The Effects Associated with Seclusion Room Use

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ABSTRACT

Confinement of a patient is a practice that has existed since the 18th century. Historically patients who were diagnosed with a mental illness were confined in an asylum as these patients were seen as immoral due to the stigma related to mental health (Newton-Howes, 2018). Currently, secure rooms are used to confine patients who are experiencing a psychiatric crisis or behavioural disturbances. Although secure rooms are a beneficial last resort intervention, secure rooms are not always used in accordance with policies. The misuse of secure rooms can lead to negative effects for both the patients and staff (Beames & Onwumere, 2021), making them a controversial intervention in mental health facilities. The goal of this project is to educate the interdisciplinary team on the negative effects of seclusion rooms, and to enhance the interdisciplinary team's knowledge of other first-line interventions that are utilized to reduce the occurrence of seclusion room use. This project took place at the Hope Centre in North Vancouver British Columbia. It utilized an educational session for the staff which included a PowerPoint presentation and the introduction of an infographic.

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LIST OF ABBREVIATIONS

CAN	Canadian Nurses Association
MCFD	Ministry of Child and Family Development
PHSA	Provincial Health Services Authority
PRN	Pro Re Nata
RPN	Registered Psychiatric Nurse
RN	Registered Nurse
TIP	Trauma Informed Practice

SECTION 1: INTRODUCTION

The practice of patient confinement dates to the 19th century. As times evolved, a practice that became well-known in mental health facilities was the use of seclusion rooms. A seclusion room, also known as a secure room, is defined as a locked room used to confine a patient who is in a behavioural crisis or is an immediate safety risk to themselves or others (Vancouver Coastal Health [VCH], 2008). Seclusion rooms are to be used as a last resort when all interventions have proven unsuccessful in managing a behavioural or psychiatric crisis (Provincial Health Services Authority [PHSA], 2023). A seclusion room is an emergency intervention that should be used short-term to ensure that therapeutic care is being provided to a patient (VCH, 2008; PHSA 2023).

For a patient to be placed in a seclusion room, necessary guidelines must be followed to maximize an individual's rights while ensuring the patient is in a safe environment if they are displaying aggressive or disturbed behaviours (Newton-Howes, 2018). As per the Vancouver Coastal Health (2008) policy, the first step is for a Code White to be initiated. This means that security and staff are preparing for the intervention in accordance with Code White procedures for the facility. Moreover, the policy also states that a patient must be certified under the Mental Health Act for seclusion rooms to be used, but in some emergency cases, voluntary patients may be placed in seclusion (VCH, 2008). Voluntary patients must be released from a seclusion room once the behaviour has stopped or if one-hour passes and the patient has not been certified (PHSA, 2023).

A seclusion room is a designated room in a psychiatric facility the location and layout of the room must be specific to ensure patient safety. The seclusion room should be located where

the patient can constantly be observed, such as near the nursing station, but away from patient hallways (British Columbia Ministry of Health, 2012). Also, a seclusion room should be a single-use space that is separate from the main unit environment (Kaar et al., 2017).

The walls of a seclusion room should be painted with non-toxic paint in a calming colour (British Columbia Ministry of Health, 2012). There should not be any safety hazards present, meaning it is essential to ensure there are no blind spots (Kaar et al., 2017). As per the British Columbia Ministry of Health (2012), the design of the room should avoid any weak points, corners, or edges to ensure safety of the patient and any staff entering the room. Walls should be made of masonry-dense blocks or bricks that have at least a thickness of 140mm to ensure structural security and to reduce noise transmission. Kaar (2017), indicates a seclusion room should have physical security, meaning the doors and locks should be made with durable material.

Patients also need access to toilets and washing facilities while they are placed in a secure room (British Columbia Ministry of Health; 2012 & Kaar et al., 2017). There should be anti-suicide stainless steel toilets and sinks with water access for these facilities outside the secure room (British Columbia Ministry of Health, 2012). This ensures easy access to shut off water in the secure room if any safety concerns arise, such as a patient attempting to flood the secure room due to their state of psychosis.

Section 1.1 Nursing Practice Problem

Although the practice of seclusion rooms still exists today, this intervention is seen as controversial (Newton-Howes, 2018). As stated policies published by various healthcare organizations in British Columbia, a seclusion room should only be used as a last resort in an

emergency (PHSA, 2023 & VCH, 2008). Although these policies are in place, in practice on multiple occasions, the use of seclusion is still a first-line intervention. This increases the risk of harm to a patient. Due to the misuse of seclusion rooms, there is an increase in negative effects that can occur such as negative feelings, trauma, and death (Sivak, 2012). As this can be a negative experience for the patient and staff, the goal of this project is to reduce or eliminate the practice of seclusion at the Carlile unit at the Hope Centre.

