



Seclusion and Physical Restraint Reduction Policy North Dublin Mental Health Services

Is this document a:

Policy ☒ Procedure ☐ Protocol ☐ Guideline ☐

Insert Service Name(s), Directorate and applicable Location(s):
CHO DNCC North Dublin Mental Health Services

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Any printed version should be considered “uncontrolled”, and is therefore subject to validation against the controlled version.

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Throughout this document where the word ‘patient’ is used. This refers to patient, resident, client or service user.

Throughout this document the words ‘Approved Centre’ is used. This refers to the Ashlin Centre & O’Casey Rooms

1.0 Policy Statement

- 1.1 North Dublin Mental Health Services is committed to the reduction of both the frequency and duration of Seclusion and Physical Restraint episodes in its Approved Centres.

2.0 Purpose

- 2.1 The purpose of this document is to direct staff on the process for the reduction and elimination where possible of Seclusion & Physical Restraint.
- 2.2 North Dublin Mental Health Services aims to reduce or, where possible eliminate, the use of Seclusion and Physical Restraint within the Approved Centres by:
 - 2.2.1 Establishing a Seclusion & Physical Restraint oversight committee in each Approved Centre
 - 2.2.2 Enhance the work force through the provision of education & training related to restrictive practice reduction.
 - 2.2.3 Conducting reviews of restrictive practice aimed at identifying areas for improvement.
 - 2.2.4 Identification and implementation of non-restrictive practices such as de-escalation, positive behaviour support and one to one therapeutic engagement.
- 2.3 This policy should be read in conjunction with the following policies, Mental Health Commissions Rules and Codes of Practice:
 - 2.3.1 Mental Health Commission Rules Governing the Use of Seclusion – September 2022 (Version 3)
 - 2.3.2 Mental Health Commission Rules Governing the Use of Mechanical Means of Bodily Restraint – September 2022 (Version 3).
 - 2.3.3 Mental Health Commission Code of Practice on the Use of Physical Restraint – September 2022 (Version 3).
 - 2.3.4 Therapeutic Management of Violence and Aggression Training (2015)

- 2.3.5 Mental Health Act, 2001
- 2.3.6 The HSE Child Protection and Welfare Policy (2018)
- 2.3.7 Children First Act (2015)
- 2.3.8 Children First National Guidance for the Protection and Welfare of Children (2017).

3.0 Glossary

3.1 APPROVED CENTRE

A “centre” means a hospital or other inpatient facility that is used to provide care and treatment of individuals 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 holds a register of Approved Centres pursuant to the Mental Health Act 2001-2018.

3.2 BREAKAWAY TECHNIQUES

A set of physical skills to help separate or break away from an individual who is displaying violence and/or aggression. This does not involve the use of Physical Restraint.

3.3 CHILD

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

3.4 CLINICAL FILE

A physical record of all items relating to a patient’s care and treatment including details of referrals, assessments, care and treatment whilst receiving mental health services. This documentation should be stored in the one file. If all relevant information is not stored in the one file, the file should record where the other information is held.

3.5 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.

3.6 CONSULTANT PSYCHIATRIST

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 maintained by the Medical Council.

3.7 CONTINUOUS OBSERVATION

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

3.8 DE-ESCALATION

The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. De-escalation is avoiding or preventing an escalation in undesired behaviour.

3.9 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.

3.10 DUTY CONSULTANT PSYCHIATRIST

The Consultant Psychiatrist on the on-call duty rota.

3.11 INDIVIDUAL CARE PLAN

A documented set of goals developed, regularly reviewed and updated by the patient's multidisciplinary team, so far as practicable in consultation with each patient 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 patient. For children, individual care plans should include education requirements. The care plan is recorded in the one composite set of documentation.

3.12 PERSON

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

3.13 PERSON-CENTRED

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

3.14 PHYSICAL RESTRAINT

For the purpose of this policy, physical restraint is defined as “the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident's body when he or she poses an immediate threat of serious harm to self or others” (Mental Health Commission 2022).

3.15 POSITIVE BEHAVIOUR SUPPORT

Positive behaviour support involves assessments that look beyond the behaviour of a patient 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.

3.16 REGISTERED MEDICAL PRACTITIONER

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

3.17 REPRESENTATIVE

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

3.18 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.

3.19 RISK ASSESSMENT

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

3.20 **SECLUSION**

For the purpose of this policy seclusion is defined as “the placing or leaving of a service user in any room alone, at any time, day or night, such that the service user is prevented from leaving the room by any means” (Mental Health Commission 2022).

3.21 **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 individuals using mental health services alongside staff members. It is also seeking to understand certain reactions or behaviours in the context of the person’s experiences. The principles of trauma informed care are: safety, trustworthiness, choice, collaboration and empowerment.

