

**WHITING FORENSIC HOSPITAL**  
**OPERATIONAL PROCEDURE MANUAL**

<b>SECTION I:</b>	PATIENT FOCUSED FUNCTIONS
<b>CHAPTER 2:</b>	Provision of Care, Treatment and Services
<b>PROCEDURE 2.26</b>	<b>Seclusion Use</b>
<b>Governing Body Approval</b>	4/4/18
<b>REVISED:</b>	

**PURPOSE:** To operationalize all standards for the provision of safe and legal use of seclusion when necessary to prevent the patient from harming self or others after all less restrictive measures have failed.

**SCOPE:** All physicians; RNs; LPNs; MHAs; FTS; Rehabilitation Therapists and other clinical staff applying, caring for, assessing or monitoring a patient in seclusion.

**POLICY:**

All patients have the right to be free from physical or mental abuse and corporal punishment. All patients have the right to be free from seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

The hospital is committed to preventing, reducing and/or eliminating the use of seclusion. Performance Improvement processes seek to identify opportunities to reduce the risks associated with seclusion use through preventive strategies, innovative alternatives, and process improvements.

***Definition:***

- A. *Seclusion* – The involuntary confinement of a patient in a room or an area whether alone or with staff supervision where he/she is prevented from leaving.

**PROCEDURE:**

**I. Initial Assessment at Admission**

- A. An initial assessment of each patient is conducted at the time of admission to obtain information about the patient which could help minimize the use of seclusion.
- B. The initial assessment identifies:
1. coping strategies, techniques, methods or tools that would help the patient control his/her behavior. When appropriate, and if possible, the patient and/or family assist in the identification of such techniques. This is a determination of the patient's personal safety preferences which are documented on the Admission Nursing Assessment and Annual Nursing Re-Assessment and when indicated on the Patient's Personal Safety Preference.
  2. pre-existing medical conditions or physical disabilities/limitations that would place the patient at greater risk during seclusion; and
  3. history of sexual or physical abuse that would place the patient at greater psychological risk during seclusion.
- C. At the time of the initial assessment:
1. the patient and/or family is informed of the hospital's philosophy on the use of seclusion to the extent that this conveyance is not clinically contraindicated at that time; and
  2. the role of the family, including their notification of a seclusion episode, is discussed with the patient and as appropriate with the family. This is done with respect to the patient's right to confidentiality.

**II. Use of Less Restrictive Therapeutic Interventions**

Prior to the initiation of seclusion, therapeutic interventions are employed considering patient-specific triggers as a means to help the patient regain control of his/her behavior. The Patient's Personal Safety Preferences are utilized to inform staff in selecting therapeutic interventions that the patient has identified as being helpful to manage his/her crisis and/or behavioral dyscontrol.

**III. Initiation of Seclusion**

- A. In the presence of immediate physical danger to the patient, staff or others, a Physician or, in the Physician's absence, a Registered Nurse (RN) may initiate seclusion.
- B. The RN ensures that sufficient staff is available to assist with the seclusion process in order to prevent injury to the patient, staff, or others.
- C. Nursing staff offer the patient the opportunity to walk to the designated area before using the Secure Guide Escort
- D. The RN notifies the Nurse Supervisor as soon as possible to review the emergency/immediate need for restraint whenever restraints are utilized.

#### IV. Orders

- A. The RN obtains a Telephone Order from the physician no later than 15 minutes after initiating seclusion when the physician is not immediately available.
- B. The RN describes the emergency/immediate risk, his/her direct assessment of the patient and justification for the use of seclusion.
- C. The RN documents and reads back the Telephone Order for seclusion, including Date and time of order, time limit of the order, and the justification for use on the Physician's Orders for Seclusion or Restraint Form.
- D. The Physician must sign the Telephone Order within one hour of the initiation of seclusion.
- E. Orders written for the use of seclusion must include the date and time of the order, must be time-limited, and specify the justification for use. The Physician describes the patient's specific behaviors which are observable and measurable, necessitating immediate risk, any contraindications to the use of this intervention and the behavioral criteria necessary for release/discontinuation from seclusion on the Physician's Order for Seclusion/Restraint.
- F. The time limit for seclusion is not to exceed two hours.
- G. PRN orders for seclusion are prohibited.

