Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Restrictive Practice Policy
Including guidance on restrictive interventions,:
This Policy needs to be put into practice AND READ along with the Policy on Restraint

Is this document a:

Policy [√] Procedure [ ] Protocol [ ] Guideline [ ]

Insert Service Name(s), Directorate and applicable Location(s):

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Quick reference guide notes:

All members of clinical staff have a responsibility and need to have an understanding of how policy affects clinical practice. This quick reference guide set out this policy, in a condensed way, and explains the approach staff should take to reduce restrictive practice.

The Nursing and Healthcare attendant staff and Administration staff: are responsible to ensure their understanding of the restrictive practice policy and how this relates to their professional practice.

Restrictive practice ensures that the care or treatment that staff are offering is lawful, necessary, proportionate, and is the least restrictive option reasonably available. These issues should be applied in conjunction with principles of dignity, equality, respect, fairness and autonomy.

Below is a summary of some of the key expectations of nursing and healthcare staff.

1. Restrictive Interventions: "deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

    - Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
    - Reduce significantly the danger to the person or others; and
    - Contain or limit the person's freedom for no longer is necessary" DoH (2014).

2. Physical restraint (adults): "any direct physical contact where the intervener's intention is to prevent, restricts, or subdue movement of the body, or part of the body of another person" DoH (2014).

3. Where the use of restraint, holding still and containment is concerned, staff must consider the rights of the resident and the legal frameworks surrounding the interventions. These actions must never be undertaken without immediate management notifications and multidisciplinary discussions.

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AS A RESIDENT I HAVE THE FOLLOWING RIGHTS.

I have the right for my privacy

I have a right to ensure my dignity is upheld

I have the right to be treated like any other human being regardless of the colour of my skin

I have a right not to be discriminated against because of my age or my disability

I have a right to feel protected

I have the right to say no.

I have the right to be cared for and receive healthcare.

I have the right to special care, enhanced care and extra support if I need it along with the appropriate activities, recreation and occupation.

I have a right to education, information, development and to be kept informed.

I have a right to live.

I have a right to express my sexuality

I have a right to vote

I have the right to have my culture, language and religion respected.

I have the right to have my identity upheld

I have the right to have my say and at all times to be listened to.

I have the right to have my family and friends

I have a right to see this centre as the place I live and see it as my home.

I have the right to healthy and adequate food

I have the right to go places and see people.

Talk to me, not at me.

I am happiest when I know I belong. I have the right for my privacy

I have a right to ensure my dignity is upheld I have a right to feel protected

I have the right to say no.

I have the right to be cared for and receive healthcare.

I have the right to special care and extra support if I need it. I have a right to education and be kept informed.

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I am happiest when I know I belong.

1.0 Introduction

A restrictive practice is defined as "Making someone do something they don't want to do or stopping doing something they want to do" (A positive & proactive workforce, Skills for Care. April 2014).

Restrictive practice may involve the physical containment of a resident by care staff, with or without the use of mechanical aids. It can include the use of equipment e.g. door locks, to ensure that the resident cannot move out of a prescribed area. More subtle forms of restrictive practices may also be used, for example removing a walking aid from the residents reach, not supporting an immobile resident if they wish to move or leave or the use of electronic devices to alert staff to the movement of a resident and chemical restraint.

While the emphasis should be on pre-emptive action, wherever possible, in order to prevent the need to restrain, there are some occasions in which the risks to the service user, or others, of inaction may outweigh those of taking action.

1.1 Purpose

The purpose and overall aim of the policy is to define restrictive practice and to allow the staff to ensure that the care or treatment that they are offering is lawful, necessary, proportionate, and the least restrictive option reasonably available. These issues should be applied in conjunction with principles of dignity, equality, respect, fairness and autonomy.

1.2 Scope

The policy will apply to adult residents that are admitted to The Village
This policy only applies to residents who require restrictive practice while receiving treatment; to make specific decisions about their own health and personal safety needs.

The Population to whom it applies will be adults who meet the admission criteria for The Village Residence.

All adults admitted to the service are covered by this policy in line with the admission criteria.

