# Seclusion: Care of the Patient Requiring Seclusion

## Site Applicability

VGH and UBCH Acute Mental Health

## Practice Level

MD, RN, RPN, PW

## Policy Statements

Because seclusion is a form of environmental restraint, care of patients in seclusion is also directed by Clinical Practice Document: Restraint: Care of the Patient at Risk for or Requiring Restraint [D-00-07-30281]. All caregivers must take direction from the philosophy, guideline and protocol of that practice document.

## Need to Know

- Seclusion is the involuntary placement of a patient in a locked room from which he/she cannot exit. All patients in seclusion should be certifiable under the Mental Health Act of British Columbia or present an immediate safety risk to themselves or others.* Seclusion may be done in VGH and UBCH Acute Mental Health for both assessment and treatment. Seclusion is part of the overall treatment plan for patients at risk for aggression or elopement and for those whose behavior causes a significant disruption to the unit milieu.
- If a seclusion room is used for patient accommodation due to the lack of another available bed and the patient does not require a seclusion order, the door should not be locked at any time.

## Practice Guideline

### MD RESPONSIBILITIES

#### Initial use of seclusion

- On admission, assess the patient to determine the need for a seclusion order. Orders may be written as seclusion PRN.
- Within 1 hour of emergency seclusion of a voluntary* patient, assess whether the patient meets the criteria for certification under the mental health act. If the patient meets the criteria for certification, fill out the certificates and write an order for seclusion. If the patient does not meet the criteria for certification, document the reason and the alternate plan for managing behavior. A voluntary patient should not remain in seclusion.
- Within 1 hour following the first emergency seclusion of an involuntary patient, assess the situation to address medical and or psychiatric issues contributing to the behavioral emergency. If not on site, obtain information from the RN/RPN in order to decide the need for

a direct assessment. Assessment following repeated behavioral emergencies is at the discretion of the M.D. therefore the MD must communicate to the RN/RPN whether he/she wants to be notified of repeated behavioral emergencies. Write a seclusion order, if there is no seclusion PRN order.

**Ongoing use of seclusion - with trials out**

- Assess and document the requirement for a seclusion order at least once every 24 hours.

**Continuous use of seclusion - with no trials out**

- Assess and document the requirement for a seclusion order at least once every 24 hours.
- Complete and document a physical assessment at least once in 24 hours.

## INITIATION OF SECLUSION

**Non-emergency Initiation of Seclusion**

Behaviors/states that raise the issue of seclusion should first trigger an assessment and intervention aimed at understanding and eliminating the underlying cause.

Examples of behaviors/states that increase the potential for seclusion include:

1. Risk to Self
    - Wandering and elopement risk when safety is an issue
    - Significant threats or attempts at self injury
2. Risk to Others
    - Physical aggression towards staff, visitors, or other patients
    - History of combative, violent behavior
    - Escalating verbal abuses and threats of violence, when the risk of follow-through is high
3. Risk to Property
    - Destructive behavior such as property damage (e.g. punching walls, breaking equipment, etc.)

Initiate seclusion only when the patient's behavior or actions could result in harm to self or others, and interventions that maximize freedom have been attempted, and deemed unsuccessful. See Alternatives to Restraint.

An MD order is required before the patient can be placed into seclusion.

Refer to Non-emergency Assessment and Care Planning in R-030 for further guidance.

**Emergency Initiation of Seclusion**

Seclusion may be initiated immediately, without an MD order, when a patient's behavior/state conveys imminent substantial and probable risk of serious injury to self,others, or property.

The MD must be notified immediately of the first behavioral emergency that results in initiation of seclusion. The PSM/delegate must be notified and consulted as soon as possible.

**After a behavioral emergency, when caring for a patient in seclusion contact Security and request "Security Standby" for a planned intervention anytime there is a safety risk for the staff, visitor or patient.**

Refer to Emergency Assessment and Care Planning in R-030 for further guidance.

## ASSESSMENT

### Assessment frequency

- Always base the frequency of assessment on the individual risk factors for each patient.
- After emergency seclusion, assess patient Q15 minutes until behavior de-escalates and there is no overt risk to the patient or others. For seclusion rooms with windows, directly assess the patient through the window. Use of monitors is for general observation only; not for direct assessment.
- Enter room and directly assess patient at least Q2 hours when the patient is awake and it is safe to do so.
- Enter room and directly assess patient at least Q4 hours when patient asleep. Avoid interrupting patient's sleep unless there is indication of a medical problem.