Section 1.2 Project Purpose

The purpose of this project is to reduce or eliminate the use of seclusion rooms in mental health facilities. As stated in the lesson plan (see Appendix A), the goal of this project is to increase the interdisciplinary team's awareness of the effective use of seclusion rooms in accordance with VCH seclusion room policies and procedures. This will be done by the following:

1. The interdisciplinary team will recall their knowledge and fill in knowledge gaps related to seclusion rooms policies by answering questions throughout the presentation

2. The interdisciplinary team will understand the positive and negative effects associated with seclusion room use for patients and staff

3. The interdisciplinary team will become aware of first-line interventions (PRN and de-escalation techniques) to prevent the use of seclusion rooms.

4. The interdisciplinary team will gain an understanding of the policies and procedures associated with seclusion room use: steps and documentation

Section 2: Literature Review

The University of Lethbridge library's nursing database was used to locate resources related to the topic. The first search engine used was CINAHL to search for articles. The search terms included "seclusion rooms" and "secure rooms". These two searches were combined using the Boolean operator search with "OR". Next the terms "health outcomes, health consequences, or health" were searched. The Boolean operator search with "AND" was used to combine the previous search with this search to ensure the articles presented incorporated all aspects of the different searches.

MEDLINE (Via Ovid) and Pro Quest were also used to find articles related to this topic. For MEDLINE the first search term was "patient isolation" and the second search was "hospital, psychiatric". These searches were then combined using the Boolean operator search with "AND". For Pro Quest the first search terms were "seclusion rooms or secure rooms" and the second search was "health effects". These searches were then combined using the Boolean operator search with "AND".

The article titles were used to identify which articles were appropriate for this project. The next step was to read the article abstract and choose which would be most beneficial for this process. Once chosen, the articles were printed and analyzed. Notes were made on the margins to draw attention to important sections. Once enough information was gathered the process of writing the literature review began by breaking it down into sections and adding pertinent information to the sections.

Section 2.1 From Past to Present

This section focuses on the previous and current use of secure rooms, describing the evolution of psychiatric care from before the 18th century to the present.

Historical Use

There is a long history related to the use of seclusion rooms that dates earlier than the 18th century (Newton-Howes, 2018). Beames & Onwumere (2021), highlight that historically, care provided to mental health patients was defined along the continuum of patient care and patient custody therefore, patients diagnosed with a mental illness have always been subject to a form of confinement which historically was the use of asylums. Newton-Howes (2018) reports that treatment provided to patients in these asylums was inhumane and not patient-centered. The rooms in the asylums were foul-smelling, unclean, and contained little to no light. Due to the unethical quality of the seclusion rooms, in 1973, Pussin and Pinel were given credit for creating the concept of 'traitement moral' which led to the improvement of the environmental conditions in an asylum in France. A few years after this change, there were environmental improvements to asylums in Italy and England.

Jacob et al., (2009), mention that before there were psychiatric institutions, there was a stigma towards mental illness. Being diagnosed with a mental illness meant you were "immortal" which led to the removal from society. These "immortal" individuals were confined in asylums (later known as institutions of madness) used to contain individuals who displayed disruptive behaviours. The confinement of these individuals was seen as an act of universal mortality, which was part of a broader perspective of control that worked to regulate an individual's behaviour. In the 1970s and 1980s, there was a shift in transferring care from asylums to community-based treatment (Beames & Onwumere, 2021).

Current Use

Today, challenges remain when managing aggression, violence, and disruptive behaviours in psychiatry wards even though there have been advances in pharmacotherapy, psychological interventions, and in community services for individuals diagnosed with psychiatric disorders (Newton-Howes, 2018). Even with these advances, hospital treatment is needed for patients who are high-risk and exhibiting psychiatric concerns; in inpatient settings, seclusion rooms are used to provide patient safety (Newton-Howes, 2018). In hospitals, there is a higher risk of seclusion room use for individuals that are stigmatized or marginalized which can lead to trauma (Askew et al., 2019).

Although Newton-Howes (2018) suggest patient safety is achieved with seclusion rooms, this practice is also controversial, because it is a form of control over patient. There is an emergent movement to end the use of seclusion rooms in practice (Varpula et al., 2020), particularly because when seclusion room use is initiated, multiple staff members restrain a patient before taking the patient into the secure room (Askew et al., 2019). This can cause harm to patients, which takes away from the patient-centered and trauma-informed perspectives in health care. This has led clinicians and service users to express concerns that the use of seclusion rooms can lead to trauma for patients (Askew et al., 2019).

From a patient perspective, most viewed the use of seclusion as a negative experience as it took away their autonomy, and seclusion rooms were viewed as a form of punishment (Kuosmanen et al., 2019). Patients describe their seclusion room experience as manipulative and punitive which disrupts the therapeutic approach in healthcare (Newton-Howes, 2018). In agreement with this project, Beames & Onwumere (2021) suggest an international focus on reducing and eventually eliminating the use of seclusion rooms.