4.0 **Introduction**

- 4.1 The use of Restrictive Practices and Interventions must only take place following a risk assessment and where there are no alternative means to support the patient safely.
- 4.2 North Dublin Mental Health Services (NDMHS) is committed to reducing the need for restrictive interventions and this policy aims to promote the development of therapeutic environments in order to minimise all forms of restrictive interventions; and where of absolute necessity, to provide for their safe application.
- 4.3 In addition, in order to maintain the safety and wellbeing of the people using services within NDMHS at all times, staff must ensure that individuals whose history, needs or current clinical presentation are predictive of behaviours that may lead to the use of restrictive interventions are identified on the basis of dynamic risk assessments, and care and support must be provided with the aim of reducing the likelihood of such risks in the first place.
- 4.4 Staff must use personalised, trauma informed de-escalation techniques where a person shows initial signs of distress or agitation, and minimising the risk of physical and emotional harm both during and after any restrictive intervention.
- 4.5 Where incidents with behavioural disturbances do occur, the processes under the Mental Health Commissions Code of Practice on the Use of Physical Restraint and the Rules Governing the Use of Seclusion provides the legal framework for the last resort interventions to be applied.
- 4.6 Such intervention will be planned, evidence based, lawful, in the patient’s interests, proportionate and dignified.

5.0 Leadership

- 5.1 Leadership refers to the support for, and the strong commitment to, seclusion and restraint reduction efforts among senior administrative and clinical staff within mental health services.
- 5.2 Proactive and persistent leadership has been highlighted in many systematic reviews to be pivotal in achieving reductions in Seclusion and Physical Restraint use (Mental Health Commission 2014).
- 5.3 Key actions include:
- Assign responsibility for local implementation.
 - The Approved Centre has a 'Seclusion and Physical Restraint Multidisciplinary Oversight Committee' to support the implementation of this policy.
 - Include Seclusion and Physical Restraint reduction as an explicit goal within the mission, vision and philosophy of care statements of the service
 - Engage staff at all levels in relation to this policy and provide opportunities for staff at all levels to participate in the ongoing developments in relation Seclusion and Physical Restraint reduction.
 - Allocate responsibilities to clinical governance committees to ensure that Seclusion and Physical Restraint reduction efforts are incorporated into all relevant policies and procedures (e.g. Seclusion, Physical Restraint and involuntary medications).
 - Implement an organisational culture which embodies a collaborative and recovery oriented approach and an atmosphere of mutual engagement and respect.
 - Monitor progress on actions.
 - Incidents of Seclusion and Physical Restraint continue to be reviewed by members of the multidisciplinary team.
 - Utilise networking between mental health services to facilitate the sharing of best practice by including Seclusion and Physical Restraint reduction. This will be achieved through collaborative working amongst other services under the clinical governance of the Area Directors of Nursing.

6.0 The use of data to inform practice

- 6.1 Approved Centre databases are a prerequisite for systems to monitor their Seclusion and Physical Restraint practice and reduction efforts in line with other national efforts. Without such a database the service would be unable to establish with any certainty whether services are reducing the use of Seclusion and Physical Restraint (Mental Health Commission 2014).
- 6.2 The Seclusion and Physical Restraint Multidisciplinary Oversight Committee (see terms of reference attached appendix 1), which is accountable to the Registered Proprietor Nominee, has been established at each Approved Centre to analyse in detail every episode of Seclusion and Physical Restraint.
- 6.3 The committee will meet at least quarterly and will:
 - i. Determine if there was compliance with the Code of Practice on the use of Physical Restraint and the Rules Governing the Use of Seclusion for each episode of Physical Restraint and Seclusion reviewed.
 - ii. Determine if there was compliance with the approved centre's own policies and procedures relating to Physical Restraint and Seclusion.
 - iii. Identify and document any areas for improvement and recognise episodes of good practice.
 - 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 physical restraint was in accordance with the Mental Health Commission's Code of Practice and each seclusions was in accordance with the Mental Health Commission's Rules Governing the Use of Seclusion.
 - vi. Produce a report following each meeting of the review and oversight committee. This report will be made available to staff who participate, or may participate, in Physical Restraint and Seclusion, to promote on-going learning and awareness.
 - vii. This report will be made available to the Mental Health Commission upon request
- 6.4 Each Approved Centre will compile an annual report form the information gathered regarding the use of Seclusion and Physical Restraint in the Approved Centre.
- 6.5 This report, which will be signed by the Registered Proprietor Nominee and will be made publicly available on the Registered Proprietor's website within six months of the end of the calendar year and available, upon request, to the public.