### Assessment criteria

- Assess patient's physical status. Physical assessment may include components of head to toe assessment as deemed necessary or may be focused assessment. Assess vital signs according to medical orders or PRN according to nursing assessment.
- Assess patient's mental status. Include the components of mental status assessment as deemed necessary.
- Assess patient for physically aggressive behavior and threatening acts towards others or the environment, verbally aggressive behavior towards others, agitation and anger not currently directed towards others (e.g. shouting, swearing), self-injurious behaviors, AWOL risk behaviors, un-cooperative behaviors, restlessness, cooperative and calm behaviors, behaviors that indicate patient is settled and or sleeping.

- Determine whether behavior is unchanged since previous assessment, has escalated since previous assessment, has decreased since previous assessment.

## INTERVENTIONS

- Offer bathing every 24 hours. Provide regular opportunity to maintain hygiene. Provide clean pajamas.
- Ensure patient is able to keep warm by providing pajamas, socks and blankets as safe to do so.
- Offer opportunity for oral hygiene after meals and at bedtime.
- Offer bathroom/urinal/bedpan every two hours if toilet not available in room. If toilet available in room ensure patient is able to access it.
- Ensure adequate fluid intake. Offer fluids every two hours when awake. Determine safety of giving hot drinks.
- Ensure adequate food intake. Provide meals and snacks at regularly scheduled times as much as possible. If necessary, individualize meal and snack times. Provide time for 1 to 1 therapeutic communication as safe to do so. Unless contraindicated, hourly determine any special individual patient care needs through personal contact. When possible, discuss with the patient the specific behaviors that are causing the need for seclusion. When possible, inform the patient of behavioral expectations for removal of seclusion. Reassure patient that help will be provided to control behavior
- Assess for appropriateness and safety of visiting, on a patient-by-patient basis. Assess patient's ability to tolerate visitors. If visiting is deemed safe and appropriate, give careful consideration to the number of visitors and duration of visit. (Note- staff continue to observe patient q 15 minutes throughout visit).
- Prepare visitors prior to visit. Discussion with visitors may include but is not limited to: number of visitors permitted, duration of visit, what to expect in relation to the physical space, items not allowed in seclusion room, how the patient may look and behave, helpful ways to respond to the patient, questions and concerns about the use of seclusion.
- As necessary, provide visitors an opportunity to debrief and discuss their thoughts and feelings about the use of seclusion.
- Provide a clean environment for patient, by arranging with cleaning services for safe access to seclusion room. Check room for unsafe items and unnecessary accumulated

### Entry to LOCKED/CLOSED Seclusion Room when PATIENT AWAKE

- Have keys readily available when room is locked. Follow unit protocol for where key is kept (e.g. in outside lock, with nurse, in marked drawer)
- Coordinate nursing and medical activities around room entry times. Plan ahead when lab work required. Have medications and all equipment ready for room entry. Use safety needles if giving an injection. Provide seclusion tray from Dietary Service, or in high risk situations

remove food items from seclusion tray and place on cardboard tray, or give finger foods. Do not give metal utensils to secluded patient.

- Determine number of personnel required for safe entry.
- Request security to attend when entering room of patient at risk for physical acting out.
- Brief any staff unfamiliar with entry routine.
- Direct patient to sit on mattress prior to entering room.
- Do not enter if patient unable to comply. Discuss with team, the necessity of entering room at present time. If patient care cannot wait, ensure adequate numbers of staff and security are on hand, discuss an entry plan, have medications and equipment ready and enter room. If patient care can wait, delay room entry until patient is more cooperative. Repeat assessment for room entry as often as necessary until able to enter room. Consult physician if unable to enter room a minimum of q 2 hours.
- Leave door fully open when entering room.
- Remove equipment, e.g. BP cuff, as soon as used.
- Leave room one person at a time, keeping patient in line of vision.
- For high risk patients, have a minimum of two staff to provide direct care at any time while the patient is in seclusion

