the care and treatment of the patient within two normal working days.

A review by the Multidisciplinary Team must be completed with the patient within five working days of the period of seclusion.

Where a patient requires seclusion for more than 72 hours continuously or has seven or more seclusion orders over a period of seven consecutive days, the consultant psychiatrist must inform in writing the Inspector of Mental Health Services in the form specified by the Mental Health Commission.

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

Care and procedures to be performed whilst in seclusion.

Input & Output Chart

Taking medication

Taking exercise

Observations taken

Case notes updated

Reason for seclusion explained to the patient and required observations and reviews.

THE DURATION OF SECLUSION MUST NOT BE PROLONGED BEYOND THE PERIOD OF SECLUSION WHICH IS STRICTLY NECESSARY TO PREVENT IMMEDIATE AND SERIOUS HARM TO THE PATIENT OR OTHERS.

In the best interest of the patients safety and the safety of others, was physical restraint necessary to seclude the patient? Yes □ No □

If Yes:

Was the Register for Physical Restraint Completed?

Did the patient have a physical medical examination by the NCHD within a timeframe of no more than two hours of the episode of restraint? Yes □ No □

Did the patient have a physical medical examination by the NCHD within a timeframe of no more than two hours of the episode of restraint? Yes/No

If no, please give reason as to why:

With the patients consent, was their next of kin informed? Yes □ No □

Name of Next of kin contacted: _____

Contacted by whom: _____

Date of Contact: _____

If not contacted please indicate reason:

_____

_____

_____

Refractory Clothing:

Was refractory clothing used? Yes / No

Must be risk assessed ☐

Must be documented in ICP ☐

Was the use of refractory clothing reviewed regularly? ☐

Was a search completed? Yes/No. If yes please complete a search log form.

The Seclusion facility was furnished, maintained and cleaned in such a way that ensure the patients right to dignity and privacy? Yes/No

Signed: _____ **Discipline: _____**

Date: _____ **Time: _____**

De-escalation Strategies

Describe how de-escalation strategies will continue to be used?

_____

_____

_____

_____

_____

_____

Document how potential Risks may be managed?

_____

_____

_____

_____

_____

_____

Describe the strategy for the ending of seclusion?

_____

_____

_____

_____

_____

_____

Daily 2 Hourly Nursing Review Record

Name: _____ Date Commenced: _____

NURSING REVIEW (2 hourly)

Date & Time	Comments	Nurse Signature

Daily 2 Hourly Nursing Review Record

Name: _____ Date Commenced: _____

NURSING REVIEW (2 hourly)		
Date & Time	**Comments**	**Nurse Signature**

Daily 2 Hourly Nursing Review Record

Name: _____ Date Commenced: _____

NURSING REVIEW (2 hourly)		
Date & Time	**Comments**	**Nurse Signature**

Daily 2 Hourly Nursing Review Record

Name: _____ Date Commenced: _____

NURSING REVIEW (2 hourly)		
Date & Time	**Comments**	**Nurse Signature**

Daily 2 Hourly Nursing Review Record

Name: _____ Date Commenced: _____

NURSING REVIEW (2 hourly)		
Date & Time	**Comments**	**Nurse Signature**

Daily 2 Hourly Nursing Review Record

Name: _____ Date Commenced: _____

NURSING REVIEW (2 hourly)		
Date & Time	**Comments**	**Nurse Signature**

Initial Medical Review Record

Name: _____ Date Commenced: _____

Initial Medical Review (No later than **2hrs post commencement** of Seclusion Episode)

Date & Time	**Comments**	***Doctors Signature***

Daily 4 Hourly Medical Review Record

Name: _____ Date Commenced: _____

MEDICAL REVIEW 4 hourly)		
Date & Time	**Comments**	**Doctors Signature**

Daily 4 Hourly Medical Review Record

Name: _____ Date Commenced: _____

MEDICAL REVIEW 4 hourly)		
Date & Time	**Comments**	**Doctors Signature**

Daily 4 Hourly Medical Review Record

Name: _____ Date Commenced: _____

MEDICAL REVIEW 4 hourly)

Date & Time	Comments	Doctors Signature

Daily 4 Hourly Medical Review Record

Name: _____ Date Commenced: _____

MEDICAL REVIEW 4 hourly)		
Date & Time	**Comments**	**Doctors Signature**

Daily 4 Hourly Medical Review Record

Name: _____ Date Commenced: _____

MEDICAL REVIEW 4 hourly)		
Date & Time	**Comments**	**Doctors Signature**

Consultant Review Record (Once every 24 hrs)

Please tick √

Treating Consultant □

On-Call Consultant □

If you are the on-call consultant, have you informed the treating consultant?

Yes □ **No** □

Patient Name: _____

Date & Time	Comments	Consultant Signature

Consultant Review Record (Once every 24 hrs)

Please tick √

Treating Consultant □

On-Call Consultant □

If you are the on-call consultant, have you informed the treating consultant?

Yes □ **No** □

Patient Name: _____

Date & Time	**Comments**	**Consultant Signature**

Consultant Review Record (Once every 24 hrs)

Please tick √

Treating Consultant □

On-Call Consultant □

If you are the on-call consultant, have you informed the treating consultant?

Yes □ **No** □

Patient Name: _____

Date & Time	**Comments**	**Consultant Signature**

Record of Seclusion Observation Sheet

Dept. of Psychiatry Midlands Regional Hospital Portlaoise

Entries on Record of Seclusion Observation Sheet.

In recording observations Nursing and Medical Staff must be cognisant that care and management of the patient is managed strictly in accordance with the "Rules Governing the Use of Seclusion" as laid down by the Mental Health Commission and in conjunction with the Dept. of Psychiatry Hospital Policy on the "Use of Seclusion".

In particular please note the following section of Rules Governing the Use of

seclusion:

5. THE MONITORING OF THE PERSON DURING SECLUSION

5.1 A person placed in seclusion must be kept under direct observation by a registered nurse for the first hour following the initiation of a seclusion episode.

5.2 After the first hour, a registered nurse must keep the person under continuous observation and be within sight and sound of the seclusion room. This observation may be completed in person or with CCTV (or other electronic monitoring).

5.3 A written record of the person must be made by a registered nurse at least every 15 minutes. This must include a record of:

i. the person's level of distress;

ii. the person's behaviour (what the person is doing and saying);

iii. the person's level of awareness;

iv. the person's physical health, especially with regard to breathing, pallor or cyanosis;

v. whether elimination/hygiene needs were met; and

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

5.4 Following a risk assessment, a nursing review of the person in seclusion must take place every two hours, unless the risk assessment indicates that to do so would place the person or staff at a high risk of injury. During this review, a minimum of two staff members, one of whom must be a registered nurse who was not directly involved in the decision to seclude (where possible), will enter the seclusion room and assess the person to determine whether the episode of seclusion can be ended. This assessment and decision must be recorded.