6.6 The annual report will 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 Seclusion and Physical Restraint.
- A statement about the Approved Centre's compliance with the Code of Practice on the use of Physical Restraint and the Rules Governing the Use of Seclusion.
- A statement about the compliance with this reduction policy.
- The data as specified below:
 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 Secluded and/or Physically Restrained during the reporting period
 4. The total number of Seclusion and Physical Restraint episodes
 5. The shortest episode of Seclusion and Physical Restraint
 6. The longest episode of Seclusion and Physical Restraint

7.0 Specific Reduction Tools/Interventions in Use

- 7.1 North Dublin Mental Health Service (NDMHS) upholds the view that all behaviour is communication and that behaviour fulfils a function for the individual that is a unique product of their own personal circumstance.
- 7.2 Each Approved Centre will use the following proactive strategies to prevent, reduce and eliminate the use of Seclusion and Physical Restraint:
 - 7.2.1 Develop a therapeutic relationship with the patient and have a better understanding of their personal triggers, vulnerabilities and early warning signs for escalation.
 - 7.2.2 Support the patient to become engaged in pursuits/activities that the individual finds to be purposeful and beneficial to them in their personal

recovery.

- 7.2.3 Development of co-produced individual care plans.
- 7.2.4 Developing an individualised understanding of factors that may increase or decrease an individuals' distress as documented in the service users care plan.
- 7.2.5 Supporting service users to develop their own skills and strategies for self-regulation i.e. grounding techniques/strategies from decider skills/sensory modulation strategies.
- 7.2.6 De-escalation Techniques (including verbal and non-verbal communication skills).
- 7.2.7 Consider referral to Occupational Therapy to assess for sensory needs or utilise sensory modulation approaches alongside the use of the sensory room (where appropriate).
- 7.2.8 Low arousal approaches, where is it deemed helpful for the individual i.e. reducing environmental demands, providing a quiet space and reducing verbal communication.
- 7.2.9 Maintaining a consistent and predictable environment e.g. visual timetables, activity scheduling with element of choice; appointments coming up.
- 7.2.10 Ensuring that the unit environment and mechanisms for communication are accessible to all, maintained, relevant and up-to-date. (to accommodate all mediums).
- 7.2.11 Ensuring that information is shared clearly between staff to ensure consistency of understanding and of implementation of agreed support strategies.
- 7.2.12 Listening to service users and their family, actively seeking involvement in care planning
- 7.2.13 Offering an opportunity for choice e.g. how service user spends their time, their food choices
- 7.2.14 Encouragement of autonomy – creating opportunities for choice, learning and recovery planning
- 7.2.15 Creativity and being innovative & inventive in suggesting interventions and using positive risk taking approaches
- 7.2.16 Using appropriate communication strategies i.e. matching communication to the persons communication ability e.g. using a communication passport, interpreter services, visual aids
- 7.2.17 Providing opportunity for positive social interactions including staff, other

residents, family, community contacts

- 7.2.18 Appropriate medical assessments, and interventions; ensure that all assessments and interventions are understood by the person
- 7.2.19 Apply learning from previous risk assessments
- 7.2.20 Service commitment to providing and adapting a supportive physical environments e.g. noise levels, temperature, lighting, place to relax, alternative settings (garden, time away from the unit following risk assessment)
- 7.2.21 Adequate staffing and developing staff expertise
- 7.2.22 Applying learning outcomes from debriefing, service user feedback, audit findings and what can be done differently.

8.0 Use of Restrictive Interventions

- 8.1 In this policy the use of the term restrictive interventions refers to all Physical Restraint techniques including Breakaway and Team Restraint. De-escalation interventions are referred to separately.
- 8.2 Restrictive interventions must only be used as a last resort and when all other measures (including de-escalation) have been unsuccessful and the situation is deteriorating.
- 8.3 Consideration must be given to the overall context of care; therefore staff must take into account the detrimental effect the use of Restrictive Interventions may have to all involved individuals.
- 8.4 The most common reasons for needing to consider the use of restrictive interventions are:
 - 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
- 8.5 Restrictive interventions should be used in a way that minimises any risk to the patient's health and safety and that causes the minimum interference to their autonomy, privacy and dignity, while being sufficient to protect the patient and other people.
- 8.6 The patient's freedom should be contained or limited for no longer than is necessary. Unless there are cogent reasons for doing, staff must not cause deliberate pain to a patient in an attempt to force compliance with their instructions.