### TRIAL Door Open/TRIAL Out of Room

- Determine the need for seclusion at least Q2 hours based on assessment of patient's physical and mental status and consultation with the team. Identify opportunity for patient to have trial door open and/or trial out of room.
- Trial door open
    - Consider a trial door open when patient has demonstrated his/her behavior is under control
        - able to follow simple directions
        - willing to accept limits set by staff
        - able to talk about what happened
        - able to give commitment to remain in control and contract for safety
    - Use a gradual approach to trialing the door open
        - open door to seclusion room for 5 to 10 minute periods and observe patient's response to increase in stimulation
        - gradually increase amount of time the door is open
- Trial out of room
    - Consider a trial out of the seclusion room when patient has demonstrated his/her behavior is consistently under control
        - able to follow directions during trial door open

- willing to accept limits set by staff
- able to give commitment to remain in control

- Use a gradual approach to trialing out of room
  - determine the need to have Security stand-by for first trial out
  - provide patient opportunity to leave seclusion room for 5 to 10 minutes to assess his/her ability to control behavior
  - as necessary, gradually increase patients time out of seclusion room.

### RETURN TO Seclusion Room

- During trial out of room, if patient's behavior necessitates return him/her to the seclusion room
- Ensure there is adequate staff to return the patient to the seclusion room.
- Request Security to attend for assistance as necessary.
- Explain to the patient the reason for return to seclusion.
- Search patient for harmful objects as necessary

### Seclusion DISCONTINUATION

- Provide the patient opportunity to talk about their thoughts and feelings about what led to seclusion, how they were put into seclusion and the experience of being in seclusion.
- Discuss the problems that lead to seclusion and ways to cope to avoid seclusion.

## Documentation

### Nursing Documentation

- As soon as possible, but within an hour, following initiation of seclusion, document in the progress notes:
  - Description of specific behavior leading to seclusion
  - Alternative intervention tried. If alternative interventions were not used, give rationale
  - Extent to which patient was able to cooperate with seclusion procedure
  - Any injury to patient or others; in addition complete Incident report
  - Readily observed physical condition of patient
  - Date and time seclusion initiated
  - Designation of staff involved in procedure
  - Explanation of, or attempts to explain to patient, reason for seclusion and criteria for removal from seclusion
- While the patient is in seclusion, document in the progress notes or on the Seclusion Documentation Record. Seclusion Documentation Record and Guidelines for Use

- Document a minimum of q 2 hours for a patient in continuous seclusion.
- At least every 24 hours, review the plan of care and document changes.
- Document interventions designed to minimize need for seclusion.
- Document patient progress toward meeting the behavioral expectation for removal from seclusion.
- When seclusion is discontinued document in the Progress Notes the following: time seclusion was discontinued, summary of patient's physical and psychological condition that indicates criteria for removal from seclusion have been met, and other relevant information. Also make revisions to the plan of care as necessary.

## Related Documents

- Restraint: Care of the Patient at Risk for or Requiring Restraint[D-00-07-30281]

### Forms

- Seclusion Documentation Record and Guidelines for Use

## References

### VCH Intranet Resources:

Workplace Violence Prevention Program (November 2004). Vancouver Coastal Health, Vancouver, BC: Author. Follow internet links: Internet Explorer ->under Quick Links

find Employee & Workplace Health & Safety -> Workplace Violence Prevention -> Workplace Violence Prevention Program (PDF)

### External Resources:

Paladin Security Group Ltd, Policy and Procedure, Code White Response, Number PAL 01 HC. August 04, 2003.

American Psychiatric Nurses Association (2007). Position paper on the use of seclusion and restraint. Available at: Restraint and Seclusion. Accessed October 2007.

Centre for Addiction and Mental Health. (2002). Patient Care Manual (2.R.1): Least Restraint. Toronto, Ontario: Author.

Haimowitz, S. Urff, J., Huckshom, K. A. (2006). Restraint and seclusion: A risk management guide. Available at: Restraint and Seclusion. Accessed October 2007.

Nelstrop, L., Chandler-Oatts, J., Bingley, W., Bleetman, T. et al. (2006), A systematic review of the safety and effectiveness of restraint and seclusion as interventions for the short-term management of violence in adult psychiatric inpatient settings and emergency departments. (2006). Worldviews on Evidence-Based Nursing, 3(1), 8-18.

Providence Health Care. (2003). Nursing Care Standards Manual. Managing unsettled/challenging behaviors: Lease restraint approach/PHC non-residential sites. Vancouver, BC: Author.

