Mental Health Commission
Code of Practice

Reference Number: COP-S33(3)/02/2006

Code of Practice on the Use of Physical Restraint in Approved Centres

1st November 2006
Preamble

The Mental Health Commission, established under the Mental Health Act 2001, is an independent statutory body. One of its statutory duties is to promote, encourage and foster high standards in the delivery of mental health care [Section 33(1)].

Section 33(3)(e) of the Mental Health Act 2001 obliges the Mental Health Commission to: “prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services”. In accordance with this section of the Act, the Commission is bringing out a code of practice governing the use of physical restraint in approved centres. This code is applicable to all residents; that is, persons receiving care and treatment in an approved centre.

Principle 11 of the Principles for the Protection of Persons with Mental Illness & the Improvement of Mental Health Care (1991) states:

“Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient and others. It shall not be prolonged beyond the period which is strictly necessary for this purpose.”

The key principle underpinning the use of physical restraint in approved centres therefore is that it shall only be used as a last resort and shall not be prolonged beyond the period of time that is necessary for its purpose. The safety and welfare of residents should always be considered paramount and the use of physical restraint should only be used to prevent a resident from injuring himself/herself or others.

Where a voluntary resident is physical restrained, the Mental Health Commission is strongly of the view that its use should involve a consideration of whether involuntary admission of the resident on the grounds of mental disorder is warranted, and if so, the appropriate procedures should be followed.
Code of Practice on the Use of Physical Restraint in Approved Centres

This Code of Practice has been prepared by the Mental Health Commission, in accordance with Section 33(3)(e) of the Mental Health Act 2001, for the guidance of persons working in the mental health services.

1st November 2006
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Glossary

**Act**
The “Act” means the Mental Health Act 2001.

**Advance directive**
An advance directive is a document signed by a competent person setting out his/her wishes regarding the health care decisions to be taken in certain circumstances in the event of him/her becoming unable to make such decisions.

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

**Care officer**
Person who is employed to fulfil the role and functions of a care officer in the National Forensic Service (Central Mental Hospital).

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

**Clinical file**
A record of the resident’s referral, assessment, care and treatment while in receipt of mental health services. This documentation should be stored in the one file.

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

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

**Dignity**
The right of an individual to be treated with respect as a person in his or her own right.

**Direct supervision**
For the purposes of this code, direct supervision means being physically present, within sight and sound, to direct the physical restraint of a resident.
Duty consultant psychiatrist
The consultant psychiatrist on the on-call duty rota.

Environment
The entire estate including building facilities, the grounds and fixtures and fittings.

Examination
In relation to this code of practice, an examination means a personal examination carried out by a registered medical practitioner or the consultant psychiatrist responsible for the care and treatment of the resident or the duty consultant psychiatrist, of the process and content of thought, the mood and the behaviour of the resident.

Individual care and treatment plan
A documented set of goals collaboratively developed by the resident and the multi-disciplinary team. The plan sets the direction for treatment and support, identifies necessary resources and specifies outcomes for the resident. The care and treatment plan is recorded in the one set of documentation.

National Forensic Service
Central Mental Hospital

Nurse in charge
The clinical nurse manager in charge or the person officially ‘acting up’ in his or her absence.

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

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

Representative
A relative, friend, legal professional, or Guardian ad Litem appointed by the resident, statutory organisation or court to represent the best interests of the resident.

Resident
A resident is a person receiving care and treatment in an approved centre.

Unsafe behaviour
When a resident acts in such a way that he or she may injure himself/herself or others.
1. Introduction

Purpose of the Code

1.1 Section 33(3)(e) of the Mental Health Act 2001 requires the Commission to:
“prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services”.

1.2 The Act does not impose a legal duty on persons working in the mental health services to comply with codes of practice, but best practice requires that they be followed to ensure the Act is implemented consistently by persons working in the mental health services. A failure to implement or follow this Code could be referred to during the course of legal proceedings.

1.3 As required by Section 33(3)(e) of the Act the Commission shall review codes of practice periodically, after consultation with appropriate bodies. This Code shall be reviewed no later than 2 years from the date of full commencement of the Act.

Scope of the Code

1.4 The scope of the Code is prescribed for in the Act by the provisions of Section 33(3)(e). The code is intended as guidance for persons working in approved centres, and in particular for staff involved in the use of physical restraint in approved centres. The Code is intended to be complementary to the Act, which should always be referred to for its precise terms.