8.7 The choice and nature of restrictive interventions will depend on various factors, but should be guided by:

- The patient's wishes and feelings, if known (e.g. by an advance statement, behaviour support plan or primary preventative strategy)
- What is necessary to meet the needs of the individual based on a current assessment and their history
- The patient's age and any individual physical or emotional vulnerabilities that increase the risk of trauma arising from specific forms of restrictive intervention
- Whether a particular form of restrictive intervention would be likely to cause distress, humiliation or fear
- Obligations to others affected by the behavioural disturbance
- Responsibilities to protect other patients, visitors and staff
- The availability of resources in the environment of care

9.0 De-brief following Interventions

- 9.1 Following all incidents of restrictive interventions such as Seclusion and Physical Restraint, a de brief and review should take place within 2 working days (other than Saturday, Sunday and Bank Holidays). All members of staff involved in the debrief must be documented.
- 9.2 Members of the MDT will be informed about the requirement for the de-brief by the inpatient nursing staff and via a daily email sent by the ward administrator.
- 9.3 The aim of the debrief is to ensure that the patient is provided with appropriate support following the episode of Physical Restraint or Seclusion.
- 9.4 The debrief should include the following (see below in appendix):
- 9.4.1 Give the person the opportunity to discuss the Seclusion and/or Physical Restraint with members of the multidisciplinary team involved in the person's care and treatment as part of a structured debrief process
 - 9.4.2 Occur within two working days (i.e. days other than Saturday/Sunday and bank holidays) of the episode of Seclusion and/or Physical Restraint unless it is the preference of the person who was restrained to have the debrief

outside of this timeframe.

- 9.4.3 The person's preferences regarding the timing of the debrief should be recorded
- 9.4.4 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 should be maintained and recorded in the person's clinical file
- 9.4.5 Include a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future
- 9.4.6 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;
- 9.4.7 Give the person the option of having their representative or their nominated support person attend the debrief with them
- 9.4.8 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.

10.0 Document Control

- 10.1 Where copies of policies and procedures are required, these are available to be either viewed or printed via the online MAPS policy portal.
- 10.2 Hard copies are also available and these shall be treated as controlled documents. These hard copies are stored centrally in hard copy folders where they are accessible for all staff.

11.0 Monitoring Audit and Evaluation

- 11.1 This policy shall be reviewed on an annual basis in line with the Code of Practice on the Use of Physical Restraint and the Rules Governing the Use of Seclusion.
- 11.2 Incidents reports are recorded for non-compliances identified in relation to the processes of this policy.

12.0 Responsibility

- 12.1 The appointed senior managers responsible for each Approved Centre's reduction of Seclusion and/or Physical Restraint are Sarah Battersby (Ashlin Centre) and Carmel Power (O'Casey Rooms).
- 12.2 Heads of Discipline should ensure that all incoming staff are added to Policy Portal and are made aware of how to access and use the platform, as part of the induction process. It is the responsibility of each individual staff member to make themselves aware of the policy and understand its contents. This information is documented digitally by policy portal once the "confirm" button is clicked.
- 12.3 It is the responsibility for all members of staff to make themselves available to attend and participate in the debrief and MDT review for their patient.

13.0 References

Government of Ireland (2001) “Mental Health Act”

Mental Health Commission (2023) “*National Quality Framework: Driving Excellence in Mental Health Services*”. MHC. Dublin, available: <https://www.mhcirl.ie/what-we-do/guidance/quality-framework-mental-health-services-ireland>

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Mental Health Commission (2025). “*Judgement Support Framework*”. Version 6.1. MHC. Dublin, available: <https://www.mhcirl.ie/sites/default/files/2025-02/Judgement%20Support%20Framework%20Version%206.1%20%282025%29.pdf>

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Mental Health Commission Ireland (2022) “*Code of Practice on the Use of Physical Restraint: Issued Pursuant to Section 33(3) (e) of the Mental Health Act 2001-2018*”. MHC. Dublin, available: https://www.mhcirl.ie/sites/default/files/2022-09/MHC_REVISED%20RULES_Physical%20Restraint.pdf

Mental Health Commission Ireland (2022) “*Rules Governing the Use of Seclusion: Issued Pursuant to Section 69(2) of the Mental Health Act 2001-2018*”. MHC, Dublin, available: https://www.mhcirl.ie/sites/default/files/2022-09/MHC_REVISED%20RULES_Seclusion.pdf

Mental Health Commission Ireland (2022) “*Rules Governing the Use of Mechanical Means of Bodily Restraint Issued Pursuant to Section 69(2) of the Mental Health Act 2001-2018*”. MHC, Dublin, available: https://www.mhcirl.ie/sites/default/files/2022-09/MHC_REVISED%20RULES_Mechanical%20restraint.pdf

Mental Health Commission Ireland (2014). "Seclusion and Restraint Reduction Strategy". MHC. Dublin, available: <https://www.mhcirl.ie/sites/default/files/2022-09/Seclusion-and-Restraint-Reduction-Strategy.pdf>