Clinical Staff:

1.2.1 The restrictive practices policy will focus collaboratively on the holistic needs of each resident which will include:

- The person: including physical, cognitive, behavioural factors,
- Their environment,
- Their activities: the required level and type of assistance to maintain safety, engaging with the resident promoting independence, resilience, choice and wellbeing.

1.2.2 The Nurse in charge of the shift is responsible for monitoring the care regularly, ensuring that any significant risks are adequately addressed and discussed. Members' clinical team have responsibility to comply with the requirements of this and associated policies and have a legal duty to have regard to it when working with, or caring for adults who may lack capacity to make decisions.

1.2.3 Registered Nurses (RNs) are accountable for delegating tasks to others, including health care assistants and Student Nurses. The NMBI Scope of practice (2015) states:

> *"Nurses and midwives are professionally responsible and accountable for their practice, attitudes and actions, including inactions and omissions. The nurse or midwife who is delegating (the delegator) is accountable for the decision to delegate. This means that the delegator is accountable for ensuring that the delegated role or activity is appropriate to the level of competence of the student or the regulated or unregulated HCW to perform".*

1.2.4 The primary accountability for assessing residents' restrictive practices is a nursing responsibility. This complies with professional standard set out by the NMBI Code of Conduct (2014) in which all nurses must uphold;

- ct for the dignity of the person.
- Professional responsibility and accountability.
- Quality of practice.
- Trust and confidentiality.
- Collaboration with others.

Medical Officer/General Practitioner/Doctor:

1.2.5 Medical Officer/ Doctor: In adhering to the General Medical Council, medical staff have a responsibility to collaborate with other colleagues to ensure that restrictive practices are in the best interest of the resident and that considerations should be given to the assessments that are specifically medical including cardiovascular, neurological and cognitive assessment and medication review.

Physiotherapist:

1.2.6 Physiotherapists: Provide evidence-based advice aimed at preventing restrictive practices and promote active and healthy lifestyles.

Occupational Therapist:

1.2.7 Occupational Therapists: Provide practical support to enable people to overcome barriers that prevent them from doing the activities that matter to them.

Pharmacy:

1.2.8 Pharmacy: Along with the Medical Officer and the nursing staff, the pharmacist will highlight 'high risk medications' associated with chemical restriction and make recommendations based on current up to date guidance and individual residents' preferences.

Risk Officer:

1.2.9 Risk Management Department: Will give advice on health and safety requirements regarding the prevention and management of restrictive practices.

Management:

1.2.10 Director of Nursing, Assistant Directors of Nursing, Practice Development, Nursing Administration, Person in Charge and Clinical Nurse Managers: Through their managerial, leadership duties, accountabilities in the prevention of restrictive practices. They have a key role and responsibility to ensure this service meets requirements set out by statutory and regulatory authorities such as the Department of Health and the Health Information and Quality Authority.

Training:

1.2.11 Professional Management of Aggression & Violence Training will be provided to ensure that each clinical team have support, advice and training input working closely with all members of staff and Nursing Management.

Manager for Services for Older People/Registered Provider:

1.2.12 The HSE Manager of Services for Older People/Registered Provider has overall responsibility to have processes in place to:

- Ensure that clinical staff are aware of this policy and adhere to its requirements.

- Ensure that appropriate resources exist to meet the requirements of this policy.

Non-Clinical Staff:

1.2.13 Administration, Maintenance, Catering and Household (Non-clinical staff) should be informed of expectations regarding their role in the preventing restrictive practices.

Role of the Relative / Carer:

1.2.14 Relatives and carers should be involved with the resident's care as much as possible, dependant on their own or the resident's wishes. In particular, explanations should be given sensitively about why limits are being set. Relatives and carers can observe the resident without staff present if this is the wish of the relatives or resident; clear instruction must be given to how they are to manage that observation, including how to summon for help and what they do when they are leaving the resident, this must be clearly documented in the individual intervention section of the care plan. Please ensure that this is noted within the Care Plan.

HSE - Safeguarding vulnerable people at risk of abuse group:

1.2.15 The Safeguarding vulnerable people at risk of abuse group is authorised by the Health Service Executive to investigate any clinical or associated activity that impacts on adults in our care and to develop, comply and monitor systems and processes to ensure the issues of safeguarding of adults in this service are adopted and embedded in practice.

