

PROTOCOL FOR: Seclusion, Behavioral: Care of the Patient In

POLICY: Seclusion is indicated when a patient's behavior requires containment without a need for complete immobilization. Indication for use of seclusion is only as an emergency measure to control behavior that is dangerous to self or others and after all other less restrictive measures have been attempted and failed. Possible contraindications include a recent history of self mutilation, uncontrolled pounding/thrashing, risks of falls, stated preference for restraint, a need for constant staff reassurance, stated fears of being alone in a locked room or medical needs requiring constant monitoring.

The Connecticut General Statutes 17a-544 provides in part as follows ".No patient may be placed involuntarily in seclusion or mechanical restraint unless necessary because there is imminent physical danger to the patient or others, and a physician so orders. A written memorandum of such an order and the reasons therefore shall be placed in the patient's permanent clinical record..."

DEFINITION: Seclusion is defined as the confinement of a patient in a room whether alone or with staff supervision, in a manner that prevents the patient from leaving.

Locked Door Seclusion Room (LDSR) - is a more restricted form of intervention; Seclusion Room Door remains closed and locked, one to one supervision is required.

Policy Standards Do Not Apply To:

- Time Out when a patient to whom it is applied is physically prevented from leaving a room for 15 minutes or less. The patient must be monitored continuously by staff for this time frame.
- Time Out when a patient requests to spend time alone in a private area such as Time Out Room or their room to diminish the stimulation from the general milieu to provide time for calming and reflection. The patient must be monitored by staff minimally every 15 minutes and Time Out must not exceed 30 minutes.

ONE TO ONE OBSERVATION IS REQUIRED FOR ANY PATIENT PLACED IN SECLUSION FOR BEHAVIORAL REASONS.

1. An RN or LPN may initiate seclusion but must promptly obtain a Licensed Independent Practitioner's (LIP) (i.e., Resident or Attending M.D., APRN or PA) verbal or telephone order as soon as possible. A written order and documentation in Progress Note is required within one hour of seclusion being initiated.

PROTOCOL FOR: Seclusion, Behavioral: Care of the Patient In

2. A Seclusion order and documentation in the Progress Note are necessary for the use of seclusion:
3. A FACE TO FACE EVALUATION BY THE LIP IS REQUIRED WITHIN ONE (1) HOUR OF SECLUSION INITIATION:
4. A FACE TO FACE RE-EVALUATION for behavioral health reasons by the RN or LPN is required:
 - a. every four (4) hours for ages eighteen (18) and older
 - b. every two (2) hours for youth ages nine (9) to 17 years of age
 - c. every one (1) hour for children under age nine (9)at which time the LIP writes a new order if restraint is to be continued
5. A FACE TO FACE REEVALUATION for behavioral health reasons by the LIP will be completed at a minimum of every:
 - a. eight (8) hours for individual ages eighteen (18) years and older
 - b. four (4) hours for individual ages nine (9) to seventeen (17) years of age
 - c. two (2) hours for individual ages under nine (9) in the event a patient remains in seclusion.
6. The LIP order for patient seclusion and documentation in the Progress Note must indicate seclusion.
 - a. Alternatives attempted
 - b. Reason for seclusion
 - c. Duration of order
 - d. Behavior for discontinuation
 - e. Time of order
 - f. MD, APRN, or PA signature
7. PRN orders MAY NOT be used to authorize the use of seclusion.
8. SECLUSION RENEWAL ORDERS:
 - a. Seclusion orders must be renewed by the LIP every:
 - four (4) hours for adults ages 18 and older,
 - two (2) hours for children and youth ages nine (9) to seventeen (17),
 - one (1) hour for children under age nine (9).
 - b. Any reinitiation of seclusion requires another face-to-face assessment within one hour and a new order by the LIP.
9. SECLUSION DISCONTINUATION ORDERS: When clinically indicated, the LIP will write an order for discontinuation of seclusion,

PROTOCOL FOR: Seclusion, Behavioral: Care of the Patient In

documenting date, time, and clinical rationale for discontinuation of seclusion in Progress Note.