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Nursing and Midwifery Board of Ireland (2015) "*Scope of Nursing and Midwifery Practice Framework*". NMBI. Dublin, available: <https://www.nmbi.ie/nmbi/media/NMBI/Publications/Scope-of-Nursing-Midwifery-Practice-Framework.pdf?ext=.pdf>

Nursing and Midwifery Board of Ireland (2021) "*Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives*". NMBI, Dublin, available: <https://www.nmbi.ie/NMBI/media/NMBI/Code-of-Professional-Conduct-and-Ethics.pdf?ext=.pdf>

Butler, L.D., Critelli, F.M. and Rinfrette, E.S. (2011) "*Trauma-Informed Care and Mental Health*". Directions in Psychiatry. 31, 197 – 210.

14.0 Appendix 1

In-Person Debrief Post Physical Restraint and/or Seclusion Episode:

Person Centred Debriefing Tool Following *Restraint* ☐ *Seclusion* ☐

To be completed within 2 working days after an episode of seclusion/restraint. (Rule 7.6)

Single episode of restraint/seclusion ☐ Date: _____

or

Multiple episodes of restraint/seclusion ☐ Dates: _____

Service User Name: _____ **Service User DOB:** _____

Preparation for debriefing session

Q1. Would you like to discuss your recent episode of seclusion/restraint?

YES ☐ **NO** ☐ **Defer to a later date** ☐ (Please tick where appropriate)

If no or deferred to a later date, please comment: _____

Q2. Would you like a member of your family/ advocate/ friend present when you discuss your recent episode of seclusion/restraint?

YES ☐ **NO** ☐ (Please tick where appropriate)

If yes, indicate who the person wishes to attend. If no, please add any relevant comment: _____

If the service user's preferred contact person does not attend the debrief, please state why or tick N/A ☐

Debriefing session

1. Was the debriefing session completed in a private space on the ward?

YES ☐ **NO** ☐ (Please tick where appropriate)

2. Was the person provided with space to express their point of view with regards to: a) the triggering event(s) that led to the incident; b) how these triggering event(s) made them feel; and c) their subjective experience of being restrained or secluded?

YES ☐ **NO** ☐ (Please tick where appropriate)

Please comment on each of the components discussed with the person:

a) Triggers (please tick corresponding box and if other, please specify):

- | | | |
|--|---|---|
| <input type="checkbox"/> Admission to the Unit. | <input type="checkbox"/> Distressing thoughts | <input type="checkbox"/> Conflict with family |
| <input type="checkbox"/> Assault on a resident | <input type="checkbox"/> Assault on a staff. | <input type="checkbox"/> Noise levels/ busy environment |
| <input type="checkbox"/> Being denied access to something (e.g., information, to leave unit/ward etc.) | <input type="checkbox"/> Waiting (e.g., for something, someone, or information) | <input type="checkbox"/> other (specify) _____ |

b) Feelings

c) Experience of Restraint/Seclusion

3. Was the person's narrative reflected back to them by summarizing the triggering event(s) that led to the incident and their emotional responses to these events? (e.g., "Joe, you mentioned you were intoxicated and confused when you arrived with the Gardaí and you didn't understand what was happening and why you couldn't leave. Is that right?").

YES ☐ **NO** ☐ (Please tick where appropriate)

Please tick corresponding box and if other, please specify:

- | | |
|---|--|
| <input type="checkbox"/> Objectively or subjectively felt heard/ understood | <input type="checkbox"/> Objectively or subjectively indifferent |
| <input type="checkbox"/> Objectively or subjectively distressed | <input type="checkbox"/> Other (specify): _____ |

4. Was the person's feelings or emotional responses connected to their behaviour in response to these triggering events? (e.g., "Joe, it sounds like you were feeling frightened and confused when you arrived with the Gardaí and you didn't understand what was happening to you and why you couldn't leave. That sounds like a threatening experience and may be why you hit out: to protect yourself and escape from the situation. Have I got that right?").

YES ☐ **NO** ☐ (Please tick where appropriate)

Please tick corresponding box and if other, please specify:

- | | |
|---|--|
| <input type="checkbox"/> Objectively or subjectively felt heard/ understood | <input type="checkbox"/> Objectively or subjectively indifferent |
| <input type="checkbox"/> Objectively or subjectively distressed | <input type="checkbox"/> Other (specify): _____ |

5. ALTERNATIVE coping strategies discussed:

Any alternative coping strategies that the person could use to avoid the use of restrictive interventions in the future?

