Secure Room: Care of the Patient

Site Applicability:

St. Paul's Hospital, Mental Health Inpatient Units (2N, 8C[1], 9A, PASU) and ABSU

Practice Level:

Basic: RN/RPN/Physician

Policy Statements

1. Seclusion must ONLY be:
    - used as an emergency containment intervention permitted after all other interventions have been trialed or considered and failed and there is risk of imminent harm to the patient or others if no action is taken
    - delivered in a room designed expressly for that intended purpose (i.e., secure room)
    - applied for the shortest duration possible
2. Seclusion must NOT be:
    - used punitively or as a disciplinary measure
    - used solely to prevent absconding
    - used on patients demonstrating signs of medical instability

Need to Know

Seclusion is a physical intervention, used in adult psychiatric settings, when there is a risk of imminent harm to the patient or other people if no action is taken. The use of seclusion is guided by a least-restraints approach, and utilized only when all attempts to prevent its use have failed. Nevertheless, seclusion is associated with a number of potentially adverse outcomes, such as further provocation of aggression,[1] injury to staff or patients,[2] trauma,[3] and damage to the therapeutic alliance.[4] There is no robust evidence to suggest that seclusion provides any long-term benefits to individuals, but there are clear links that it can be harmful to the patient and to those who witness or deliver the intervention.[5] Therefore ***the use of seclusion should be considered unusual, exceptional and as a short term intervention.***

Definitions:

- The BC Ministry of Health (MoH) defines ***seclusion*** as a physical intervention 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" (p.19).[5]

[1] ONLY the *Physician Orders for Seclusion* section of this guideline apply to 8C.

- The use of seclusion in a secure room is an example of an environmental restraint (see B-00-13-10059 – Unsettled/Challenging Behaviours). ***Restraints*** are defined as a means of controlling or restricting a person's freedom of movement through the use of any chemical, environmental, mechanical or physical intervention. [6]

Guideline

This guideline was developed from a core framework of best practice evidence and is designed to maximize a patient's freedoms and protect their liberty while providing a safe environment. Our approach is grounded in recovery-oriented, trauma informed and person and family-centered approaches (Appendix A).[7,8] This guideline complies with legislation in British Columbia, which includes the *Mental Health Act* [9] and the *Health Care (Consent) and Care Facility (Admission) Act*. ***The use of seclusion should always consider patient rights, current standards, and relevant professional codes of practice (e.g., British Columbia College of Nursing Professionals).***

Prevention

Prevention, minimization, and reduction of secure room use are a priority. People at risk of or experiencing seclusion require interventions that take their specific histories and individual needs into account. At present, there are a number of program-wide and person-specific prevention strategies available to staff and patients (see Table 1). Every effort should be made to include these approaches, resources and services into care delivery.

Table 1 - Program & Person-Specific Secure Room Prevention Strategies

Program strategies	Person-specific strategies
• offering a welcoming physical environment • collaborating with family/friends/partners • promoting a non-coercive approach to care • encouraging respectful and empathetic communication ensuring adequate staffing levels • offering staff training in interventions to prevent seclusion (e.g., *Provincial Violence Prevention Curriculum*,[10] sensory modulation room use, and de-escalation techniques) • *documenting, reporting* and evaluating secure room use over time • *violence alert syste*m • promoting a *least restraint* environment • providing *mental health act rights advice*	• thorough medical, psychiatric, and violence risk assessments performed upon admission and throughout care • meaningful daily activities (e.g., group walks, recreation therapy, etc.) • offering private or quiet spaces (e.g., consider single occupancy rooms) • offering sensory interventions to promote self-management (e.g., *sensory modulation rooms*) • increasing *levels of observation* for patients showing signs of escalation • assessing and managing risk (e.g., *violence* and *self-harm/suicide*) • using *personal safety plans* to identify individual triggers, coping strategies, and medication plans of care

Indications

Seclusion is an emergency containment intervention required only when all attempts to prevent its use have failed and there is imminent risk of physical harm to the service user or other people if no action is taken.[5,11] **The use of seclusion should be considered unusual, exceptional and as a short-term intervention.**

In an effort to **minimize** use and impact of seclusion, clinicians should further consider whether the use of a secure room is:

- proportionate to the risk and potential seriousness of harm
- the least restrictive option
- appropriate for the patients' physical health, degree of frailty, and cognitive capacity

When the use of seclusion is contraindicated (e.g., signs of medical instability, self-harm) and deemed unsafe, consider other alternatives, such as the use of physical restraints (e.g., 4 –limb restraints)–(See B-00-13-10059).

Initiation

Physician Orders for Seclusion

Duration

- No order (PRN or STAT) for seclusion will exceed **12 hours** in duration**.**

Type

- The preferred method for ordering seclusion is **STAT** (specific to an event).
- **PRN seclusion orders should be avoided**; however, are permitted:
  - **in high acuity areas (ABSU/PASU)**
  - in inpatient areas **ONLY** when clinically indicated and immediately following physician face-to-face assessment of a patient; and
  - must be accompanied by clear documentation and clinical rationale.