10. STAFF DEBRIEFING: BEHAVIORAL HEALTH SETTING ONLY
 - a. Staff debriefing will be initiated immediately following each episode of seclusion utilizing the Staff Debriefing Form, including the following:
 1. identification of behaviors that led to seclusion initiation.
 2. review less restrictive alternative interventions that may have been utilized.
 3. determine that patient's physical and psychological well-being and right to privacy were considered.
11. PATIENT DEBRIEFING: BEHAVIORAL HEALTH SETTING ONLY
 - a. Patient debriefing will be initiated 8 hours after seclusion initiation, utilizing the Patient Debriefing On Restraint/Seclusion Form. In the event the patient refuses and/or is unable to participate, the nurse will document "unable to complete", reason for not being able to complete the Patient Debriefing Form, date, time and signature.
12. HIGH RISK REPORTING: ALL SETTINGS:

Clinical leadership, (Nursing Manager, Assistant Nurse Manager, and Director of Nursing) will be notified directly of any of the following:

 - a. Any injury that results from the use of seclusion.
 - b. Any death that occurs while a patient is in seclusion.

FOR BEHAVIORAL HEALTH SETTING ONLY:

Clinical leadership, (Nursing Manager, Assistant Nurse Manager) will be notified directly and/or via the Acuity Record Form.

- a. Any patient who remains in seclusion 12 hours.
- b. Any patient who experiences two separate episodes of seclusion within a 12-hour period.
- c. Every 24 hours thereafter if either (a) or (b) continues.

DESIRED
PATIENT
OUTCOMES:

The following are desired patient outcomes. All of which will be documented on Behavioral Health Restraint/Seclusion/1:1/CO Flow sheet (HCH 591).

1. Patient's rights, dignity, well being and safety will be maintained.
2. Patient's hydration, nutrition and elimination needs will be met.
3. Patient's behavioral control will improve to allow

PROTOCOL FOR: Seclusion, Behavioral: Care of the Patient In

reinitiation to milieu.

4. Patient will be educated concerning reason or reasons for seclusion and behaviors required for discontinuation of seclusion every one (1) hour by the RN or LPN.

INITIAL
 ASSESSMENT:

1. At the time of admission to a BEHAVIORAL HEALTH SETTING, the patient will be assessed by utilizing the High Risk Assessment Form (HCH-1346) to determine the potential for or presence of behaviors that present an imminent risk of harm to self or others. This assessment will include:
 - a. Active suicidal intent
 - b. Self harming behavior
 - c. Homicidal/aggressive behavior (including fire setting)
 - d. Sexually reactive behavior
 - e. History of physical/sexual abuse that would place the patient at greater psychological risk.
 - f. Acute detox with seizures or delerium tremens
 - g. Acute medical problem (i.e. fall risk, immobility, unstable diabetes, seizures, COPD, etc.)
2. In the BEHAVIORAL HEALTH SETTING, the coping skills that the patient has utilized to maintain behavioral control will be identified by utilizing the PERSONAL SAFETY FORM located in Multidisciplinary Database and incorporated into the treatment plan.

ONGOING
 ASSESSMENT
 AND CARE:

Throughout hospitalization, the patient will be continually assessed for changes in behavior which require seclusion - refer to the initial policy statement. Nursing care is continually provided while the patient is in seclusion with particular attention to safety, food, and fluid intake, elimination, circulation, range of motion, respiration, and exercise.

Patients will be educated concerning the reason for seclusion and behavior(s) required for discontinuation of seclusion. Seclusion will be discontinued by a registered nurse at the earliest possible time.

The following grid outlines the standards for monitoring and performing care while seclusion is utilized. Patients in seclusion are provided with continued staff attendance and reassurance, as well as safety checks and professional assessment.