Stokowski, L. (March 23, 2007). Alternatives to restraint and seclusion in mental health settings: Questions and answers from psychiatric nurse experts. Available at: Restraint and Seclusion. Accessed October 2007.

## Revised By

**PROGRAM/UNIT:** Psychiatry

**Task Group / Individual Names:**

Vancouver Acute Mental Health Clinical Practice Review Committee

## Endorsed By

Acute Mental Health Quality Improvement Council

Medical Director, VA, Community and Rehabilitation Mental Health Services VA Nursing Practice Advisory Council

## Approved for Posting

Acting Professional Practice Director, Nursing VA

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## Alternate Search Terms

## Appendices

Vancouver CoastalHealth R-030

## Appendix E: Alternatives to Restraint Guidelines for Maximum Freedom

| BEHAVIOUR | UNDERLYING REASONS | INTERVENTIONS FOR MAXIMUM FREEDOM |
|---|---|---|
| **1. Fall Risk**<br><br>**See #3, Climbing or Falling Out of Bed** | ❑ Poor vision<br>❑ Decreased balance<br>❑ Postural hypotension<br>❑ Muscle weakness<br>❑ Unsteady gait<br>❑ Poorly fitting footwear<br>❑ Environmental hazards<br>❑ New or recent increase in medications<br>❑ Taking contributing meds (i.e., cardiac, oral hypoglycemics, benzodiazepines, laxatives, antihypertensives, diuretics)<br>❑ Cognitive impairment<br>❑ Poor safety awareness<br>❑ Perceptual impairment<br>❑ Bowel/bladder incontinence<br>❑ Language barrier<br>❑ Fear of falling | ❑ Consult PT for assessment of balance, gait, strength, walking aids<br>❑ Consult OT to assess seating, footwear, assistive devices<br>❑ Assist patient to use assistive devices such as a cane, walker, grab bars, bath stools, reacher<br>❑ Monitor blood pressure lying and standing<br>❑ Remove mobility restrictions such as foley catheters, drains, IV lines as soon as possible<br>❑ Review medications and consult MD/pharmacist as needed<br>❑ Toilet regularly or increase frequency while awake<br>❑ Keep commode or urinal at bedside<br>❑ Ensure mobility aid and footwear are reachable<br>❑ Keep bedside and walking paths free from clutter<br>❑ Ensure appropriate footwear<br>❑ Ensure glasses & hearing aids are properly placed, clean and in working condition<br>❑ Use signs (i.e. toilet) to increase orientation<br>❑ Use side rails sparingly, especially at night<br>❑ Use bed and/or chair alarms |
| **2. Pulling at Tubes** | ❑ Pain/Discomfort<br>❑ Cognitive impairment<br>❑ Delirium<br>❑ Tubing not incorporated into body image | **IV Peripheral/Central**<br>❑ Assess need & discontinue ASAP<br>❑ Wrap site with gauze or use Freedom Splint<br>❑ Use saline lock<br>❑ Remove equipment from patient's field of vision (i.e. under clothing, behind bed, under a dressing)<br>❑ Inspect site regularly & treat pain/discomfort<br>❑ Provide guided exploration of tubing<br><br>**Urinary Catheter**<br>❑ Assess need & discontinue ASAP<br>❑ Ensure urine flows freely<br>❑ Assess/treat pelvic/urethral pain & bladder spasm<br>❑ Tape catheter to leg to avoid pulling on urethra<br>❑ Disguise tubing under clothing/continence |