5.5 A medical examination must be carried out by a registered medical practitioner every four hours. This examination must take account of the records of the nursing observations and any previous medical examination(s). The decision to end or continue seclusion must be recorded.

5.6 Where a person is sleeping, clinical judgement needs to be used as to whether it is appropriate to wake the person for a nursing review or medical examination. In such instances medical examinations may be suspended. Nursing reviews must continue every two hours. However, the nature of the nursing review may be such that the person is not woken. A registered medical practitioner must be on call to carry out a medical examination during the night, should the need arise.

5.7 Upon commencement of an episode of seclusion, a Seclusion Care Plan for the person must be developed by a registered nurse. A Seclusion Care Plan must include as a minimum:

i. personal details;

ii. known clinical needs (including mental and physical considerations);

iii. how de-escalation strategies will continue to be used;

iv. the person's preferences in relation to seclusion, where known (e.g. access to music or reading material while in the seclusion room), and take into account outcomes of any previous debrief with the person, if applicable;

v. recognising signs where the person's behaviour is no longer deemed an unmanageable risk towards themselves or others, e.g. evidence of tension reduction, improved communication etc;

vi. how potential risks may be managed;

vii. reference to specific support plans for the person and details of how the person's mental health needs will continue to be met while in seclusion;

viii. meeting of food/fluid needs;

ix. meeting of needs in relation to personal hygiene/dressing;

x. meeting of elimination needs (with specific reference to how privacy and dignity will be managed);

Please use the below codes with recording seclusion observations

CODE A Level of Distress	CODE B Behaviour	CODE C Awareness/ alertness	CODE D Activity	CODE E Appearance
1 – No Distress	*Agitated* *Demanding* *Threatening*	A - Alert	*T-Toilet* *VS- Vitals* *FT-Food Taken*	**(N) Normal**
2 – Mild Distress Unhappy but not upset	*Assaultive* *Self-Abusive* *Crying*	V- Responds to voice	*DT- Diet Taken* *MT-Medication taken* *PC- Personal Care/hygiene*	**(PE) Pale**
3 – Moderate very unhappy and upset	*Yelling* *Singing* *Withdrawn*	E – Eupnoeic (Normal Healthy Breathing)	*PG – Pacing* *EX – Exercising* *KD – Knocking on the Door*	**(M) Mottled**
4 – Distressed upset and unable to regain control	*Disrobing* *Delusional* *Hallucinating*		*LB – Lying on the Bed* *SP – Sleeping* *SB -Sitting on the bed*	**(C) Cyanotic**
	Mumbling		*SF – Sitting on the floor*	

5 - Extremely distressed requiring urgent review	*Restless* *Resting* *Other **(Specify)***	U – Unconscious	*ST – Standing* *BT - Breathing* *O – Other **(Specify)***	**(R) Red**	

xi. medication reviews (in consultation with a registered medical practitioner);

xii. monitoring of physical observations; and

xiii. a strategy for ending seclusion; indicating the criteria required for this to be reached.

Record of Seclusion Observation Sheet

Patient Name:_____ **Date:** _____

Has the patient been informed of: Reason for use of Seclusion ☐ Likely duration of Seclusion ☐ Behaviours which lead to an end of seclusion ☐ Was the use of refractory clothing assessed?

Signed: _____

Direct Observation Should be carried out by a Registered Psychiatric Nurse for 1 Hour **Time Seclusion Commenced** _____☐____

Action	**Code A**	**Code B**	**Code C**	**Code D**	**Code E**	**Direct Obs**	**Signature**	**Time**
15 min obs								*:*
15 min obs								*:*
15 min obs								*:*
15 min obs								*:*

Action	**Code A**	**Code B**	**Code C**	**Code D**	**Code E**	**CCTV Obs**	**Signature**	**Time**
15 min obs								*:*

15 min obs :

15 min obs :

15 min obs :

Has the patient been informed of: Reason for use of Seclusion Likely duration of Seclusion Behaviours which lead to an end of seclusion Was the use of refractory clothing assessed?
Signed:_____

A comprehensive nursing review of the patient must be undertaken after every 2 hours of seclusion and documented in detail in the patients seclusion notes.

Action	**Code A**	**Code B**	**Code C**	**Code D**	**Code E**	**CCTV Obs**	**Signature**	**Time**
15 min obs								:
15 min obs								:
15 min obs								:
15 min obs								:
15 min obs								:
15 min obs								:
15 min obs								:
15 min obs								:

A comprehensive nursing review of the patient must be undertaken after every 2 hours of seclusion and documented in detail in the patients seclusion notes.

Has the patient been informed of: Reason for use of Seclusion Likely duration of Seclusion Behaviours which lead to an end of seclusion Was the use of refractory clothing assessed?
Signed:_____

A comprehensive Medical review of the patient must be undertaken after every 4 hours of seclusion and documented in detail in the patients clinical notes

Action	**Code A**	**Code B**	**Code C**	**Code D**	**Code E**	**CCTV Obs**	**Signature**	**Time**
15 min obs								:
15 min obs								:
15 min obs								:
15 min obs								:
15 min obs								:
15 min obs								:
15 min obs								:

15 min obs *:*

Has the patient been informed of: Reason for use of Seclusion Likely duration of Seclusion Behaviours which lead to an end of seclusion Was the use of refractory clothing assessed?
Signed:_____

A comprehensive nursing review of the patient must be undertaken after every 2 hours of seclusion and documented in detail in the patients seclusion notes.

Action	**Code A**	**Code B**	**Code C**	**Code D**	**Code E**	**CCTV Obs**	**Signature**	**Time**
15 min obs								*:*
15 min obs								*:*
15 min obs								*:*
15 min obs								*:*
15 min obs								*:*
15 min obs								*:*
15 min obs								*:*
15 min obs								*:*

A comprehensive nursing review of the patient must be undertaken after every 2 hours of seclusion and documented in detail in the patients seclusion notes.

Has the patient been informed of: Reason for use of Seclusion Likely duration of Seclusion Behaviours which lead to an end of seclusion Was the use of refractory clothing assessed?
Signed:_____

Record of Seclusion Observation Sheet

Patient Name*:*_____ **Date:** _____

Time Seclusion Commenced _____

Action	**Code A**	**Code B**	**Code C**	**Code D**	**Code E**	**CCTV Obs**	**Signature**	**Time**
15 min obs								*:*
15 min obs								*:*
15 min obs								*:*
15 min obs								*:*
15 min obs								*:*

15 min obs :

15 min obs :

15 min obs :

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Signed:_____

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Patient has restricted access to diet and fluids.

Patient may neglect nutrition due to disturbed mental state.