Beames & Onwumere (2021) examined factors that may increase the use of seclusion rooms, including involuntary young adult males of an ethnic minority, patients aged 18 and 25, those diagnosed with schizophrenia, and patients exhibiting aggressive behaviours. If these individuals experienced more severe symptoms related to their mental illness it amplified their risk of being placed in a seclusion room.

Section 2.2 Negative and Positive Experiences

The use of seclusion takes away a patient's autonomy as it restricts their freedom and increases the chances that the patient will be forcefully medicated by the healthcare team (Newton-Howes, 2018). In healthcare, the team is supposed to increase patient autonomy and use the least restrictive approach, which allows the patient to guide their own recovery (Newton-Howes, 2018). As the use of seclusion rooms can lead to ethical concerns, it is essential that attention be paid to the effects that seclusion rooms have on patients. According to the Canadian Nurses Association [CNA] (2019), patient safety focuses on reducing and mitigating any unsafe acts while providing care to patients by following best practices. Issues that occur while providing patient safety do result from the actions of a single person, but instead are system-based problems. In the case of seclusion rooms, the system-based problem at the Carlile unit at the Hope Center is that the seclusion room policy in place is from 2008, thus is 15 years old.

Negative Impact

The negative effects associated with seclusion room use are not only experienced by the patients but also by the staff involved in initiating this intervention (Beames & Onwumere, 2021). Staff injuries may include sprains, strains, concussions, bruises, fractures, stress, and anxiety (Varpula et al., 2020). In addition, Askew et al., (2019) suggest studies have shown

overwhelmingly negative experiences for patients who are confined in seclusion rooms. The use of seclusion rooms can cause a patient to feel extremely distressed, which can cause many negative emotions. Some patients have also compared the experience of a seclusion room to being in prison. The overwhelming emotions experienced by patients take away from the therapeutic culture that exists in hospitals.

Varpula et al., (2020) note that there is trauma associated with this practice, and there is a potential for psychological distress and post-traumatic distress disorders for patients. There is also a risk of cardiac and vascular injuries to patients, respiratory injuries, blunt force trauma, an increased risk of falls, and patients engaging in self-harm. As per Sivak (2012), approximately 150 people die each year because of seclusion room use. As there are so many opportunities for something to go wrong, it is essential that staff identify and address any safety hazards that may be present (Varpula et al., 2020).

Another negative effect of seclusion rooms is that this intervention can cause a patient to be frightened (Happell & Koehn, 2010). The data collection results from a study by Askew et al., (2019) show that patients experience fear when a secure room is utilized due to the physical environment of the seclusion room and the involved staff. Moreover, while confined in this room, the patient's own thoughts caused them to experience fear. One patient stated that he was so scared every time staff entered the room because he thought the staff member was going to kill him. This patient's experience shows how this room can be detrimental to a patient's mental health and well-being. Having to live in fear that you are going to be killed strongly detracts from the therapeutic aspect of a hospital.

Along with fear, Askew et al., (2019) found that patients felt some of the staff's actions felt like a form of abuse since patients felt powerless while being confined. Although no

allegations were made of actual abusive behaviour, the staff's behaviour was interpreted as abuse. For example, constant observation, having to shower or utilize the bathroom knowing that staff may be watching, and having staff entering the room whenever they needed to triggered feelings of abuse. Although this constant observation is needed to ensure patient safety, it is understandable that patients have a negative outlook on the same.

Neglect is another negative experience that patients reported when they were placed in a seclusion room (Askew et al., 2019). Feeling of neglected can also cause a patient to become sad or depressed as their needs are not being met (Happell & Koehn, 2011). Patients stated that they did not receive any form of basic care which caused some patients to feel abandoned (Askew et al., 2019). Staff left patients confined in seclusion rooms without their basic care needs met, which can lead to distress and helplessness for a patient in such a vulnerable state.

Furthermore, patients placed in seclusion rooms are at higher risk of feeling abandoned, helpless, hopeless, depressed, and isolated (Jacob et al., 2009; Fish, 2018; Happell & Koehn, 2010; Happell & Koehn, 2011; Hoekstra et al., 2004; Holmes et al., 2009; Larue et al., 2013). Patients placed in a seclusion room, view the seclusion room as a punitive intervention (Jacob et al., 2009). Throughout their study, Holmes et al., (2009) focus on understanding a patient's emotions related to seclusion room use. The researchers used semi-structured non-directive interviews to gather data. The results of their study showed that patients felt rejected and isolated when being in a seclusion room. In addition, the patients experienced sadness and shame.

Another negative emotion patients experience is anger (Happell & Koehn, 2010; Happell & Koehn, 2011; Holmes et al., 2009). In a study by Happell & Koehn (2010), the data show strong agreement that patients experience anger due to this intervention. As per Holmes et al., (2009), patients experienced anger as they were confined in the seclusion room for long periods

of time. Moreover, the care that is provided in a seclusion room was not effective. This can lead to violent behaviours towards the staff or the seclusion room itself.