Health Information and Quality Authority/HIQA:

1.2.16 Regulation 31(3) (a) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 requires that 'the person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used'.

In addition to reporting the use of restrictive procedures on a quarterly basis, the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 also place the following additional responsibilities on registered providers and persons in charge:

Regulation 7(4) requires that:

'the registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice'.

Regulation 7(5) requires that:

'the person in charge shall ensure that, where a resident's behaviour necessitates intervention under the Regulation –

(a) every effort is made to identify and alleviate the cause of the resident's challenging behaviour;

(b) all alternative measures are considered before a restrictive procedure is used; and

(c) the least restrictive procedure for the shortest duration necessary, is used'.

1.3 Objective(s)

1.3.1 Provide guidance to staff for residents on restrictive practices. Make clear the roles and responsibilities of all staff (including non-clinical staff).

1.3.2 Established the method to raising and maintaining awareness of the policy with staff.

1.3.3 Define the steps that will be taken to promote resident autonomy.

1.3.4 Explain how policy compliance will be tested and reported.

1.4 Outcome(s)

1.4.1 Restrictive Interventions are defined as: "Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and - end or reduce significantly the danger to the person or others; and - contain or limit the person's freedom for no longer than is necessary" DoH (2014).

When using restrictive practice a balance must be achieved between minimising risk of harm or injury to the patient and others, and maintaining the dignity, personal freedom and choice of the patient. Assessment should always place the individual at the centre of the process, involving them and those who are important to them in their lives, as is practical to do so. Evidence of a person centred approach to assessment and planning must be recorded.

If a restriction is deemed appropriate the following points must be considered:

- The practice needs to have a legitimate aim. It must be necessary in order to protect the health and wellbeing of the individual or to protect the safety or human rights of others (patients, staff, and visitors, public).
- All individuals who may be affected by the practice must be involved in the decision making process to the fullest possible extent of their understanding.
- The practice that is implemented must be proportional, i.e. the least restrictive practice required to achieve the aim.
- Principles of dignity and respect should be observed during the implementation of any restrictive practice.
- The effectiveness of the practice in meeting its aims should be continually reviewed and the practice should continue only for as long as it remains both necessary and effective.
- If the resident has capacity (which all residents currently have, unless deemed otherwise) to give valid consent and their agreement or consent can be gained, without undue pressure, from the person then the restriction can be put in place so long as it does not contravene the law. It must be remembered that the person has the right to withdraw their agreement or consent and they should be informed of this right at the onset.
- If the resident withdraws their consent but it is felt that the restriction should continue, this can only be achieved if the practice is sanctioned under law.

1.4.2 Restrictive practice is not confined to physical restraint; it also refers to actions or inactions that contravene a person's rights. Listed below are some restrictive categories. It must be remembered that to apply any of these to an individual there must have a lawful and legitimate right and reason to do so. The following list is not exhaustive.

Types of restriction:

Physical: "in which a person or a mechanical device restricts someone's freedom of movement or access to their own body. Any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person". For example, the use of bed rails may be an acceptable restrictive procedure under certain circumstances.

Mechanical: A device used on a person to restrict free movement such as placing a person in a chair which they are unable to get up from.

Chemical: is the use of medication to control or modify a person's behaviour when no medically identified conditions is being treated, or where the treatment is not necessary for the condition or the intended effect of the drug is to sedate the person for convenience or disciplinary purposes. Administering sedatives to a person who wanders during the night primarily for the convenience of staff is an example of chemical restraint which is not acceptable in any designated centre. Chemical restraint can also be the use of drugs and prescriptions to modify a person's behaviour. Medication that is prescribed to be taken 'as and when required' can be used as a form of restraint unless applied responsibly. For more information please refer to: Guidance for Designated Centres: Restraint Procedures (HIQA,2016).

Environmental: is the intentional restriction of a person's normal access to their environment, with the intention of stopping them from leaving. This also includes denying a person their normal means of independent mobility, means of communicating, or the intentional taking away of ability to exercise civil and religious liberties. Single separation is a type of environmental restraint which may be acceptable for a limited time in certain circumstances (HIQA, 2016). Environmental restriction could also be the design of the environment to limit people's ability to move as they might wish, such as locking doors or sections of a building, using electronic key pads with numbers to open doors, complicated locking mechanisms and door handles.

