

NF39A Form DCSC	Health Information and Quality Authority Designated Centre – Special Care Unit (DCSC) Quarterly notification of incidents* NF39A Any occasion where physical, environmental or other restraint was used	 <p>Health Information and Quality Authority An tÚdarás Um Fhaisnéis agus Cailíocht Sláinte</p>
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Section 1. Centre details			
Centre name			
Centre ID (OSV)			
Unit or ward name (if applicable)			
Please tick the applicable quarter and state the year.			
Quarter 1 (January, February, March)	<input type="checkbox"/>	Year	
Quarter 2 (April, May, June)	<input type="checkbox"/>	Year	
Quarter 3 (July, August, September)	<input type="checkbox"/>	Year	
Quarter 4 (October, November, December)	<input type="checkbox"/>	Year	

* Please complete this form with HIQA's notification guidance. You can download the guidance at www.hiqa.ie

Section 2. Restraints

Details of any occasion where a restraint was used

Have **physical restraints**[†] been used in the quarter?

Yes No

If **yes**, please state the type of physical restraint.

Type of physical restraint	No. of occasions	No. of residents
One person restraint <input type="checkbox"/>		
Team restraint <input type="checkbox"/>		
Other <input type="checkbox"/>		

If you have ticked **other**, please provide details.

Have **environmental restraints** been used in the quarter?

Yes No

If **yes**, please state the type of environmental restraint.

Type of environmental restraint	No. of occasions	No. of residents
Structured time away <input type="checkbox"/>		
Single separation <input type="checkbox"/>		
Single occupancy <input type="checkbox"/>		
Other <input type="checkbox"/>		

If you have ticked **other**, please provide details:

[†] As per the Health Act 2007 and regulations thereunder, the person in charge shall ensure that a written report is provided to the Chief Inspector at the end of each quarter in relation to any occasion when restraint was used.

Section 2. Restraints

Details of any occasion where a restraint was used

Have **chemical restraints** been used in the quarter?

If **yes**, please state the number of occasions and residents.

Yes No

No. of **occasions**

No. of **residents**

Please include any **additional information** relevant to this section.

Section 3. Declaration

I, the undersigned, declare that the information I have provided in this notification form is true to the best of my knowledge and belief.

Name (print)	
Position	Person in charge <input type="checkbox"/> Authorised signatory for and on behalf of the registered provider <input type="checkbox"/>
Signed	
Date	
Contact number (during office hours)	

This form should be either:

- **emailed** to: children@hiqa.ie or,
- **posted** to: Regulatory Support Team, Regulatory Support Services, Health Information and Quality Authority, Dublin Regional Office, George's Court, George's Lane, Smithfield, Dublin 7, D07 E98Y.

Telephone no: (01) 814 7400

Email: children@hiqa.ie