Seclusion

Procedure Responsibilities and Authorisation

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Procedure Review History

Version	Updated by	Date Updated	Description of Changes
05	Areann Libline	14 August 2017	The 8 hour SMO or delegate review involves a face to face assessment and a review of the current medication. Communication via email to the clinical director, service director and inpatient operations manager when a tāngata whaiora has been in seclusion for a period of 24 hours in a calendar month. This action is undertaken by the clinical nurse manager during working hours or the associate charge nurse manager Bureau, after hours. Communication via email or phone message to the district inspector when a tāngata whaiora has been in seclusion for a period of 48 hours in a calendar month. This action is undertaken by the registered nurse responsible for the tāngata whaiora care at that time. Addition of entry and exit of the seclusion room. Explicit reference to using a separate restraint event notification form if utilising personal restraint in the process of transferring to seclusion.
06	Areann Libline	3 August 2020	The inclusion of the RN clinical practice skills checklist (tier 3) for competency to make decisions relating to seclusion, the provision of care during and the ending of restraint / seclusion The inclusion of the use of high care lounges in the forensic inpatient service – (previously Doc ID 0538) The inclusion of set 8 hourly seclusion reviews by responsible clinician or delegate (0800, 1600 and 2400 hours) and the support by the ACNM Bureau to facilitate this.

Seclusion

Contents

Seclusion

1. Overview

1.1 Purpose

The purpose of this procedure is to:

- Clarify the roles and responsibilities of staff and the requirements for initiating, monitoring, reviewing and terminating the use of seclusion
- Maintain the safety of tāngata whaiora and others
- Ensure that practice implemented is guided by national standards and New Zealand legislation inclusive of the Mental Health (Compulsory Assessment and Treatment) Act 1992
- Ensure that practice implemented is guided by the Waikato DHB Restraint Policy

1.2 Scope

This procedure is applicable to all Waikato DHB Mental Health and Addictions staff involved in the process of seclusion at any point

This procedure outlines the use of seclusion and does not cover environmental restraint for example, a locked ward.

1.3 Patient / client group

Tāngata whaiora under the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Criminal Procedure Mentally Impaired Persons Act 2003 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 who meet the parameters for the use of seclusion.

1.4 Exceptions / contraindications

Seclusion can only be used for tāngata whaiora under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

In the event of an emergency if seclusion is required for a tāngata whaiora who is not under the Mental Health Act, a registered nurse must make an application for assessment under Section 111 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

1.5 Definitions

Restraint:

The use of any intervention by a service provider that limits a tāngata whaiora normal freedom of movement (NZS 8134:0: 2008, Health and Disability Services (General) Standards, p.30)

Seclusion:

Where a tāngata whaiora user is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit (NZS 8134.0:2008, Health and Disability Services (General) Standards, p.30). Tāngata whaiora can only be subject to the use of seclusion when there is a continued risk to the safety of the tāngata whaiora or others.

Responsible Clinician:

The responsible clinician is the clinician in charge of treatment for a patient. After hours this role is usually delegated to the duty psychiatrist (Senior Medical Officer), or senior registrar approved by the Director of Area Mental Health Services (DAMHS).

Tier 3 Registered Nurse – competent in the use of seclusion

A registered nurse who has demonstrated tier 3 competency in the use of seclusion and has been signed off by the CNM / ACNM working in the area where seclusion is utilised.

Care Manager:

Responsible person for a tāngata whaiora under the ID (CC&R) Act 2003

Taonga
Refers to a treasure or something prized for example an item of cultural significance.

2. Clinical Management

2.1 Competency required

The Director of Area Mental Health Services must ensure seclusion rooms are fit for purpose and has an oversight of the quality systems monitoring for the use of seclusion within the service.