Cultural restriction: Preventing a person from the behaviours and beliefs characteristic of a particular social, religious or ethnic group.

Other forms of restraint:

Forced Care Actions: to coerce a person into acting against their will, for example having to be restrained in order to comply with the instruction or request.
Decision making: Making a decision on the person's behalf or not accepting or acting on a decision the person has made.

Contact with community: Preventing the person from participating in community activities, including work, education, sports groups, community events or from spending time in the community such as parks, leisure centres, shopping centres.

Contact with family and friends: Preventing or limiting contact with the person's friends and family, for example not allowing the person to receive visitors, make phones calls or not allowing contact with a specific friend or family member.

1.4.3 The following methods of restriction are unacceptable, however if the resident requests or is consenting to any of the following it may be considered and applied as appropriate. This must be clearly documented. Inappropriate use of restrictions may be viewed as abuse and a safeguarding concern. The following list is not exhaustive:

- Inappropriate bed height, this is an unacceptable form of restraint, one reason being that it increases the risk of injury resulting from a fall out of bed. In addition it also could prevent someone from getting up from the bed easily and safely, i.e. if it is too low or too high

- Inappropriate use of wheelchair safety straps. The safety straps on wheelchairs should always be used, when provided for the safety of the user. However residents should only be seated in a wheelchair when this type of seating is required, not as a means of restraint.

- Using low chairs for seating, low chairs should only be used when their height is appropriate for the user. Again they should not be used with the intention of restraining a person. Low chairs also pose risks to staff in relation to manual handling.

- Chairs whose construction immobilises residents e.g., reclining chairs, bucket seats. Reclining chairs should be used for the comfort of the user and not as a method of restraint.

- Locked doors, on the occasion that doors are locked clear signage should be displayed informing residents and the public that doors are locked and who they should ask to have them unlocked to exit the Unit. If a resident is asking to leave and being prevented by the locked door that resident is being restricted.

- Furniture arranged to impede movement. Other methods of dealing with behaviour such as wandering should be pursued. Any equipment, including furniture, should only be used for the purpose for which it is intended.

- Inappropriate use of night clothes during waking hours, this is demeaning and should not be used as a way of restraining people. Removal of outdoor shoes and other walking aids.

- Questions staff should ask if they themselves were being admitted to a nursing home

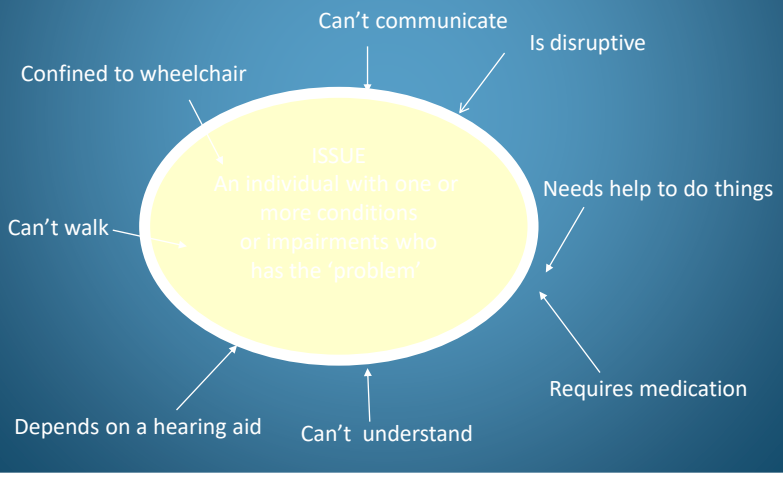
- What would it be like for you?
- What are you leaving behind?
- Do I pay to be here?
- Do I pay for meals?
- Who are all these people?
- What are your roles?
- Can I leave?
- Can my family visit at any time?
- Can I go out whenever
- Is there someone who will support me?

