



## Statement on compliance with the rules governing seclusion, restraint & mechanical restraint for 2024

Approved Centre Name: \_\_\_\_\_ **Lakeview Unit** \_\_\_\_\_

The total number of persons that the centre can accommodate at any one time	29
The total number of persons that were admitted during the reporting period	325

### Rules Governing the Use of Seclusion

Issued Pursuant to Section 69(2) of the Mental Health Act 2001-2018.

The total number of persons who were secluded during the reporting period	11
The total number of seclusion episodes	16
The shortest episode of seclusion	1hr
The longest episode of seclusion	28hrs

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

KWWMHS set up a Reducing Restrictive Practices Committee in 2021. In 2023 with the launch of the updated Rule Governing the Use of Seclusion an MDT review and oversight committee was established to review each episode of restrictive practice. This committee continue to meet quarterly.

KWWMHS give a clear and transparent commitment to the people who use our services that all our leaders, managers and front line staff will endeavour to work together to ensure that the use of restrictive practices is minimised to the least restrictive method for the least time possible. The approved centre 'Lakeview Unit' is working towards a reduction in restrictive practices through continuous learning and improvement.

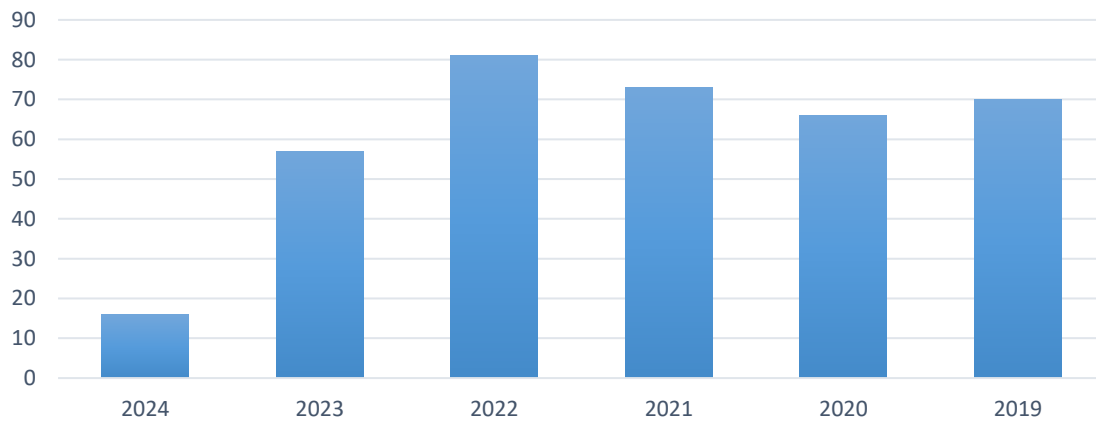
The KWWMHS and the approved centre 'Lakeview Unit' staff are committed to ensuring high standard of care is provided to patients. The service is committed to continuous quality improvement to improve the compliance with the standards set out by the Mental Health Commission and to reduce the occurrences of the use of seclusion. Year on year there has been a reduction in the number of episodes of seclusion.

See below graph 2024 has seen a 72% decrease on 2023.



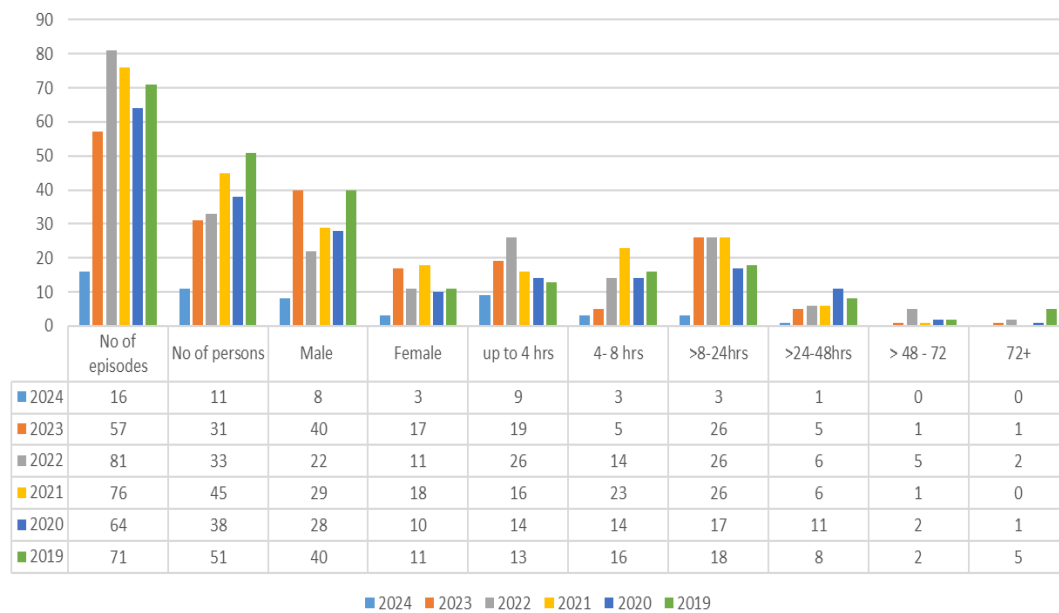
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### Seclusion Episodes



