Aurora

Enriching lives, Enriching Communities

Restrictive Practice Policy

Policy Number	Policy Developed by	Date Developed
6 – Schedule 5	Restrictive Practice Committee	1/10/2017

Version	Amendments
5	Full Review of Policy

Reviewed by	Review completed
Claire Wilson, Ciaran Murphy, Sarah McCollam, Mirjam O'Keeffe	20/03/2026

CEO signature	Next Review Date
Davies CEO	20/03/2029

Mission Statement

Enable people with complex needs to experience the same rights as every other citizen and as equal members of the community.

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1.0 Policy Statement

1.1. Human Rights Based Approach - Aurora is committed to promoting an environment that is free from restriction, in line with a Human Rights–Based approach.
All supports are underpinned by the principles of Fairness, Respect, Equality, Dignity, and Autonomy (FREDA) and are informed by Person-Centred Planning and Social Inclusion.

1.2. Aurora recognises that people supported are rights holders and are entitled to:

- Liberty and freedom of movement
- Autonomy and self-determination
- Dignity, respect, and equality

2.0 Positive Risk Taking

2.1. Aurora supports positive and proportionate risk-taking as an essential part of living a meaningful life with dignity.

2.2. Risks are managed collaboratively in line with Aurora risk management policy, with the aim of:
- Maximising autonomy and choice
- Minimising harm
- Avoiding unnecessary restriction

3.0 Restrictive Practices and Rights

3.1. Aurora acknowledges that restrictive practices constitute a restriction of a person's human rights.

3.2. Therefore, any restrictive practice must:
- Be necessary, proportionate, and clearly justified
- Be the least restrictive option available
- Be used for the shortest duration possible
- Be informed by a documented restrictive practice impact assessment, management plan and risk assessment
- Be deemed to be less impactful than the risk of harm
- Be subject to robust monitoring, review, and oversight
- Include a Rights Restoration Plan, where appropriate

4.0 Therapeutic and clinically indicated restrictions.

4.1. Aurora recognises that, for some people, due to diagnosed complex health needs restrictive practices may be required to ensure the ongoing safety and wellbeing and therapeutic treatment of the person.

4.2. In such circumstances, restrictive practices must:
- Be time-limited.
- Be clinically and ethically justified.

- Be implemented alongside proactive and preventative supports
- Include a clear plan for the reduction and restoration of rights, where possible

5.0 Associated Policies

5.1. This policy must be read in conjunction with:
- Personal Planning Framework Policy
- Risk Management Policy
- Positive Behaviour Support Policy
- Medication Management Policy

6.0 Purpose and Scope

6.1. Purpose - The purpose of this policy is to provide clear guidance on the:
- Identification and assessment
- Authorisation
- Implementation
- Monitoring
- Review
- Reduction and
- Elimination
- Oversight of restrictive practices.

6.2. Scope - This policy applies to:
- All Aurora employees
- All People supported

7.0 Regulatory Context

7.1. This policy is informed by:
- Health Act 2007 and associated Regulations
- HIQA Restraint Procedures (2016)
- HIQA Guidance on Promoting a Care Environment Free from Restrictive Practices (2019, 2023)
- HSE Preventing the Need for Restrictions – Guiding Principles
- Assisted Decision-Making (Capacity) Act 2015
- National Consent Policy

8.0 Consent and Decision-Making

8.1. Informed Consent - In line with HIQA regulations, consultation and consent must be sought prior to the introduction of any restrictive practice.

8.2. The person must be supported to understand:
- The reason for the restriction
- Potential risks and impacts
- Available alternatives

8.3. Information must be provided in an accessible and appropriate format. The following should guide and underpin consultation.

- Decision-making must comply with the Assisted Decision-Making (Capacity) Act 2015
- The person's ascertainable will and preferences must be central
- Relevant supporters, representatives, or advocates must be consulted

9.0 Person-Centred Participation

9.1. Aurora ensures that people supported are actively involved in:
- The creation of the Restrictive Practice Management Plan and Review
- Rights restoration planning
- Reviews and decision-making processes

9.2. Evidence of meaningful involvement with the person supported must be clearly documented by the Person in Charge.

10.0 Definitions

10.1. Restrictive Practice - A restrictive practice is any intervention that intentionally limits a person's freedom of movement, choice, or behaviour.