#### V. Patient Safety Considerations

- A. Staff ensures that the seclusion room has been checked and cleared of all non-permissible items prior to use.
- B. Staff ensures that the patient's clothing is checked for any potentially harmful objects prior to his/her placement in seclusion. Items such as eyeglasses worn to correct vision need to be evaluated by the RN and may be removed only if patient safety is jeopardized.
- C. During hours of darkness, staff ensures that the night light in the seclusion room is lit at all times to allow for viewing of the patient and to ensure safety of staff when entering the room.

- D. If evacuation is necessary in a building emergency, ensure that the patient in seclusion is quickly and safely evacuated. Follow specific fire and evacuation procedures as posted on the unit and maintain alertness to the patient's needs.

#### VI. Special Considerations

- A. Any pre-existing medical conditions or physical disabilities that would place the patient at greater risk during seclusion must be considered and documented by the Physician and RN.
- B. Any history of sexual or physical abuse that would place the patient at greater risk during seclusion must be considered and documented by the Physician and RN.

#### VII. Patient Assessment

- A. The RN conducts a behavioral and physical assessment of the patient for whom seclusion is being considered.
- B. The RN ensures that therapeutic interventions (Personal Safety Preferences) identified by the patient have been employed. The specific patient responses to each intervention are documented on Part 1 of the Seclusion/Restraint Initial Assessment form by RN/MD.
- C. The RN considers whether other less restrictive therapeutic interventions can be offered. When the patient's personal preferences are not used, the clinical justification for so doing is documented.
- D. The RN considers any special needs of the patient based on the history or presence of medical conditions, physical disabilities, and/or trauma experiences.
- E. The RN reviews with the patient, as appropriate, the behavioral criteria/conditions necessary for release from seclusion as ordered by the Physician.
- F. The RN Supervisor performs a direct assessment of the patient and reviews with the assessing RN and staff member monitoring the patient the continuing presence of immediate risk.
- G. The RN conducts a physical and behavioral reassessment of the patient in seclusion at both the first 15 and 30-minute intervals and hourly thereafter to determine if seclusion can be discontinued.
- H. The Physician conducts a face-to-face behavioral and physical assessment of the patient within 60 minutes of the initiation of seclusion.

- I. The Physician documents his/her face-to-face assessment of immediate risk, determination regarding the need for continued seclusion and the physical assessment noting any special interventions required.
- J. The Physician documents his/her face-to-face assessment of the patient including:
  - An evaluation of the patient's immediate situation
  - The patient's reaction to the intervention
  - The patient's medical and behavioral condition
  - The need to continue or terminate the seclusion
- K. When a Physician other than the Attending Psychiatrist orders the seclusion, the Attending is consulted as soon as possible but no longer than two hours after the initiation of seclusion.
- L. The Physician and RN review their respective assessments, the identified release criteria, patient status and consider additional de-escalation and engagement strategies including medication.

#### VIII. Observation and Care of the Patient

- A. The patient who is in seclusion is monitored on continuous observation by competently\* trained nursing staff.
- B. The 15-minute observation and care interventions include, as appropriate to the use of seclusion:
  - 1. signs of any injury associated with the use of seclusion;
  - 2. hydration/nutrition;
  - 4. vital signs;
  - 5. hygiene and elimination;
  - 6. physical status and comfort;
  - 7. mental status and patient's preference for conversation, silent companionship, distraction such as music; use of sensory modalities; and
  - 8. readiness for discontinuation of seclusion.
- C. Staff provide interventions to help the patient meet behavioral criteria for the discontinuation of seclusion.
- D. If the patient meets behavioral criteria for discontinuation of seclusion when a RN is not present, the assigned MHA must notify the RN so that the patient can be removed from seclusion as soon as possible.
- E. Observation and care of the patient is documented on Seclusion/Restraint, Part II, Nursing Observation and Care of the Patient.