The use of seclusion can only be authorised or initiated by the following registered health professionals / or a care manager who may or may not be a health professional (registered or otherwise) appointed pursuant to Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003:

- The responsible clinician or delegate, for tāngata whaiora legally subject to the Mental Health Compulsory Assessment and Treatment Act 1992
- The care manager for care recipients legally subject to the Intellectual Disability (Compulsory Care and Rehabilitation) ACT 2003 Section 60 (2).

All staff initiating seclusion must be competent in the process of restraint as per the Mental Health and Addictions restraint procedures (1865)

A tier 3 registered nurse, competent in the use of seclusion, is responsible for the seclusion environment and makes decisions in relation to the use of seclusion. They must be involved in the initiation, daily care of the secluded tāngata whaiora and ending of any episode of seclusion.

2.2 Equipment

The seclusion room must be a room designated for that purpose by the Director of Area Mental Health Services (DAMHS) and meet the requirements as set out in the Health and Disability services (Restraint Minimisation and Safe Practice) Standards – Seclusion NZS 8134.2.3:2008.

Appropriate mattress, pillow and blanket/s for the identified tāngata whaiora

Documentation:

Electronic seclusion authorisation form

Restraint Event Notification - electronic

Risk tools - electronic

Seclusion record form (monitoring) (A1029MHF)

Electronic seclusion evaluation form

DATIX incident reporting system

Electronic Clinical Work Station

Past seclusion debrief information is noted in the tangata whaiora recovery plan

Tāngata whaiora / Multidisciplinary Team Treatment Plan / Recovery Plan Adult Deterioration Detection System ADDS

Fluid Balance Chart

2.3 Procedure

Pre-seclusion

Recovery Plans and Advance Directives will outline the tāngata whaiora wishes in respect to the management of early warning signs and triggers of escalation.

Risk tools for a tāngata whaiora are to be updated as part of the dynamic risk management process.

When supporting distressed Infants, Children and / or Adolescents, it is preferred that a ratio of 2:1 be maintained to support the tāngata whaiora. Only under extreme violent conditions where de-escalation techniques have proved ineffective would consideration be made to use seclusion.

Medication plays a vital role in minimising distress and agitation and can reduce the likelihood of seclusion.

The use of high care secure lounges

The high care lounge (HCL) areas in Puna Maatai and Puna Awhi-rua are used for de-escalation or seclusion. This provides a safe environment to attempt and / or continue de-escalation of an individual whilst protecting their dignity and their right to privacy. If the HCL is to be utilised as a seclusion room, the tier 3 registered nurse competent in the use of seclusion is to initiate and monitor the seclusion episode in accordance with this seclusion procedure.

Any high care use involves the following

- Informing the CNM / ACNM after hour's coordinator of the intention to use high care so all staff are aware of the situation and ongoing safety requirements.
- Ensuring a three person team (in accordance with the personal restraint procedure) is present to ensure safety of the tangata whaiora and staff are not compromised.
- Consideration is given to nursing the tāngata whaiora with an open door or to initiate seclusion.

If high care is utilised to provide an environment to self-manage de-escalation, a sign is placed on the door indicating that the HCL is in use and the neighbouring ward is notified of the same. The tāngata whaiora utilising this area is to be

- Advised that they are able to exit at any time
- Reviewed by the team at 30 minute intervals and if they choose to, exit before this, a review of the service users / tāngata whaiora mental state, presentation and risk must be completed and documented.
- At a minimum, on significant risk observations.

Initiation of seclusion

Seclusion is a restrictive intervention that should only be utilised to prevent imminent violent behaviour compromising safety. In order to maintain safety, the minimum of a three person team, trained in the use of SPEC techniques need to be available.

In the absence of the medical team to assist in decision making, the decision to use seclusion can be made by a tier 3 registered nurse competent in the use of seclusion who has considered the following:

- All appropriate and available interventions have been utilised prior to the initiation of seclusion e.g. de-escalation strategies, negotiation, anger management, medication management, diversional activities, presence of whānau
- Staff have made a clinical assessment and taken into account actual clinical indicators that there is imminent risk to the tāngata whaiora or others
- Seclusion should not be used as punishment, used due to stress within the environment, used due to resource issues, used as a behavioural intervention or used for managing self-harm or risk of suicide.