10.2. Types of Restrictive Practices

These may include:
- Physical restraint
- Environmental restraint
- Chemical restraint
- Mechanical restraint
- Seclusion
- Emotional or psychological restriction
- Rights restriction

10.3. Medication

Aurora does not apply chemical restraint to people supported. Psychotropic medication does not constitute chemical restraint where all of the following are in place:
- Prescribed by relevant professional for therapeutic purposes
- Clearly documented
- Subject to regular review
- Used alongside positive behavioural supports

11.0 Guiding Principles

11.1. Prevention and Reduction

11.2. Aurora prioritises prevention, reduction, and elimination of restrictive practices through:
- Proactive support planning
- Environmental and relational approaches
- Familiar staffing and therapeutic relationships
- Guiding Support plans

11.3. Least Restrictive Practice

Restrictive practices may only be used where:

- All alternatives have been explored
- The restriction is proportionate to the assessed risk
- The impact is less than the potential harm

11.4. Prohibited Use

Restrictive practices must never be used:

- For employee convenience
- As punishment
- Due to staffing shortages
- In a manner that causes pain, distress, or humiliation

11.5. Rights Restoration Planning.

- All management plans should consider restoration of rights.
- Consideration of restoration should form part of quarterly reviews and committee meetings, facilitated by at least two committee members and attended by some of the following, Person Supported, Person in Charge, Team Lead/Team member.
- Where rights restoration planning is appropriate, documentation must outline the following:
  - Measurable actions to reduce or remove restrictions
  - Clear communication with Person Supported
  - Specify the responsibilities of employees and the review of timelines
  - Restrictive practices are to be reviewed at least quarterly, or following related incidents.

11.6. Long-Term Restrictions

The service recognises that for some people restoration is not possible due to lifelong medical or clinical needs, some restrictions are necessary enablers without which people would be unable to engage in daily living activities. To ensure these measures are used as intended and to the benefit of people supported, the following applies.

- The restriction must remain under regular review, which ensures the application of the restriction remains enabling and in line with support plans.
- Ongoing necessity, proportionality, and correct application must be considered and documented.
- The person's dignity and quality of life must be safeguarded.

12.0 Emergency and Unplanned Restrictive Practices

12.1. Emergency restrictive practices may only be used to prevent immediate and serious harm.

12.2. Unplanned restrictive practices are not permitted when outside emergency situations and where no potential risk of harm is evident.

12.3. Following the implementation of an emergency or unplanned restrictive practice:

- The incident must be documented on all relevant Aurora systems
- Following implementation of an unplanned/emergency restrictive, line management must be contacted
- Debriefs must occur with the person and employee
- The Restrictive Practice Register must be updated
- Necessary monitoring notifications to HIQA must be completed
- A Review and Rights Restoration Plan must be initiated or amended
- Incident recorded on the Restrictive Practice Management Plan and Review
- All Aurora systems relevant to the incident must be used

13.0 Governance, Roles, and Responsibilities

13.1. Provider and Restrictive Practice Committee

- Ensure governance, oversight, and compliance
- Maintain Organisational Restrictive Practice Register
- Review restrictive practices at least annually
- Promote reduction and rights restoration

13.2. Person in Charge (PIC) / Team Leaders

- Maintain accurate documentation and registers
- Complete and review risk assessments
- Submit HIQA notifications within required timeframes
- Ensure the person is consulted and supported to participate

13.3. Workforce Training

Aurora ensures all employees:

- Receive mentoring and support in human rights and restrictive practice reduction
- Complete mandatory rights-based training. (HSEland)
- Are supported through supervision and practice development

14.0 Monitoring, Audit, and Quality Improvement

- Restrictive practice data is collected by the committee and analysed via the organisational register to identify trends and reported quarterly to DOS.
- Findings from analysis inform quality improvement actions
- Oversight includes provider audits, committee reviews quarterly, and HIQA Inspections

15.0 Final Statement

Aurora is committed to continuous reduction of restrictive practices and to promoting environments that uphold human rights, dignity, autonomy, and inclusion.