In a study based in Finland conducted by Kuosmanen et al. (2015), the focus was on having two mental health nurses voluntarily spend 24 hours in a seclusion room, allowing them to understand the experience of secure rooms. The goal of this study was to gain a more in-depth understanding of the experience of seclusion rooms, which will open more discussions on this controversial intervention. The nurses voluntarily spent time in the seclusion rooms and reported their experience every six hours. The nurses reported that this intervention can increase anxiety and frustration, leading to a negative view of seclusion rooms. The nurses disclosed that they did not find this intervention to be nursing or caring in nature due to the minimum interaction that patients have with the staff. If the nurses themselves are stating that this is not a positive intervention, there is a need for increased discussion about changes to be made for this intervention.

Although nurses recognize that there are negative effects associated with the seclusion room, they still support this intervention as it helps manage patient behaviour (Happell & Koehn, 2010). However, there are effective first-line interventions for nurses to use to reduce the harm associated with seclusion room use that should be explored through professional development opportunities.

Positive Impact

Even though most of the data collected shows the negative effects of seclusion rooms, there were a few positive effects. Happell & Koehn (2010) noted that the use of seclusion rooms can support patients in settling and improving behaviours that led to seclusion room use. In

addition, some patients stated that they were happy with their seclusion room experience, feeling that they were in a safe environment which allowed them to feel relieved and calm.

A secure room is an intervention used to maintain the safety of patients and other individuals in psychiatric units (Varpula et al., 2020). For some patients, the use of seclusion rooms is an opportunity to reflect which is seen as a positive aspect of seclusion room use (Askew et al., 2019). Some patients also thought this practice was beneficial in helping control their behaviours and can understand the rationale behind using this intervention (Kuosmanen et al., 2015). When utilized appropriately, seclusion rooms are effective in managing aggressive and disturbed behaviour that a patient may display (Newton-Howes, 2018). This ensures that the unit is a safe environment for staff and the other patients in the unit.

Section 2.3 Current Nursing Practice

Secure Room Policies

This section focuses on the seclusion room policies in British Columbia from two health authorities, VCH (2008) and PHSA (2023). According to these policies, seclusion rooms are to be used as a last resort in emergency situations, when all other are less restrictive interventions are ineffective in managing a patient's behaviour. As this is an emergency intervention, it is essential that when a secure room is used, it be for a short duration of time and when the behaviour is managed, the use of the secure room is discontinued (VCH, 2008). This ensures that a trauma-informed approach is used and that the therapeutic relationship between staff and patients is maintained. When a patient is in a secure room, the healthcare team must complete an ongoing risk of harm assessment (PHSA, 2023).

Further, patients who are voluntary, meaning that the patient is not certified under the Mental Health Act, should not be placed in a seclusion room unless they are an immediate risk to themselves or others. If a voluntary patient needs to be placed in seclusion, this intervention should not last more than an hour if the patient remains uncertified under the Mental Health Act. On the other hand, involuntary patients may be placed in seclusion if there is a clinical indication that this intervention is needed (VCH, 2008).

If it is deemed by the healthcare team that a secure room is needed as per the policies, a Code White must be initiated. A Code White occurs when the Code White team assembles and works to manage an unpredictable behaviour that is aggressive or impulsive in nature (VCH, 2015). The Code White team will complete a point-of-care risk assessment for a patient and a seclusion room before the patient is safely taken to the seclusion rooms. When transferring a patient into seclusion, it is essential ensure that all patient items that can cause harm to the patient or others are removed.

The policies state that a physician's order is required for seclusion room use; this can also be completed by the nurse and sent to the doctor for a co-signature in the case of an emergency. If the doctor is not on-site, they will receive a report from the nurses, decide if this intervention is appropriate at the time, and write a seclusion room order. If the physician does not believe that a patient is required to be in the seclusion room, the patient must be removed immediately.

The policies also indicate the need for continuous documentation when a patient is in a seclusion room. The first documentation known as the 'Restraint/Seclusion Initiation' form needs to be completed once the seclusion room is initiated. Moreover, a patient must be monitored every 15 minutes and checks should be documented on the 'Restraint/Seclusion Monitoring and Evaluation' sheet. A nursing narrative documentation that describes the

behaviours that led to the use of seclusion and what alternative interventions were used prior to seclusion room use must be completed. The nurse should also document if the patient was cooperative with the transfer and if there were any injuries to anyone during the process.

Misuse of Seclusion Rooms

Although the VCH (2008) and PHSA (2023) state that seclusion rooms should be used as a last-resort intervention, seclusion rooms are still used as a first-line intervention. There is concern that seclusion rooms are used to benefit the nurses instead of providing safety for the patients (Askew et al., 2019; Kirkpatrick, 2001; Larue et al., 2013). This leads to a patient's needs being neglected as staff benefit from utilizing this intervention. In addition, Larue et al., (2013) identified that patients were not offered alternative interventions and staff did not take the time or effort to utilize safer alternative measures. As seen in practice, this is a way to reduce the nurse's workload and make their shift easier.

