



Seclusion of Clients Procedure

Procedure Number

CHC-MHS-0036

Version Nos:

6

1. Purpose

This Procedure is performed as a means of establishing clear guidelines for the use of seclusion in the West Coast District Health Board (WCDHB) Mental Health Services (MHS), which will maintain consumer safety and meet clinical and legal requirements

2. Application

This Procedure is to be followed by all WCDHB staff working in the WCDHB MHS.

3. Definitions

For the purposes of this Procedure:

Seclusion is taken to mean the placing of a client, at any time and for any duration, alone in a specified seclusion room with the door(s) shut so that he/she cannot freely exit from that area. Seclusion is a specific clinical intervention requiring valid, objective clinical reasons for its use.

Seclusion Room is taken to mean a room designated for the purpose of seclusion by or with the approval of the Director of Area Mental Health Services, and shall provide a safe environment. This is the locked seclusion room(s) and does not include the courtyard or lounge.

Note: At no time should a person be locked in the overall "seclusion area" (seclusion rooms + lounge space in between and the courtyard) without a staff person present. The lounge space and courtyard in no way comply with expected standards for a seclusion room and therefore cannot be used at such.

Seclusion Episode/Event is taken to mean a discrete period of seclusion defined as ended when a client has been out of the conditions of seclusion for more than one hour. The purpose of this is to allow a short period of evaluation out of seclusion.

4. Responsibilities:

For the purposes of this Procedure:

Except in emergency situations seclusion should only be used with the authority of the **Responsible Clinician**.

In an emergency, a Registered Nurse having immediate responsibility for the client, may place the client in seclusion but shall forthwith bring the case to the attention of the Responsible Clinician.

A **Registered Nurse** is allocated to provide care for each client in seclusion and will be responsible for the care and observation of the client during their time in seclusion.



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5. Resources Required

This Procedure requires:

- i. Designated Approved Seclusion Area
- ii. WCDHB Mental Health Service Treatment Plan
- iii. WCDHB Seclusion Nursing Observation Record
- iv. WCDHB Seclusion Authorisation & Reporting Form
- v. WCDHB Clinical Progress Notes
- vi. WCDHB Seclusion Hours Recording Form

6. Process

1.00 General

- 1.01 It is the Policy of the WCDHB MHS to provide the safest, least restrictive and least intrusive treatment possible.
- 1.02 The decision to use seclusion will always be based on a documented assessment of the type and level of risk to the consumer and/or others.
- 1.03 Seclusion shall be used only where, and for as long as it is necessary, for the care and treatment of the client, or the protection of others.
- 1.04 To minimise the psychological impact of seclusion, its implementation must always incorporate thoughtful and considerate treatment of the individual and demonstrate respect for the need for information, privacy, cultural safety, dignity and self-respect.
- 1.05 Staff must always be mindful of, a responsive to culturally determined experiences for clients that are engendered by the seclusion process.
- 1.06 The assessment process will identify the consumer's needs and risk(s) to themselves and/or others.
- 1.07 The treatment plan will be developed in collaboration with the client and their family/whanau/carers including the use of seclusion (where it may be applicable).
- 1.08 If it is not possible to develop the treatment plan collaboratively (or to consult family/whanau/carers), the reasons must be documented.
- 1.09 The registered nurse will document in the treatment plan the strategies/interventions that will be used to manage the identified risk(s).
- 1.10 Staff must inform the client (and the family/whanau/carers) about the specific circumstances in which the risk management strategies will apply if the treatment plan has not been developed in collaboration with the consumer. **Note:** Continuing attempts to achieve collaboration with the client should be documented in the clinical notes.



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- 1.11 The use or proposed use of seclusion must be an intervention of last resort and should be planned wherever possible. The indications and specific circumstances for its use must be documented in the individual's treatment plan. **Note:** The client's legal status must be considered. Seclusion may only be used for clients who are under Sec 11 – sec 15, Sec 29 3(a) / 3 (b), and/or Sec 30 of the Mental Health (CAT) Act 1992.