YES ☐ **NO** ☐ (Please tick where appropriate)

Please tick corresponding box and if other, please specify:

- | | | |
|--|--|--|
| <input type="checkbox"/> Ask staff or other patient to give me space | <input type="checkbox"/> Walk away and have time alone | <input type="checkbox"/> Go outside for a walk |
| <input type="checkbox"/> Take 10 deep breaths | <input type="checkbox"/> Meditate | <input type="checkbox"/> PRN medication |
| <input type="checkbox"/> Read | <input type="checkbox"/> Watch TV or listen to music | <input type="checkbox"/> Take a shower |
| <input type="checkbox"/> Call a friend/ family/ support person/ advocate | <input type="checkbox"/> Other (specify): _____ | |

6. PLAN developed:

Was the debriefing session summarized and a plan developed encompassing a) alternative coping skills the person can use; b) alternative de-escalation strategies or environmental

supports staff can provide; and b) the person's preferences in the event of a restrictive intervention being needed in the future?

YES ☐ **NO** ☐ (Please tick where appropriate)

Plan:

a) **Alternative coping skills the person can use (as above):** _____

b) **Alternative de-escalation strategies or environmental supports staff can implement:**

- | | | |
|---|---|---|
| <input type="checkbox"/> Prompt person to use coping strategy | <input type="checkbox"/> Verbal intervention (e.g., reassurance, information, first-then limit setting) | <input type="checkbox"/> Offer/ administer medication |
| <input type="checkbox"/> Provide person with space | <input type="checkbox"/> Prompt person to quieter area | <input type="checkbox"/> Provide person with 1:1 |
| <input type="checkbox"/> Provide person with item relative to their immediate need, if possible | <input type="checkbox"/> Reduce language and eye contact | <input type="checkbox"/> Use a calm, even tone of voice |
| <input type="checkbox"/> Co-regulate with the person (e.g., take deep breaths, model self-soothing, and actively listen to the person's concerns) | <input type="checkbox"/> Remove specific triggers, if possible | <input type="checkbox"/> Reduce demand(s) |
| | <input type="checkbox"/> Other (specify): _____ | |

c) **Person's preferences in the event of restrictive intervention in the future:**

- | | | |
|---|--|---|
| <input type="checkbox"/> Wants space and time away from others | <input type="checkbox"/> Wants sensory objects | <input type="checkbox"/> Wants PRN medication |
| <input type="checkbox"/> Wants certain triggers removed from the environment, if possible | <input type="checkbox"/> Wants 1:1 with staff | <input type="checkbox"/> Wants to be provided with what he/she needs, if possible [e.g., information, support, item etc.] |
| | <input type="checkbox"/> Wants to walk in the garden | |
| | <input type="checkbox"/> Wants more access to NRT | |

7. **ENTER the person back onto the ward:**

Was the staff-service user relationship restored? **YES** ☐ **NO** ☐ (Please tick where appropriate)

Did the person appear regulated or back to their baseline and return to their typical routine?

YES ☐ **NO** ☐ (Please tick where appropriate)

Any other

comments: _____

Record of attendees:

Signature of service user: _____

MDT signature: _____

Date of debrief: _____

MDT Review Date: _____

To be completed within 5 working days after an episode of Seclusion ☐ Restraint ☐. (Rule10.3)

Service User Name: _____ **Service User DOB:** _____

Date of Seclusion and/or Physical Restraint: _____

1. Alternative means of de-escalation attempted prior to the use of seclusion/restraint:

- | | | |
|--|---|---|
| <input type="checkbox"/> Prompted person to use coping strategy | <input type="checkbox"/> Verbal intervention (e.g., reassurance, information, first-then limit setting) | <input type="checkbox"/> Offered/ administered medication |
| <input type="checkbox"/> Provided person with space | <input type="checkbox"/> Prompted person to quieter area | <input type="checkbox"/> Provided person with 1:1 |
| <input type="checkbox"/> Co-regulated with the person (e.g., took deep breaths and actively listened to the person's concerns) | <input type="checkbox"/> Reduced language and eye contact | <input type="checkbox"/> Reduced demand(s) |
| <input type="checkbox"/> Provided person with item or information relative to their immediate need, if possible | <input type="checkbox"/> Used a calm, even tone of voice | <input type="checkbox"/> Removed specific triggers from environment |
| <input type="checkbox"/> Physical restraint | <input type="checkbox"/> Offered person opportunity to contact family member/ advocate/ friend | <input type="checkbox"/> Other (specify): _____ |
| | <input type="checkbox"/> No alternatives attempted | |