Staff

According to the CNA (2019), nursing shortages in health care settings play a significant role in patient safety. Further, to ensure that staffing levels on the unit are safe, it is essential that baseline staff levels are determined using evidence-informed decisions. Tamata & Mohammadnezhad (2023) report that a major factor contributing to nursing shortages is burnout. This is due to being stressed, overworked, and experiencing psychosomatic disorders, which lead to a decrease in the number of nurses working, leading to a burden on the healthcare system. This is a chronic issue requiring measures to address it effectively. Due to units being short-staffed, nurses must work overtime which increases the level of burnout. Registered psychiatric

nurses (RPNs) and registered nurses (RNs) are expected to take on heavier patient loads which can lead to safety concerns for nurses and patients (Reda, 2022).

In addition, Janssen et al., (2007) identified that if nurses were trained and well-educated, the use of seclusion rooms decreased in mental health facilities. When staff working on the unit are incompetent, there is an increased risk of seclusion room utilization. This is due to a nurse's lack of communication with other staff members or limited work experience in a psychiatric facility. In addition, nurses who believe that they have authority over the patients are more likely to place a patient in a seclusion room. In a study conducted by Barr et al., (2022) there was an increase in seclusion room use if RNs were working on the unit. As per Happell & Koehn (2010) 48.8% of seclusion events were initiated by RNs and 33.9% were initiated by RPNs. This may be due to the difference in education of the two types of nurses. The gender of the nurses also affects the rate of seclusion room use. If there are more female nurses working on the unit, the rate of seclusion room use decreases.

Section 2.4 Gaps

Due to very limited research studies, there is a lack of knowledge regarding the safety hazards that may be associated with the use of secure rooms (Varpula et al., 2020). Kuosmanen et al., (2015) report that seclusion room use causes ethical dilemmas, leading to a lack of evidence that shows if seclusion room use is effective in reducing aggression and serious mental illness. Furthermore, there is little evidence showing that the use of seclusion rooms provides any long-term benefits for a patient when it comes to treating symptoms or reducing aggression (Newtown-Howes, 2018). It was also difficult to find evidence of the long-term effects associated with secure room use.

Askew et al., (2019) report that the research shows insight into patient experiences of being in a seclusion room, but the data is limited as studies focus on multiple restrictive practices, not just seclusion rooms. This means that the patient's experience of seclusion rooms is not analyzed in-depth, making it difficult to fully understand the seclusion room experience. There needs to be a better understanding of the experiences different patients go through when experiencing this intervention. For example, there is limited data regarding forensic patients (also known as mentally ill patients who have been charged with an offense), which may lead to increased use of seclusion. Additionally, a patient's recollection of their seclusion room experience may not be accurate, causing gaps in the data being collected.

Further, there is a limited data related to the effectiveness of the design of a seclusion room (Kaar et al. 2017). This makes it difficult to determine if the current design of the seclusion room is beneficial to patients or if changes are needed. There is also minimal published literature related to alternative interventions that can be used to reduce the use of seclusion rooms in psychiatric settings (Cummings et al., 2010). Due to these limitations, there is an ongoing need for research to be conducted to understand the efficacy of seclusion rooms.

Section 2.5 How to Proceed

It is recommended that there are nationwide policies, unit management, and interventions that are patient-centered in nature be developed to reduce the use of seclusion rooms (Newton-Howes, 2018).

Trauma Informed Practice

McCartan (2020) defines trauma as a distressing or disturbing event that an individual experiences. Trauma can be presented in different ways such as psychologically, emotionally, or

physically. Trauma can be caused by a single event, multiple events that are similar in nature, or a combination of diverse events that are serious in nature. The trauma that is experienced can impact an individual's emotional and mental health. As many individuals in psychiatric units have previous trauma, it is essential that nurses can recognize the trauma and provide care in a therapeutic manner. Trauma-Informed Practice (TIP) is a framework that is grounded in understanding how individuals respond to trauma (Ministry of Child and Family Development [MCFD], 2020). TIP emphasizes providing physical, psychological, and emotional safety for patients (MCFD, 2020). The goal of a trauma-informed approach is to not re-traumatize a patient but instead recognize the patient's strengths and rebuild confidence.

Training and Education

Self-awareness training needs to be provided to both RNs and RPNs, so they understand that their actions have the potential to cause negative effects on patients (Varpula et al., 2020). Staff actions that potentially can cause harm to patients include unsafe administration of medication or leaving hazardous items in the secure room (Varpula et al., 2020). Also, there should be training provided to staff on ways to influence patient behaviours using theoretical models, as this can help staff formulate therapeutic responses when providing care to patients who are exhibiting such behaviours (Askew et al., 2019). In addition, there must be clinical supervision when utilizing seclusion rooms as it allows staff members to thoroughly reflect on their practice. This ensures that there is no power-seeking behaviour of staff while providing care to these vulnerable patients (Askew et al., 2019).

