



Labrador - Grenfell  
**Health**

# Mental Health/Acute Care Policies



# **Constant/Close Observation**



# Purpose

- To provide guidelines for nurses, medical, mental health and support staff regarding the provision of constant/close observation services and case management of suicidal/high-risk mental health clients



# Constant/Close Observation

- An increased level of observation and supervision of high-risk clients
- Used to provide for the safety and well-being of the client, other clients, staff and the client care environment
- Provides the client that is at risk direct, continuous, unobstructed visual observation



# Constant/Close Observation

May be required for individuals who:

- Have been assessed to be a risk for harming themselves or others, or for endangering the client care environment
- Are in a psychotic state or confused, and are a potential danger to themselves, others, or to the client care environment
- Have a high risk of flight
- Have been chemically restrained or placed in seclusion



# Close Observation

- A clinical intervention to monitor and maintain safety of a client on an intermittent basis
- Used when a client is on close observation they must be physically seen **every 15 minutes**



# Constant Observation

- Clear sight of all client activity at all times
- Continuous monitoring of a client on a one to one basis
- Engaging with client to build trust and rapport
- Communication with the client and family around the need for constant observation



# Constant Observation

Points to remember:

- No electronic devices/cell phones to be used while providing constant observation
- Visitors do not assume responsibility for client observation
- Ensure safety for yourself and client at all times
- All items brought to the client from external sources are to be searched prior to being received by the client





# Constant/Close Observation

- A physician order is required and assessed every 12 hours and as needed
- The client should be placed in a private room
- The client is to remain on the unit at all times, the only exception is a physician ordered escort



# Documentation

## Documentation and materials required:

- Constant/Close Observation Record
  - <http://lghealth/documents/files/Constant%20Close%20Observation%20Record%20Feb%2029%202016.pdf>
- High Risk Mental Health Checklist
  - <http://lghealth/documents/files/High%20Risk%20Mental%20Health%20Checklist%20%20Feb%2029%202016.pdf>
- Client's Chart
- Constant observation information for clients and families



# Seclusion Room Protocol



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# Purpose

- To provide guidelines to employees regarding the safe and appropriate use of the seclusion room



# Definitions

- **Physical Restraining:** The use of manual holds to restrict movement of all or part of an individual's body in emergency situations in which the individual's aggressive behavior presents an immediate risk of physical harm to self or others. Physical restraints will not be used unless all other options have been ruled out



# Definitions

- **Seclusion:** The involuntary confinement of a client in a designated visually observable locked room with the client under **constant observation**. A staff member is situated directly outside the seclusion room door, constantly observing the client through an observation window and/or video monitor



# Definitions

- **Code White:** A team response to a situation in which an individual demonstrates a loss of control that could result in injury to self, others and/or damage to property



# Seclusion Initiated

- For individuals who display aggressive/violent behavior
- When all potential physical and psychological risks have been considered
- Benefits associated with the use of seclusion outweigh the risks





# Seclusion

## Points to remember:

- All necessary measures should be taken to protect client's confidentiality, privacy and dignity
- Treatment should be delivered in the least restrictive manner
- This is not a form of punishment it is an emergency intervention when less restrictive measures are ineffective
- It should not be used as a standing order or part of a treatment order



# Key Points for Staff

- Know where the seclusion room key is located and be always accessible
- When possible staff should be trained in NVCI
- A safety engineered device will be used to administer intramuscular medications
- Debrief after incidents



# Seclusion

The following options for responding to escalating behavior will be considered in descending order:

- Interaction and redirection (one-on-one staff attendance)
- Setting limits
- Quiet time
- Medication offered
- Physical effort/restraint
- Seclusion



# Seclusion

- In an emergency situation when a physician is not immediately available to make a decision regarding seclusion, the Clinical Nurse Manager or designate (i.e. Nursing Site Manager, Nursing Site Supervisor, Nursing Administrator On-site, Nurse-in-Charge, Primary Care Nurse) may make the decision to initiate seclusion
  - After hours, the nurse in charge (or designate) may initiate the use of seclusion
- The Primary Care Nurse must notify the physician within 30 minutes of implementing the seclusion room
- Within one hour of initiation of seclusion the physician is required to assess client face to face and reassess every 12 hours