Vital Signs	BEHAVIORAL ASSESSMENT	OFFER FOOD & FLUID	OFFER TOILET/ BATHED/ ORAL CARE
-------------	-----------------------	--------------------	---------------------------------

PROTOCOL FOR: Seclusion, Behavioral: Care of the Patient In

q 4°	q 15 min	q 2°	q 2°
------	----------	------	------

1. BEHAVIORAL OBSERVATION will be documented every 15 minutes on the flow sheet. The RN will continue to assess the patient's behavior to implement a less restrictive intervention when appropriate.
2. Medicate the patient as prescribed to assist the patient to feel less anxious, improve mental status, and raise comfort level, (consider using deltoid or thigh muscles for IM injections). Document on Flowsheet and Progress Note.
3. Provide nutritional, hydration and elimination needs of the patient. If the patient is not able to communicate, these needs must be provided at least every two hours while awake and every four hours when asleep.
4. Provide care, unless contraindicated secondary to threatening and/or combative behavior. Use care to protect self from unpredictable behavior.

PATIENT
SAFETY

MEASURES:

1. The patient is never left unattended while in seclusion.
2. Inspect Seclusion room prior to use:
 - a. Bathroom door is locked when not in use.
 - b. A mattress may be provided on the floor.
 - c. No other furniture is allowed in the room.
3. Street clothing, including undergarments, jewelry, and personal articles are to be removed as soon as possible and hospital gown provided. Any exception requires a physician order based upon clinical assessment of safety. If patient has valuables, place them in the hospital safe.
4. Assess the need for the removal of pierced body jewelry. Identify and document what body piercing exists and what is not removed (with MD consult and order).
5. Assigned member of the nursing staff must be in possession of a seclusion key when the patient is in locked seclusion.
6. The RN or LPN in consultation with the LIP will develop an alternative plan if the patient's condition deteriorates while in seclusion.
7. In the event that a patient is required to be evacuated from the unit, it is preferable to maintain them in restraints either in the bed or on a stretcher.

STAFF SAFETY

MEASURES:

1. Whenever utilizing any hands on intervention, all staff must wear vinyl gloves.

PROTOCOL FOR: Seclusion, Behavioral: Care of the Patient In

2. When a hands on intervention is initiated, patients may resort to kicking, biting, verbal abuse, spitting, and head hitting. Appropriate safety measures need to be initiated by staff, for example:

Spitting: Apply mask to patient's mouth area.
Staff will wear protective eyewear.

Kicking/Hitting: Avoid being in close proximity to patient's extremities. Obtain help from additional staff members when needed.

Biting: Avoid close proximity to patient's mouth. The staff member assigned to the patient's head should wear safety gloves to protect self, ensuring patient's head is secured to prevent biting.

3. Locked door seclusion will be interrupted every two hours (or more often, if indicated) by two staff members entering the room.
4. Prior to entering, staff will:
 - a. Plan ahead for tasks that need to be completed (e.g., prepare dietary tray, medication, ADL supplies, vital signs)
 - b. Provide additional staff/University Police available as required.
 - c. Identify each staff's responsibility to accomplish patient care (who is in charge, communicates with patient, completes vital signs, toilets, etc.).
 - d. Identify plan for exit (e.g., which staff member will be last to exit.)
5. Upon staff entering:
 - a.. Inform patient that you are entering and request patient move a safe distance away from door.
 - b. Activate alarm system (indicates that staff members have entered room) by using alarm key to turn on light next to seclusion room.
6. In preparation for staff leaving:
 - a. Inform patient of staff departure.

PROTOCOL FOR: Seclusion, Behavioral: Care of the Patient In

- b. Reassure patient staff will return as required and will provide continuous visual monitoring through window.
- c. Instruct patient to knock on door when requiring staff assistance (e.g. for bathroom, concerns/questions).
- d. Ensure patient is at a safe distance from door or direct patient to sit on mattress.
- e. Last staff member to exit will close door while maintaining eye contact with patient.
- f. Deactivate alarm system

PATIENT

TEACHING:

1. Inform and educate the patient regarding the rationale for the use of the seclusion, documenting on Order Sheet, Flow sheet and Progress Note.
2. Inform patient of the behaviors expected for progression to less restrictive behavior plan.