Renewal

- Seclusion orders are renewed by the MRP Monday - Friday between 0800 and 1700h. If renewal is required outside of these days and times, a telephone discussion will occur between the charge nurse (or designate) and on-call physician at a pre-determined time (e.g., 2030). The decision to renew a seclusion order should include a discussion of the following factors:
  - risk for violence
  - patient specific behaviours/needs
  - potential alternative interventions (e.g., medications)

  - rationale for continuation of secure room use
  - duration of order
- If renewal is required the charge nurse (or designate) will obtain a telephone order and document the rationale for continued use of seclusion in the client health record.

Nurse Initiated

- In the event that a physician is not present at the time emergency containment is required an RN/RPN may initiate the use of seclusion, and notify the attending or covering physician immediately (within one hour) to obtain an order.

Secure Room Entry

Initiation of seclusion is a collaborative, team approach led by the patient's primary nurse. For the **safety of all staff**, the entry team should include:

- patient's primary nurse
- secondary nurse; and
- three security personnel (locked entry only)

An **environmental risk assessment** must be performed:

- identify anything that can be used as a weapon
- ensure the patient is within sight
- take note of hazards such as spilled liquids and other potential risks
- consider exit points

All **patients in seclusion** shall receive the following basic provisions:

- adequate food and fluid;
- access to toilet and washing facilities;
- clothing that ensures dignity and safety[2]; and
- clean room and bedding.

[2] There should be an effort to provide security personnel and nursing staff of the same gender identity whenever possible to maintain patient dignity and privacy.

Roles and Responsibilities: Initial Secure Room Entry

Roles	Responsibilities
Primary Nurse	• Contact security based on the immediacy of the response needed o **Routine – 4777** o **Urgent – 5800** o **Code White – 7111** • Assemble entry team and escort patient to the secure room • Direct patient to change into hospital gown and remove items that may pose a safety risk. • Conduct medical, psychiatric (mental status) and risk assessments - document promptly in clinical record (see Documentation) • Provide medication (if applicable) and assess for effects of rapid tranquilization • Communicate the rationale for seclusion and the behaviours that will facilitate discontinuation • Exit secure room ensuring door is locked
Secondary and Supporting Nurses	• Attend secure room and provide assistance as directed by the primary nurse • Clear environment of hazards as well as other patients • When possible, prepare the room prior to entering, providing food,* fluid, and other necessary supplies. • Prepare PRN medication as required • Notify MRP/physician and ensure there is a valid order for seclusion ***within 1 hour of initiation***: o During Business Hours – MRP o After Hours – Physician on call
Security	• In attendance for all secure room entries • Assist as directed by primary nurse • Perform duties as outlined in security training including hands on tasks as required • Ensure door is securely locked on exit from secure room

* Peanut butter in any form is restricted from use in secure rooms. Please provide alternative food/snacks.

Ongoing Monitoring and Assessment

Observation

The primary nurse or designate must observe the patient through the secure room window *at a minimum every 15 minutes***. All observations shall be documented in the clinical** record (See Documentation). Video monitors are available for general observation only; not for direct assessment.

Assessments

The patient's mental, physical, and behavioral status must be assessed at a ***minimum once per shift or at a*** frequency determined by the patient's condition. Document care at ***a minimum of every two hours*** in the *Interdisciplinary Progress Notes*. If the patient's condition deteriorates changes unexpectedly, or the patient is at risk of imminent self-harm, assemble a team for emergency entry.

Scheduled Secure Room Entry

Notify security when ready for a scheduled entry, coordinate care/assessments and ensure a valid order for seclusion.

Emergency Secure Room Entry

If emergency entry is required call *7111* (or personal protective alarm) to request *Code White* or *Code Blue* response (as clinically indicated). **Security should be present for all secure room entries**, with the exception of immediate entry to provide lifesaving intervention.

Review of Seclusion

If seclusion use persists past *8 hours continuous or 12 hours intermittent*, a review shall occur between two clinicians (e.g., primary nurse and MRP)[5]. During a review, the designated clinicians should discuss the rationale for seclusion, determine if seclusion remains warranted and document the rationale. Clinicians required for review should include:

- the primary nurse and MRP during business hours (Mon-Fri 0800-1700)[3]
- the primary nurse and or Stream 2 physician during holidays and weekends (Saturday-Sunday 0800 to 1700)
- two nursing staff (e.g., primary nurse and co-staff) during off-hours (Mon-Sunday 1700 to 0800),

If continuation of secure room use is required - See Physician Orders for Seclusion . If prolonged periods of seclusion occur escalation of care is required (See B-00-16-10017 – Transfers to and From Timber Creek PICU).