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| | | products<br>❑ Place tubing between the legs and the bag at the foot of the bed<br>❑ Use a leg bag to promote mobility & prevent falling<br><br>**Feeding Tube**<br>❑ Question reason/goals for feeding tube. Refer to Guidelines re Provision of Food & Fluids (N-096)<br>❑ Hide PEG under abdominal binder/large dressing Remove tube and pump from patient's visual field<br>❑ Provide guided exploration of tubing<br>❑ Assess for discomfort with feeding<br>❑ Provide distraction during feeding times |
| 3. **Climbing or Falling Out of Bed**<br><br>**See #1, Fall Risk** | ❑ Toileting needs<br>❑ Pain/discomfort<br>❑ Biorhythms incompatible with hospital routine<br>❑ Bored, lonely, not tired<br>❑ Cognitive impairment<br>❑ Decreased safety awareness | ❑ Use side-rails sparingly. Top rails up only in most cases. If climbing, leave one side completely down<br>❑ Put mattress on the floor<br>❑ Keep bed in low position<br>❑ Ensure bedside is well lighted. Night light PRN<br>❑ Toilet regularly or increase frequency while awake<br>❑ Commode and urinal at bedside<br>❑ Shoes on while in bed<br>❑ Use bed and/or chair alarms<br>❑ Reposition frequently while awake<br>❑ Assess & treat acute/chronic pain |
| 4. **Leaning Forward or Sideways; Sliding Out of a Chair**<br><br>**See #1, Fall Risk** | ❑ Decreased awareness of body parts<br>❑ Poor chair mobility<br>❑ Lack of upper body strength<br>❑ Uncomfortable chair<br>❑ Fatigue/tired of sitting<br>❑ Decreased balance<br>❑ Reaching for objects<br>❑ Decreased safety awareness | ❑ Avoid fatigue by getting patient up for short periods<br>❑ Assess & treat acute/chronic pain<br>❑ Ask OT to assess seating/positioning/chair mobility<br>❑ Place pillow on overhead table<br>❑ Place patient closer to desk for observation<br>❑ Assist patient to use assistive devices such as a long handled reacher<br>❑ Toilet regularly or increase frequency while awake<br>❑ Position patient appropriately for meals to avoid aspiration |
| 5. **Wandering** | ❑ Cognitive impairment<br>❑ Inability to recognize a new, strange environment<br>❑ Looking for home, family, pets, familiar surroundings | ❑ Track patterns of wandering in Nurses Notes<br>❑ Determine if behaviour occurs at particular times of day & adjust care/investigations to minimize stress. Redirect using a calm, positive, & gentle approach |

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| | ❑ Trying to accomplish a goal (i.e. going to the bank)<br>❑ Seeking an exit from building<br>❑ Following staff or visitors who are leaving<br>❑ Exploring environment<br>❑ Restlessness | ❑ Toilet regularly or increase frequency while awake<br>❑ Use distraction & involve in another activity<br>❑ Acknowledge patient's "agenda" and feelings about need to leave (i.e. worried children will be home alone)<br>❑ Ask the family their views on the patient's behaviour<br>❑ Avoid reality orientation. Instead, validate emotions, give reassurance, and problem-solve around leaving the unit<br>❑ Reduce levels of noise, clutter, & people<br>❑ Personalize room as much as possible<br>❑ Use positive phrases to indicate what the patient is to do. Say, "Turn around" rather than "Don't go there."<br>❑ Activate wandering-alert system |
| **6. Aggression** | ❑ Delirium<br>❑ Cognitive impairment<br>❑ Psychosis<br>❑ Impaired communication. vision, hearing<br>❑ Disinhibition due to illness and medications<br>❑ Loss of control & independence<br>❑ Behaviour of other patients, families, visitors<br>❑ Inability to understand the intentions of caregivers<br>❑ Approach of caregiver (body language, voice level/tone, touching without permission) | ❑ Track triggers & what time behaviour(s) occur in Nurses Notes or Flowsheet<br>❑ Assess & treat acute/chronic pain<br>❑ Identify warning signs of escalating aggression<br>❑ Minimize fatigue by balancing rest with activity<br>❑ Encourage pacing to relieve anxiety<br>❑ Increase interaction and social contact with staff/family<br>❑ Consider past experiences & coping strategies<br>❑ Contact the family/facility/other caregivers for clues to understanding behaviour<br>❑ Establish eye contact as appropriate<br>❑ Speak slowly and clearly<br>❑ Use active listening skills<br>❑ Identify yourself, repeat questions and allow time for response with each contact<br>❑ Use positive phrases. Tell patient what you would like him/her to do, rather than what not to do<br>❑ Ask permission to touch the patient. Always explain what is going to happen<br>❑ Provide increased staff observation with opportunity to talk about concerns<br>❑ Move patient from stimulating milieu to a quiet area<br>❑ Administer PRN medications<br>❑ Move patient to single room with close observation |

vancouver coastalHealth
Vancouver Acute

# Seclusion Documentation Record Guidelines for Use

## 1.0 Purpose

The Seclusion Documentation Record may be used by Vancouver Acute Mental Health nursing staff to record assessments and interventions for patients who are in seclusion rooms.