In addition, Mlambo et al., (2021) note the importance of continuing professional development for nurses. This ensures that the nurse's skill and knowledge are current, which allows them to provide proper care to patients. Gallagher (2007) mentions that nursing education

should not end once a nurse has received their registration, but instead, the nurse should continue to participate in education throughout their career. Nursing is a dynamic and ever-changing profession that requires lifelong learning. By engaging in continuous education, a nurse will always be aware of new policies and procedures that exist along with new techniques to provide care. This allows nurses to advance in practice and ensure that nurses are competent.

Patient History

A study conducted by Vapula et al., (2020), focused on understanding the importance of maintaining a patient's history. This allows nurses to better understand a patient's background. To find this vital information, the healthcare team should read through a patient's medical records. Within the medical records, nurses should be looking for potential triggers for escalation or safety incidents that have occurred in the past. Incident reporting systems should also be utilized to report any safety hazards that occur on the unit to inform other staff members. Staff tend to underreport incidents, leading to an underestimation of the problem. It is essential that staff report all incidents that occur as this can lead to a safer environment.

Pro Re Nata (PRN) Medication

Jimu & Doyle (2019) describe pro re nata (PRN) medications as medications that are not scheduled, but given if a certain circumstance arises. In mental health settings, a PRN is administered by nurses when a patient is experiencing behaviours of escalation. PRN medications are commonly administered in mental health settings where approximately 70-90% of patients are administered PRNs. PRNs are effective in reducing psychosis and agitation experienced by a patient. Due to the effectiveness of these medications, it is essential that nurses can administer the medication as soon as they notice an escalation. This will lead to the best

results for a patient. Common PRN medications for managing psychosis and aggression are Benzodiazepines, Chlorpromazine, Haloperidol, Olanzapine, Zuclopenthixol, Loxapine, Quetiapine, and Risperidone (Du et al., 2017).

De-escalation Techniques

A recommended non-physical intervention in mental health settings is de-escalation techniques (Price et al., 2018). Cowin et al., (2003) suggests there is growing violence in healthcare due to hostile and aggressive behaviour and it is important that nurses can de-escalate patients. De-escalation is defined as resolving a violent or aggressive situation using verbal and physical expressions of empathy to set limits in non-confrontational manner. De-escalation techniques use psychosocial techniques to stop a patient from escalating by allowing them to self-monitor and manage the emotions that are leading to the escalation (Du et al., 2017 & Price et al., 2018). De-escalation techniques utilize non-provocative verbal and non-verbal clinician communication to negotiate a solution to an escalation that is occurring (Price et al., 2018). De-escalation techniques include, but are not limited to verbal communication, the use of body language, recognizing and preventing strategies (risk assessments), the attitude and skill of nurses, limit setting, and controlling the environment (Du et al., 2017).

De-escalation techniques are important as they establish a therapeutic relationship with a patient and allow a patient to be part of the treatment process (Du et al., 2017). To effectively de-escalate a patient, a nurse needs to maintain a patient's autonomy and dignity (Cowin et al., 2003). Moreover, a nurse needs to be self-aware, intervene in the early stages of escalation, and provide options for the patient (Cowin et al., 2003). Price et al., (2018) propose to utilize these techniques effectively, nurses need to attend skill labs and modify their attitudes toward the patient. The skills labs enhance a nurse's confidence as nurses learn behavioural skills and

strategies on how to regulate their emotions. In addition, if nurses modify their attitude, it will allow them to understand what caused the escalation and empathize with patients. This will lead to better outcomes when managing an escalated patient, which will reduce the risk of assault.

Enhancements in Design

In a Finnish study conducted by Kuosamanen (2019), the focus was on understanding a nurse's perspective of being in a seclusion room. These nurses suggested change to seclusion rooms to make it a more positive experience. First, they suggested adding a bed in the room that is of normal height to make it easier to sleep. These nurses also stated that there should be a table or chair in a seclusion room if it is appropriate for the situation. Additional suggestions were to have a clock in a seclusion room and access to light switches to control brightness. Although these changes are easy to make, they may not be feasible as having extra furniture in a seclusion room can pose a safety concern; these patients are at a higher risk of harm to themselves or others and can use these objects to cause harm.

Comfort Rooms

Comfort rooms are designated rooms in inpatient units (Cummings et al., 2010). These rooms are not used as an alternative to seclusion rooms, but they are used to prevent or reduce seclusion room use (Cummings et al., 2010 & Sivak, 2012). Cummings et al., (2010) state that comfort rooms are designed with furniture, soothing colours, music, soft lights, and sensory objects. These features help reduce the stress that is experienced by patients who are not settled. The use of comfort rooms leads to higher patient satisfaction and reduced rates of seclusion room use in hospitals.