[3] ABSU hours may vary based on care team discretion (e.g., nurse and MRP [0800-2300]; nurse to nurse [2300-0800])

Visitors

A patient requiring seclusion may not receive visitors, with the exception of lawyers or legal advocates. Staff must respectfully and compassionately respond to concerns from family/visitors while ensuring the patient's right to privacy and confidentiality.

Discontinuation

Seclusion should be discontinued when the patient has de-escalated to the *point that they are no longer an imminent risk to self or others*. Factors in this decision-making may include the patient's ability to:

- Follow simple directions
- Tolerate an increase in stimulation
- Manage self independently on the unit

The decision to discontinue seclusion can be made by a nurse (RN/RPN) or physician with input from the interprofessional team and should include a plan for reintegrating the patient into the open environment and managing future emergencies.

Post-Seclusion

Leaders and staff will participate in the reflection and review process as soon as possible after a seclusion event to ensure there is a thorough assessment and deconstruction of all factors leading to secure room use. The review process shall treat seclusion events as serious and unusual, and requires the clinical team to review a patient's treatment plan and make adjustments that correspond with the patient's increased acuity. Review of the treatment plan will be done in partnership with patient and family members as appropriate. Clinicians will review the incident and provide education to the patient and family/caregiver (where appropriate) within **24 hours** after the end of seclusion.

When required a more formal critical incident review will be conducted by Mental Health program leadership in consultation with Occupational Health and Risk Management.

Patient and Family Education

The goals of patient and family education are to provide information on:

- The decision/rationale for use of seclusion, including initiation, continuation and discontinuation (if patient consent received, family disclosure should occur within 24 hours - as appropriate)
- Their rights under the **BC Mental Health Act** and how to contact a lawyer or legal advocate (Form 13 and "Your Rights" – Appendix B pamphlet)
- Treatment of psychiatric illness (e.g., adherence to medication, psychotherapy, etc.)
- Individual coping strategies and strengths (e.g., Personal Safety Plan PS192)
- Recovering in a Least Restraint Environment (Appendix C)

Patient and Family Supports

- The Chapel (Room 345)

- Indigenous Health Team – Tel: 604-682-2344 ext. 62937
- Spiritual Health – Tel: 604-806-8163
- Patient Relations - Tel: 604-806-8284

Employee Supports

It is important for staff to know there are psychological health and safety supports and services available to help cope with critical incidents.

- Employee Family Assistance Program – Tel: 604-872-4929
- WorkSafeBC Critical Incident Response – Tel: 1-888-922-3700
- Workplace Health Call Centre – Tel: 1-866-922-9464
- PHC Staff Mental Health and Wellness Toolkit
- The Chapel (Room 345) and Meditation/Quiet-Space (Room 372)
- Occupational Health & Safety Advisor

Patient Safety Learning System (PSLS)

It's recommended that any use of seclusion regardless if patient safety is compromised (or the potential for patient safety was at risk or averted, e.g., near misses) be documented in PSLS. This process promotes:

- continual improvement to the quality of health service delivery
- timely, accountable and consistent process for incident investigations
- reduced risks to patients, providers and the organization

All events involving serious harm or death must be documented in PSLS and communicated to the Patient Care Manger (or designate), Program Director and PHC's Director of Risk Management.

Documentation

Physicians

Documentation Type	Details
Prescriber's Orders	• A physician order for seclusion must specify: o Reason (e.g., specific behaviours requiring use of seclusion) o Duration (up to 12 hours) **All orders must be reviewed *at least every 12 hours***
Assessment *Progress Notes*	• **Face- to- face at least every 24 hours** • Documentation should accompany every physician-led assessment of a patient in seclusion and include: o risk for violence o patient specific behaviours/needs o potential alternative interventions (e.g., medications)

Assessment *Mental Health Act*	• Assess whether patient meets criteria for certification under the BC Mental Health Act, if not already certified • Document reasons for involuntary certification on *Form 4* • Document alternative plan of care in *progress notes* if criteria for certification are not met

Nurses

In addition to the standardized tools listed below, ***narrative documentation related to seclusion is required*** to be written in the *Interdisciplinary Progress Notes*.

