Ngā Rau Rākau Seclusion Procedures

MHAPPM/8501

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Purpose

The purpose of this document is to outline the processes for staff involved in seclusion as a clinical intervention for people who are under the care of the Mental Health and Addictions Service.

This document is to be used in conjunction with MHAPPM/8953 – Mental Health and Addiction Group Policy which outlines the shared vision and expectations for the direction, values, principles, attitudes and ways of working to deliver a values based service.

Principles

All Te Whatu Ora, Te Matau a Māui Hawke's Bay documents are based on and link back to our values; **He Kauanuanu** (respect), **Ākina** (improvement), **Raranga Te Tira** (partnership) and **Tauwhiro** (care), and are detailed so all persons are provided with clear information on the way they are expected to practice and undertake tasks.

Alongside the values noted above, the use of seclusion needs to be considered in the context of our obligations under Te Tiriti O Waitangi. At an organizational level, Maori need to be engaged in co-governance of seclusion practices and at a clinical level, decisions about seclusion need to be made, wherever possible, with appropriate cultural input. Ideally, cultural support should be engaged early in the assessment process, prior to any decision about seclusion being considered. In all cases, cultural input should be sought for subsequent, 24-hour review.

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (Section 71) sets out the legal basis for the use of seclusion. It states: A tāngata whaiora (a person who is formally subject to the Act) may be placed in seclusion in accordance with the following provisions:

(a) seclusion shall be used only where, and for as long as, it is necessary for the care or treatment of the tāngata whaiora, or the protection of other tāngata whaiora:

(b) a tāngata whaiora shall be placed in seclusion only in a room or other area that is designated for the purposes by or with the approval of the Director of Area Mental Health Services (DAMHS):

(c) except as provided in paragraph (d), seclusion shall be used only with the authority of the responsible clinician:

(d) in an emergency, a nurse or other health professional having immediate responsibility for a tāngata whaiora may place the tāngata whaiora in seclusion, but shall forthwith bring the case to the attention of the responsible clinician:

(e) the duration and circumstances of each episode of seclusion shall be recorded in the register kept in accordance with section 129(1)(b).

The following New Zealand Legislation and Standards are also applicable to this document:

- Ngā Paerewa Health and Disability Services Standard
- Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992 Ministry of Health 2009

Scope

This procedure applies to all staff working within Ngā Rau Rākau and any other staff that may be involved with a seclusion event.

Definitions

Refer to the Mental Health Service Definitions Glossary \\FS3\share\Public\All Users\MHS Policy review\DEFINITIONS FOR WORDS AND TERMS IN USE WITHIN THE MENTAL HEALTH SERVICE.docx.

Nga paerewa the Health and Disability Services Standards includes seclusion as a form of restraint. NZS 8134:2021 contains the standards for restraint and seclusion. The Standard does not provide a definition of seclusion. The following definitions are provided for clarity:

Term/Abbreviation	Meaning
Emergency Seclusion	In an emergency, a nurse or other health professional having immediate responsibility for a tāngata whaiora may place the tāngata whaiora in seclusion. Mental Health (Compulsory Assessment and Treatment) Act 1992 section: 71(2)(d). When emergency seclusion is initiated then the tāngata whaiora must be assessed by the responsible clinician or delegate (out of hours) within two hours of commencement of seclusion. For the purpose of this definition, an emergency refers to a situation in which there is a substantial risk of imminent danger to the person or others, due to a condition that is covered by the Mental Health (Compulsory Assessment and Treatment) Act 1992, "the Mental Health Act". The Mental Health Act in section 71(2)(a) allows for a tāngata whaiora to be placed in seclusion only where and only for as long as necessary for their own treatment, or for the protection of other tāngata whaiora. The Mental Health Act does not permit the use of seclusion for the safety of staff.
Constantly monitored	Tāngata whaiora should be in the line of sight of the person responsible for the observation
Tāngata whaiora	The term used to describe a patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Refer to a person who is the subject of care, assessment and treatment processes in mental health. For this document "patient" is referred to as tāngata whaiora.
Seclusion	Seclusion is type of restraint where a person is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit. It can only be used within the Mental Health (Compulsory Assessment and Treatment) Act 1992.
De-escalation	An interactive process in which a clinician engages with a highly aroused person in such a manner as to assist the person to achieve a calmer emotional state. This usually occurs through timely, appropriate and effective interventions and is achieved by using empathy, good communication and by offering safe options for the person to express their needs.
Seclusion Area	A seclusion area is a room specifically designed and designated for the purpose and approved by the Director of Area Mental Health Services. The emphasis is on providing a safe environment that meets the relevant legal requirements.