Another notable change is length of time of a seclusion episode. This demonstrates the approved centre's focus, commitment and drive to end an episode as early as possible.

### Seclusion 2024





## Statement on compliance with the rules governing seclusion, restraint & mechanical restraint for 2024

### A statement about the approved centre's compliance with the rules governing the use of seclusion

The approved centre uses a clinical document called a pathway that addressed all requirements of the rules governing the use of seclusion. This pathway guides staff through the elements of a seclusion episode along with direction and guidance on the care and treatment of the patient. It provides the outline of the next steps required to support and ensure the human rights the patient are forefront to management of the episode and the time-frame in which to be completed.

Each episode is reviewed in real time by the nurse in charge then CNM2. The Mental Health Act Administrator oversees the process and sends out communication prompts to MDT members in relation to completion of the debrief with the patient within 2 days and the 5 day MDT review.

Each episode is audited by the CNM3 against the parameters set out in the rules governing the use of seclusion. The audit tool has 36 questions. Of the 16 episodes of seclusion in 2024, the average compliance with rules governing the use of seclusion was 97 %.

Audit results are communicated back to the treating Consultant Psychiatrist and MDT. Results are presented monthly to the local governance group called the compliance committee. Gaps or deficits are identified and action plans initiated to mitigate further recurrences. A quarterly MDT review and oversight committee meet to review the audit results and further explore each episode. A report is formulated following the committee and forwarded to the Registered Proprietor.

In 2024 CHO 7 senior management established the CHO 7 Restrictive Practices Oversight Committee with members of the 4 approved centres in CHO7. This committee has worked on a number of sub committees developing standardised audit tools, reports and policies. The Group has also been tasked with reviewing all local interventions that have assisted in the reduction of restrictive practices. This facilitates a culture of shared learning and demonstrated that the leadership continues to aim to reduce and eliminate restrictive practices.

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

A Policy Development Group in CHO 7 came together from 4 approved centres under the 1 registered proprietor (Head of Mental Health) to draft a reducing restrictive practices policy. The policy set out the direction and vision of CHO 7 mental health in reducing restrictive practices and the mechanisms that need to be in place to support and facilitate same. The Policy outlined how KWW MHS shall adopt the key intervention themes outlined in the MHC (2014) Seclusion and Restraint Reduction Strategy as the main guidance to demonstrate their commitment to reducing restrictive practices. In a similar fashion to the MHCs 2014 strategy each key theme outlines actions that shall be implemented. It is envisaged that through the approved centres proactive approach to ensuring each theme and subsequent actions are addressed, that this will ultimately result in an overall reduction of restrictive practices. In 2024 a number of quality initiatives were implemented to promote the reduction/ elimination of restrictive practices. All staff and management of Lakeview Unit, KWWMHS continued to work under the themes of the policy. See below;



## Statement on compliance with the rules governing seclusion, restraint & mechanical restraint for 2024

### Leadership

- Safety Pause introduced at 12 midday to facilitate a clinical handover for all staff. The focus of the safety pause is around patient safety and to recognise patients at risk and intervene early to mitigate the need for restrictive practices. The safety pause uses the ISBAR tool and HSE safety pause prompts.
- Established CHO 7 Reducing Restrictive Practices Oversight group, members of Lakeview Unit Management team attend.
- Restrictive practices placed as agenda item on all meetings in Lakeview Unit