Documentation Type	Details
Seclusion Initiation *Restraint Initiation: Nursing Record (PHC-NF139) (Appendix D)*	• **Context**: date and time of seclusion episode, behaviour(s) observed, rationale, security involvement, and preventive interventions employed or attempted • **Physician Notification**: physician informed within one hour of seclusion initiation and order written
Seclusion Monitoring *Seclusion Nursing Record (PHC-PS120) (Appendix E)*	• **Q 15-minute monitoring:** to include observed patient behaviours, respiratory status, and nursing interventions employed or attempted (e.g., fluids offered) • **Rationale for seclusion:** reviewed after *8 hours continuous or 12 hours intermittent* • **Vital signs:** taken and documented in the Clinical Record (PHC-NF498) per assessment guidelines
Seclusion Discontinuation *Progress Notes*	• Document care at ***a minimum of every two hours*** • **Rationale:** reason for discontinuing seclusion (e.g., assessment findings, successful trials out of seclusion, etc.) • **Nursing care:** mental status assessment, level of observation, supportive interventions, etc.
Care Plans *Personal Safety Plan (PHC-PS192) (Appendix F)*	In an effort to reduce the use of seclusion in the future, behavioural care plans should be created or updated, with a focus on identifying: • patient's stressors/triggers • behavioural warning signs • effective clinical interventions so support patient

Related Documents

1. B-00-13-10059 – Managing Unsettled/Challenging Behaviours: Least Restraint Approach
2. B-00-13-10050 - Suicide Risk Assessment and Management (Acute and Tertiary Mental Health)
3. B-00-11-10190 - Code White Emergency Response Policy
4. B-00-13-10081 - Close or Constant Care: Decision Making Process
5. B-00-11-10110 – Corporate Policy: Consent
6. B-00-11-10124 - Search of Inpatient Rooms and/or Belongings
7. B-00-11-10196 - Workplace Violence Prevention Policy
8. B-00-16-10017 – Timber Creek PICU
9. B-00-16-10008 – Urgent Transfer 8C to 9A
10. B-00-11-10204 - Patient Safety Incident Management

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Definitions

- **De-escalation** - in the context of psychiatric care, refers to interpersonal, behavioural, sensory and environmental interventions that support people through an emotional crisis and reduce risk of harm to self or others. The goal is to reduce a person's distress so that discussion and problem-solving become possible.
- **Mental Health Act (BC) –** law which regulates the administration of Mental Health care in British Columbia.
- **Patient-** means anyone receiving care or services from VCH/PHSA/PHC, and includes clients and residents.
- **Patient-centered Care - puts** patients at the forefront of their health and care, ensures they retain control over their own choices, helps them make informed decisions and supports a partnership between individuals, families, and health care services providers.
- **Recovery-oriented Practice -** supports people to define their goals, exercise their capacities and use their strengths to attain their potential. Recovery-oriented practice acknowledges that each patient's journey is both unique and complex, and assists people in maximizing their ability to direct and manage it themselves. Hope is the foundation on which a journey of recovery is built. A recovery approach focuses on the values, hopes and dreams of each person, while never losing sight of the impact of the social context on people's lives.
- **Secure Room** - a room designed expressly for the purpose of delivering seclusion interventions. Consistent with Accreditation Canada's approach, the Standards & Guidelines use the term "secure room" exclusively to refer to the room in which seclusion should be delivered.
- **Trauma-informed Practice** considers trauma in all aspects of service delivery and places priority on the individual's safety, choice and control.

Persons/Groups Consulted

Psychiatry Department Head, SPH
Inpatient Psychiatry Physician Leads
Inpatient Clinical Nurse Leaders
Inpatient Mental Health Nursing Consortium Members
Director of Risk Management, SPH
Psychiatry Program Director, SPH
Psychiatric Assessment Nurse Educator, SPH
Ministry of Health
Patient/Family Partner

Developed By

Clinical Nurse Specialists, Psychiatry
Nurse Educator Psychiatry
Patient Care Manager, Mental Health Program

Effective Date:	MAY-2002
Posted Date:	MAY-2002
Last Revised:	02-JUL-2019
Last Reviewed:	13-DEC-2018
Approved By:	PHC
	Mental Health QPIC Professional Practice Standards Committee
Owners:	PHC
	Mental Health Program

Appendix A: Fig 1: Seclusion as Part of Recovery-Oriented, Trauma-Informed, and Person-Centered Approaches

Examples of how seclusion fits within the recovery-oriented, trauma-informed and person-centred approaches at PHC

Recovery-Oriented, Trauma-Informed, Person-Centred Practice	Sample Prevention Strategies	Last Resort
• Welcoming physical environment • Respectful, non-coercive and empathic communication • Personal safety plans • Ensuring access to basic needs • Acknowledge and assess for trauma history • Inclusion in health care decisions	• Sensory modulation rooms • Meaningful daily activity (e.g. group walks, recreation therapy) • Single occupancy rooms • Identify triggers and coping strategies • Spiritual practice • Music therapy	• Seclusion

Adapted from the Ministry of Health – Provincial Standards and Guidelines for Secure Room 2014)

Appendix B: Your Rights under BC's Mental Health Act (https://www.bcmentalhealthrights.ca)

➢ You have the right to ask for a second medical opinion

If you don't agree with your psychiatric treatment, you can ask for a second opinion from another doctor. To do this, ask a nurse to help you fill out **Form 11**.

You can choose any doctor licensed to practise in BC to examine you, but you may have to pay for their travel costs.

Be aware that the second opinion is just an opinion, and your treatment team doesn't have to follow the other doctor's recommendations.