1.5 The Code does not purport to be all encompassing. The Mental Health Commission however hopes that it will enable mental health professionals to work together effectively in the management of unsafe behaviour.

Definition of Physical Restraint

1.6 For the purpose of this code, 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”.
2. Orders for Physical Restraint

2.1 Physical restraint should only be used in the best interest of the resident and only when a resident poses an immediate threat of serious harm to himself/herself or others and all alternative interventions to manage the resident’s unsafe behaviour have been considered.

2.2 The duration of the period of physical restraint should be the minimum necessary to protect the resident and/or others from immediate and serious harm.

2.3 Physical restraint should never be used to ameliorate operational difficulties including where there are staff shortages.

2.4 Special consideration should be given when restraining residents who are known, by the staff involved in restraining the resident, to have experienced physical or sexual abuse.

2.5 The use of physical restraint may be initiated by a registered medical practitioner or a registered nurse or a care officer (National Forensic Service).

2.6 Where the use of physical restraint has been initiated by a registered nurse or care officer (National Forensic Service), a registered medical practitioner should be notified immediately of the fact and this fact should be recorded in the resident’s clinical file.

2.7 The consultant psychiatrist responsible for the care and treatment of the resident or the duty consultant psychiatrist should be notified by the registered medical practitioner as per 2.6 as soon as is practicable and this should be recorded in the resident’s clinical file.

2.8 As soon as is practicable, and no later than 3 hours after the episode of physical restraint, the medical practitioner, under the supervision of either the consultant psychiatrist responsible for the care and treatment of the resident or the duty consultant psychiatrist, should examine the resident and complete the relevant section of the “Clinical Practice Form for Physical Restraint”. The clinical practice form for physical restraint should also be signed by the consultant psychiatrist responsible for the care and treatment of the resident or the duty consultant psychiatrist as soon as is practicable and in any event within 24 hours.

2.9 The resident should be informed of the reasons for and likely duration of physical restraint, unless the provision of such information might be prejudicial to the resident’s mental health, well-being or emotional condition. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the resident’s clinical file.
2.10 a) As soon as is practicable, and with the resident’s consent, the resident’s next of kin or representative should be informed of the resident’s restraint and a record of this communication should be placed on the resident’s clinical file. In the event that this communication does not occur, a record explaining why it has not occurred should be entered on the resident’s clinical file.

b) Where the resident lacks capacity and cannot consent, the resident’s next of kin or representative should be informed of the resident’s restraint and a record of this communication should be placed on the resident’s clinical file. In the event that this communication does not occur, a record explaining why it has not occurred should be entered on the resident’s clinical file.

3. Resident Dignity & Safety

3.1 Approved centres should have a policy in relation to who may carry out physical restraint.

3.2 The application of physical restraint should be under the direct supervision of a registered medical practitioner or a registered nurse or a care officer (National Forensic Service).

3.3 The resident should be continually assessed throughout the use of restraint to ensure his or her safety. Any specific requirements/needs of the resident in relation to the use of restraint, including any “advanced directives” noted in his or her individual care and treatment plan should be considered.

3.4 The use of holds intended to deliberately inflict pain is prohibited.

3.5 The following should be avoided -

a) Neck holds

b) The application of heavy weight to the resident’s chest or back.

3.6 Limited use of physical restraint involving the resident in the ‘prone’, face down, position is permitted in exceptional circumstances by staff who have received appropriate training. A record of the use of prone restraint should be entered into the resident’s clinical file.
3.7 A designated member of staff should be responsible for leading the physical restraint of a resident and for monitoring the head and airway of the resident.

4. **Ending the Use of Physical Restraint**

4.1 The use of physical restraint may be ended at any time by the designated member of staff responsible for leading the physical restraint of the resident and monitoring the head and airway of the resident.

4.2 Following physical restraint, the resident concerned should be afforded the opportunity to discuss the episode with the multi-disciplinary team involved in his or her care and treatment as soon as is practicable.

5. **Recording the use of Physical Restraint**

5.1 All uses of physical restraint should be clearly recorded in the resident’s clinical file.

5.2 All uses of physical restraint should be entered as soon as is practicable on a “Clinical Practice Form for Physical Restraint” prescribed by the Mental Health Commission (Appendix).

5.3 The completed form should be placed in the resident’s clinical file and a copy should be available to the Inspector of Mental Health Services and/or the Mental Health Commission on request.