- Do I know who to go to if I had a concern?
- If I felt threatened who do I go to?
- Can I have a beer, vodka, wine with my dinner?
- Can I bring my dog to stay with me?
- Etc etc etc

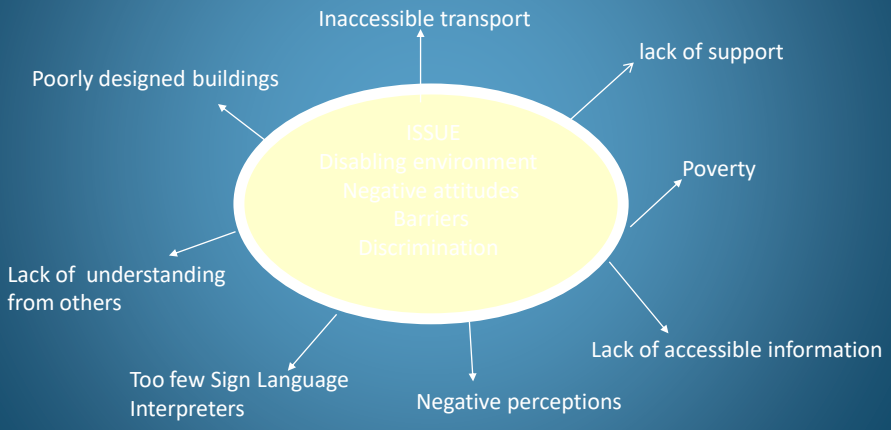
Medical Model	**Person-Centered Care Model**
Hierarchical • Care is dictated to patient. • Patient has little to no choice in treatment or care. • Patient's expertise in own health is seldom or not taken into consideration.	Team based • Participant and staff are equal and care is collaboratively agreed upon. • Participant knowledge of self and choice is integral to improving health. • Participant expertise in own life is paramount to determining course of care.
Views the patient as multiple unrelated diseases. • Treats the disease and not the person • Diagnoses are treated individually and separately without considering the interaction of diagnosis or patient's own motivation to treatment or feelings. • Medical diagnoses are viewed as more important than cognitive or emotional.	The participant is viewed as a whole human being, not a disparate set of diagnoses which much be "treated". • Treats the person and not the disease. • The human being is considered and understood first, then overall health goals of the participant. • The interaction of diagnosis is crucial as well as the participant's personal qualities and choices in regards to life and well-being. • All diagnoses are as important as the participant views them to be and how they affect one another.
Clear boundaries between participant and expert.	Healing occurs within the relationship between staff and the participant.
Language • Judgmental • Clinical and detached: impersonal, builds boundaries. • Problem and goals written in clinical language and are the staff's observation of what the patient's problems are. • Example: Refers to patient in documentation as "patient" (or "participant")	Language • Removes stigma and judgement • Personal and relationship focused, increases view of the participant as a human, not as "work". • Problem & goals written in functional language of the participant. • Example: Refers to participant the name by which they would like to be called "Mrs. Smith" or "Jane".

Medical model

- The medical model sees the disabled person as the problem that needs to be fixed or changed



The social model of disability



What is the Principle of Normalization?

- '*A concept (originating in Scandinavia and further developed in North America) that emphasises the desirability for people with a learning disability to live a lifestyle as close as possible to the norms of the surrounding society*' (Thomas and Pierson 1996).