➢ You have the right to speak with a lawyer

A lawyer can help you challenge your certification by asking a judge to review your case. You may have to pay the lawyer's fee and court costs.

A lawyer can also give you legal advice about your rights as a certified patient. If you can't afford a lawyer, Access Pro Bono offers 30 minutes of free legal advice over the phone. Call to make an appointment:

604-482-3195 ext. 1500 in the Lower Mainland
1-877-762-6664 ext. 1500 elsewhere in BC
10 AM–4 PM, Monday to Friday

What happens when I leave the hospital?

You may either:

- be discharged and be free to go, or
- be placed on extended leave.

Being on extended leave means you can live out in the community, but you will still be certified and will have to follow conditions, like visiting a mental health team and taking psychiatric medications.

You have the right to know if you're being discharged or placed on extended leave. You have all of the same rights on extended leave as you do in the hospital, including the right to ask for a review panel hearing.

What if I'm unhappy about my care?

If you have complaints about the way you've been treated, you can contact the Office of the Ombudsperson:

1-800-567-3247

PO Box 9039
STN PROV GOVT
Victoria, BC
V8W 9A5

bcombudsperson.ca

The Office of the Ombudsperson is an independent body that investigates public institutions, like the hospital.

Where can I get more information about my rights?

Read a summary of your rights on **Form 13**. A nurse will ask you to sign that form to show that someone has told you about your rights.

If you'd like a family member or friend to help you with your rights, you can ask a nurse to give them rights information.

If you have questions about your rights, talk to a nurse or a mental health team member to learn more.

This pamphlet was created by the Mental Health Act Rights Advice research team (bcmentalhealthrights.ca). Funding for this research was provided by

YOUR RIGHTS

under BC's

MENTAL HEALTH ACT

What you can do if you're certified as an involuntary patient

What does it mean to be certified under BC's *Mental Health Act*?

The *Mental Health Act* is the law that sets out the rules for when a person can be kept in the hospital against their will.

That law says that you can be certified as an involuntary patient *only* if a doctor has examined you and believes you meet *all four* of these criteria:

1. your ability to react to your environment and associate with others is seriously impaired because of a mental disorder,
2. you need psychiatric treatment,
3. you need care, supervision, and control:
   - to protect you or others, or
   - to prevent you from deteriorating substantially, either mentally or physically, and
4. you can't be admitted as a voluntary patient.

If you've been certified, you may feel scared, confused, or angry, especially if you aren't sure what your rights are.

When you're certified:

- you can't leave the hospital without your doctor's permission, and
- you can't refuse psychiatric treatment, including medication.

But you can still talk to your doctor about your treatment, **and you don't lose all your rights.**

How long do I have to stay in the hospital?

That depends on how many certificates have been completed. One certificate lets your doctor keep you in hospital for up to 48 hours. If a second certificate is completed, you may have to stay for up to 1 month.

If, at any point, the doctor believes you no longer meet the criteria, you will be decertified.

	1st certificate	2nd certificate	1st renewal	2nd renewal	3rd & further renewals
CERTIFICATION PERIODS	48 hrs	1 month	1 month	3 months	6 months (can repeat)

If the doctor believes you still meet the criteria after a month, they can renew your certification, first for 1 month, then for 3 months, then for periods of 6 months.

During each of these certification periods, you have the right to:

- be told what your rights are,
- be examined by a doctor to see if you still meet the criteria for certification,
- ask for a review panel hearing, and
- ask for a second medical opinion.

What rights do I have if I'm certified?

➢ You have the right to know where you are

Ask a nurse if you need to know the name and address of the hospital.

➢ You have the right to know why you've been certified

The doctor must write the reasons for your hospitalization on your medical certificate (Form 4) or, if your certification has been renewed, on your renewal certificate (Form 6). You have the right to know what is on your certificate.

➢ You have the right to ask for a review panel hearing

If you don't agree with the doctor's decision to certify you, you can challenge your hospitalization. One way is to ask for a hearing with a review panel. **There is no cost for a hearing.**

A review panel is independent of the hospital and includes:

- a lawyer,
- a doctor who isn't on your treatment team, and
- a member of the community.

They will hear your case and decide if you meet the criteria for hospitalization. If they decide that you don't, you'll be decertified. If they decide that you do, you'll have to stay in the hospital.

To apply for a review panel hearing, ask a nurse to help you fill out **Form 7**. If you are in a 1-month certification period, your hearing will be scheduled within 14 days from when you apply.

You have the right to have an advocate or lawyer represent you and help you prepare and present your case to the review panel.

You can call witnesses to testify on your behalf.

You can ask the review panel if you can bring someone to support you, but it's up to the chair of the panel to decide if this will be allowed.