Where restrictive practices are necessary, they are:

- Lawful
- Proportionate
- Person-centred

- Regularly reviewed

16.0 Procedures

16.1. These procedures outline how Aurora implements the Restrictive Practices Policy in practice, ensuring that any restriction:
- Respects human rights
- Is lawful, proportionate, and necessary
- Is used only as a last resort
- Is regularly reviewed and reduced

16.2. These procedures apply to all employees employed by Aurora.

17.0 Identifying the Need for a Restrictive Practice

17.1. Recognition of Risk

Before considering a restrictive practice, employees must demonstrate that all reasonable alternatives have been considered, including:
- Environmental adjustments
- Communication supports
- Sensory or emotional regulation strategies
- Positive behaviour support strategies

17.2. Staff must identify and document:
- A specific and likely risk of harm to the person or others
- Evidence that the risk cannot be managed through non-restrictive means

17.3. Risks must be:
- Clearly described
- Current and realistic
- Linked to the person's environment, health, or behaviour

18.0 Risk Assessment Procedure

Completion of Risk Assessment

The Person in Charge (PIC) or delegated Team Leader/team member must ensure:
- A formal risk assessment is completed
- The assessment clearly identifies:
  - Nature of the risk
  - Likelihood and severity of harm
  - Who is at risk?
  - Existing and additional controls

19.0 Restrictive Practice Impact Assessment. Appendix E

The assessment must clearly demonstrate that:
- The proposed restrictive practice is less harmful than the risk itself

- The restriction is the least restrictive option available

Note: Risk Assessment seeks to establish the risk presented to the person. Impact Assessment seeks to establish the impact of applying a restrictive practice.

20.0 Consent and Consultation Procedure

20.1. Supporting consent and consultation

Prior to implementation:

- The person is supported to understand:
  - What is the restriction
  - Why it is proposed
  - How it affects their rights
  - What alternatives were considered

20.2. The following should inform and be central to how we consult with people.

- Assisted Decision-Making (Capacity) Act
- HSE Consent Policy
- The person's will and preferences must guide decisions
- Relevant supporters, representatives, or advocates are consulted as required.
- All steps and outcomes are documented.

20.3. PIC must ensure that all information is provided in an accessible format in a way the optimises understanding and consultation for the person supported.

- Authorisation of Restrictive Practices
- Planned Restrictive Practices
- A planned restrictive practice may only be implemented when:
  - A completed risk assessment is in place
  - Consultation processes are completed
  - A Restrictive Practice Management Plan and Review is developed
  - Rights Restoration Planning forms part of the management plan (where applicable)
  - The practice is approved through local governance processes (Person in Charge & WCI Manager)

21.0 Governance Oversight

21.1. All restrictive practices must be:

- Recorded on the Designated Centre Restrictive Practice Register
- Reviewed Quarterly by Person in Charge
- Reviewed Annually by Restrictive Practice Committee
- Documented in the Organisation Restrictive Practice Register.
- Notified to HIQA within the required timeframes

22.0 Developing the Restrictive Practice Management Plan and Review (Appendix B)

22.1. Each plan must include:

- Description of the restrictive practice
- Clear rationale linked to assessed risk
- A record of all restrictive practices added, removed or modified since the last quarterly review
- Review dates (Quarterly)

22.2. Plans must be:

- Person-centred
- Written in clear language
- Shared with the person in an accessible format
- Seek to restore rights where applicable

23.0 Implementation of Restrictive Practices

23.1. Staff Responsibilities

Staff implementing a restrictive practice must:

- Follow the approved plan exactly
- Use the restriction only when the criteria are met
- Maintain dignity, respect, and calm communication
- Discontinue immediately once the risk reduces

23.2. Prohibited Practice

Staff must never:

- Use restrictions for convenience or punishment
- Use restrictions outside the agreed plan
- Use restrictions to cause pain, fear, or humiliation

Any deviation is a serious governance concern.