2.00 Parameters For The Use Of Seclusion

2.01 Situations where, according to the duty of care seclusion may be appropriate:

- a) The control of harmful behaviour occurring during the course of a psychiatric illness which cannot be adequately controlled with the psychosocial techniques and/or medication.
- b) Disturbance of behaviour as the result of marked agitation, thought disorder, severe confusion, hyperactivity or grossly impaired judgement.
- c) To reduce the disruptive effects of external stimuli in a person who is highly aroused due to their illness.
- d) To prevent harmful or destructive behaviour, using specific indicators of impending disturbance which may be identified by either the individual or the staff, and which should wherever possible be part of an agreed management plan.

2.02 Seclusion should be used with extreme caution in the following circumstances:

- a) Where the client is receiving medication and there is evidence of altered or fluctuation consciousness, or other neurological side effects
- b) Likelihood of respiratory suppression or other cardiovascular side effects
- c) Physical deterioration
- d) Where the client is in need of intensive assessment and/or observation, especially where there is a history suggestive of significant trauma, ingestion of unknown drugs/substances, or organic diagnosis
- e) Presence of physical illness or injury requiring specific physical treatment
- f) Presence or likelihood of self injurious behaviour
- g) Likelihood of escalation of anxiety, aggression or distress or a previous adverse response
- h) No demonstrable psychiatric diagnosis
- i) Intoxication with alcohol, or possibility of other drug ingestion

***Note:** When a person in any of the above situations wishes to be accompanied and supported by family/wbanau, it is preferable to review the need for seclusion. Staff, assisted by the direct involvement of family/wbanau may be able to maintain safety for the client in an open room.*

3.00 Authority To Implement Seclusion

- 3.01 Seclusion shall be used only with the authority of the client's Responsible Clinician. (Mental Health Act, Sec 71)
- 3.02 If the Responsible Clinician is not immediately available, the decision to initiate its use may be made by a senior registered nurse after consultation with the on call psychiatrist.
***Note:** "In an emergency, a nurse or other health professional having immediate responsibility for a client may place the client in seclusion, but shall forthwith bring the case to the attention of the Responsible Clinician" (Sec 71 (2)(d)) or on call psychiatrist.*
- 3.03 The client must be examined (assessed) by the medical practitioner (Responsible Clinician) or delegated psychiatrist, **within 4 hours** of seclusion being initiated and signed authorisation given (WCDHB Seclusion Authorisation and Reporting form).



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- 3.04 Between the hours of 2300 and 0800, this assessment may be waived if the use of seclusion has been approved in advance by the client's Responsible Clinician or the on call psychiatrist at weekends. This approval must be made on the day seclusion is to be used and after examination has been carried out.

Note: Initiating seclusion between these hours should be an infrequent event.

- 3.05 The Responsible Clinician is required to review the situation with the persons involved on the next working day and to countersign the WCDHB Seclusion Authorisation and Reporting Form.

- 3.06 The IPU/Dementia Unit Team Leader must be notified of every seclusion event if not directly involved in the decision to implement seclusion. The nurse in charge of the shift and After Hours Co-ordinator must be informed after hours.

4.00 Before Initiating Seclusion

- 4.01 Before initiating seclusion, the nursing team will ensure that:
- The legal status of the client is taken into account.
 - All possible less intrusive interventions to manage the situation have been attempted including:
 - Strategies to reduce/manage anxiety or distress
 - De-escalation techniques
 - Use of a de-escalation room
 - Negotiation (where appropriate)
 - Consideration given to an increased level of observation or special nursing
 - Use of prescribed medication
 - Other strategies as outlined in the client's treatment plan.
 - There are no contra-indications present.
 - The reasons for seclusion must be based on clinical judgement and fully explained to the client.
 - The Maori Mental Health Team is to be informed as soon as possible when Tangata Whaiora is involved.