Once you have a hearing scheduled, if you need help finding an advocate or lawyer to represent you, call the Mental Health Law Program:

604-685-3425 in the Lower Mainland
1-888-685-6222 elsewhere in BC
10 AM–noon & 1:30 PM–4:30 PM, Monday to Friday

Appendix C: Recovering in a Least Restraint Environment

We are committed to our patients' and residents' dignity, freedom of choice, freedom of movement, comfort, and reasonable risk.

We consider the use of restraints to be unusual, exceptional, and for a short-term. We will only use a restraint after all other options have been tried and have not helped.

IA.200.R245.PHC (R.June-12)

Providence HEALTH CARE
How you want to be treated.
www.providencehealthcare.org

Providence HEALTH CARE
How you want to be treated.

Recovering in a Least Restraint Environment

IA.200.R245.PHC (R.June-12)

'Restraint' is a way to control a person's challenging behaviour by restricting the person's movement. This could include physical restraints, changes to the environment, or medications to keep the person, and others, safe.

What do we mean by a 'least restraint' environment?

Your recovery is important to us.

When you can do things for yourself and increase your strength and ability to move around, it helps you recover faster.

At the same time, a safe environment is important for both our patients and our staff.

Our approach is to always use the least restrictive way that keeps you and others safe.

We only use a restraint when other ways to help you do not work.

If a restraint is needed, it is used for as short a time as possible.

Unless there is a great risk that you might hurt yourself or someone else, you can say "no" to a restraint.

Before we use restraints

We encourage you and your family to be involved in your care and in making decisions about the use of a restraint. We can look at different ways to help you without using a restraint.

Some options we can try:

- Have a family member sit at the bedside.
- Increase your activity level with such things as walking more often or exercises.
- Arrange for you to listen to your favourite music.
- Have you wear hip protectors. These protect your hips from injury should you fall.
- Identify and treat any pain or discomfort you might have.
- Keep to a normal daily routine.
- Review and adjust your medications.
- Use a bed or chair alarm. This alerts us should you get out of the bed or chair on your own.
- Use reminders such as signs, calendars, or photos.
- Give you any support and reassurance you might need.

If a restraint is necessary

- We try to find out why a restraint might be needed.
- We work with everyone on the health care team to find other ways to help.
- We always respect your rights.
- We keep you informed.
- We use the least restrictive restraint possible.
- We watch you closely to make sure you are safe.
- We remove the restraint as soon as possible.
- We continue to care for your daily needs.

It's good to ask questions

Feel free to ask us any questions or to share your concerns about this.

Appendix D: Restraint Initiation Record

Providence HEALTH CARE

☐ Holy Family Hospital
☐ Mount Saint Joseph Hospital
☐ St. Paul's Hospital

RESTRAINT INITIATION: NURSING RECORD

Ensuring Informed Consent
1. Discuss the application of restraint with the capable patient. Provide information and attempt to get consent. Document discussion in the progress notes. A patient who is capable has the right to personal risk and so to refuse a restraint when his/her unsettled/challenging behaviour does *not* pose an imminent danger, defined as violent or life-threatening towards self or others.
2. Discuss the application of restraint with the patient's Substitute Decision Maker (SDM) or Temporary Substitute Decision Maker (TSDM), if the patient is unable to make his/her own decision [see form PHC-MR081]. Provide information and attempt to get consent, as soon as possible within 72 hours
3. Work with the interdisciplinary team in discussing restraint with the SDM and refer to Social Work if necessary.
4. If the patient is certified under the Mental Health Act of British Columbia, consent for restraint use is not required; however, discussion should still occur with patient and be documented.

Section A - Nursing Protocol	
For *all restraints*, the RN/RPN writes a Nursing Protocol on this record. A Nursing Protocol for restraint initiation is always required, whether or not a physician has already written an order on the Physician Order Sheet.	
Date:	**Behaviour Code(s):**
Time:	**Alternative Intervention Code(s):**
RN/RPN Name:	
Signature:	**Restraint Type Code:**

Section B - Physician Notification/Orders		
The physician must be informed of the use of restraints and the behaviour that necessitated it as follows: 1. For *4 - Limb Restraints*: Inform physician **within 1 (one) hour**. 2. *For Seclusion:* Inform physician **and** obtain a physician order **within 1 (one) hour.** Avoid PRN orders. Request an order that reads "*Seclusion x 12 hours*". 3. For *all* other restraints: Inform **within 72 hours**.		
Name of MD notified/order obtained from:	**Signature of RN/RPN:**	**Date/Time:**

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Providence HEALTH CARE

☐ Holy Family Hospital
☐ Mount Saint Joseph Hospital
☐ St. Paul's Hospital

RESTRAINT INITIATION: NURSING RECORD

ASSESSMENT PARAMETERS

Please enter all that apply on the Restraint Initiation and/or Restraint Use Nursing Records

BEHAVIOURS OBSERVED (Codes)