24.0 Emergency / Unplanned Restrictive Practices

24.1. Use in Emergencies

- Emergency restrictive practices may be used only to prevent:
- Immediate
- Serious or Unavoidable harm

24.2. Post-Incident Actions (Mandatory)

Following emergency use:

1. Incident is documented
2. Debrief occurs with:
    - The person
    - Staff involved
3. Restrictive Practice Register is updated.
4. Risk assessment is reviewed if one is in place, and developed if not.
5. Relevant support plans reviewed.

6. Future planning occurs and is evidenced as appropriate (e.g., Restrictive Practice Management Plan and Review, Rights Restoration, employee training, behaviour support)

25.0 Monitoring and Review

25.1. Ongoing Monitoring

The PIC must ensure:

- Daily monitoring of use and evidence (Daily Notes) by employees.
- Where necessary, monitoring use with the Restrictive Practice Monitoring form.
- Accuracy of documentation
- Early identification of opportunities to remove or reduce restrictions

25.2. Formal Reviews

Restrictive practices must be formally reviewed:

- Quarterly at centre level by PIC
- Annually, by the restrictive practice committee
- Following incidents or significant changes
- Bi annually via six monthly provider audits.

26.0 HIQA Notifications and Records

26.1. The PIC is responsible for:

- Notifying HIQA within 5 working days of introduction
- Submitting updates for changes or reviews
- Completing quarterly restrictive practice returns

Process	Evidence
Risk Assessment	Risk Assessment
Restrictive Practice Identified as Control Measure	Where a risk assessment identifies a restrictive practice as a control measure a copy of the risk assessment must be filed in the restrictive practice folder.
Impact Assessment	Impact Assessment (Appendix E)
Decsion to Implement Restrcitive Practice(Person Supported, relevent MDT, team memebers ,PIC & WCI, Committe Memebers can be consulted if necessary)	Evidence of person Supported involvement in decision and information sharing with person supported. E.g., Social Story, Easy Read Materials or similar. MDT recommendations. Meeting minutes
Develop Plan	Restrictive Practice Management Plan and Review (Appendix B)
Implement	Daily Notes Restrictive Practice Implementation/Reduction/Monitoring from.
Review & Notifications	Quarterly Reviews – Designated Centre Annual Review – Committee HIQA Notifications – Quarterly (Notification within five days required for application of emergency restriction)

27.0 Appendix A – Restrictive Practice Register

Restrictive Practice Register	Policy	Restrictive Practice Policy
	Appendix	A

Designated Centre Name:	

Quarter 1	PIC Signature:		Date:	
Quarter 2	PIC Signature:		Date:	
Quarter 3	PIC Signature:		Date:	
Quarter 4	PIC Signature:		Date:	

Person Supported Unique Identifier Number	Name of Restrictive Practice	Date of Restrictive Practice Risk Assessment

28.0 Appendix B – Restrictive Practice Management Plan and Review

Restrictive Practice Management Plan and Review	Policy	Restrictive Practice Policy
	Appendix	B

Designated Centre Name:		Person Supported Name:		Date of Birth:	

Completed by:		Date:		PIC Signature:		Date:	

Restrictive practice (Include details of frequency and duration)	**Rationale for restriction**	Tick below if in place		
		Risk assessment	**Support plan**	**Impact assessment**

Review of Restrictive Practice Management Plan

Quarter 1	Completed by:		Date:	

Since the last review has a **new restriction** been put in place? If yes, please provide details:
Since the last review has a **restriction been removed**? If yes, please provide details:
Since the last review has a **restriction been modified**? If yes, please provide details:
Since the last review has an **emergency/unplanned restriction** been put in place? If yes, please provide details:

Quarter 2	Completed by:		Date:	

Since the last review has a **new restriction** been put in place? If yes, please provide details:
Since the last review has a **restriction been removed**? If yes, please provide details:
Since the last review has a **restriction been modified**? If yes, please provide details:
Since the last review has an **emergency/unplanned restriction** been put in place? If yes, please provide details:

Quarter 3	Completed by:		Date:	

Since the last review has a **new restriction** been put in place? If yes, please provide details:
Since the last review has a **restriction been removed**? If yes, please provide details:
Since the last review has a **restriction been modified**? If yes, please provide details:
Since the last review has an **emergency/unplanned restriction** been put in place? If yes, please provide details:

Quarter 4	Completed by:		Date:	

Since the last review has a **new restriction** been put in place? If yes, please provide details:
Since the last review has a **restriction been removed**? If yes, please provide details:
Since the last review has a **restriction been modified**? If yes, please provide details:
Since the last review has an **emergency/unplanned restriction** been put in place? If yes, please provide details:

29.0 Appendix C – Restrictive Practice Committee Review

Restrictive Practice Committee Review	Policy	Restrictive Practice Policy
	Appendix	C

Designated Centre Name:		Person Supported Name:		Date of Birth:	

Completed by:		Date:		PIC Signature:		Date:	

Staff members in attendance:	

Document	Date Completed	Comments	
HIQA self-assessment questionnaire			
Restrictive practice management plan			
Person supported informed of details of restrictive practice management plan		Name of staff member who discussed restrictive practices with person supported	
Restrictive practice management plan - quarter 1			
Restrictive practice management plan - quarter 2			
Restrictive practice management plan - quarter 3			
Restrictive practice management plan - quarter 4			
Most recent aurora provider audit			
Behaviour support plan			

Restrictive Practice Risk Assessments	Yes	No
Do all known restrictive practices have an up-to-date risk assessment?		
Following the restrictive practice committee review, are there any newly identified restrictive practices?		
If yes, please list the restriction(s):		
Do any newly identified restrictive practices require a risk assessment?		

Emergency/Unplanned Restrictive Practices		Yes	No
Since the last review has an emergency/unplanned restriction taken place?			
If yes, please provide details:			
Since the last review has an emergency/unplanned restrictive practice become an approved restriction?			
If yes, please list the restriction(s):			

Restrictive practice	Rationale for restriction	Level of impact on person	Rights restoration if Applicable

Committee Comments & Recommendations

Committee Member Signatures:

Name: _____ **Name:** _____
Role: _____ **Role:** _____
Date: _____ **Date:** _____

30.0 Appendix D – Restrictive Practice Introduction/ Reduction/Removal/Monitoring Form

Restrictive Practice Introduction/ Reduction/Removal/Monitoring Form	Policy	Restrictive Practice Policy
	Appendix	D

Designated Centre Name:		Person Supported Name:		Date of Birth:	

Completed by:		Date:		PIC Signature:		Date:	

Description of Restrictive Practice	Reason for Introduction/Reduction/ Removal/Monitoring of restrictive practice?	Method of Introduction/Reduction/ Removal/Monitoring of restrictive practice?

Date	Action	Impact on Person	Comment	Signature

31.0 Appendix E – Restrictive Practice Impact Assessment

Restrictive Practice Impact Assessment	Policy	Restrictive Practice Policy
	Appendix	E

Assessment to be completed where a restrictive practice is in place to mitigate a potential risk

Designated Centre Name:		Person Supported Name:		Date of Birth:	

Completed by:		Date:		PIC Signature:		Date:	

Details of Restrictive Practice	
Description of restrictive practice and its application (e.g., method, duration and frequency of use)	
Reason for restriction (risk being addressed)	

Expected impact of proposed restrictive practice on person	
Expected impact on person's independence and choice	Negligible ☐ Minor ☐ Moderate ☐ Major ☐ Extreme ☐
Expected impact on person's emotional and physical wellbeing	Negligible ☐ Minor ☐ Moderate ☐ Major ☐ Extreme ☐
Expected impact on person's social and daily activities	Negligible ☐ Minor ☐ Moderate ☐ Major ☐ Extreme ☐

Consultation of use of restrictive practice	
Person supported involvement	
Significant other	
Staff and/or MDT input	