Nutrition

Day Date:	Sign	Day Date:	Sign	Day Date:	Sign
Breakfast Yes/No Comment:		Breakfast Yes/No Comment:		Breakfast Yes/No Comment:	
Lunch Yes/No Comment:		Lunch Yes/No Comment:		Lunch Yes/No Comment:	
Dinner Yes/No Comment:		Dinner Yes/No Comment:		Dinner Yes/No Comment:	

Snack Yes/No Comment:		Snack Yes/No Comment:		Snack Yes/No Comment:	
Snack Yes/No Comment:		Snack Yes/No Comment:		Snack Yes/No Comment:	

Hydration

Fluids 2hourly	Day Quantity in mls	Sign	Day Quantity in mls	Sign	Day Quantity in mls	Sign
	Date		**Date**		**Date**	
Review 1						
Review 2						
Review 3						
Review 4						
Review 5						
Review 6						
Review 7						
Review 8						
Review 9						
Review 10						
Review 11						
Review 12						

Seclusion Environment

Regularly Check Temperature and ventilation of seclusion/ask patient.

	Day Date:	Sign	Day Date:	Sign	Day Date:	Sign
Review 1						
Review 2						
Review 3						
Review 4						
Review 5						
Review 6						

Review 7						
Review 8						
Review 9						
Review 10						
Review 11						
Review 12						

Room Cleaned

Day Date:	Day Date:	Day Date:
Time: Comment:	Time: Comment:	Time: Comment:
Time: Comment:	Time: Comment:	Time: Comment:
Time: Comment:	Time: Comment:	Time: Comment:

Blinds

Day Date:	Day Date:	Day Date:
Time: Comment:	Time: Comment:	Time: Comment:
Time: Comment:	Time: Comment:	Time: Comment:
Time: Comment:	Time: Comment:	Time: Comment:

11. ENDING OF SECLUSION

Post Seclusion Checklist

Has the patient been informed regarding the ending of seclusion? ☐

Has the post seclusion risk assessment been completed? ☐

Has the following people been notified of the ending of the seclusion episode?

CNM 2 ☐

CNM 3 ☐

Duty ADON or ADON On-Call ☐

Duty Consultant or On-Call Consultant ☐

Patients N.O.K (Only if consent is given) ☐

Has the MHC been notified of the ending of the seclusion episode? ☐

Has the need of seclusion been resolved in the patient ICP? ☐

Has the patients debriefing tool being completed by the Key nurse or MDT Member within two working days? ☐

Has the Multidisciplinary team reviewed the episode of the seclusion within five working days? ☐

New Updated Risk Management Summary & Risk Management Plan

Date & Time: _____

Name:_____ ___ **Address:**_____ _____ ____ **DOB:**_____**DOA:** _____	The following criteria are devised to assist clinicians in the formulation and management of risk. Y – Yes, risk present. N – No, no risk. U – Unknown, it is Not possible to rate at present. ***Where a risk is assessed insert a √***

Risk Determination

A: ABSCONDING RISK	**Y**	**N**	**U**	**S: SUICIDE RISK (brief risk screen)**	**Y**	**N**	**U**
Expressing desire to leave/not come into hospital				*History of previous suicide attempt*			
Pacing/watching doors				*Current thoughts or plan that indicate risk*			
Active addictions (detoxing/craving) – strong desire take alcohol or non prescribed drugs				*Current problems with alcohol or substance abuse*			
Currently impulsive (dis-inhibited erratic)				*An expression of concern from others about suicide*			
History of impulsivity, defiance, non compliance, boundary breaking behaviour				*History of repeated self-harm*			
Previously absconded from (any) hospital				**F: FALLS RISK**			
Current suspiciousness re the hospital or staff especially command hallucinations				*Significant past history of falls*			
Expressing dissatisfaction with care/treatment				*Hypotension*			
Current social stressors increasing absconding risk				*Muscle rigidity*			
Risk of wandering – mobile and confused				*Visual impairment*			
V: VIOLENCE RISK (brief risk screen)				*Ataxia*			

Current thoughts plans or symptoms indicating risk				*An expression of concern from others about the risk of falls*			
Significant past history of violence				*Current behaviour suggesting there is a risk*			
Current behaviour with alcohol or substance abuse							
O: OTHER RISKS							
	Y	**N**	**U**		**Y**	**N**	**U**
Risk of self neglect				*Risk of exploitation*			
Risk of non compliance with treatment plan				*Risk to children*			

Place the appropriate heading A, S, F, O or V within the risk category rated most appropriate following clinical assessment

Risk	**Category**	**Time**	**Date**	**Assessor**	**Grade**
High – *imminent risk of harm/injury to self or others*					
Medium – *background risk but no imminent risk*					
Low – *no evidence of risk of harm to self or others*					

Risk Management Summary & Risk Management Plan

This assessment forms part of the overall mental health assessment/ care plan. It is not an exhaustive list of risk factors, but does give an initial indicator of potential sources of risk and the risk management responses are contained in the care plan section of this patient document. Where specific risk issues are identified the assessment is discussed with the MDT members and further assessment /actions are documented as required. On-going monitoring and review of risk factors forms part of the overall ICP evaluations.

Give details of positive risks identified and protective factors / strengths and assess remaining risk

Identified risks are carried forward to care plan with management and follow up documented

Seclusion Observation		**When the risk assessment is completed the assessor should rate the level of observation necessary to maintain an appropriate therapeutic environment. Please tick √**
Special Observation		
High Observation, Nurse supervision always		**Special nursing observations can only be initiated following consultation with the Treating/On-Call Consultant Psychiatrist**
General Observation Circulate freely on the ward		

Name: _____Signed: _____ Discipline: _____

Date: _____ Time: _____

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

LAOIS OFFALY MENTAL HEALTH SERVICES

HSE Midlands Louth Meath

Community Healthcare Organisation CHO 8

Dept. of Psychiatry MRHP

Portlaoise

Co. Laois

R32 RW61

Tel: (05786) 96396

Fax: (05786) 96416

Patient Debriefing completed by the Multidisciplinary Team Following Episode of Seclusion within two working days.

Patient / Resident's Name: _____ DOB: ____/____/____

Patient / Resident's ID Number: _____ Date: ____/____/____ Time: _____

Members of the MDT present please include Signatures:

Nursing

Social Worker

Medical

Psychologist

Occupational Therapist

Other

Q1. Would you like to discuss your recent episode of Seclusion and/ Restraint? ☐ ☐

If not has it been recorded in the clinical file if the person does not wish to participate in the debrief

_____

_____

_____

Q2. What is your understanding of why you were Restraint / Secluded?

_____

_____

_____

Q3. Is there anything that could have helped you to prevent the incident occurring?

_____

_____

_____

Q4. In your estimation, was length of time spent in Restraint / Seclusion appropriate?

Yes ☐ No ☐(✓ One)

Q5. Do you think the Seclusion / Restraint could have ended sooner? Yes ☐ No ☐ (✓ One)

If yes what would have ended it sooner?