Term/Abbreviation	Meaning
Consumer Evaluation	A consumer evaluation must be completed when a tāngata whaiora has been in seclusion and seclusion is terminated. Consumer advocates will be notified by then team to come and do an independent review of the tāngata whaiora's experience whilst in seclusion. As soon a seclusion has been terminated, staff are to contact WIT (consumer advocate) or Te Matau a Maui Hawke's Bay Consumer Advisor to follow up on a formal debrief. In the interim, if the tāngata whaiora is willing, staff can also participate in an informal debrief with the tāngata whaiora on the ward.
Staff Debrief	All staff must complete a restraint debrief following the implementation of seclusion.
Nursing Shift Summary	During the period of each shift an ongoing programme of care and assessment must be provided and recorded and documented on the nursing shift summary. If seclusion is initiated or terminated part way through a shift a shift summary still needs to be completed for the period of time the person was in seclusion. Shift periods: 0700 hours – 1500 hours 1500 hours – 2300 hours 2300 hours – 0700 hours
SPEC	Safe Practice Effective Communication. SPEC is a national training programme for Mental Health and Addiction Services.
Situational awareness	is about personal safety and keeping yourself safe at all times through preparation. Situational awareness can be understood as: A collection of skills needed to set limits in situations that make us uncomfortable or are possibly dangerous. An awareness of the environment and basic understanding of how to avoid potentially dangerous situations. Aspects of how we feel about ourselves (ex: self-esteem and confidence), how we relate to our bodies and how to trust our instincts.

Roles and Responsibilities

Role	Responsibility
Designated Senior Seclusion Nurse	A Registered Nurse approved by the Director of Area Mental Health Services to complete the eight hour review of a tāngata whaiora in seclusion.
Responsible Clinician	The Responsible Clinician is the clinician who is designated as being responsible for the care of a tāngata whaiora under the Mental Health Act. The clinician is usually a psychiatrist but may be a senior nurse, psychologist, medical officer or psychiatric registrar who has been appointed to the role by the Director of Area Mental Health Services. After hours, the on-call psychiatrist, senior registrar or an appropriately qualified senior nurse may act in the role of the Responsible Clinician to initiate seclusion.

Procedural Principles

Seclusion is a highly restrictive intervention and needs to be considered as a last resort after all other options have been considered. Planning for termination of seclusion should begin when clinicians decide that seclusion is required. The decision to seclude a person should be supported by thorough documentation of the clinical reasons for its use and its aims, a brief description of the less restrictive measures that were considered, the measures in place to support the person during seclusion and the plan for terminating seclusion.

The Mental Health Service supports the reduction in the use of all forms of restrictive practice and encourages the use of least restrictive practices. Restraint minimisation and safe practice is underpinned by 'Recovery and person centred' orientated service delivery.

The use of seclusion should be based upon the following principles:

- Seclusion is used as a last resort for safety and not as a therapeutic intervention.
- Clinicians will use other interventions in a timely and competent manner to minimize or avoid the need for seclusion. The decision to seclude should be made uncommonly or a rarity.
- Seclusion will be used for as short a time as possible.
- Seclusion will only be used when no other safe and effective intervention is possible.
- Staff are able to demonstrate and practice competent safe care in relation to seclusion, always considering the least restrictive interventions, and appreciating the physical, psychological and cultural impact seclusion has on the individual tāngata whaiora, their family/whānau and others and that the tāngata whaiora's dignity, privacy and self-respect are promoted and upheld by staff throughout the entire seclusion process.
- The decision to use seclusion should be based on the needs of the individual tāngata whaiora and other tāngata whaiora.
- Seclusion should be used with extreme caution in the following circumstances:
    - Where the tāngata whaiora is receiving medication and there is:
        - evidence of altered or fluctuating levels of consciousness, or other neurological side effects
        - likelihood of respiratory suppression or other cardiovascular side effects.
    - Physical deterioration.
    - Where the tāngata whaiora requires intensive assessment or observation, especially where there is a suspected physical or brain trauma, unknown substances ingestion or organic diagnosis.
    - Presence of physical illness or injury requiring specific treatment.
    - Presence or likelihood of self-injurious behaviour.
    - Likelihood of escalation of anxiety, aggression or distress or a previous adverse response to seclusion.
    - No demonstrable psychiatric diagnosis.
    - Intoxication with alcohol, or possibility of other drug ingestion.
    - Seclusion shall be in a room or area designed for that purpose by, or with the approval of, the Director of Area Mental Health Services.
- The emphasis shall be on providing a safe environment. As a minimum, the room must have:
    - Adequate light, heat and ventilation.
    - Means to easily observe the tāngata whaiora that also allows the tāngata whaiora to see the head and shoulders of the observer.
    - Means for a secluded tāngata whaiora to call for attention.
    - fittings recessed to avoid potential for harm.
    - Furnishings (other than bedding) that are fixed to avoid the potential for harm.