5.00 Preparing To Implement Seclusion

- 5.01 Assemble the necessary number of staff required to implement seclusion safely and assign responsibility for:
 - co-ordinating the procedure
 - interacting with the client/remaining with the client (where possible)
 - preparing medication (if applicable)
 - locking the seclusion room door
- 5.02 Consider the gender mix of staff. At least one staff member must be of the same gender as the client, where this is at all possible. **Note:** For clients who are known, or suspected, to have a history of being sexually abused use staff of the gender considered by the client to be safe (wherever possible).
- 5.03 Check that a designated seclusion room is available and prepare the room as considered safe and appropriate for this client.



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- 5.04 Prepare medication as per orders (if applicable)
- 5.05 Remove own watches, scissors or other items that may cause injury if restraint is indicated
- 5.06 Inform the client of the intention to begin the seclusion process. Explain the reasons and give him/her the opportunity to place controls on the behaviour causing concern.
- 5.07 Clear the immediate vicinity of the room (if possible) and open doors flush with the wall.
- 5.08 Provide a brief explanation and reassurance to other clients and remove them from the area if possible.

6.00 Movement of Clients to Seclusion

- 6.01 Continue dialogue with the client throughout.
- 6.02 Continue to use calming techniques to minimise further escalation.
- 6.03 Move the client to the room in planned stages. Movement should not be sudden or rushed.
- 6.04 If restraint needs to be applied, follow the recognised procedure

7.00 In The Seclusion Room

- 7.01 Inform the client that staff will need to check for unsafe/potentially harmful items.
- 7.02 Assess the client's attire (belts, buckles etc) for risk of harm to the client and review regularly if the client's own clothing has been replaced with safer attire.
Note: The secluded individual should be allowed as much of their normal clothing as possible within the dictates of safety, and should not necessarily be deprived of all their personal possessions.
- 7.03 Administer any prescribed medication as required/indicated.
- 7.04 Stay with the client until calm, whenever possible.
- 7.05 Inform the client what observations will be made while in seclusion and the clinical criteria for ending seclusion. **Note:** These should be negotiated with the client where possible.
- 7.06 Orientate the client to the room facilities (drinking fountain, en-suite, intercom)
- 7.08 Ensure that drinking fluids are provided.
- 7.09 Ensure that the client has access to the time, day and date.
- 7.10 Exit the room safely, preferably when the client is settled.
Note: One staff member is always made responsible for locking the door on exit from the room.



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8.00 Entering Seclusion Room Safely

8.01 **A minimum of two staff are present whenever the seclusion room is entered, for assessment and provision of care.** One member of staff will be the same gender as the client, where possible, and one will be an experienced registered nurse.

8.02 If there is a considered risk of harm to staff:

- a sufficient number of staff to deliver care and treatment safely will enter the room
- at least one more member of staff will remain outside the room should further assistance be required
- staff will request that the client sit on the bed **before** unlocking the door

Note: Do not enter the room unless entry is deemed to be safe.

8.03 Assemble equipment and medication before entering the room (where applicable).

9.00 Nursing Care Of A Client In Seclusion

9.01 Nursing care of a client in seclusion will include:

- a. Careful listening to clients' explanation of their needs, and attempts to address these wherever possible. An explanation must be given to clients if their needs are not able to be met.
- b. Monitor response to medication and assess level of sedation. Nursing observation and assessment provided will include assessment of both physical and mental state.
- c. Giving ongoing, full explanations about:
 - the reason for seclusion
 - the observation procedure, including rationale for observations
 - when seclusion will be reviewed
 - why and how it will be likely to end
 - The client and the family/whanau must be part of this process wherever possible.
- d. Ensuring that the client is able to speak through an advocate, relative or close friend, or interpreter, when there is a communication problem.
- e. Provision of reality orientation, including orientation to time and place and event, each time the room is entered, and on request from the client.
- f. Provision of food and fluids:
 - offer choice of meal/fluid wherever possible
 - Check presentation/correct food(s) before delivering meals to the client
 - Maintain a fluid balance chart (if fluid/food intake/output is an identified problem)
 - Consider use of 'finger food' as an alternative to the use of cutlery
 - Ensure that all cutlery, if issued, with a meal/snack is returned at the end of the meal/snack.
- g. Ensuring regular access to toilet/washing/showering facilities if there is no en-suite.
- h. Asses the need to provide NRT products to assist the person avoid nicotine withdrawals, for any client secluded shortly after admission or who is already using NRT as an in-client
- i. Providing the opportunity for socialisation if considered safe for all involved: i.e. visits from staff, family/close friends, chaplain or other special needs person as per visiting arrangements outlined in the treatment plan.