_____

_____

Q6. Did you find this intervention helpful? Yes ☐o (☐ One)

If not helpful can you explain why?

_____

Q7. How do you feel you were treated during this episode? **E.g. with dignity and respect** – Comment:

_____

_____

_____

Q8. What could you and the staff have done to make it easier for you after the Seclusion / Restraint?

_____

_____

_____

Q9. If this was required in the future do you have a preference with alternative de-escalation strategies that could avoid a seclusion episode?

_____

_____

_____

Q10. Do you think your episode of seclusion/restraint could have been managed differently?

_____

_____

_____

Signature: _____ (MDT member / Key worker)

Signature: _____ (Patient / Resident)

Debriefing is deferred due to the Patient's / Resident's mental / clinical state.

For Review again in 24 Hours. Next debriefing Date: ____/____/____

Signature: _____ Date: ____/____/____

MHC INFORMATION BOOKLET ON SECLUSION GIVEN TO RESIDENT: Yes □ No □

IF NO, PLEASE STATE REASON:

_____

_____

_____

Feidhmeannacht na Seirbhíse Sláinte
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MULTIDISCIPLINARY REVIEW FOLLOWING ENDING OF SECLUSION within five working days.

Members of the MDT present please include Signatures:

Nursing

Social Worker

Medical

Psychologist

Occupational Therapist

Other

Q1. Identify any triggers which may have contributed to the Seclusion Episode.

_____

_____

_____

Q2. Review any missed opportunities for earlier intervention in line with the principles of positive behaviour support i.e. Inclusion, Choice, participation and equality of opportunity.

_____

_____

_____

Q3. Alternative De-escalation strategies discussed that could avoid Seclusion Episode in the future.

_____

_____

_____

Q4. Was the Seclusion Episode the shortest possible duration for this person with evidence in the Seclusion Core Care plan?

_____

_____

_____

Q5. Considerations of the outcomes of the person centred debrief if possible.

_____

_____

_____

Q6. Identify if there were any factors in the physical environment that may have contributed to the use of Seclusion.

_____

_____

_____

Signature: _____ (MDT member / Key worker)

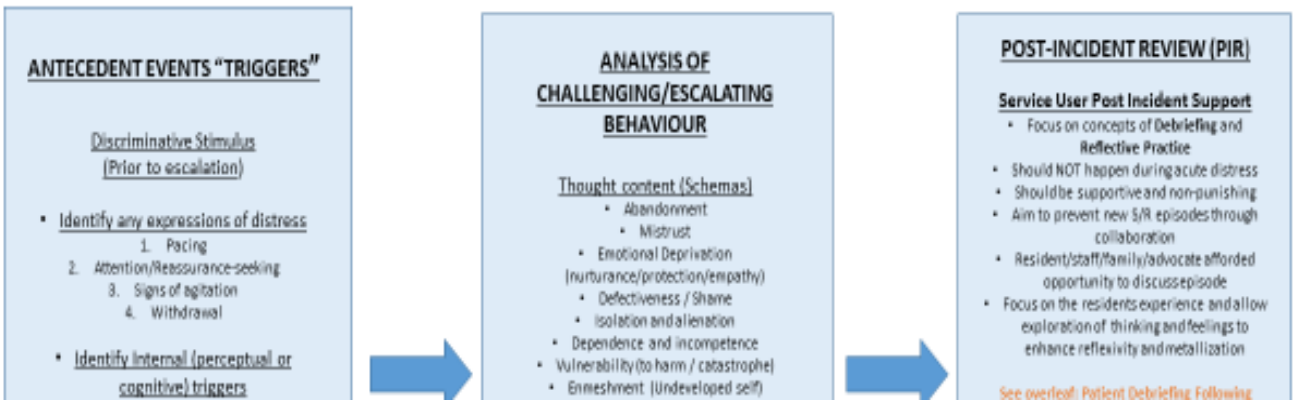
Signature: _____ (Patient / Resident)

Debriefing is deferred due to the Patient's / Resident's mental / clinical state.

For Review again in 24 Hours. Next debriefing Date: ____/____/____

Signature: _____ Date: ____/____/____

MULTIDISCIPLINARY POSITIVE BEHAVIOURAL SUPPORT PLAN FOLLOWING SECLUSION/RESTRAINT (S/R)



Patient Debriefing Following Episode of Physical S/R (within Two Working Days)

Q1. Would you like to discuss your recent episode of Physical Restraint? Yes ☐ No ☐
(If not, has it been recorded in the clinical file if the person does not wish to participate in the debrief?
Q2. What is your understanding of why you were physically restrained?
(Note Comment)
Q3. Is there anything that could have helped you to prevent the incident occurring?
(Note Comment)
Q4. In your estimation, was length of time you were Physically Restrained appropriate? Yes ☐ No ☐
Q5. Do you think the Physical Restraint could have ended sooner? Yes ☐ No ☐
(If yes, what would have been done to end it sooner?)
Q6. Did you find this intervention helpful? Yes ☐ No ☐
(If not helpful, can you explain why?)
Q7. How do you feel you were treated during this episode? E.g. With Dignity and Respect.
(Note Comment)
Q8. What could you and the staff have done to make it easier for you after you were Restrained?
(Note Comment)
Q9. If this was required in the future, do you have a preference with alternative de-escalation strategies that could avoid another Physical Restraint episode?
(Note Comment)
Q10. Do you think your episode of restraint could have been managed differently? Yes ☐ No ☐
(If yes, what would have ended it sooner?)

Multidisciplinary Review Following Episode of Physical S/R (within Five Working Days)

Q1. Identify any triggers which may have contributed to the Physical Restraint Episode.
Q2. Review any missed opportunities for earlier intervention in line with the principles of positive behaviour support i.e. Inclusion, Choice, participation and equality of opportunity.
Q3. Alternative de-escalation strategies discussed that could avoid a Physical Restraint Episode in the future.
Q4. Was the Physical Restraint Episode the shortest possible duration for this person with evidence in the Seclusion Core Care plan?
Q5. Considerations of the outcomes of the person centred debrief if possible.
Q6. Identify if there were any factors in the physical environment that may have contributed to the Physical Restraint Episode.

Appendix III

Membership of the Approval CMT Governance Group (Template)

Please list all members of the relevant approval governance group (and title) who have final approval of the PPPG document.

Clinical Director
Area Director of Nursing
Hospital Administrator
Principal Psychologist
Occupational Therapy Manager
Social Work Manager
Mental Health Engagement Area Lead
Dietitian Manager
Business Manager
Risk Advisor
Registered Proprietor
SLT Manager

Appendix IV

Signature Sheet

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

Print Name	Signature	Area of Work	Date

Appendix IV

Signature Sheet

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

Print Name	Signature	Area of Work	Date

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Signature Sheet

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

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Signature Sheet

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

Print Name	Signature	Area of Work	Date

Appendix 5: Use of Mechanical Means of Bodily Restraint for Immediate Threat of Serious Harm to Self or Others

Policy Title: Use of Mechanical Means of Bodily Restraint for Immediate Threat of Serious Harm to Self or Others.