Seclusion Procedure

1 **Use of alternative interventions and strategies must occur prior to deciding the tāngata whaiora requires seclusion.** This can include, but is not limited to: sensory modulation, medications, one-to-one with nursing staff, use of quiet areas away from others, family/cultural involvement and this must be documented in the health record and on the seclusion documentation.

2 **Contact tāngata whaiora's Responsible Clinician** for additional advice and treatment options.

3 **Consider use of the seclusion area as a low stimulus area** for the person to self-regulate away from other tāngata whaiora with minimal stimulus

4 **Assess level of seclusion required.** If attempts to avoid seclusion use are unsuccessful then assess whether the tāngata whaiora require:

a. Seclusion with access to the seclusion lounge
b. Seclusion in room with access to en-suite
c. Seclusion in room with no en-suite access

Rationale for this must be documented in health record and on seclusion documentation and must be subject to review throughout the process.

5 **Tāngata whaiora must be advised of the plan to implement seclusion.** Staff must inform the tāngata whaiora of the use of seclusion, rationale for seclusion and expected/required behaviours to negate the need for seclusion. The seclusion room doors lock automatically on closing so seclusion is deemed to have commenced once the seclusion room door is closed (the key only engages the door bolts for extra stability of the door).

6 **If the Responsible Clinician or their delegate (out of hours only) is not present** when seclusion is implemented then the Responsible Clinician or their delegate (out of hours only) must assess the tāngata whaiora as soon as possible; within two hours of seclusion implementation.

7 **Tāngata whaiora engagement and observation while in seclusion**. Every person placed in seclusion will be constantly monitored by a Registered Nurse in the first instance or as an exception this task may, at times, be delegated to a competent and appropriately skilled, Health Care Assistant, allied health, or medical staff member. This constant monitoring is for the entire duration of the seclusion event and should be incorporated within the existing staff mix. It is expected that staff will be actively engaging with the tāngata whaiora to continue to de-escalate, reassure and assess the tāngata whaiora. In addition to this engagement staff need to record the general condition, colour (for example cyanosis, pallor), breathing, position, activity and behaviour of the tāngata whaiora at a maximum of ten-minute intervals.

8 Tāngata whaiora assessment while in seclusion

a. Two-hourly assessment/room entry. A genuine attempt must be made by a qualified clinician at least once every two hours to enter the room. This is to assess the physical wellbeing and mental state of the tāngata whaiora. If an attempt to enter the room is unsuccessful, the reason why must be recorded on the observations form and in the health record.
b. Eight-hourly ongoing assessment/care. The Registered Nurse is responsible for the ongoing care delivery and observations for each eight-hour shift (or part shift). A physical assessment (blood pressure, pulse, temperature and respiration rate and hydration) is to be completed during every eight-hour shift, with the exception of overnight if the tāngata whaiora is asleep. If the tāngata whaiora is too disturbed for this to occur then the minimum requirement is respirations and hydration. This is to be documented in the health record and on the seclusion shift summary form.
c. Eight-hour review. It is a mandatory requirement for the tāngata whaiora to have a mental state review at the end of each eight-hour shift and this can only be completed by a Consultant Psychiatrist, a Medical Officer Special Scale, a Registrar, or a Designated Senior Seclusion Nurse.

9 **Prolonged seclusion.** If the cumulative hours of seclusion exceed 24 hours in a four-week period of one admission then a case management conference must occur. If this occurs out of normal business hours then a review is to be completed by the on-call team and nursing staff and the next working day a case management conference is to be held and should include; Director of Area Mental Health Services, Medical Director, Director of Nursing and clinicians involved in the care and treatment of the tāngata whaiora during the admission.

10 **Reintegration of tāngata whaiora out of seclusion.** This should occur at the earliest opportunity and will require a planned, and, at times, graduated approach. This should start during time of least stress and disruption and should be part of the assessment as to whether seclusion is to continue or cease. A period of one-hour evaluation/time out of seclusion is available before the seclusion episode is considered to be terminated. The tāngata whaiora can be returned to seclusion within this hour without commencing a new seclusion event.