#### IX. Documentation

- A. The medical record contains documentation of each episode of seclusion on the Physician Orders for Seclusion or Restraint Seclusion/Restraint Part I: Initial Assessment by RN and MD Part II: Nursing Observation and Care of the Patient Part III: Reassessment by the RN and MD/Reorder of Seclusion/Restraint by MD as applicable. The following are documented:
1. a description of the emergency/immediate risk behaviors;
  2. antecedents and precipitating factors that led to the behaviors
  3. description of therapeutic interventions attempted and/or considered;
  4. patient response to each intervention attempted.

*\*Staff competence is defined as current certification in Collaborative Safety Strategies (CSS), Restraint Application Training (RAT) CPR/AED and First Aid.*

5. description of the justification for the use of seclusion;
6. written orders for use;
7. a description of behavioral criteria/conditions necessary for release;
8. face-to-face assessment and re-assessment of the patient;
9. fifteen-minute observation and care interventions;
10. assistance provided to the patient to help meet the behavioral criteria for discontinuation of seclusion;
11. debriefing of the patient with staff;
12. any injury sustained and treatment provided for injury; and
13. Notification of use of seclusion to family, significant other or designated advocate as identified and authorized by the patient.

- B. The Nursing Supervisor reviews the required documentation to ensure accuracy and completion and signs accordingly.

X. Notification of the Patient's Family and/or Conservator

- A. When the patient has consented to have family, a significant other, or designated advocate informed, the identified individual is notified, as agreed upon, each time seclusion is initiated.
- B. The conservator of person is notified when the patient requires seclusion per the agreement made between the conservator and the Treatment Team. Notification also applies to the patient's health care agent and/or legal advocate.
- C. These notifications are documented on Seclusion/Restraint form.

XI. Discontinuation of Seclusion

- A. Seclusion is discontinued as soon as immediate risk subsides and the patient meets the behavior criteria as outlined in the Physician Orders: The RN will document the rationale for release should a circumstance exist where all behavior release criteria is not met.

- B. The RN documents the discontinuation of seclusion on the Seclusion/Restraint form.

## XII. Reorder of Seclusion/Physician Reassessment of Patient

- A. If the patient continues to present immediate risk to self or others beyond the time limit of the initial order, a new time-limited order is required to continue the use of seclusion.
- B. The Physician must conduct a face-to-face behavioral and physical assessment of the patient within 60 minutes of the reorder of seclusion.
- C. The Physician must notify the Service Medical Director of the reorder of seclusion and the RN must notify the Nursing Supervisor of the reorder.
- D. The Nursing Supervisor must notify the Director of Nursing of the reorder of seclusion.
- E. The Service Medical Director and Director of Nursing provide oversight through a review of the continuing circumstances necessitating seclusion and suggest alternative interventions to progress to discontinuation of seclusion.

## XIII. Patient Debriefing

- A. The patient and staff participate in a debriefing about the seclusion episode in order to reduce the recurrent use of seclusion.
- B. The patient and, if appropriate and available, the patient's family participates in the debriefing with staff who were involved in the episode.
- C. Each episode is debriefed as soon as possible and appropriate, but no longer than 24 hours after the episode, and documented on the Seclusion/Restraint Patient Debriefing form.
- D. Debriefing is used to assist the patient in:
  - 1. identifying what led to the incident and what could have been handled differently;
  - 2. ascertaining that the patient's physical well-being, psychological comfort and right to privacy were addressed;
  - 3. counseling the patient for any trauma that may have resulted from the incident; and
  - 4. when indicated, modifying the patient's treatment plan.

#### XIV. Focused Treatment Plan Review (F-TPR)

- A. When a seclusion occurs the physician on duty and the charge RN will collaboratively assess the event and discuss the need for changes in the patient's plan of care; these will be documented in detail by both the physician and the RN in the Integrated Progress Notes, including any follow-up issues to be addressed. The treatment changes will be communicated to all unit staff through the inter-shift report process.
- B. The treatment team will convene on the next business day to do a Focused Treatment Plan Review (FTPR), which includes a review of the seclusion episode looking at the predisposing, precipitating and perpetuating factors, any changes in the treatment plan in response to the episode, or the rationale for not making changes.