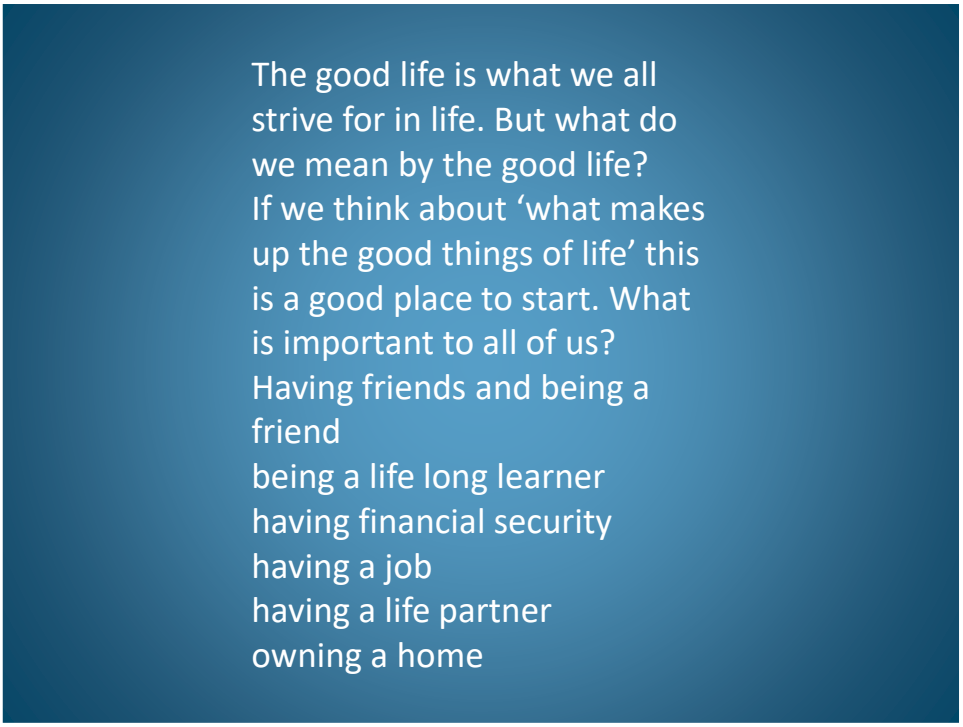
- It's aim was to assist individuals into 'socially valued life conditions and socially valued roles' (Wolfensberger and Thomas 1983:24)

The aim here is that residents within the Village live normal lives

- Vision is to structure supports consistent with:

- Normal rhythm of the day;
- Normal rhythm of the week;
- Normal rhythm of the year;
- Normal life cycle developmental experiences;
- Normal right to choices and self-determination;
- Normal sexual patterns of their culture;
- Normal economical patterns of their society;
- Normal environmental patterns of their community.

What is a Good Life?



1.4.4. **Unacceptable Methods of Restriction:**

- Withdrawal of sensory aids such as spectacles.

- Removal of sensory aids can cause confusion and disorientation.

- Isolation:

  It is important to note that residents may be "isolated" for infection control reasons and if a resident is cared for in a side room, when he or she wishes to be on the main Unit, this may be construed as restraint. This is a complex issue, which should be discussed on a case by case basis with the multidisciplinary team, including the Infection Control Team.

1.4.5 **Decision making and Assessment:**

- Individual assessment should be carried out that considers:
- The residents' behaviour and underlying condition and treatment.
- Understanding a resident's behaviour and responding to their individual needs should be at the centre of resident care.
- All residents should be thoroughly assessed to establish what therapeutic behaviour management interventions may be of benefit.

1.4.6 **The resident's mental capacity and/or mental health:**

It is necessary to consider a resident's mental capacity as consent must be gained from residents to use any type of restriction. Since the introduction of the Assisted Decision Making (Capacity) Act, 2015, all residents are deemed to have capacity to make a specific decision at a particular time about a particular thing, even if it is a case that we may not like that decision, even if we think it is a wrong decision and even if we think that decision could result in harm to that resident.

1.4.7 **The environment:**

Every effort should be made to reduce the negative effects of the care environment. Examples of negative environmental factors include: High levels of noise or disruption, inappropriate temperature, inappropriate levels of stimulation, negative attitudes of care staff, poor communication skills.

14.8 **Care Planning**

It is essential that any restriction is identified and justified in the care plan; this should include rationale for the use of restrictive practice.

- The frequency of re-assessment of the need for restrictive practice. Review times should be specified in advance.
- All discussions that have taken place to allow the resident to give informed consent and to assess best interests.
- Discussions with relatives, carers and others with regard to the restriction.
- Details about the use of the restriction itself.
- Which legislative framework is being used to legitimise the restriction.
- Any person affected by the restriction needs to be involved in the decision to the fullest possible extent. Clear communication is essential.

- Residents who have no family/friend support may need additional support and consideration should be given as neededto advocacy services.

- In cases where it is not possible to establish a person's view, e.g. due to mental incapacity, staff will need to consider if the restriction is likely to cause more harm than good.

1.4.7 **Duty of Care**

The best practice guidance Independence Choice and Risk (2007), states 'Duty of Care' as, 'an obligation placed on an individual requiring that they exercise a reasonable standard of care while doing something (or possibly omitting to do something) that could cause harm to others. Exercising 'duty of care' to a person cannot be used to justify restrictive practices except where a person has capacity and gives consent to the practice or where the practice is sanctioned under the Mental Health Act or the Assisted Decision (Capacity) Act of 2015.