### Engagement

- Engagement with patients continues at weekly community meetings in Lakeview unit under the item 'feeling safe in Lakeview and respecting dignity and privacy'.
- An official launch day for Safewards was held in Lakeview on October 9th. With information stand and activities for both patients and staff to engage with. An introduction to Safewards leaflet was devised for staff and patients. Lakeview Unit has now implemented 5 Safewards Initiatives;
  1. Discharge Messages (Tree of hope)
  2. Talk Down Methods
  3. Mutual Help
  4. Calm down boxes
  5. Know Each Other

### Training

- TMVA training programme delivered throughout the year. This training course focuses on the early identification and de-escalation of behavioural responses and includes trauma informed care module
- Human Rights training day provided
- Positive Behavioural Support training day provided
- Trauma informed care training day provided
- Decider Skills training provided
- Staff inductions days for nurses x 2 in 2024.
- Bi-annual NCHD education on RP
- The Senior OT attended Sensory Attachment Intervention Training

### Debrief

- All patients are offered a formal debrief after a restrictive practice
- Clinical Supervision sessions monthly available in the approved centre
- Schwartz Rounds continued throughout the year to facilitate staff reflection

### Data

- Data is gathered and reviewed at all committees
- Incident reports are monitored and escalated as per local processes
- Each episode of a restrictive practice is audited

### Environment

- A newly refurbished Seclusion Facility was completed in December 2024, to provide improved measures to ensure privacy and dignity. Facility designed and products & equipment installed to provide for the sensory and orientation needs of patient.



## Statement on compliance with the rules governing seclusion, restraint & mechanical restraint for 2024

- A new de-escalation couch was purchased for level 1. Which provides staff and patients with a comfortable area to sit. The couch is designed to make physical intervention as safe and dignified as possible. Lowered central seating and tapered foot well aides' staff in safe de-escalation practices. The design allows for closer patient engagement, aiding verbal de-escalation.
- A new rocking beanbag was purchased to promote self-soothing in the sitting room of level 2. The 'boden' rocker is designed to provide gentle, controllable vestibular stimulation, helping to comfort and calm those in crisis. The shape, size and softness of the product also offers tactile (touch) and proprioceptive (sense of body positioning) inputs which provides a supportive feeling of reassuring wrap-around contact.

### **Regulation**

- Our annual MHC inspection was completed in November 2024 await report and CAPAs
- The HSE internal Audit Team inspected Lakeview's Health and Safety Function in December 2024

### **Staffing**

- Additional 0.5 WTE Clinical Nurse Manager 3 allocated to Lakeview Unit
- Staff Health & Well-being committee in KWWMHS re-established. Away day arranged for self-care and resilience in 2024



## Statement on compliance with the rules governing seclusion, restraint & mechanical restraint for 2024

### Code of Practice on the Use of Physical Restraint

Issued Pursuant to Section 33(3)(e) of the Mental Health Act 2001-2018

<b>The total number of persons who were physically restrained during the reporting period</b>	34
<b>The total number of episodes of physical restraint</b>	48
<b>The shortest episode of physical restraint</b>	1
<b>The longest episode of physical restraint</b>	10

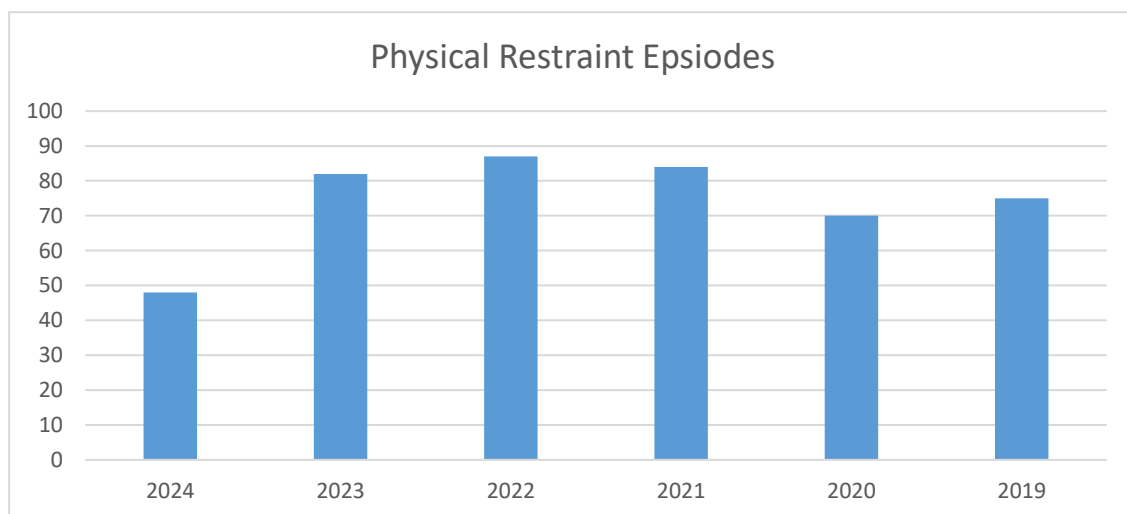
#### **A statement about the effectiveness of the approved centre's actions to eliminate, where possible, and reduce physical restraint**