The FTPR is documented in the Recovery Management System (RMS), printed, signed and filed in the Treatment Plan section of the medical record that day.

#### XV. Staff Debriefing

- A. Staff directly involved in the seclusion episode review all aspects of the episode with their clinical peers with an emphasis on circumstances leading up to the episode, how the episode was handled by the involved staff and whether anything could have been handled differently.
- B. The debriefing occurs prior to the end of the shift in which the seclusion episode occurred.
- C. The debriefing is documented on the Staff Debriefing Form

#### XVI. Leadership Oversight

- A. Prior to the initiation of a second renewal order for seclusion, and for every subsequent renewal order, the Chief Medical Officer, through the Service Medical Director and the Nurse Executive, will be consulted.
- B. Daily clinical reviews and monitoring of seclusion reports over the last 24 hours are conducted by the Chief Medical Officer and Nurse Executive.
- C. The services of a behavioral consultant may be obtained to assist the treatment team in developing or revising a behavioral support plan.



- D. Clinical leadership will conduct a quality review of any patient who has four or more episodes of seclusion within any four-week period.
- E. Should a patient be involved in 12 or more episodes of seclusion for 48 hours or more within a one-week period (with all previous efforts having been reviewed at the facility level), the Chief Medical Officer or his/her designee will notify the DMHAS Office of the Medical Director for review and consultation regarding the patient's ongoing care needs.
- F. The hospital ensures through its Quality & Risk Management functions that both individual and aggregate data related to seclusion use are accurate, and seeks to improve the quality of care provided, as well as look for opportunities to prevent, reduce and eliminate use of this intervention.

## XVII. Reporting Requirements

- A. All serious patient injuries and deaths as a result of seclusion are reported via the incident reporting system to the Office of the Commissioner, through the Office of the Chief Executive Officer (CEO).
- B. Serious injuries and deaths as a result of seclusion are reported to Disability Rights Connecticut through the Office of the Commissioner. Serious injury is defined as physical harm, injury or damage requiring the intervention of a physician or licensed medical professional, utilizing medical procedures more intensive than first aid treatment, including but not limited to: treatment in an emergency room, sutures, fractures, head traumas of a concussion level or greater, or admission to a general hospital for the treatment of serious injury. This would also include severe, multiple contusions, bruises and abrasions, and a loss of consciousness requiring examination by a licensed medical practitioner.
- C. The CEO will initiate the notification process to the Centers for Medicare and Medicaid Services (CMS) of all patient deaths.
- D. Such notification is made to the CMS Regional Office in Boston by the close of the next business day for all patient deaths during seclusion, all patient deaths within twenty-four hours (24 hours) of seclusion and if death occurs within seven (7) days of seclusion, where it is reasonable to assume that the use of seclusion directly or indirectly contributed to the death.
- E. Notification is documented on the Hospital Restraint/Seclusion Death Report form and filed in the legal section of the patient's medical record.
- F. The Report of a Hospital Death Associated with Restraint or Seclusion (CMS-10455) is faxed to the Regional Office of CMS by the CEO's office at the time of notification.

## Staff Education and Training

- A. All staff involved in assessing, caring for, and monitoring patients in seclusion will be trained in CSS, Restraint Application Training, CPR/AED and First Aid. Training will be provided and competence validated annually.
- B. Training will include the following:
1. techniques to identify staff and patient behaviors, events and environmental factors that may trigger the use of seclusion;
  2. recognition and techniques aimed at understanding the nature of age, development, gender, ethnicity and history of sexual or physical abuse as they impact physical contact;
  3. use of nonphysical intervention skills;
  4. identification of behavioral changes that indicate that seclusion is no longer necessary; and
  5. monitoring physical and psychological well-being of patient.