11 **Termination of seclusion occurs when** the goals for seclusion have been achieved. Seclusion is deemed to have ended when the person exits seclusion and there is no expectation of returning into seclusion. Two Registered Nurses are to make the decision to terminate the seclusion and advise the Responsible Clinician of this decision.

12 Recording the use of seclusion

The Mental Health (Compulsory Assessment and Treatment) Act 1992, section 129(1)(b) requires that the Director of Area Mental Health Services keeps a record of restraint and seclusion. The following are required in order to comply with this:

a. All seclusion events (start time and date – end time and date) must be recorded in the tāngata whaiora's electronic record in ECA using the correct process (i.e. bed transfer and change specialty).

b. Recording should start as soon as seclusion has been initiated.

c. Reasons for seclusion being used and less restrictive alternatives that were considered or tried.

d. Adverse events, if any, related to or caused by seclusion.

e. Family or cultural support engaged to minimize seclusion or its impact.

13 **Debriefing**

a. Tāngata whaiora are offered an opportunity to debrief following the end of seclusion.
The Tāngata whaiora Advocate will explain this process to the tāngata whaiora.
Staff also have the option to debrief after seclusion

Seclusion Room Entry Process

Safety precautions must be taken when entering the room and the number of staff involved in the room entry must reflect the level of potential risk of the tāngata whaiora – a **minimum of three staff who have all completed 'Safe Practise, Effective Communication' (SPEC) training** are required to enter seclusion.

It is imperative that a team approach is used and that the person in the lead role (Number 1) is lead in the entire process. All other staff, regardless of designation, must follow their instructions unless there is a safety risk to any person. Additional staff may be required for additional functions i.e. door, clean up, food, medication administration etc. The lead in the role of Number 1 continues to de-escalate and reassure the tāngata whaiora throughout the entire process.

Prior to Room Entry Ensure

- All staff (including doctors and security) know the plan and goals of the room entry.
- Everything is organised e.g. medications, food, fluids, toiletries.
- That all staff know their role and adhere to this.
- Exit options have been discussed.
- Clarify who is the leader (Number 1 role).

When Entering the Room

- Ask the tāngata whaiora to sit down on the mattress/bed prior to unlocking the door.
- The two people responsible for the potential securing of the upper limbs are to enter first and position themselves so they have quick access to the upper limbs if required.
- The person identified as the leader (Number 1) enters and positions themselves a safe distance in front of the tāngata whaiora ensuring that they are not in the way of the people on the upper limbs – at this time they explain to the tāngata whaiora the plan, expectations etc.
- Auxiliary people then enter the room at the direction of the leader (Number 1).
- Only the leader (number 1) will interact with the tāngata whaiora – any other staff member required to interact with the tāngata whaiora will do so only at the direction of the leader (Number 1).

Once in the Room

- The tāngata whaiora is to remain seated unless specifically directed to do otherwise.
- The staff on the upper limbs are to ensure that the tāngata whaiora remains seated – if the tāngata whaiora attempts to stand, the leader should direct them to remain seated, the staff on the upper limbs can apply gentle pressure to the shoulders to encourage the tāngata whaiora to remain seated. Restraint of the upper limbs should only occur as a last resort.
- The three SPEC trained staff (Number 1 and arms) are not to leave the room for additional items. If additional items are required a decision needs to be made to send one of the auxiliary staff or to exit seclusion and return once additional items have been obtained.
- If the leader (Number 1) indicates that there is a need to exit the room then this must occur without debate (as discussed prior to room entry).

When Exiting the Room

- All auxiliary staff exit first ensuring they do not block the doorway once out of the room.
- The lead (Number 1) then exits the room.
- The last people to leave are the people responsible for the upper limbs.
- Once everyone is clear of the room then the door is locked if seclusion is to continue.
- Debrief is to be completed if restraint was required during room entry.

Remember that if seclusion is used inappropriately or without good clear clinical rationale then it is deemed to be **false imprisonment** and is a form of assault.

Measurable Outcomes

Seclusion documentation is to provide a basis for internal quality assurance as well as review and audit.

As in other aspects of the Mental Health (Compulsory Assessment and Treatment) Act 1992, it is expected that District Inspectors will monitor that procedures are properly used.

Related Documents

MHAPPM/8953 – Mental Health and Addiction Group Policy

References

Ngā Paerewa Health and Disability Services Standard

Mental Health (Compulsory Assessment and Treatment) Act 1992 and amendments

Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992 Ministry of Health 2009

Keywords

Seclusion
Restraint
Mental Health

For further information please contact the Director of Area Mental Health Services