KWWMHS set up a Reducing Restrictive Practices Committee in 2021. In 2023, with the launch of the updated Code of Practice on the Use of Physical Restraint an MDT review and oversight committee was established to review each episode of restrictive practice. This committee continue to meet quarterly.

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The KWWMHS and the approved centre 'Lakeview Unit' staff are committed to ensuring high standard of care is provided to patients. The service is committed to continuous quality improvement to improve the compliance with the standards set out by the Mental Health Commission and to reduce the occurrences of the use of seclusion. Year on year there has been a reduction in the number of episodes of Physical Restraint.

2024 has seen a 41% decrease on 2023. The lowest number in 6 years. See below graph.



Each Approved Centre should also produce a comprehensive Annual Report



## Statement on compliance with the rules governing seclusion, restraint & mechanical restraint for 2024

### A statement about the approved centre's compliance with the code of practice on the use of physical restraint

The approved centre uses a clinical document called a pathway that addresses all requirements of the code of practice on the use of physical restraint. This pathway guides staff through the elements of a physical restraint episode along with direction and guidance on the care and treatment of the patient. It provides the outline of the next steps required to support and ensure the human rights the patients are forefront to management of the episode and the time-frame in which to be completed. The pathway is completed alongside the clinical practice form.

Each episode is reviewed in real time by the nurse in charge then CNM2. The Mental Health Act Administrator oversees and prompts communication to MDT members in relation to completion of debrief with the patient within 2 days and the 5 day MDT review.

Each episode is audited by the CNM3 against the parameters set out in the code of practice on the use of physical restraint. The audit tool has 38 questions. Of the 48 episodes of physical restraint in 2024, the average compliance with the code of practice on the use of physical restraint was 95%.

Audit results are communicated back to the treating Consultant Psychiatrist and MDT. Results are presented monthly to the local governance & compliance committee. Gaps or deficits are identified and action plans initiated to mitigate further recurrences.

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

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### Staffing

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## Rules Governing the Use of Mechanical Means of Bodily Restraint

Issued Pursuant to Section 69(2) of the Mental Health Act 2001-2018.

<b>The total number of persons who were mechanically restrained under Part 3 (Immediate Risk of Harm)</b>	0
<b>The total number of episodes of mechanically restrained under Part 3 (Immediate Risk of Harm)</b>	0
<b>The shortest episode of mechanically restraint under Part 3 (Immediate Risk of Harm)</b>	N/A
<b>The longest total episode of mechanically restraint Part 3 (Immediate Risk of Harm)</b>	N/A
<b>The total number of persons who were mechanically restrained (Part 4: enduring risk of harm to self or others)</b>	N/A

### **A statement about the effectiveness of the approved centre's actions to reduce and, where possible, eliminate mechanical means of bodily restraint**

The approved centre does not use mechanical means of bodily restraint.

### **A statement about the approved centre's compliance with the rules governing the use of mechanical means of bodily restraint**

The approved centre does not use mechanical means of bodily restraint.



## Statement on compliance with the rules governing seclusion, restraint & mechanical restraint for 2024

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

The approved centre does not use mechanical means of bodily restraint.

**Signed by Registered Proprietor Nominee:** Kevin Brady

*\*If you do not have a Digital Signature, typing your name will be accepted as your signature.*