In addition, for comfort rooms to be beneficial, it is essential that a nurse has a good rapport with their patients. This will allow a nurse to notice signs of and engage in conversation to understand what is causing the distress. If a patient is in distress, the nurse can offer the patient a comfort room to self-settle in. These rooms allow patients to experience their feelings of anger and anxiety in a safe room within acceptable boundaries (Sivak, 2012). Sivak (2012), stated that 92.9% of patients who utilized comfort rooms found them to be helpful when they were experiencing distress. These results show that there are other first-line interventions that work in reducing patient escalations and psychiatric concerns instead of resorting to seclusion room use.

As stated in this section, there are many alternative interventions that can reduce the use of seclusion rooms. This ensures therapeutic care is being provided to patients, which reduces the potential for patient trauma.

Section 3: Project Description

The purpose of this project was to reduce or eliminate the use of seclusion rooms at the Carlile Unit in The Hope Centre. The goal of this project is to increase the interdisciplinary team's awareness of the effective use of seclusion rooms in accordance with VCH seclusion room policies and procedures This project also provided the interdisciplinary team with up-to-date information related to the policies and procedures related to seclusion room use.

The project consisted of two parts: the development of an educational session with a PowerPoint presentation and an infographic to display on the unit after the session. The project was presented as a 1-hour educational session for staff working at the Hope Center in North Vancouver, British Columbia. The educational session focused on a PowerPoint presentation, the introduction of the infographic, a role-play activity, and a questionnaire/feedback form at the

end. This helped ensure that the presentation was interactive, which allowed staff to get the best experience and gain more knowledge.

Kemp Instructional Design Model

The Kemp Instructional Design Model was used to guide the development of the educational intervention to address the practice problem for this Master of Nursing project. According to Kurt (2016), this theory is learner-centered and goal-orientated. This ensures that instructional goals are defined at the start, and the purpose of the education session learning objectives and evaluation of learning is to determine if the instructional goal was achieved or not.

The Kemp Instructional Design Model uses multiple approaches from different disciplines. This model is circular in design, meaning that the nine core elements represented by this model are interdependent. This provides flexibility in how the model is used, as individuals can begin the design process at any core component. Some stages of this model may occur simultaneously, and other stages may not, which makes it easier to achieve the desired learning outcomes (Kurt, 2016).

For the best outcomes, it is essential that the instructional designer considers learning objectives along with other factors that may exist. These factors may be the needs of a learner, the content of the activity, instructional resources, and the evaluation tools that will be used. This allows the four important elements of this model learner, objective, methods used, and evaluation of the learners to be included.

The nine core elements of the Kemp Instructional Design Model are:

1. Determining the goal

2. Identifying the characteristics of the learners who will be using this education

3. Clarification of the content that will be utilized in this course

4. The instructional objectives and what is supposed to be achieved are defined

5. The content flows logically

6. Making strategies to ensure that the learners are meeting the outcome

7. Identifying the message and mode of delivery

8. Ensuring there is an evaluation instrument that will adequately measure the outcomes

9. Ensuring there is an appropriate resource to support the teaching and learning outcomes

This model best reflects this project and a majority of the nine core elements were incorporated in the lesson plan (see Appendix A). The goal of this project is to increase the interdisciplinary team's awareness of the effective use of seclusion rooms in accordance with VCH seclusion room policies and procedures, and this model encompassed this goal.

Following the development of the lesson plan, a PowerPoint presentation was created with essential instructional content. The PowerPoint was then shared with the unit manager for feedback. The feedback provided was to check references and change some of the language within the PowerPoint. To determine the impact of the educational in-service for staff an evaluation feedback form (see Appendix B) was prepared with questions to measure the proposed learning outcomes in the lesson plan.

After consulting with the stakeholders at the Carlile unit to determine how seclusion rooms are being utilized on the unit, an infographic was designed that catered to these nurses (see Appendix C). While creating the infographic it was important to ensure that the information was relevant to the unit. The information presented also needed to flow logically to ensure an easy understanding of the content. Unit educators/managers, as subject matter experts, reviewed the infographic and provided valuable insight for improvement. The feedback was to change "food" to "finger food" and to add "when safe to do so" for allowing pillows in the seclusion room.

Feedback and Completion Process

A lesson plan (Appendix A) was created to ensure that the deliverables were completed in accordance with the theoretical model being used. In addition, a PowerPoint presentation and infographic were completed and emailed to the instructor for feedback on June 1, 2023. Feedback was received on June 2, 2023, and the instructor requested speaker notes. On June 6, 2023, speaker notes for the PowerPoint presentation were submitted to the professor for review. Feedback was received from the instructor, and a Microsoft Teams meeting took place on June 11, 2023 to discuss changes needed to ensure the project reflected the intended purpose. Changes included editing the PowerPoint to curtail the information for the target audience. The feedback provided during the meeting was utilized and further changes were made to the project and resubmitted to the instructor on June 12, 2023. On June 13, 2023, once feedback was provided from the instructor, the project was emailed to the nurse educator for review. Feedback was provided and final changes were made to the project with the assistance of the nurse educator and the professor.