Department of Psychiatry, Laois/ Offaly MHS

Document reference number	DOPMBC 035c	Document developed by	Policy Committee for the Approved Centres
Revision number	3	Document approved by	Approved Centre Governance Group
Approval date	February 2024	Responsibility for implementation	Designated ADON's CNMs, Consultant Psychiatrist , NCHD's
Revision date	February 2025	Responsibility for review and audit	Designated ADONs; Policy Sub Group; Clinical Governance.

Table of Contents:

1.0 Policy Statement

The Department Of Psychiatry advocates the use of strategies to prevent aggression and violence occurring focused on early recognition, prevention and de-escalation but acknowledges that an individual's behaviour may escalate to a point where mechanical means of bodily restraint becomes necessary to protect the person, staff or others from significant injury or harm.

Definition of Mechanical Means of Bodily Restraint:-

Mechanical means of bodily restraint is defined by the MHC as “the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a person’s body”.

2.0 Purpose

The purpose of this policy is to assist clinical staff with the process involved in mechanical means of bodily restraint for immediate threat of serious harm to self or others in our approved centres in LOMHS.

3.0 Scope

All clinical members of staff of Approved Centres in LOMHS must be made aware of this policy.

4.0 Glossary of Terms

APPROVED CENTRE A “centre” means a hospital or other inpatient facility for the care and treatment of persons suffering from mental illness or mental disorder. An “approved centre” is a centre that is registered pursuant to the Mental Health Act 2001-2018. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the Mental Health Act 2001-2018.

BREAKAWAY TECHNIQUES A set of physical skills to help separate or break away from an aggressor in a safe manner. They do not involve the use of restraint.

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

CLINICAL FILE A record of the person’s referral, assessment, care and treatment while in receipt of mental health services. This documentation should be stored in the one file. If all relevant information is not stored in the one fie, the file should record where the other information is held.
CLINICAL GOVERNANCE A system for improving the standard of clinical practice including clinical audit, education and training, research and development, risk management, clinical effectiveness and openness.

CONSULTANT PSYCHIATRIST means a consultant psychiatrist who is employed by the HSE or by an approved centre or a person whose name is entered on the division of psychiatry or the division of

child and adolescent psychiatry of the Register of Medical Specialists maintained by the Medical Council.

DEVICE an item/object made or adapted for the purpose of restraining a person's movement or access to the person's body.

DE-ESCALATION The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression.

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

DUTY CONSULTANT PSYCHIATRIST The consultant psychiatrist on the on-call duty rota. 5 Mental Health Commission | 2022 Code of Practice on the Use of Mechanical means of bodily restraint

INDIVIDUAL CARE PLAN A documented set of goals developed, regularly reviewed and updated by the person's multidisciplinary team, so far as practicable in consultation with each person receiving care and treatment. The individual care plan should specify the treatment and care required which should be in accordance with best practice, should identify necessary resources and should specify appropriate goals for the person. For children, individual care plans should include education requirements. The care plan is recorded in the one composite set of documentation.

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

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

POLICY Written statement that clearly indicates the position of the organisation on a given subject.

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

REGISTERED MEDICAL PRACTITIONER A person whose name appears on the General Register of Medical Practitioners.

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

RIGHTS-BASED APPROACH Integrating human rights norms and principles in the design, implementation, monitoring and evaluation of policies and programmes. The principles of equality and freedom from discrimination are central.

RISK ASSESSMENT An assessment to gauge risk in relation to the person, designed and recognised for use in mental health settings.

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

5.0 Roles and Responsibilities

5.1It is the responsibility of the Approved Centre Governance Committee to ensure that this is policy is reviewed three yearly or at any time if there is a change of practice.

5.2 It is the responsibility of each line manager to ensure that staff within their work area are aware of, and are adhering to the requirements of this policy.

6.0 Procedure

6.1The use of mechanical means of bodily restraint must only be initiated and ordered by a consultant psychiatrist.

6.2The order must confirm that there are no other less restrictive ways available to manage the person's presentation.

6.3The use of mechanical means of bodily restraint must only occur following as comprehensive an assessment of the person as is practicable. This must include a risk assessment, the outcome of which must be recorded in the person's clinical file. A copy of the risk assessment must be made available to the Mental Health Commission on request.

6.4The consultant psychiatrist must record the matter in the clinical file and on the Register for Mechanical Means of Bodily Restraint.

6.5A copy of the Register must be placed in the person's clinical file and a copy must be available to the Mental Health Commission on request.

6.6A medical examination to be carried out no later than four hours after the commencement of the episode of mechanical restraint. The medical examination must be undertaken by a registered medical practitioner.

6.7The medical examination must include: an assessment and record of any physical, psychological and/or emotional trauma caused to the person as a result of the mechanical restraint.

6.8Each order is for a maximum of four hours. A medical examination by a registered medical practitioner is required before a renewal order can be made.

6.9As soon as is practicable, and no later than 30 minutes following the medical examination, the registered medical practitioner must contact the consultant psychiatrist responsible for the care and

treatment of the person, or the duty consultant psychiatrist, to inform them of the outcome of the medical examination. The consultant psychiatrist must discontinue the use of mechanical means of bodily restraint unless they order its continued use.

6.10The registered medical practitioner must record this consultation in the clinical file and indicate on the Register for Mechanical Means of Bodily Restraint that the consultant psychiatrist ordered or did not order the continued use of mechanical means of bodily restraint.

6.11If the consultant psychiatrist orders the continued use of mechanical means of bodily restraint, they must also indicate the duration of the order, and this must be recorded on the Register for Mechanical Means of Bodily Restraint. Each order is for a maximum of four hours.

6.12Each person's communication needs must be addressed. For instance, if a person uses their hands to communicate and are mechanically restrained, this may prevent effective communication. Special care must be taken in these situations. The staff who are familiar with the communication needs of the person, and the availability of communication aids required by the person, must be used as appropriate.

6.13The consultant psychiatrist responsible for the care and treatment of the person, or duty consultant psychiatrist, must undertake a medical examination of the person and sign the Register for Mechanical Means of Bodily Restraint within 24 hours of the commencement of the mechanical restraint episode. The examination must be recorded in the person's clinical file.

6.14The person must be informed of the reasons for, likely duration of, and the circumstances which will lead to the discontinuation of mechanical means of bodily restraint unless the provision of such information might be prejudicial to the person's mental health, well-being or emotional condition. If informed of the reasons, a record of this must be recorded in the person's clinical file as soon as is practicable. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the person's clinical file as soon as is practicable.