- Acknowledgement of the potential for traumatisation / re-traumatisation in response to the use of seclusion
- Respecting the tāngata whaiora preferences and individual needs inclusive of advance directives

When moving a tāngata whaiora to the seclusion room continued dialogue, and calming techniques to minimise further escalation must be utilised. The tāngata whaiora should be moved in a planned manner, utilising restraint only if necessary in accordance with the Mental Health and Addictions restraint procedure/s (1865). If the tāngata whaiora is able to be de-escalated safely, without the use of seclusion, use this opportunity to discuss and document what worked in the tāngata whaiora recovery plan.

An assessment of risk must be made relating to items of clothing the person may be wearing at the time of seclusion. Any removal of items must be clearly validated based on a clinical risk assessment, communicated to the tāngata whaiora as to why, and documented in the clinical file. If using safety garments, only a Tier 3 registered nurse, competent in the use of safety garments can apply them, strictly following the guideline, completing the checklist in CWS, documenting, incident reporting (Datix) and escalating their use to those listed in the Use of Safety Garments in the Inpatient Acute Adult and Forensic Mental Health and Addictions Service (Doc ID 5788).

At the time of initiation of the seclusion episode the tāngata whaiora must receive an explanation as to why they are being placed in seclusion and what needs to occur for the seclusion episode to end. Every effort should also be made to provide the tāngata whaiora with information on what to expect within the seclusion room and how their basic needs can be met.

The tāngata whaiora must be informed of their rights, including the right to advocacy. The self-respect, dignity, gender needs and privacy of the tāngata whaiora is to be respected throughout the process.

The decision to use seclusion must be discussed with the tāngata whaiora whānau as soon as practicable i.e. during normal waking hours unless contraindicated.

Commence the Restraint Event Notification electronic form in CWS. If personal restraint was utilised to initiate the seclusion episode, a separate Restraint Event Notification electronic form requires completion.

Support may be accessed from the recovery advisor via email.

Complete a DATIX incident report outlining the preceding events resulting in the need for a seclusion episode.

Authorisation

If the Responsible Clinician (RC) or delegate has not been involved in the process of initiating seclusion they must be informed of the seclusion episode as soon as possible and have authorised continuing seclusion within 2 hours of its initiation using the electronic seclusion authorisation form. A face to face meeting must occur as soon as practicable and a clinical entry made in CWS that includes the review and plan to minimise the use of seclusion.

The tāngata whaiora care manager (or delegate) based on the Intellectual Disability (Compulsory Care and Rehabilitation Act) must be notified **immediately** of the decision to use seclusion. The delegate after hours is the night registrar.

A delegate must inform the RC as soon as practicable of the seclusion episode through handover processes.

The RC or delegate holds an ongoing responsibility for the authorisation or otherwise for the seclusion episode throughout the seclusion episode.

Seclusion is a restrictive practice and must be deemed a priority for review of the treatment approach by the RC or delegate at the very minimum of each shift.

Monitoring

A staff member as delegated by the responsible clinician or a registered nurse provides oversight of the seclusion episode to monitor the tāngata whaiora throughout the seclusion episode. The registered nurse holds responsibility for the overall monitoring process, and should enter the seclusion room at a minimum of 2 hourly intervals. Between the hours of midnight to 0600 hours, if considered more beneficial for the tāngata whaiora to sleep and not be woken, the room can be entered quietly to check their physical health status. Any room not entered at the 2 hourly assessment point must have a detailed rationale recorded in the clinical notes as to why it did not occur. The normal process of assessment will take place at any other time and will include:

- Mental state assessment
- Clinical risk assessment
- Physical state assessment
- Consideration of spiritual / social needs

There will be a delegated staff member present outside the seclusion room for the purpose of engagement and attending to the service users' needs for the duration of the episode. As per the seclusion record form, clinical documentation will be made at a minimum of every 10 minutes (Seclusion record form A1029MHF). The minimum observations within the 10 minute interval include and are not limited to general condition, colour (e.g. cyanosis, pallor), breathing, position, activity and behaviour.