1. Agitation
2. Aggression
3. Combative
4. Pulling out tubes
5. Level of consciousness
   - 5.1 Alert
   - 5.2 Responsive to voice
   - 5.3 Responsive to pain
   - 5.4 Non-responsive to pain stimulus
6. Mental status
   - 6.1 Disoriented
   - 6.2 Hallucinating
7. Memory deficit
8. Impaired mobility
9. Falling
10. Movement disorder
11. Participating in other activities
12. Calm and settled
13. Sleeping
14. Other _____

INTERVENTIONS / ALTERNATIVES ATTEMPTED (Codes)

Establishing Rapport
- 1.1 Eye contact
- 1.2 Friendly tone
- 1.3 Calm manner
- 1.4 Approach slowly
- 1.5 Explain procedures
- 1.6 Listen to non-verbal/verbal communication
- 1.7 Maintain consistent care plan
- 1.8 Provide communication aids
- 1.9 Involve family members, as appropriate

Nursing Interventions
- 2.1 Regular toileting
- 2.2 Pain control
- 2.3 Food and intake
- 2.4 Eliminate unnecessary tube/lines
- 2.5 Administration of psychoactive medications
- 2.6 Review of prescribed medications
- 2.7 Consider constant/close care
- 2.8 Diversionary activities
- 2.9 Involve OT/PT

3. Environmental Interventions
- 3.1 Adjust stimuli (lighting, noise, proximity to nursing station, number of contacts, roommate selection)
- 3.2 Consider using a private room

NON-RESTRAINT ALTERNATIVES (Codes)

4. Non-restraint product alternatives
- 4.1 Pinel self-release waist belt
- 4.2 Self-release wheelchair belts
- 4.3 Bed and chair alarms
- 4.4 Exit alarms
- 4.5 Floor mats
- 4.6 Non-skid socks
- 4.7 Hip protectors (O.T. consult required)
- 4.8 Helmet (O.T. consult required)
- 4.9 One, two or three split side rails

RESTRAINT TYPE (Codes)

1. Wheelchair belts
2. Waist restraint
3. Limb restraint
4. Mitts
5. Arm splint
6. Secure room
7. Four side rails, (must be used with bed alarm, waist or limb restraint)

PHYSICAL ASSESSMENT

Positioning ✓ Side-lying is preferred for limb restraints, but supine or prone may be used, dependent on clinical judgement & patient condition	**Respiratory Status** ✓ Ensure breathing is not compromised
Limb Circulation ✓ Ensure that the hand/foot is not discoloured, edematous, cold, or painful	**Skin Condition Under Restraint** ✓ Ensure that the skin under the restraint is intact and that there is no chafing or skin breakdown

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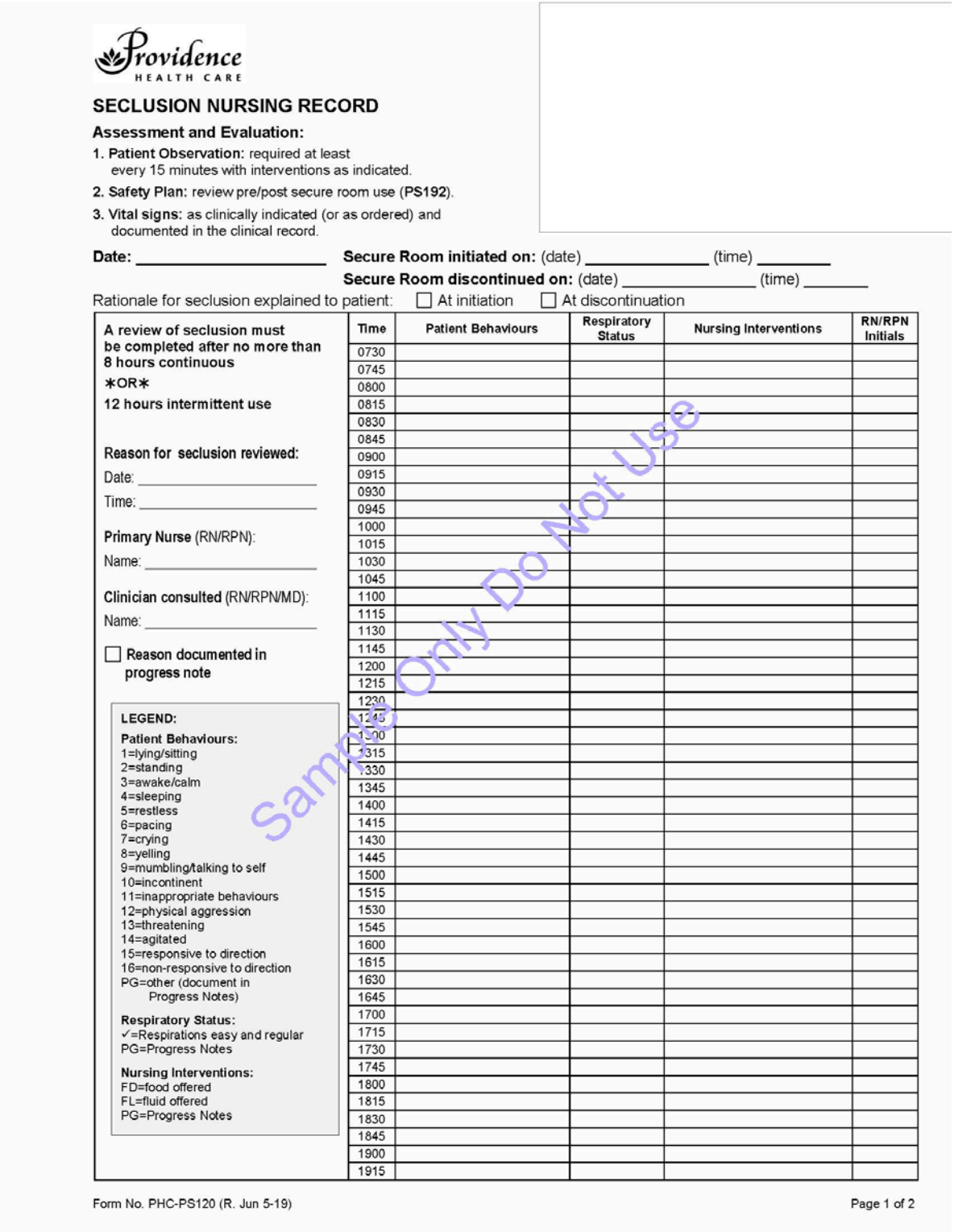
Appendix E: Seclusion Nursing Record