2. Identification of the trigger/antecedent events which contributed to the seclusion/restraint episode:

- | | | |
|--|---|---|
| <input type="checkbox"/> Admission to the Unit. | <input type="checkbox"/> Distressing thoughts | <input type="checkbox"/> Conflict with family. |
| <input type="checkbox"/> Assault on a resident. | <input type="checkbox"/> Assault on staff | <input type="checkbox"/> Noise levels/ busy environment |
| <input type="checkbox"/> Being denied access to something (e.g., information, to leave unit/ward etc.) | <input type="checkbox"/> Waiting (e.g., for something, someone, or information) | <input type="checkbox"/> other (specify) _____ |
| <input type="checkbox"/> Physical illness/Pain | <input type="checkbox"/> Boredom | |

3. Missed opportunities for earlier intervention, in line with the principles of positive behaviour support.

E.g., noticing the precursors/ warning signs that a person is becoming dysregulated (pacing, shouting, verbal aggression, changes in facial expression, space invading, property destruction, banging on nurses station door etc.) and responding accordingly in a way that meets the immediate need the person is communicating. Some examples below. Please tick accordingly:

- | | | |
|--|--|--|
| <input type="checkbox"/> Active listening and determining what need the person is communicating and responding accordingly (e.g., giving information or access to something) | <input type="checkbox"/> Offering/ administering medication | <input type="checkbox"/> Reducing demands |
| <input type="checkbox"/> Offering 1:1 or an opportunity to contact family member/ advocate/ friend | <input type="checkbox"/> Providing person with space | <input type="checkbox"/> Removing specific triggers from environment |
| | <input type="checkbox"/> Reducing language and eye contact | |
| | <input type="checkbox"/> Other (specify what <i>may</i> have helped to regulate the person and avoid use of restrictive intervention): _____ | |

4. Identification of alternative de-escalation strategies to be used in the future:

- | | | |
|---|---|---|
| <input type="checkbox"/> Prompt person to use coping strategy | <input type="checkbox"/> Verbal intervention (e.g., reassurance, information, first-then limit setting) | <input type="checkbox"/> Offer/ administer medication |
| <input type="checkbox"/> Provide person with space | | |
| <input type="checkbox"/> Remove specific triggers, if possible | <input type="checkbox"/> Prompt person to quieter area | <input type="checkbox"/> Provide person with 1:1 |
| <input type="checkbox"/> Provide person with item or information relative to their immediate need, if possible | <input type="checkbox"/> Reduce language and eye contact | <input type="checkbox"/> Use a calm, even tone of voice |
| <input type="checkbox"/> Co-regulate with the person (e.g., take deep breaths, model self-soothing, and actively listen to the person's concerns) | <input type="checkbox"/> Physical restraint | <input type="checkbox"/> Reduce demand(s) |
| | <input type="checkbox"/> Offer person opportunity to contact family/ friend/ advocate | <input type="checkbox"/> Other (specify): _____ |
| | | _____ |
| | | _____ |

5. The duration of the seclusion/restraint episode and whether it was for the shortest possible duration:

YES ☐

NO ☐ (Please tick where appropriate)

Duration of Restraint: _____ Duration of Seclusion: _____

If no, please comment:

6. Outcomes of the person-centred debrief, if available:

- | | | |
|---|---|---|
| <input type="checkbox"/> Prompt person to use coping strategy | <input type="checkbox"/> Verbal intervention (e.g., reassurance, information, first-then limit setting) | <input type="checkbox"/> Offer/ administer medication |
| <input type="checkbox"/> Provide person with space | <input type="checkbox"/> Prompt person to quieter area | <input type="checkbox"/> Provide person with 1:1 |
| <input type="checkbox"/> Provide person with item relative to their immediate need, if possible | <input type="checkbox"/> Reduce language and eye contact | <input type="checkbox"/> Use a calm, even tone of voice |
| <input type="checkbox"/> Co-regulate with the person (e.g., take deep breaths, model self-soothing, and actively listen to the person's concerns) | <input type="checkbox"/> Remove specific triggers, if possible | <input type="checkbox"/> Reduce demand(s) |
| | <input type="checkbox"/> Other (specify): _____ | |
| | | |

7. Factors in the physical environment that may have contributed to the use of seclusion/restraint:

- | | | |
|---|--|--|
| <input type="checkbox"/> Less than optimal staffing levels | <input type="checkbox"/> Noise levels/ busy environment (e.g., mid-week) | <input type="checkbox"/> Another person triggered service user |
| <input type="checkbox"/> Ward restrictions (e.g., no leave/no smoking,) | <input type="checkbox"/> Lack of structure/boredom (e.g., over weekend) | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Prompt person to quieter area | | _____ |
| | | _____ |

8. Actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the service user. (Rule 10.4).

Please refer to part 6 (Plan) of debriefing tool where actions were indicated during the debriefing session (E.g., alternative coping skills person can use; de-escalation strategies or environmental supports staff can implement; and person's preference in the event of a restrictive intervention being needed in the future).