Documentation of a seclusion episode is within the Seclusion Progress note section of the Clinical Workstation (CWS) and will include all of the assessments undertaken during the seclusion episode.

The process for entry to the seclusion room / high care seclusion room will include:

- The minimum of three SPEC trained staff and a registered nurse for the administration of medications / staff member for the transfer of equipment into the room
- All equipment required will be assembled outside the seclusion room and an assessment for safety and cooperation will be made prior to entry to the room
- Clear plan is agreed by staff prior to entry to the room: inclusive of communication, actions, responsibilities
- Communication with the tāngata whaiora is established
- When entering the room inform the tāngata whaiora of entry and why and request that they sit / lie on the mattress

When the seclusion room / high care seclusion room is entered and exited:

- Staff to maintain visual contact on the tāngata whaiora at all times
- Maintain awareness of the team roles as outlined in SPEC if the situation escalates
- communicate to the tāngata whaiora and ensure understanding of what you require e.g. monitoring of vital signs
- If the tāngata whaiora declines care requirements or becomes agitated / aggressive NO equipment is to be taken into the room. The team must assess safety and / or exit the room at any point of resistance / agitation / aggression
- A safe exit of the seclusion room may require restraint as per SPEC training and the Personal Restraint Procedure
- If the tāngata whaiora remains amenable with care requirements then equipment can be brought into the room preferably by the fourth staff member
- Ensure ALL equipment is removed from the room prior to staff exit of the room
- Full documentation of entry and actions taken must be completed in the Clinical Workstation (CWS)

Each entry of the seclusion room is an opportunity to assess the readiness of the tāngata whaiora for reintegration.

Handover of care between shifts is in accordance with the Clinical Handover, Mental Health inpatient wards procedure (0451).

8 hourly assessments of seclusion and care

The responsible clinician or delegate completes an 8 hourly, face to face assessment of all tāngata whaiora in seclusion. This assessment includes a review of the current medication prescribed. This assessment is to be documented on the clinical workstation as a clinical note.

To ensure 8 hourly reviews are better co-ordinated, the reviews will be conducted at the following times:

- 0800 hours
- 1600 hours
- 2400 hours

This provides the treating team with two opportunities to review during week days and on weekends and after hours allows the duty doctor to plan based on the routine times for

seclusion reviews. The ACNM Bureau will monitor the seclusion episodes occurring in both the adult and forensic inpatient settings and will support the review process.

If a tāngata whaiora is placed in seclusion and the seclusion is authorised before or after the stated review times, the next review is conducted at the next review time and thus falls into the 8 hourly review timeframes.

Following the 8 hourly assessment/s the RC or delegate communicates a decision as to the continuation or otherwise of seclusion to the tier 3 registered nurse competent in the use of seclusion who has oversight of the seclusion episode of care.

24 hourly reviews

When a tāngata whaiora has been in seclusion for a period of 24 hours whether continuously or in a calendar month the following needs to occur:

- Case management discussion with the treating team inclusive of RC by a CNM / ACNM / CNS. If the 24 hour period is reached during the night, the review will be conducted as soon as practicable the following day. If the 24 hour period is reached over a weekend, then a review by the on duty SMO and ACNM Bureau is undertaken.

A daily review by the RC / SMO is undertaken for each tāngata whaiora in seclusion, inclusive of weekends.

Outcomes of the case review are fully documented in the seclusion progress note by the CNM / ACNM / CNS.

The tāngata whaiora whānau will be informed of the case review outcome(s).