6.15As soon as is practicable, and if it is the person's wish in accordance with their individual care plan, the person's representative must be informed of the person's restraint and a record of this communication must be entered in the person's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the person's clinical file.

6.16 Where it is the person's wish in accordance with their individual care plan that the person's representative is not to be informed of the restraint, no such communication must occur outside the course of that necessary to fulfil legal and professional requirements. This must be recorded in the person's clinical file.

6.17It must be assumed that any person who is restrained by mechanical means may have a past history of trauma and/or abuse. Therefore, the principles of trauma-informed care must underpin the use of restraint on a person.

6.18Where practicable, the person must have a staff member of the same gender present during the initiation of the restraint.

6.19The person must be subject to continuous observation by a registered nurse throughout the use of mechanical means of bodily restraint to ensure the person's safety.

6.20The person must be reviewed by the registered nurse every fifteen minutes for the duration of the period of mechanical restraint.

i. details of the person's behaviour;

ii. respiratory status/rate;

iii. pressure areas/tissue viability check;

iv. colour/movement/sensation of restricted limb;

v. whether elimination/hygiene needs were met;

vi. whether hydration/nutrition needs were met.

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

6.21Where mechanical means of bodily restraint is used on a person for a period beyond 24 hours, it must be subject to an independent review by a consultant psychiatrist who is not directly involved in the person's care and treatment.

6.22Mechanical restraint may be ended:

i. by a registered medical practitioner at any time following discussion with the person who is restrained and relevant nursing staff; or

ii. by the most senior registered nurse in the unit/ward, in consultation with the person who is restrained and a registered medical practitioner.

6.23Where mechanical restraint is ended by a registered medical practitioner or the most senior registered nurse on duty in the unit/ward, the consultant psychiatrist responsible for the care and treatment of the person, or the duty consultant psychiatrist acting on their behalf, must be notified.

6.24The time, date and reason for ending the mechanical means of bodily restraint must be recorded in the person's clinical file on the date that the mechanical means of bodily restraint ends.

6.25An in-person debrief with the person who was restrained must follow every episode of mechanical means of bodily restraint. This debrief must be person centred and must:

i. give the person the opportunity to discuss the mechanical means of bodily restraint with members of the multidisciplinary team involved in the person's care and treatment as part of a structured debrief process;

ii. Occur within two working days (i.e. days other than Saturday/Sunday and bank holidays) of the episode of mechanical restraint unless it is the preference of the person who was restrained to have the debrief outside of this timeframe. The person's preferences regarding the timing of the debrief must be recorded;

iii. respect the decision of the person not to participate in a debrief, if that is their wish. If the person declines to participate in the debrief, a record of this must be maintained and recorded in the person's clinical file;

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

v. include a discussion regarding the person's preferences in the event where a restrictive intervention is needed in the future e.g. preferences in relation to which restrictive intervention they would not like to be used; and

vi. give the person the option of having their representative or nominated support person attend the debrief with them, and, if the person's representative or nominated support person does not attend the debrief, a record of the reasons why this did not occur must be recorded in the person's clinical file.

6.26Where multiple episodes of restraint occur within a 48-hour timeframe, these episodes may be reviewed during a single debrief.

6.27The person's individual care plan must be updated to reflect the outcome of the debrief, and in particular, the person's preferences in relation to restrictive interventions going forward.

6.28A record must be kept of the offer of the debriefing, whether it was accepted and the outcome.

6.29A record of all attendees who were present at the debrief must be maintained and be recorded in the person's clinical file.

6.30Where a person's representative has been informed of the person being restrained, the person's representative must be informed of the ending of the episode of mechanical means of bodily restraint as soon as is practicable. A record of this communication must be entered in the person's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the person's clinical file.

6.31Any use of a restrictive intervention may be traumatic for the person who experiences it. Appropriate emotional support must be provided to the person in the direct aftermath of the episode. Staff must also offer support, if appropriate, to other persons who may have witnessed the restraint of the person.

6.32The multidisciplinary team must develop a plan of care for each person who is restrained by mechanical means. This plan of care must include information on how the approved centre is attempting to reduce or eliminate the use of restraint for the person.

6.33Each episode of mechanical means of bodily restraint must be reviewed by members of the multidisciplinary team involved in the person's care and treatment and documented in the person's clinical file as soon as is practicable, and in any event no later than five working days (i.e. days other than Saturday/ Sunday and bank holidays) after the episode of restraint. The review must include:

i. the identification of the trigger/antecedent events which contributed to the restraint episode;

ii. a review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support;
iii. the identification of alternative de-escalation strategies to be used in future;

the duration of the restraint episode and whether this was for the shortest possible duration;
iv. considerations of the outcomes of the person-centred debrief, if available; and
v. an assessment of the factors in the physical environment that may have contributed to the use of restraint.

6.34The multidisciplinary team review must be documented and must record actions decided upon and follow-up plans to eliminate or reduce restrictive interventions for the person.

6.35The Registered Proprietor must notify the Mental Health Commission of the start time and date, and the end time and date of each episode of mechanical restraint in the format specified by the Mental Health Commission, and within the timeframes set by the Mental Health Commission.

6.36The DOP Oversight Approved Centre Governance group meet on a monthly basis and analyse in detail every episode of mechanical means of bodily restraint. This group determine compliance with the MHC rules governing mechanical means of bodily restraint and local PPPg's., identify improvement needs and actions required and produce a report on same.

6.37Children must never be subjected to mechanical means of bodily restraint for immediate threat of serious harm to self or others.

Use of Mechanical Means of Bodily Restraint for enduring Risk of Harm to Self or Others

6.38The use of mechanical means of bodily restraint on an ongoing basis for enduring risk of harm to self or others may be appropriate in certain clinical situations but must be used only to address an identified clinical need and/or risk. Examples include the use of cot sides, bed rails, and lap belts.

Note: While the use of bed rails and cot sides may be considered a restrictive practice, it is important to note that they may also be an important safety measure for some people. Staff must regularly review and assess the use of bed rails and cot sides. Bed rails and cot sides must not be used where a person is severely confused and mobile enough to climb over them.

6.39As mechanical restraint limits freedom, it must only be used when less restrictive alternatives are deemed not suitable. The use of mechanical restraint for the enduring risk of harm to self or others must only be used where:

i. a risk assessment of the safety and suitability of the mechanical restraint for the person has been undertaken. The risk assessment must specify the monitoring arrangements which shall be implemented during the use of mechanical restraint and the frequency of same. A copy of the risk assessment, and a record of the

monitoring of the person, must be available to the Mental Health Commission on request;

ii. the risk assessment has been reviewed and updated regularly, at least quarterly, in line with the person's individual care plan. Depending on the level of risk, some persons will require review of their risk assessment at daily or weekly intervals; and

the multidisciplinary team has developed a plan of care for each person who is restrained by mechanical means. This plan of care must include information on how the approved centre is attempting to reduce the use of restraint for the person.