DOCUMENTATION:

Document as follows:

1. Alternatives attempted on Behavioral Restraint/Seclusion/1:1/CO Flow sheet.
2. Document assessment and care on the Behavioral Health Restraint/Seclusion/1:1/CO Flowsheet.
3. Complete a Progress Note every 4 hours and 8 hours and/or when seclusion is discontinued, documenting:
 - a. The patient's status and symptoms/behaviors that necessitate the use of seclusion.
 - b. Alternatives attempted to prevent use of seclusion.
 - c. Medications administered and response to medications by patient.
 - d. Any attempts to reduce/eliminate the use of seclusion.
 - e. Improvement in symptoms/behaviors that may allow for progression to less restrictive alternatives.
 - f. The plan of action to reduce/eliminate seclusion.
 - g. Patient counseling for any trauma that may have resulted from the incident.
 - h. Discontinuation of seclusion - clinical rationale and time discontinued.
4. RN or LPN will document on the Behavioral Health Restraint/Seclusion/1:1/CO Flow sheet every one (1) hour that patient was educated concerning the reason for seclusion

PROTOCOL FOR: Seclusion, Behavioral: Care of the Patient In

and behavior(s) required for discontinuation of seclusion.

5. Document 15-minute checks on the 15 Minute Checklist.
6. Document any restraint and treatment plan modifications in the Interdisciplinary Treatment Plan.
7. Document on Acuity Record Form and Daily Restraint Log.

STAFF
TRAINING
AND
COMPETENCY:

The use of restraints and seclusion is limited to personnel who have been trained, have confirmed competencies and recertified annually thereafter.

- a. Initial and ongoing training for all staff with direct patient care responsibilities must include:

Basic Training Elements:

- Philosophy of organization regarding restraint and seclusion
- Restraint techniques/holds/types of restraints
- Proper and safe application and use
- Assessment of the need for restraint and seclusion, and ongoing assessment of the need for continuation of restraint and seclusion and possible less-restrictive alternatives
- Alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints or seclusion, including de-escalation, mediation, self-protection, and other techniques
- Underlying causes of threatening behavior, including the potential that a medical condition (for example, delirium in fevers, hypoglycemia) is causing the behavior
- Understanding the effect of their own behavior on the patient's behavior
- Recognizing signs of physical distress in individuals being held, restrained or secluded
- Elements and timeframes of orders for restraint and seclusion
- Release, reapplication and discontinuation, including skills validation of application and release
- Application and removal of mechanical restraints

- b. In addition to the basic training elements above, for staff caring for Behavioral Health Patients authorized to physically apply restraint and seclusion, training must

PROTOCOL FOR: Seclusion, Behavioral: Care of the Patient In

include:

- Certified in PMT (Physical/Psychological Management Training) and annual recertification
- Physical holding techniques, including the differences between life-threatening and physical restraint
- Take-down Procedures

PERFORMANCE
IMPROVEMENT:

Performance improvement processes seek to identify opportunities to reduce restraint or seclusion use and reduce the risks associated with its use through the introduction of preventive strategies, innovative alternatives, and process improvements. Performance improvement measures will include the aggregation of both unit-based and hospital-wide restraint use volumes and unit-based strategies to monitor policy and procedure understanding and compliance.

Performance Improvement Activities:

1. Data collection includes 100% of restraint or seclusion episodes on behavioral health settings/units, and includes:
 - Shift (day, evening, night)
 - Staff who initiated restraint or seclusion by category and name
 - Start and end times of each episode of restraint or seclusion
 - Date and time each episode of restraint or seclusion is initiated
 - Type of restraint used
 - Physical injuries sustained, if any (such as fracture, dislocation) by the patient or staff, and deaths, and
 - Age and gender of patient
2. Chart Audits are conducted for all restraint/seclusion episodes on the Behavioral Health Units.

APPROVAL: Nursing Standards Committee

EFFECTIVE
DATE: 9/94

REVISION
DATES: 5/95, 11/95, 9/97, 6/99, 9/00, 10/00, 12/00, 8/01, 10/01, 4/03, 5/03, 10/03, 6/06, 8/08