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- j. Providing (appropriate and safe) material to assist the client to keep focused on reality and occupied, for example the newspaper, a radio, magazines and/or writing materials.
- k. Pay particular attention to a person's cultural dignity and to the wishes of their family/whanau.
- l. Continuously assess progress (with the client), towards meeting the clinical criteria for ending seclusion.

Note: The Registered Nurse is responsible for the care and treatment given to the client during seclusion (including observations) and for communicating all care and treatment requirements to the following shift.

10.00 Required Observations and Documentation

10.01 Increased rather than decreased levels of care and observation are required, and should be provided in the least restrictive and most dignified manner possible in the circumstances.

10.02 Ten Minute Observations

The client's assigned nurse must:

- **physically observe the client every 10 minutes** (at irregular intervals if possible)
- note the client's; colour, breathing rate, position, activity and behaviour(s)
- record their observations on the Seclusion Nursing Observation Record

10.03 Two Hourly Observations

- a) An attempt should be made by a registered nurse (or doctor) at least once every two hours to enter the room to assess the physical wellbeing of the client. If an attempt to enter the room is unsuccessful, the reason why will be recorded on the observation form.
- b) An assessment of the client's mental state shall be made by the registered nurse (or doctor) at this time. Further assessment will be carried out as clinically indicated.
- c) Safety precautions, as outlined in 8.00 of this document, will be taken into account whenever the room is entered
- d) Each entry into the seclusion room is an opportunity to assess the readiness of the client to reintegrate back into the ward.

10.04 Eight-Hourly Assessment and Care

During the period of each shift and ongoing programme of care and assessment must be provided and recorded. Responsibility for care delivery and observations during seclusion is that of the registered nurse. In particular they are responsible for ensuring the following:

- a) Observations and care as described above are undertaken (Ten minute and two-hourly observations)
- b) Clinical consultation with the Responsible Clinician occurs and is documented
- c) Communicating all care requirements both verbally and via the client's plan to the following shift, for example
 - food/fluid intake
 - person care, hygiene, toileting arrangements
 - medication requirements
 - exercise/physiotherapy
 - visitors (chaplain, advocates, family)



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- d) Where practicable care should be carried out predominantly by staff of the same gender and culture of the client
- e) It is mandatory that a suitably qualified clinician (registered nurse or psychiatrist) shall psychiatrically assess the person in seclusion at least once every eight hours. A record of this assessment is documented in the clinical notes.
- f) Before the completion of an eight-hour period, when a decision is taken to extend seclusion, confirmation should be provided by the initiating and supporting clinicians or another suitably qualified nurse and doctor if the original clinicians are not available. The Responsible Clinician should be notified at an appropriate time.
- g) The senior nurse on duty may conduct the other psychiatric assessments. This must involve a telephone consultation with the Responsible Clinician if the nurse on duty has any particular concerns or the circumstances are unusual.
- h) The person conducting the psychiatric assessment must document the assessment and the outcome **in the clinical notes**.
- i) The registered nurse will document consultations, including telephone consultations with the Responsible Clinician/on call psychiatrist.

11.00 Prolonged Seclusion

- 11.01 If, over the course of one admission, the cumulative hours of seclusion exceed 24 hours in a four week period, reassessment in the form of a case management conference shall occur. The purpose of this is the review the management plan, the rationale for continuation of seclusion and the expected path of treatment.
- 11.02 If the client is unresponsive to alternative modalities, consultation about the use of prolonged seclusion will occur with the Clinical Director, or another delegated senior clinician.