## 2.0 General Considerations

2.1 The Seclusion Documentation Record may be utilized while patients in UBCH and VGH Acute Mental health are in seclusion rooms.

2.2 An RN/RPN/ LPN may initiate the Seclusion Documentation Record. The PW may initiate the Seclusion Documentation Record under the direction of the RN/RPN.

2.3 An RN/RPN/LPN may complete the record. The PW/ Student may complete the record under the direction of the RN/RPN.

2.4 Each column is to be completed and initialed by one individual only.

2.5 The legend at the top of the page is to be used unless another legend is indicated within a section. If a box is not applicable leave it blank. If an assessment or intervention occurred place a √ in the box. If additional documentation was made in the Progress Notes, record PN.

2.6 The Seclusion Documentation Record is a permanent part of the Health Record.

2.7 All notations are to be made in blue or black ink using a ballpoint pen.

2.8 The completed record is to be filed behind the chart tab Clinical Charts.

## 3.0 Specific Guidelines

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| 3.1 | Place a PCIS label in the upper right hand corner of the form. | **PCIS label** |
| 3.2 | Place a √ in the box corresponding to the site (UBCH, VGH). | **Site** |
| 3.3 | Record the month and year in the space provided: month and year (MMM/yyyy). | **Month/Date** |
| 3.4 | Record the date in the space provided: day (dd). | **Day** |
| 3.5 | Record the time in the space provided: (24 hour clock). | **Time** |
| **Seclusion Room Use** | | |
| 3.6 | Place a check in the box if the door is locked. For seclusion rooms with an inside doorknob, the patient is considered to be in seclusion when the door is locked with a key or latch. For seclusion rooms without an inside doorknob, the patient is considered to be in seclusion when the door is closed. However, the door may be locked with a key or latch for additional security. | **Door Locked** |
| 3.7 | Place a check in the box if the door is closed. For seclusion rooms without an inside doorknob, the patient is considered to be in seclusion when the door is closed. | **Door Closed** |

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| 3.8 | Place a check in the box if the door is left open. For example, the seclusion door may be trialed open to assess the patient's ability to cooperate. If additional documentation is required in the Progress Notes, record PN. For example, record the explanation given to the patient regarding behavioral expectations and other conditions for the door to remain open. | **Trial Door Open** |
| 3.9 | Place a check in the box if the patient is permitted out of the room for a trial period of time. If additional documentation is required in the Progress Notes record PN. For example, record the explanation given to the patient regarding behavioral expectations and other conditions for them to remain out of the room. | **Trial Out of Room** |
| 3.10 | Place a check in the box if the patient is returned to the seclusion room. For example, the patient may self seclude, the patient may be returned to the seclusion room with the assistance of staff and/or security. If additional documentation is required in the Progress Notes record PN. For example, record the reason and circumstances if security was required to return the patient to the seclusion room. | **Return to Room** |
| 3.11 | Record PN in the box, when seclusion is discontinued. Record in the Progress Notes the following: time seclusion was discontinued, summary of patient's physical and psychological condition that indicates criteria for removal from seclusion have been met, and other relevant information. | **Seclusion Discontinued** |
| **Assessment** | | |
| 3.12 | Assessments must be completed Q15 minutes until behavior deescalates, then Q2 hours when awake, and Q4 hours when asleep. | **Physical assessment**<br>**Vitals signs**<br>**Mental Status** |
| 3.13 | Using the legend to the side, record the corresponding number(s) for behavior(s). | **Behavior observed** |
| 3.14 | At each assessment, indicate if the behavior is unchanged, escalating or decreasing. Escalating behavior requires documentation in the Progress Notes and a review of the Plan of Care. Record PN in the box by escalating. | **Unchanged**<br>**Escalating**<br>**Decreasing** |
| **Interventions** | | |
| 3.15 | Place a √ in the box for all interventions completed. | **Interventions** |
| 3.16 | Doctor assessment is required at least Q24 hours. Place a √ in the box when completed. | **Doctor Assessment** |
| 3.17 | Record initials. | **Initials** |
| 3.18 | Record designation (e.g. RN, RPN, PW, LPN) | **Designation** |