1.4.8 **Recording Restrictive Practice**

This must be documented in the medical records, with a Mental Capacity assessed description, where appropriate. All documentation in relation to restrictive practices should be clear, detailed and contemporaneous. Physical restraint must be reported on NIMS when there is: direct physical contact, with or without resistance, where the intention is to prevent, restrict or subdue movement of the body, or part of the body of another person, by two or more staff.

Any injuries to a resident, member of staff or visitor to the HSE premises, involving the use of restraint or any restrictive practice, should be reported on NIMS. Incidents should also be documented in the nursing / multidisciplinary notes.

1.5 Governance and Approval

1.5.1 Membership of the Policy Development Group (Appendix 1).

1.5.2 Membership of the Approval Governance Group (Appendix 2).

1.6 Supporting Evidence

Health Information and Quality Authority (2013) Guidance on restraint as outlined by the Safeguarding Vulnerable Persons at risk of abuse.

HSE (2014) Safeguarding Vulnerable persons at risk of abuse.

Health Service Executive (HSE) (2018) Service User Falls: A Practical Guide for Review.
HSE (2018) Safety, Health and Welfare at Work Act.

HSE (2017) Safety Incident Management Policy

HSE (2018) Manual Handling and People Handling Policy.

HSE (2018) Incident Management Framework
Drogheda Services for Older People (DSOP) (2018) Safety Statements for The Cottage Hospital, St Mary's Hospital and Boyne View Nursing Home.

HSE (2015) About the Assisted Decision Making (Capacity) Act.

1.7 Glossary of Terms

HSE - Health Service Executive.

PPPG - Policies, Procedures, Protocols and Guidelines.

HIQA - Health Information and Quality Authority.

2.0 Development of Policy -

Literature Review.

Restrictive practices in health and social care refer to the implementation of any practice or practices that restrict an individual's movement, liberty and/or freedom to act independently without coercion or consequence (RCN, 2013). Restrictive practices can take a number of forms: restraint, including restrictive physical interventions, chemical restraint and psychosocial restraint and isolation. Often residents serious mental illness, learning disabilities and challenging behaviour (Allen, Lowe, Brophy & Moore, 2009; Duxbury, Aiken

& Dale, 2011) are more at risk of restrictive practices. There are risks and side effects of restrictive practices e.g. feelings of humiliation, loss of dignity, diminished quality of life, confusion, stress and fear, depression, isolation, anger, frustration, hostility and aggression, learned dependence, and diminished staff opinions (e.g. Frueh et al., 2005; Holmes et al., 2004).

The use of policy documents and guidance have been to reduce restrictive practices and recognised that where a resident's behaviour places themselves or others at impending risk of serious harm, and other strategies such as de-escalation have not been deterrent, the use of restrictive practices may be reasonable and necessary in a crisis or emergency. For certain restrictive practices, if an action fits the definition it is not automatically unacceptable or wrong (RCN, 2008). A values-based, person-centred approach should be used in order to decide the least intrusive restrictive practices to use if necessary, whilst also acknowledging that what may be suitable for one resident it may not apply to the next resident and so considering the person as an individual is a must. A person-centred approach and respond with interpersonal strategies as opposed to restrictive practices, residents and their relatives are more positive in their views (Duxbury et al., 2012). The restrictive practices should only ever be employed for the shortest time possible, out of necessity and as a last resort. The use of restrictive practices must be lawful. Lawfulness includes compliance with the European Convention on Human Rights (ECHR) (Council of Europe, 1950) and the use of restrictive practices must not breach a residents rights. There is limited empirical evidence that exists about which methods are preferred by residents (Bowers et al., 2004: Georgieva et al, 2012).

There is a gap between understanding of the place of implementing restrictive practices and their actual applications and justification. Evidence suggests that variations in the use of restrictive practices are largely influenced by environmental, interpersonal and contextual, factors and individual differences such as challenging behaviour and service practices.

Staff need to know how to create a environment that provides safety, equality and respect for all service users (O'Hagan, 2003) and to consider how the coercive context could contribute to service user aggression and violence. Therefore the interactions between individual residents and the staff who care for them should be based on mutual respect for the knowledge and expertise that both parties bring to the relationship.

