MENTAL HEALTH PROGRAMS: USE OF SECLUSION

PURPOSE
To outline the use of seclusion in the Mental Health Programs in a manner that supports a trauma informed approach to all client and family care. We provide an environment that promotes psychological, physical and emotional safety for patients, families and staff, and minimizes the need for coercion, restraints and seclusion. We recognize seclusion can result in adverse physical, emotional and psychological effects for client and staff outcomes.

POLICY STATEMENTS

1. Seclusion is only used as a last resort when the adequate protection of the patient or others cannot be ensured by other interventions, and where there is an immediate risk of serious physical harm to self or others. Seclusion must not be used as a punishment or consequence and only when all de-escalation strategies have been exhausted.

2. The use of a seclusion room is a high risk intervention and therefore a secluded patient will be placed on continuous observation.

3. Only the following rooms may be used for seclusion: The Seclusion Rooms on Child Psychiatry Unit and Adolescent Psychiatry and CAPE. In the event that the Seclusion room in CAPE is already in use and another Seclusion room is needed, CAPE bedrooms may be used for this purpose.

4. A STAT physician’s order is REQUIRED for any type of Seclusion. There shall be no PRN (“as needed”) orders for Seclusion or Restraint.

5. Informed Consent for treatment is required (Mental Health Act Form 2 and Form 5) prior to any seclusion. The care team will discuss potential use and risks of this intervention.

6. Seclusion is limited to a maximum of one hour.

SITE APPLICABILITY
Child, Youth, and Reproductive Mental Health (Inpatient Programs)

PRACTICE LEVEL/COMPETENCIES
All staff (including physicians, nursing, youth and family counsellors, allied health professionals, and administrative staff) are required to be trained in either the Mandt Relational Conceptual and Technical (RCT) system or the BC Provincial Violence Prevention Curriculum (PVPC), as below;

Inpatient Nursing & Youth & Family Counselling staff
Required to complete Provincial Violence Prevention Curriculum Levels 1-8 AND MANDT RCT & Advanced Workshops. Staff must be trained in Advanced Mandt before restraining for the purpose of IM injection.

Out-Patient Department Staff
Staff – Required to complete Provincial Violence Prevention Curriculum Levels 1 – 8 AND PVPC Classroom 8 hour session
Inpatient Allied Staff

Allied Staff – Required to complete Provincial Violence Prevention Curriculum Levels 1 – 8 AND PVPC Classroom 8 hour session or MANDT RCT Workshop as per Program Direction.

Physicians/Psychiatrists

All Physicians/Psychiatrists are required to complete Provincial Violence Prevention Curriculum Levels 1 – 8 AND PVPC Classroom 8 hour session

DEFINITIONS

Seclusion: a method of restraint during which a patient perceived to be in psychiatric crisis is contained in a room that is either locked or from which free exit is denied

Debrief: the discussion and processing of an event in which a restrictive physical interaction may or may not have occurred

Disclosure: informing clients, families and staff of an event

EQUIPMENT

Video Observation Equipment in Seclusion Rooms

PROCEDURES

A. Ordering and Beginning Seclusion

1. Ensure all other interventions have been exhausted.

2. Staff will check physician’s orders to ensure that seclusion is not medically contraindicated. Ensure patient has been certified and/or given informed consent for treatment.

3. A STAT order for seclusion from the child’s psychiatrist or on-call physician must be obtained.

   Example A

   Seclude patient STAT (or NOW) not to exceed one hour, for _______________ (rationale). Signature

   Or

   Example B

   STAT Telephone order: Seclude patient now, for _______________ (rationale). Not to exceed one hour. Signature

4. TEAM LEAD is identified. Determine need for security either as participants or back up.

5. Once SECURITY is present, TEAM LEAD DIRECTS those who are involved in the
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seclusion. SECURITY follows the clinical direction of the TEAM LEAD. The TEAM LEAD speaks with client communicator, and addresses the client directly as needed.

6. Patient is escorted/transported to the designated seclusion room using the least restrictive method possible.

7. If situation remains resolved at one hour, a Psychiatrist/Resident on Call must attend to support treatment decision.

B. While In Seclusion

1. At the initiation of seclusion the patient is on constant observation and the seclusion & restraint record is started.

2. Staff will monitor for signs of physical distress.

3. Patient Communicator immediately informs patient what is expected of them in order for seclusion to be terminated. Plan with the child/youth for a safe re-entry to the unit.

4. Seclusion is terminated when there is no longer an immediate or imminent risk of serious physical harm to self or others.

5. Request consent from the child / youth to take vital signs following seclusion.

C. Disclosure, Debrief and Documentation

1. Nurse in Charge or Delegate will notify the Attending Psychiatrist that the patient has been in seclusion.

2. Nurse in Charge, Delegate or Psychiatrist will notify patients/legal guardian as soon as possible after the event and document this notification in the chart.

3. All staff involved in the event will debrief the incident with at least one of the following: Psychiatrist, Program Director, Clinical Nurse Coordinator, Clinical Nurse Leader, Nurse in Charge, Educator.

4. Patient will be offered the opportunity to debrief with the staff of their choice.

5. Other patients and families will be offered the opportunity to debrief with staff when indicated.


7. Complete a report in the Patient Safety and Learning System (PSLS) including the rationale for the use of seclusion.

DOCUMENTATION

Details of seclusion are documented on the Seclusion/Restraint Record.
REFERENCES


KEY WORDS for search criteria:
Seclusion
Isolation
Aggression