Notification of the outcome(s) of the 24 hourly review is made to the Director of Clinical Services / Director of Area Mental Health Services (DAMHS).

When a tāngata whaiora has been in seclusion for a period of 24 hours within a calendar month the following needs to occur:

- Communication via email to the Clinical Director and inpatient Operations Manager
- Communication via email to the Director of the associated service

The above communication will be undertaken by the Charge Nurse Manager or delegate and after hours by the Associate Charge Nurse Manager Bureau.

When a tāngata whaiora has been in seclusion for a period of 48 hours within a calendar month the following needs to occur:

- Communication via email or telephone to the District Inspector

This communication will also be undertaken by the registered nurse responsible for the service user / tāngata whaiora care.

Nursing Care whilst in seclusion

Mental Health

Listen to the tāngata whaiora explanation of their needs and address these wherever possible. Provide explanations if needs are not able to be met.

Take and document nursing observations of mental state as component of observations.

Provide reality orientation, inclusive of orientation to time, place and event, whenever the seclusion room is entered, or upon request by the tāngata whaiora.

Provide appropriate and safe material to assist the tāngata whaiora to keep focused on reality, grounded and occupied e.g. Newspaper, magazines, radio, appropriate sensory modulation items.

Continually assess progress with the tāngata whaiora towards the goal of re-integration.

Physical Care

The physical status of the tāngata whaiora must be monitored on an ongoing basis inclusive of vital signs and other monitoring as clinically indicated.

The effectiveness and any side effects of any medication administered are to be monitored and documented.

All physical needs e.g. toileting; washing must be met as appropriate throughout the seclusion episode.

Assess the need to provide NRT products to assist the tāngata whaiora to avoid nicotine withdrawals, if they are secluded after admission or who are already using NRT as an inpatient.

Food and Fluids

The tāngata whaiora is provided with finger foods / soft foods utilising disposable plates and spoons when required for breakfast whilst in seclusion.

Fluids are to be offered regularly.

Monitoring of food and fluid intake is to be maintained and documented for all service users / tāngata whaiora in seclusion.

Cultural and Spiritual

Taonga are to be assessed as to the safety for the tāngata whaiora. If taonga are removed it must be kept safely and returned to the tāngata whaiora when assessed to be safe by clinical staff.

Whānau can visit a tāngata whaiora if they are able to be safely supported to a less restrictive environment outside of the seclusion room area. If this possible, then seclusion may not need to continue.

The tāngata whaiora will be able to access support of kaitakawaenga whilst in seclusion and during the process of re-integration during normal office hours.

Other support such as lawyer / district inspector should also be accessible to the tāngata whaiora in seclusion.

Support may be accessed from a recovery advisor role Monday to Friday during working hours.

Blessing of the seclusion room may be appropriate following a seclusion episode and staff may wish to facilitate this by contacting Te Puna Oranga during working hours or the after-hours chaplaincy service.

The tāngata whaiora is to be able to undertake religious observance with due regard to risk management.

Re-integration period

The movement of a tāngata whaiora out of a seclusion room into open areas must be pre-planned, occur safely, be evaluated and documented in the seclusion progress note in the clinical record. Resources to do this must be available for example, an appropriate space and safe staffing (three person team).

On re-integration out of seclusion the tāngata whaiora will be assessed and placed on a level of observation to reflect their level of risk. The level of observation will be regularly reviewed during the reintegration period.

Whānau should be informed that their whānau member is out of seclusion as soon as is practicably possible.

Ending seclusion

As soon as there is no longer an imminent risk to tāngata whaiora or others, seclusion **must** cease. The responsible clinician (or their delegate) or the registered nurse in discussion with a senior or Tier 3 registered nurse can end seclusion at any time based upon a current risk assessment.

Consultation with the tāngata whaiora responsible clinician / care manager (or delegate) should occur simultaneously where possible.