# Seclusion

## Points to remember:

- Clinical Nurse Manager (or designate) will communicate to client why seclusion is being used.
- Examine client's belongings (Refer to Examination of Belongings Policy)
- Place the individual on Constant Observation
- The Primary Care Nurse will inform the client's next-of-kin



# Monitoring

- Two staff members must be present when the following care is provided to the individual in seclusion:
  - Toileting
  - Fluids and meals
  - Medication administration
  - Assessment of the individual
- At the earliest possible time seclusion should be discontinued and an appropriate care plan is put in place



# Documentation

Staff will use:

- Seclusion Restraint Flow Sheet
  - <http://lghealth/documents/files/Seclusion%20Restraint%20Flow%20Sheet.pdf>
- Client chart



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# Examination of Belongings – High Risk Clients





# Purpose

- To provide guidelines to clinical staff regarding the examination of belongings for high-risk clients. The objective is to ensure that these clients do not have easy access to potentially harmful objects



# Definition

- High risk clients are those who pose a threat to themselves and/or others, to the client care environment, and/or are acutely psychotic



# Client Search

A search will be conducted on:

- A high-risk client upon admission
- A client whose condition changes while they are admitted
- A client under constant/close observation as per policy
- A client admitted under the MHCTA with a first certificate of involuntary admission



# Procedure/Documentation

- Inform the client or guardian of the need to search belongings and remove any potentially dangerous objects
- Complete the Examination of Belonging – High Risk Clients form
  - <http://lghealth/documents/files/Examination%20of%20Belonging%20High%20Risk%20Clients%20Form%202.pdf>



# Examination of Belongings

- In the presence of the client and at least one other clinical staff member, search all of the client's belongings and clothing regardless of whether or not the client has signed the form
- The following steps should be followed:
  - Examine the contents of any luggage, backpacks, parcels, etc. for any items that may pose a danger to the client or others in the client care environment
  - Ask the client to pull out and/or empty all of their pockets and examine and assess these items for potential danger
  - If safe and possible, give the client a hospital gown and instruct the client to remove their clothing so that it can be further searched



# Examination of Belongings

Examples of items to be confiscated:

- All medication (prescription and nonprescription)
- Potentially harmful objects (i.e. knives, belts, razors, scissors, lighters, electronic devices, watches with glass face, shoe laces, ties, etc.)
- Potentially harmful substances (i.e. aftershave lotion, alcohol, etc.)



# Examination of Belongings

- Points to remember:
  - If a firearm(s) found during the search, staff must immediately notify Security at LGH and the local police. Staff should not directly handle a firearm if found in a client's belongings. If safe and possible (i.e. if the firearm is found in a bag), then the bag with the firearm should be removed from the client's room
  - If illicit or unidentifiable drugs or substances are found during the search, staff will confiscate the substance(s), lock them in a secure area, and notify the local police. The staff member will not disclose the name of the client unless required by law to do so by subpoena. An Occurrence Report must be completed



# Examination of Belongings

- Points to remember:
  - The staff member who conducted the search will document information about the search in the client's chart, including why, where, and when the search took place, what items were confiscated, who conducted the search, as well as any other pertinent information





# Examination of Belongings

- Tips to keep in mind:
  - Be alert to any increase or change in client's behavior
  - Ensure basic needs are met
  - Be non-judgmental and empathic
  - Be an active listener- give undivided attention
  - Allow patient to have some control
  - Attempt to divert- especially in clients with dementia
  - Speak in simple, short, clear sentences
  - Allow to “blow off steam” don’t challenge or argue
  - Don’t take it personally
  - Take threats seriously and seek help



# Training Opportunities

- Non-Violent Crisis Intervention
- Mental Health First Aid (Youth & Adults)
- Anti-Stigma Campaign
- Fundamental Concepts in Addictions
- Motivational Interviewing
- Applied Suicide Intervention Skills Training (ASIST)
- Suicide Talk



# Questions