6.40Mechanical means of bodily restraint for enduring risk of harm to self or others must be ordered by a registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the person, or the duty consultant psychiatrist acting on their behalf.

6.41Mechanical means of bodily restraint for enduring risk of harm to self or others ordered under Rule 10.3 is not required to be entered on the Register for Mechanical Means of Bodily Restraint for Immediate Threat to Self or Others.

6.42The clinical file must contain a contemporaneous record (Appendix 2) that specifies the following:

i. That there is an enduring risk of harm to self or others;
ii. That less restrictive alternatives have not been successful;
iii. **T**he type of mechanical restraint;
iv. The situation where mechanical means of bodily restraint is being applied;

v. The duration of the restraint;
vi. The duration of the order;
vii. The review date.

6.43A review of all persons at the approved centre who are/were the subject to Mechanical Means of Bodily Restraint for Enduring Risk of Harm to Self or Others in the previous quarter must take place to determine the appropriateness of the use of this restrictive practice. This review must be undertaken by the multidisciplinary review and oversight committee and must outline the arrangements that are in place at the approved centre to reduce or, where possible, eliminate the use of mechanical means of bodily restraint as it relates to Enduring Risk of Harm to Self or Others.

6.44The committee must meet at least quarterly and must:

i. determine if there was compliance with the rules on the use of mechanical means of bodily restraint for enduring risk of harm to self or others;
ii. determine if there was compliance with the approved centre's own policies and procedures relating to mechanical means of bodily restraint for enduring risk of harm to self or others;
iii. identify and document any areas for improvement;
iv. identify the actions, the persons responsible, and the timeframes for completion of any actions;

v. provide assurance to the Registered Proprietor Nominee that each use of mechanical restraint for enduring risk of harm to self or others was in accordance with the Mental Health Commission's Rules; and

vi. produce a report following each meeting of the review and oversight committee. This must be available to the Mental Health Commission upon request.

6.45The Registered Proprietor must notify the Mental Health Commission about the use of mechanical restraint for enduring risk to self and others in the format specified by the Mental Health Commission, and within the timeframes set by the Mental Health Commission.

6.46Mechanical means of bodily restraint must never be used to ameliorate operational difficulties including where there are staff shortages; as a punitive action; where the person is in seclusion; solely to protect property; where a safety assessment of the device has not been carried out; as a substitute for less restrictive interventions.

6.47The approved centre has developed and implemented a reduction policy on the use of mechanical means of bodily restraint. This is published on the Registered Proprietors website who has overall accountability for the reduction policy.

6.48All information gathered regarding the use of mechanical means of bodily restraint must be held in the approved centre and used to compile an annual report on the use of mechanical means of bodily restraint at the approved centre. This report, which must be signed by the Registered Proprietor Nominee, must be made available on the Registered Proprietor's website within six months of the end of the calendar year and available, upon request, to the public. The annual report must contain:

i. aggregate data that must not identify any individuals;

ii. a statement about the effectiveness of the approved centre's actions to reduce and, where possible, eliminate mechanical means of bodily restraint;

iii. a statement about the approved centre's compliance with the rules governing the use of mechanical means of bodily restraint;

iv. a statement about the compliance with the approved centre's own reduction policy; and

v. the data as specified in Appendix 3.

6.49All approved centres must produce and publish an annual report on their use of mechanical restraint. Where mechanical restraint has not been used in the relevant 12-month period, then points I and ii above must only be reported on.

6.50The approved Centres has a written policy in relation to the use of mechanical means of bodily restraint and maintains a written record indicating that all staff involved in mechanical means of bodily restraint read and understand the policy.

6.51All staff who participate, or may participate, in the use of mechanical restraint must have received the appropriate training in its use and in the related policies and procedures.

7. STAFF TRAINING

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

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

1. The prevention and therapeutic management of violence and aggression (including “breakaway” and de-escalation techniques)

2. Alternatives to mechanical means of bodily restraint

3. Trauma-informed care

4. Cultural competence

5. Human rights, including the legal principles of restrictive interventions

6. Positive behaviour support including the identification of causes or triggers of the person’s behaviours including social, environmental, cognitive, emotional, or somatic

7. 3The monitoring of the safety of the person during and after the mechanical means of bodily restraint. The identification of appropriately qualified person(s) to give the training; and the mandatory nature of training for those involved in bodily restraint.

7.4 The appropriate person identified by Laois / Offaly Mental Health Service to provide the training needs identified in Rules governing the use of Mechanical Means of Bodily Restraint is Ms. Amelia Cox.

7.5 A record of attendance at training should be maintained.

8.0 Revision and Audit

A triennial review will be carried out unless for example, an audit, serious incident, organisational structural change, scope of practice change, significant changes in international best practice or legislation identifies the need to update the policy sooner.

9.0 Method used to review operation of Standard Operating Procedure / Guideline.

Policy committee.

10.0 References

11.0 Appendices

Appendix 1

Section 69 – Register for mechanical means of bodily restraint for immediate threat to self or others.

Appendix 2

Pro forma for Mechanical means of Bodily Restraint for Enduring risk of harm to self or others.

Appendix 3

Data that is required to be published as part of the approved centres annual report on the use of means of bodily restraint for immediate threat of serious harm to self or others.

Appendix 4

Data that is required to be published as part of the approved centres annual report on the use of mechanical means of bodily restraint for enduring risk of harm to self or others.

APPENDIX 1 SECTION 69 - REGISTER FOR MECHANICAL MEANS OF BODILY RESTRAINT FOR IMMEDIATE

THREAT TO SELF OR OTHERS

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

5. Approved Centre Name:	**6. Unit/Ward Name:**
Mechanical Means of Bodily Restraint Details	
7. Date restraint commenced: _____/_____/_____ (dd/mm/yyyy)	**8. Time restraint commenced:** ____:____ (24hr clock e.g. 2.41pm is written as 14.41)

9. (a) Who initiated and ordered mechanical restraint:

Name (print): _____ _____

Signed: _____

9. (b) Who assisted with the mechanical restraint:

Name (print): _____ _____

Signed: _____

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

Signed: _____

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

Signed: _____

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

Signed:

Job title (print):

10 a) Type of mechanical restraint device used:

Soft cuffs n

Other (please specify) n _____

10 b) Mechanical restraint application/type:

Arms and Legs n

Legs n

Arms n

11. Why is mechanical restraint being used:

Immediate threat of serious harm to self	n
Actual harm caused to self	n
Immediate threat of serious harm to others	n
Actual harm caused to others	n
Transfer to seclusion room	n
Escort from the approved centre elsewhere	n
Other (please specify)	n _____

Please provide further details on the above:

12: Detailed description of alternative means of de-escalation attempted prior to the use of mechanical restraint:

13. Was the person's representative informed of the person's mechanical restraint?

Yes n No n

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

14. To be completed by the person who ended/renewed mechanical restraint Did the mechanical restraint episode result in any injury to the person? Yes n No n

If yes, please provide further details:

15. Initial Order (to be completed by a consultant psychiatrist):

I _____ have examined _____ on

Date: ____/____/_____ at ____ hrs ____ mins and I initiated and ordered n / do not order n the use of Mechanical Restraint from

Date: ____/____/_____ at ____ hrs ____ mins until no later than ____ hrs ____ mins

Name (print): _____ Signed: _____

16. Mechanical restraint ended n **Mechanical restraint renewed*** n

Who ended/renewed mechanical restraint:

Name (print): _____ Signed: _____

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

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

** If mechanical restraint is renewed, a new entry on the Register for Mechanical Means of Bodily Restraint and an Order must be completed.*

17. Mechanical Means of Bodily Restraint has been renewed under the supervision of the: *(Please tick as appropriate and sign below)*

Consultant Psychiatrist responsible for the care and treatment of the person n

Duty Consultant Psychiatrist n

Name (print): _____ Signed: _____

Date: ____/____/_____ at ____hrs ____mins

APPENDIX 2

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

LAOIS OFFALY MENTAL HEALTH SERVICES
HSE Midlands Louth Meath
Community Healthcare Organisation CHO 8
Dept. of Psychiatry MRHP
Portlaoise
Co. Laois
R32 RW61
Tel: (05786) 96396
Fax: (05786) 96416

Department of Psychiatry, Portlaoise - Oversight and Review Committee for the Reduction of Seclusion and Physical & Enduring Mechanical Restraint

Index

*****Please complete all sections sign*****

Risk Assessment for use of bed rails

Resident's Name DOB	Date	Date	Date	Date
Is it the Resident's (and /or family)own wish or preference for bed rails	Y N	Y N	Y N	Y N
Is it likely that the Resident will fall out of bed	Y N	Y N	Y N	Y N
Is it likely that the Resident would be injured from a fall from bed	Y N	Y N	Y N	Y N
Will the resident fell anxious if bed rails are not in place	Y N	Y N	Y N	Y N
Will the bed rails stop the Resident from being independent	Y N	Y N	Y N	Y N
Could the Resident climb over the bed rails	Y N	Y N	Y N	Y N
Could the Resident injure themselves on the bed rails	Y N	Y N	Y N	Y N
Could using the bed rails cause the Resident distress	Y N	Y N	Y N	Y N
Could the Resident's physical or mental condition increase the risk of entrapment	Y N	Y N	Y N	Y N
Can an alternative method of bed management be used	Y N	Y N	Y N	Y N
Are any of the following present • Communication problems • Confusion , Agitation, Delirium • Dementia • Repetitive or involuntary movements • Impaired or restricted mobility • Learning Disability • High or low body mass • Visual impairment • are using a pressure relieving mattress	 Y N Y N Y N Y N Y N Y N Y N Y N Y N	 Y N Y N Y N Y N Y N Y N Y N Y N Y N	 Y N Y N Y N Y N Y N Y N Y N Y N Y N	 Y N Y N Y N Y N Y N Y N Y N Y N Y N
Outcome of Assessment If you answer yes to (6) do not use bed rails				
Signature of Assessor				

Maryborough Centre/ Department of Psychiatry

RISK ASSESSMENT FOR LAP-BELT

NAME: _____ DATE: _____

STAFF SIGNATURE: _____

- Is the patient immobile? Yes/No
- Is there a history of falls? Yes/No
- Is it likely that the patient could fall out of the chair? Yes/No
- Has the patient any of the following?
  - Confusion Yes/No
  - Dementia Yes/No
  - Osteoporosis Yes/No
  - Seizures/Spasms Yes/No
  - Visual Impairment Yes/No
  - Vascular Disease Yes/No
  - Long term health issues Yes/No
  - Frailty Yes/No

- Is the patient on any of the following medications?
  Anti-coagulants Yes/No
  Sedatives Yes/No
  Anti-psychotics Yes/No

- Is the chair and lap belt correctly assessed and fitted to the individual patient?
  _____

- Does the patient understand the reason for using the lap belt?
  _____

- Does the patient consent to using the lap belt?
  _____

- Could the lap belt cause the patient distress?
  _____

- Is it likely that the patient could open the lap belt? Yes/No

- Is it likely that the patient could injure themselves if they fell out of the chair
  _____

- Is the lap belt prescribed by the patient's doctor and documented in their care plan?

_____

Maryborough Centre/ Department of Psychiatry

Clinical Decision for the use of Bed Rails/Lap Belt

Resident Name _____ DOB_____ ID Number_____

<table>
<tr><td colspan="3">Clinical Decision:
Has a risk Assessment been completed
What are the key factors from risk assessment for/against prescribing bed rails/lap belt</td></tr>
<tr><td colspan="3">Is there a less restrictive alternative
Is there an alternative option

Are there any particular concerns from clinical /resident /family</td></tr>
<tr><td colspan="3">Has the reason for bed rails/lap belt been explained to Resident</td></tr>
<tr><td>Resultant Action
Bed rails/Lap belt to be fitted</td><td colspan="2">Comments</td></tr>
<tr><td>Name of Assessor</td><td>Title</td><td>Date</td></tr>
<tr><td colspan="2">Signature of Consultant</td><td>Date</td></tr>
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Unit/Service	Review Date (every 3 mts)

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APPENDIX 3

DATA THAT IS REQUIRED TO BE PUBLISHED AS PART OF THE APPROVED CENTRE'S ANNUAL REPORT ON THE USE OF MEANS OF BODILY RESTRAINT FOR IMMEDIATE THREAT OF SERIOUS HARM TO SELF OR OTHERS.

1. The total number of persons that the centre can accommodate at any one time*
2. The total number of persons that were admitted during the reporting period*
3. The total number of persons who were mechanically restrained as a result of immediate threat to self or others during the reporting period*
4. The total number of episodes of mechanical restraint
5. The shortest episode of mechanical restraint
6. The longest episode of mechanical restraint

**Where this number is five or less a report must state "less than or equal to five"*

APPENDIX 4

DATA THAT IS REQUIRED TO BE PUBLISHED AS PART OF THE APPROVED CENTRE'S ANNUAL REPORT ON THE USE OF MECHANICAL MEANS OF BODILY RESTRAINT FOR ENDURING RISK OF HARM TO SELF OR OTHERS.

1. The total number of persons that the centre can accommodate at any one time*
2. The total number of persons that were admitted during the reporting period*
3. The total number of persons who were mechanically restrained as a result of the use of Mechanical Means of Bodily Restraint for Enduring Risk of Harm to Self or Others*

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