The electronic seclusion ending form and the seclusion evaluation form are completed when the tāngata whaiora has been out of seclusion for more than one hour.

Review the risk tool documentation and tāngata whaiora recovery plan at the end of a seclusion episode and include any relevant updates arising from the seclusion episode, including but not limited to early warning signs and triggers.

Complete the electronic Restraint Event Notification in CWS

Inform the whānau when seclusion has been terminated.io

Following the use of the seclusion room the area is to be cleaned by inpatient staff and if a sanitising clean is required this should be requested through ISS cleaners

2.4 Potential Complications

Extreme caution in the use of seclusion must be taken when a tāngata whaiora is intoxicated, actively suicidal, potential delirium, physically unwell, ingested unknown substances, unstable medical condition, pregnancy, where age is a vulnerability factor e.g. over 65 years of age, those under 18 years of age, fluctuating levels of consciousness or other neurological side effects, likelihood of respiratory suppression or other cardiovascular effects, possibility of escalation of anxiety, aggression or distress or a previous adverse outcome from the use of seclusion. Under these circumstances, a clear plan must be formulated with the Tier 3 RN and the medical team to ensure appropriate care is provided. This will be documented in the clinical file and be referred to and used by staff working in the Low Stimulus Area.

2.5 After Care

A debriefing process for the tāngata whaiora is completed post seclusion episode. This involves the ACNM or delegate discussing what could have helped to prevent the seclusion episode for example, the use of sensory equipment, whānau involvement, specific PRN medications that are known to have good effect. Any learning is included in the recovery plan and listed as acute care interventions.

Staff diffusion and debrief processes.

3. Patient Information

Waikato DHB Restraint pamphlet

Staff must tell the tāngata whaiora why they are in seclusion and what the goals are to be achieved to end the seclusion episode

4. Audit Indicators

4.1 Indicators

Total hours of seclusion

Number of seclusion episodes per month

Number of seclusion episodes (Māori)

Seclusion room audit completed at a minimum of six monthly

Seclusion episode debrief with interventions in the recovery plan

4.2 Tools

Enterprise reporting process

Seclusion room audit tool

Recovery plan

5. Evidence Base

5.1 Summary of Evidence, Review and Recommendations

The Seclusion procedures from the following District Health Boards were reviewed in the updating of the Waikato DHB procedure: Capital and Coast; Bay of Plenty; Whanganui Southern District, MidCentral Health, Auckland and West Coast.

5.2 References

The Health and Disability Services (Restraint Minimisation and Safe Practice) Standards NZ8134.2.3:2008. Wellington: MOH.

Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992, 2010. Wellington: MOH.

The Mental Health Compulsory Assessment & Treatment Act 1992 and 1999 amendments. Wellington: MOH.

The Criminal Procedure Mentally Impaired Persons Act 2003 Wellington: MOH.

The care manager for care recipients/consumer/care recipient legally subject to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 Section 60 (2). Wellington: MOH

5.3 Associated Documents

- Mental Health & Addictions Clinical Handover – Mental Health Inpatient Procedure (0451)
- Mental Health & Addictions Family Whānau Participation Policy (0896)
- Mental Health & Addictions Levels of Observation in Inpatient Services procedure (5238)
- Mental Health & Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others (5241)
- Mental Health & Addictions Sensory Modulation Procedure (3248)
- Mental Health & Addictions Personal Restraint in Mental Health and Addictions Inpatient Setting (1865)

- Mental Health and Addictions Use of Safety Garments in the Inpatient Acute Adult and Forensic Mental Health and Addictions Service Guideline (5788)

- Mental Health and Addictions Registered Nurse Clinical Practice Skills checklist (E1085HWF)

- Waikato DHB Clinical Records Policy (0182)
- Waikato DHB Incident Management Policy (0104)
- Waikato DHB Restraint Policy (2162)
- Waikato DHB Restraint – Wrist and Ankle (2158)