Providence HEALTH CARE

SECLUSION NURSING RECORD

Assessment and Evaluation:

1. **Patient Observation:** required at least every 15 minutes with interventions as indicated.
2. **Safety Plan:** review pre/post secure room use (**PS192**).
3. **Vital signs:** as clinically indicated (or as ordered) and documented in the clinical record.

Date: _____ **Secure Room initiated on:** (date) _____ (time) _____

Secure Room discontinued on: (date) _____ (time) _____

Rationale for seclusion explained to patient: ☐ At initiation ☐ At discontinuation

A review of seclusion must be completed after no more than 8 hours continuous

OR

12 hours intermittent use

Reason for seclusion reviewed:

Date: _____

Time: _____

Primary Nurse (RN/RPN):

Name: _____

Clinician consulted (RN/RPN/MD):

Name: _____

☐ **Reason documented in progress note**

LEGEND:

Patient Behaviours:
1=lying/sitting
2=standing
3=awake/calm
4=sleeping
5=restless
6=pacing
7=crying
8=yelling
9=mumbling/talking to self
10=incontinent
11=inappropriate behaviours
12=physical aggression
13=threatening
14=agitated
15=responsive to direction
16=non-responsive to direction
PG=other (document in Progress Notes)

Respiratory Status:
✓=Respirations easy and regular
PG=Progress Notes

Nursing Interventions:
FD=food offered
FL=fluid offered
PG=Progress Notes

Time	Patient Behaviours	Respiratory Status	Nursing Interventions	RN/RPN Initials
0730				
0745				
0800				
0815				
0830				
0845				
0900				
0915				
0930				
0945				
1000				
1015				
1030				
1045				
1100				
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1900				
1915				

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Appendix F: Personal Safety Plan

PERSONAL SAFETY PLAN

This form is part of the patient's permanent health record and MUST be completed in pen.

When I become upset, I experience:

Changes in my body:

☐ Sweating ☐ Breathing hard ☐ Clenching teeth/fists ☐ Red face ☐ Cannot sit still ☐ Pacing
☐ Other: _____

Changes in how I talk:

☐ Become loud ☐ Become quiet ☐ Yell ☐ Swear ☐ Cry
☐ Other: _____

Changes in my behaviour:

☐ Become rude ☐ Hurt self ☐ Hurt others ☐ Throw objects ☐ Isolate (Withdraw)
☐ Other: _____

My major activators:

☐ Not being listened to ☐ Being touched ☐ Yelling ☐ Loud noises ☐ Feeling anxious
☐ Not having control ☐ Not having my needs met ☐ Cravings for alcohol/drugs/nicotine
☐ Other: _____

Patient preferred comfort measures:

Please number in order of preference (e.g. 1st choice = 1, 2nd choice = 2)

_____ Talking with members of my treatment team
_____ Talking with family/friends
_____ Taking medications
_____ Going to my room
_____ Exercising
_____ Listening to music
_____ Quiet activity
_____ Journaling
_____ Sensory modulation room (see Sensory Diet PHC-PS230)

Other Notes: _____

In extreme emergencies, seclusion and/or restraints may be used and your nurse will explain the rationale for this decision to you.

Completed by:

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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