6. **Clinical Governance**

6.1 a) Each approved centre should have a written policy in relation to the use of physical restraint, including the provision of information to the resident.

b) The approved centre should maintain a written record indicating that all staff involved in physical restraint have read and understand the policy.

c) The record should be available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.

d) An approved centre should review its policy on physical restraint as required and in any event at least on an annual basis.
6.2 Each episode of physical restraint should be reviewed by the multi-disciplinary team involved in the resident’s care as soon as is practicable and in any event no later than 2 normal working days (i.e. days other than Saturday/Sunday and bank holidays).

6.3 All information gathered regarding the use of physical restraint should be held in the approved centre and used to compile an annual report on the use of physical restraint at the approved centre. This report should be available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.

7. **Staff Training**

7.1 Approved centres should have a policy and procedures for training staff in relation to physical restraint. This policy should include, but is not limited to, the following:

   a) Who will receive training based on identified needs of residents and staff.

   b) The areas to be addressed within the training programme, including training in alternatives to physical restraint.

   c) The frequency of training.

   d) Identifying appropriately qualified person(s) to give the training.

   e) The mandatory nature of training for those involved in physical restraint.

7.2 A record of attendance at training must be maintained.

8. **Child Residents**

In addition to sections 2-7 which apply to all residents, the following considerations apply to children being provided care and treatment in approved centres.

8.1 An approved centre physically restraining a child should ensure the child’s parent or guardian is informed as soon as possible of the child’s physical restraint.

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


Bibliography


Commission for Healthcare Audit and Inspection (CHAI) 2005, Count me in. Results of a national census of inpatients in mental health hospitals and facilities in England and Wales. London. CHAI.


Craig, K 2005, Can Mental Health Nursing Ever Give Up The Option Of Restraint? Community Care, 16.


Donat, DC 2003, An Analysis of Successful Efforts to Reduce the Use of Seclusion and Restraint at a Public Psychiatric Hospital. Psychiatric Services, 54(8).


Irish Nurses Organisation 2003, Guidelines on the use of Restraint in the Care of the Older Person.


Manchester City Council, UK 2003, Responding To Aggression and Violence.


Royal College of Surgeons 1998, Management of imminent violence-Clinical practice guidelines to support mental health services. www.rcpsych.ac.uk

Sailas, E. & Fenton, M 2000, Seclusion and Restraint for People with serious mental illness. Cochrane Database System: CD001163


Appendix

Clinical Practice Form for Physical Restraint
**CLINICAL PRACTICE FORM FOR PHYSICAL RESTRAINT**

**RESIDENT’S PERSONAL DETAILS:**

<table>
<thead>
<tr>
<th>1. First name:</th>
<th>2. Surname:</th>
<th>3. Gender: Male [ ] Female [ ]</th>
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<td>4. Date of Birth: / / /</td>
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**PHYSICAL RESTRAINT DETAILS:**

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<th>6. Date Restraint Commenced:</th>
<th>7. Time Restraint commenced:</th>
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<th>8. Date Restraint Ordered:</th>
<th>9. Time Restraint Ordered:</th>
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10(a). Who Initiated Physical Restraint:

Name (print) ___________________________ Job title (print) ___________________________

Signed: ________________________________

10(b). Who assisted with the Physical Restraint:

Name (print) ___________________________ Job title (print) ___________________________

Signed: ________________________________

Name (print) ___________________________ Job title (print) ___________________________

Signed: ________________________________

Name (print) ___________________________ Job title (print) ___________________________

Signed: ________________________________

11. Brief description of why physical restraint is being used:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
**CLINICAL PRACTICE FORM FOR PHYSICAL RESTRAINT**

12. Brief description of alternatives to physical restraint considered:

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14. Who ended Physical Restraint:

Name (print) _________________________________  Signed: _________________________________

Date and time restraint ended:  Date: / / at hrs mins

**ORDER:**

15. Registered Medical Practitioner:

I ________________________________________________ have examined ____________________________ on Date: / / at hrs mins and I **authorise** / **do not authorise** the use of Physical Restraint from Date: / / at hrs mins **for up to a maximum period of** hrs mins

Signed: _________________________________  Name (print): _________________________________

16. Physical Restraint has been authorised under the supervision of the:

Please tick as appropriate and sign below.

- Consultant Psychiatrist responsible for the care and treatment of the resident
- Duty Consultant Psychiatrist

Signed: _________________________________  Name (print): _________________________________

Date: / / at hrs mins