

Title: Seclusion Room Protocol		
Document Path: Regional Documents/Policies & Procedures/General		
Approved By: VP of Nursing		Version: 1.0
Effective Date: 29/02/2006	Status: Current	Page 1 of 5

Policy Name: Seclusion Room Protocol

Purpose:

To provide guidelines to employees for the safe and appropriate use of the seclusion room.

Policy / Standard:

All clients have an inherent right to be treated with dignity, concern and receive quality competent care.

Clients have the right to appropriate and respectful treatment and care should be delivered in the least restrictive manner to ensure positive clinical outcomes.

The seclusion room is utilized for clients who display aggressive or violent behavior.

The decision to initiate seclusion is made when:

- All potential physical and psychological risks of the procedures are considered;
- The benefits associated with the use of seclusion outweigh the risk of its use;
- All necessary measures to protect the clients' confidentiality, privacy and dignity are in place;
- If aggression towards property is posing a risk to the client or others.

Physical restraints and seclusion are not treatment interventions and are initiated as an emergency intervention when other less restrictive methods have proven ineffective.

The Primary Care Nurse (PCN) and the Observer is responsible to know the location of the seclusion room key and have access to the key at all times.

Physical restraints, seclusion and code white procedures will not be initiated or maintained as a:

- Part of any treatment program;
- Form of punishment or to enhance good behavior;
- Standing order or as necessary (PRN) basis;
- Once physical restraints and/or seclusion are initiated, it shall be of the least possible duration.

A safety engineered device will be utilized to administer any intramuscular medications.

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Staff providing care and constant observation for clients in seclusion should be trained in de-escalation techniques.

Materials Required:

Client's Clinical Chart

[Emergency Codes](#)

[Mental Health/Acute Care Policies Audit Tool](#)

[Seclusion Restraint Flow Sheet](#)

Seclusion Room Key

Related Policies:

Constant/Close Observation

Procedure:

1. 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.
2. In an emergency situation, when a physician is not immediately available the Clinical Nurse Manager (CNM) or designate (i.e. Nursing Site Manager, Nursing Site Supervisor, Nursing Administrator On-Site, Nurse-in-Charge or Primary Care Nurse) may make the decision to initiate the use of seclusion.
3. The CNM or designate must notify the physician within thirty (30) minutes of initiating the seclusion room.
4. The CNM or designate will:
 - Inform the client why seclusion is being used;
 - Advise the client that behavior must be acceptable to end the seclusion period;
 - Ensure the client's clothing is searched and harmful objects removed;
 - Not deprive the client of clothing.

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5. The client will immediately be placed on constant observation.
6. The CNM or designate will inform the client's next-of-kin (NOK) of the admission to the seclusion room, as soon as possible.
7. Within one hour of initiation of seclusion, it is recommended the physician perform a face-to-face assessment of the client to determine the need for seclusion; and an order must be written to either continue or discontinue the intervention.
8. A physician re-assessment should be completed at least every 12 hours or more often as clinically indicated.
9. If extra help is required, a Code White may be paged.

Monitoring Care Requirements:

1. When seclusion is initiated, the nursing staff will use the [Seclusion Restraint Flow Sheet](#) to record details of the intervention.
2. The [Seclusion Restraint Flow Sheet](#) will be part of the permanent clinical record. The PCN will document on the [Seclusion Restraint Flow Sheet](#) and in the clinical chart.
3. Two (2) staff members must be present when the following care is provided to the client in seclusion:
 - Toileting;
 - Fluids and meals;
 - Medication administration;
 - Assessment of individual.
4. All clients in seclusion will be monitored continuously through the seclusion room observation window and/or video monitor.
5. The PCN is responsible to ensure ongoing cycles of the nursing process: assess, plan, diagnosis, implement and evaluate the client's care during seclusion.
6. The PCN is responsible to provide relief breaks.

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Ongoing Assessment for Continuation of Seclusion:

1. While the client is in seclusion, the PCN will observe the client hourly or more often (if required) to assess physical and mental state, and the effects of medication(s) (if administered). Vital signs should be monitored as indicated.
2. Renewal of orders by the physician must occur at least every twelve (12) hours, and as required, along with a face-to-face re-evaluation of the client.

Discontinuation of Seclusion:

1. Assessment of client condition is required to discontinue seclusion. When the use of seclusion is no longer clinically indicated, the physician will write an order to discontinue its use.
2. An appropriate care plan will be implemented based on clinical assessment prior to discontinuation of seclusion.
3. For an individual whose seclusion is discontinued but require seclusion again, the process will be restarted and a new order obtained.

Documentation:

1. The PCN and observer is responsible to chart the assessment, plan, interventions and evaluation in the clinical chart and ensure the [Seclusion Restraint Flow Sheet](#) is completed.

Audit:

1. The Mental Health/Addictions Manager will complete four random chart audits monthly using the [Mental Health/Acute Care Policies Audit Tool](#).

Definitions:

For the purpose of this policy, the following definitions will apply:

Physical Restraints: 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.

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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.

Code White: Is the emergency code used to alert staff if there is a violent patient or incident.

References:

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