3.0 Implementation and Dissemination

4.1 Staff training will be delivered annually to all staff. .

4.2 The quick reference guide sets out in this policy, is a condensed way to explain the approach staff should take in regards to restrictive practice.

4.3 The policy will be distributed to each area. This will include posters and guideline.

4.4 All clinical staff must, undertake the agreed training programme.

4.5 All staff will be expected to read and sign that they understand the policy (Appendix 3)

4.0 Monitoring, Audit and Evaluation

4.1 Compliance with this policy will happen in three ways:

- Audit and evaluation of each service/ward, looking into procedures, ward rules and blanket restrictions, measuring it against the risk it was meant to address
- In conjunction incident management framework - NIMS Incident reporting.
- The management teams are responsible for action planning to address any policy shortfalls.
- Complete the restrictive practice self-assessment questionnaire and the restrictive practice thematic program quality improvement plan and keep this under regular review.

4.2 **Audit and Metric**

- Overall figures of incidents that led to restrictive interventions such as restraint will be audited 3 monthly.
- Restrictive Practice awareness campaign to support staff in understanding the meaning of restrictive practice and its impact

5.0 REVISION/UPDATE

5.1 The procedure for updating the policy will be amended based on best practice guidelines.

5.2 A version control sheet will be updated on POLICY Template cover sheet**.**

References:

Allen, D., Lowe, K., Brophy, S., & Moore, K. (2009). Predictors of restrictive reactive strategy use in people with challenging behaviour. Journal of Applied Research in Intellectual Disabilities, 22(2), 159-168

Bowers, L., Alexander, J., Simpson, A., Ryan, C., & Carr-Walker, P. (2004). Cultures of psychiatry and the professional socialization process: the case of containment methods for disturbed patients. Nurse Education Today, 24(6), 435-442.

Duxbury, J., Pulsford, D., Hadi, M., & Sykes, S. (2012). Staff and relatives' perspectives on the aggressive behaviour of older people with dementia in residential care: a qualitative study. Journal of psychiatric and mental health nursing.

Duxbury, J., Aiken, F. and Dale, C. (2011) Deaths in custody: the role of restraint Journal of Learning Disabilities and Offending Behaviour 2(4): 178-189

Georgieva, I., Vesselinov, R., & Mulder, C. L. (2012). Early detection of risk factors for seclusion and restraint: a prospective study. Early Intervention in Psychiatry, 6(4), 415- 422.

Frueh, B. C., Knapp, R. G., Cusack, K. J. et al. (2005). Special section on seclusion and restraint: Patients' reports of traumatic or harmful experiences within the psychiatric setting. Psychiatric Services, 56(9), 1123-1133.

Holmes, D., Kennedy, S. L., & Perron, A. (2004). The mentally ill and social exclusion: a critical examination of the use of seclusion from the patient's perspective. Issues in mental health nursing, 25(6), 559-578.

O Hagan, M. (2004). Force in mental health services: international user and survivor perspectives. Mental Health Practice, 7(5), 12-17.

Royal College of Nursing (2013). Draft guidance on the minimisation of and alternatives to restrictive practices in health and adult social care, and special schools

Royal College of Nursing (2008). Let’s Talk about Restraint: Rights, risks and responsibility

Appendix 1 -Membership of the Policy Development Group.

Please list all members of the development group (and title) involved in the development of the document.

Michael Seamus McCaul Director of Nursing	Signature: _____ Date: _____
Eimear Hickey Assistant Director of Nursing	
Leenamma Varghese	Signature: _____ Date: _____
Jolly Varghese	
Loretta Byrne	
	Signature: _____ Date: _____
	Signature: _____ Date: _____
Chairperson:	
Seamus McCaul Assistant Director of Nursing	Signature: _____ Date: _____

Appendix 2 - Membership of the Approval Governance Group.

Membership of the Approval Governance

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

Michael McCaul Director of Nursing	Signature: _____ Date: _____
Maura Ward Older People Services Manager/Louth & Meath	Signature: _____ Date: _____

Appendix 3

Signature Sheet

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

Print Name	Signature	Area of Work	Date