- | | | |
|---|---|---|
| <input type="checkbox"/> Prompt person to use coping strategy | <input type="checkbox"/> Verbal intervention (e.g., reassurance, information, first-then limit setting) | <input type="checkbox"/> Offer/ administer medication |
| <input type="checkbox"/> Provide person with space | <input type="checkbox"/> Prompt person to quieter area | <input type="checkbox"/> Provide person with 1:1 |
| <input type="checkbox"/> Provide person with item relative to their immediate need, if possible | <input type="checkbox"/> Reduce language and eye contact | <input type="checkbox"/> Use a calm, even tone of voice |
| <input type="checkbox"/> Co-regulate with the person (e.g., take deep breaths, model self-soothing, and actively listen to the person's concerns) | <input type="checkbox"/> Remove specific triggers, if possible | <input type="checkbox"/> Reduce demand(s) |
| | <input type="checkbox"/> Provide recreational activities | <input type="checkbox"/> Refer for anger management. |
| | <input type="checkbox"/> Other (specify): _____ | |

9. Service user's individual care plan updated to reflect the outcome of the debrief, including the service user's preferences in relation to restrictive interventions going forward. (Rule 7.8)

YES ☐ NO ☐ NA ☐ (Please tick where appropriate)

Record of Attendees:

Signature MDT: _____ **Date:** _____

15.0 Terms of Reference

North Dublin Mental Health Services Seclusion and Restraint Multidisciplinary Oversight Committee Terms of Reference.

Purpose

The Mental Health Commission emphasizes the importance of strong governance and oversight mechanisms as key to successful reduction and elimination strategies. Mental Health Services have a duty to ensure that they regularly review and update policy and practice in this area.

Aims and Objectives

A multidisciplinary review and oversight committee aims and objectives will be to effectively analyse in detail every episode of physical restraint and/or episode of seclusion.

The Terms of Reference for the Seclusion and Restraint Multidisciplinary Oversight Committee is as following:

- Multi-disciplinary oversight committee membership includes at minimum: 1 Consultant Psychiatrists, 1 Senior Nurse, 1 Health & Social Care Professional and Mental Health Act Administrator.
- Multi-disciplinary oversight committee is accountable to the Register Proprietor Nominee and is established in the Approved Centre to analyse in detail each episode of seclusion and physical restraint in accordance with MHC Rules Governing Use of Seclusion (Sept 2022) and MHC Code of Practice on the Use of Physical Restraint (Sept 2022).
- The oversight committee in the Approved Centre will meet at least every 3 months to review in detail episodes of Seclusion and Physical Restraint from the previous period.
- A report will be completed for the Quality and Patient Safety Committee (QPS) on a three monthly basis.
- The oversight committee will determine if there was compliance with the Rules Governing the Use of seclusion and Code of Practice on the Use of Physical Restraint for each episode of Seclusion and Physical Restraint reviewed.
- The oversight committee will determine if there was compliance with the Approved Centre's policies and procedures in relation to Seclusion and Physical Restraint.
- The oversight committee will identify and document any areas for improvements, identify actions, the person's responsible, and the timeframes for completion of any actions.

- The oversight committee will provide assurance to the Registered Proprietor Nominee that each use of Seclusion and Physical Restraint was in accordance with the MHC's Rules and Code of Practice.
- The oversight committee will produce a report following each meeting and this report will be made available to staff who participate or may participate, in seclusion, to promote ongoing learning and awareness.
- The oversight committee will make the report available to the MHC upon request

Quorum for meeting

50% + 1

Chairperson and Secretary Term

The chairperson and secretary will be elected by the group and will maintain their roles for a period of twelve months. A re-election of chairperson and secretary will occur then.

Duties: Chairperson

Call and chair meetings

Develop the meeting agenda with the secretary

Review and revise meeting minutes

Communicate with members regarding updates for next meeting

Secretary

Develop meeting agenda with Chairperson

Write up and disseminate minutes of meeting via e mail

Ensure agenda is disseminated to all members

Frequency

The Multi-Disciplinary Oversight Committee will meet at least every 3 months with scope to either increase or decrease this as the need arises.

A representative must be identified to attend if Multi-Disciplinary Oversight Committee member cannot attend themselves.

Minutes

The secretary will ensure minutes are typed and sent by e mail to each member of the group. Meeting minutes will be sent out within 2 weeks to each group member. The secretary will also request that agenda items for the next meeting are forwarded to them by a specific date.

Review

The Clinical Governance group will review these terms of reference every year and approve any revisions.