12.00 Reintegration for clients undergoing seclusion

- 12.01 A planned and graduated process of reintegration into the ward may be required, particularly after a prolonged period of seclusion.
- 12.02 Reintegration should start with the door open and move to integrations during times of least stress and disruption
- 12.03 An assessment of reintegration attempts should be taken into account when making a decision whether or not to continue seclusion.

13.00 Ending Seclusion

- 13.01 If the goals of seclusion have been achieved, a decision to end seclusion should be taken by two suitably qualified clinicians (two registered nurses or a registered nurse and a doctor) in agreement with the Responsible Clinician. If the decision to end seclusion is made after hours, the delegated authority must be notified at an appropriate time.
- 13.02 Each episode of seclusion is deemed to have ended if the client leaves the conditions of seclusion without expectation of return, and in any case, is deemed to have ended if the client has been out of seclusion for more than one hour. The purpose of this is to allow a short period of evaluation out of seclusion.



14.00 Recurrent Seclusion

14.01 If it is necessary to replace an individual back in seclusion after a short period of evaluation or attempted reintegration exceeding one hour, a new seclusion event must be commenced.

15.00 Recording the Seclusion Process

15.01 The WCDHB Seclusion Reporting Forms must be used to record the use of seclusion and will be supported by clinical notes. These forms include

- Seclusion Nursing Observation Record includes the ten minute and two hourly observations
- Seclusion Authorisation & Reporting Form – completed for each seclusion event or for a maximum period of 24 hours. This form
- Details reasons for commencement of seclusion
- Authorisation to continue for more than eight hours
- Details of decision to end seclusion
- Seclusion Hours Recording Form - record of accumulated hours over any four week period.

15.02 Recording will start as soon as seclusion has been initiated

15.03 One copy of the complete set of seclusion records will be retained in the client's notes and another retained in a central seclusion register (as per sec 129 of the Mental Health (CAT) Act 1992.

15.04 The main purpose of the seclusion register is to provide a basis for internal quality assurance as well as review and audit. As in other aspects of the MH(CAT) Act 1992, it is expected that the District Inspector will monitor that procedures are properly used.

16.00 Evaluating the Seclusion Process

16.01 The seclusion process must be evaluated with the consumer at an appropriate time to:

- Evaluate the effects of the procedure on the consumer
- discuss future treatment planning options
- obtain feedback about the process that may assist to improve clinical practice in the future using client feedback form (Seclusion Feedback Form)

16.02 As part of risk management, the staff involved in a seclusion event and the shift co-ordinator on duty will, as soon as possible, after the procedure review:

- the reason for seclusion
- its management, including other interventions tried before seclusion was
- initiated
- its outcome
- the effects on staff and client/s



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- 16.03 If a staff member is injured physically or psychologically, the appropriate support will be arranged/offered by the shift co-ordinator for example medical assistance, individual support discussed and agreed with the staff member and the line manager (EAP, provision for leave.)
- 16.04 The review will also be based on consultation with the client, whanau/primary caregivers and others involved.
- 16.05 The treatment plan may be modified at this meeting.

7. Precautions And Considerations

- It is the policy of the WCDHB MHS to provide the safest, least restrictive and least intrusive treatment possible.
- The decision to use seclusion will always be based on a documented assessment of the type and level of risk to the consumer and/or others.
- The aim is to use seclusion for the least time possible to achieve the desired outcome.
- Staff are required to be aware that clients in seclusion need increased care and observation, and that this must also be documented.
- To minimise the psychological impact of seclusion, its implementation must always incorporate thoughtful and considerate treatment of the individual and demonstrate respect for the need for information, privacy, cultural safety, dignity and self-respect.
- Staff must always be mindful of, a responsive to culturally determined experiences for patients that are engendered by the seclusion process.

8. References

- Mental Health (Compulsory Assessment and Treatment) Act (1992) and Amendments
- Ministry of Health Guidelines On The Use Of Seclusion
- Ministry Of Health Guidelines On The Use of Physical Restraint
- Health & Disability Sector Standards NZS 8134:2008

9. Related Documents

- WCDHB Personal Restraint Procedures
- WCDHB Smoke Free Policy and Procedure

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