Presentation and Infographic

This project consisted of an educational session provided to staff that works at the Hope Centre in North Vancouver. Staff were invited to attend the educational session on June 15, 2023, via email. The PowerPoint presentation and the infographic contained a condensed version of important information related to secure room use.

At the top of the infographic, there was a condensed bullet point version of the VCH secure room policies. This allowed easy access to essential information during emergency situations. This is an important component of the infographic, as there is no time to look up policies when a patient begins to escalate, especially if there is a staffing shortage. Below the policies section, the negative and positive effects for both staff and patients are discussed. This allows staff to better understand the effects associated with the use of seclusion rooms which hopefully will reduce the use of seclusion rooms.

The next section focused on providing information on other potential first-line interventions such as PRN medications and de-escalation techniques. This section provides staff with a quick reminder of different interventions that must be utilized before a seclusion room is utilized. The final section addressed when and how to appropriately utilize seclusion rooms. The PowerPoint contained an in-depth version of the same information included on the infographic.

ARRECI Screening Tool

When completing this project, it was mandatory to ensure the project was ethical. To ensure this project did not pose any ethical risks, the ARECCI Ethics Screening Tool was used (Alberta Innovates, 2017). After completing this assessment in accordance with the project, the final score was 0. This means that this project contained minimal risk and there should be no

breaches of ethics. This project was designed for the healthcare team, especially nurses. This meant that the patients were not involved in this project which limited any breaches in patient care or confidentiality. Due to minimal to no contact with the patients, the score for the ethics screening was 0. In addition, an experienced instructor is supervising the project development, implementation, and evaluation to reduce the risk of an inexperienced project lead.

Implementation

On June 15, 2023, an educational session was held at the Carlile Unit at the Hope Centre in North Vancouver. The project was presented twice, as the front-line staff who were working during the presentation were unable to attend. Attendance for the first presentation included the nurse educator, patient care coordinator, occupational therapist, two social workers, a nursing student, and the unit manager who was only able to attend the first 10 minutes due to other arrangements. The educational session lasted approximately 45 minutes, which was shorter than planned. This was due to the group being small, which led to less discussion than anticipated.

During the educational session the PowerPoint was presented to the participants, including prompting questions throughout to facilitate a discussion. Next, the infographic was presented to the participants, and who provided positive feedback on the content and design of the infographic. The third part of the presentation was a station that included supplies and required documentation when a seclusion room is being utilized. Finally, a role-play activity took place. Although participants were not pleased that they had to engage in this activity, they were still supportive and took part. During this activity, a psychiatric nurse played an escalated patient and participants had to work together to de-escalate the patient. The participants were able to successfully utilize the different skills discussed during the presentation and the actor was

able to settle. After the presentation was over, a meaningful discussion took place with the participants.

The second presentation took place shortly after the first presentation. This presentation was informal as it took place in the nursing station to allow the front-line team to attend to patients when needed. This presentation only consisted of the PowerPoint presentation, the introduction of the infographic, and the seclusion room supply station. There was no role-play activity due to limited time and space. Throughout this presentation, meaningful discussions took place and although the presentation was informal compared to the first presentation, it was deemed successful.

Both groups completed anonymous feedback forms before exiting the presentation. All forms were completed in pencil and placed in an envelope to ensure that there was no way to track which form was completed by whom. The feedback forms were analyzed, and the results will be discussed in the data analysis section.

Data Analysis

Feedback surveys were completed by 10 participants; six from the first presentation which included the role-play activity, and four from the second presentation with no-role play activity. The survey consisted of seven questions related to the presentation (see Appendix B). The data was transcribed to a Microsoft Excel sheet and analyzed to determine the effectiveness of the presentation. The results are as followed:

Q1: Did the presentation help enhance your understanding of the VCH seclusion room policies? 10/10 respondents expressed that their knowledge related to seclusion room policies was enhanced.

Q2: Did the presentation include information that was important to your practice at Carlile? 10/10 respondents agreed that the information that was presented was important to their practice.

Q3: When and why should seclusion be used? 9/10 respondents were able to identify that seclusion rooms are utilized as a last resort.

Q4: What are the two other interventions that were discussed that should be utilized before seclusion? 9/10 respondents were able to identify that PRNs and de-escalation techniques were the other two interventions discussed.

Q5: From the two first-line interventions discussed, can you name two from each? 6/10 respondents were able to identify two PRN medications and two de-escalation techniques that were discussed during the presentation. Confusion related to the wording of this question may have contributed to the reduced number of correct responses.

Q6: Did you find the role-play activity beneficial in practicing first-line interventions? 6/10 respondents were a part of the role-play activity, and all six respondents agreed that the role-play was beneficial.

Q7: Is the infographic easy to follow? 8/10 respondents stated "yes" in response to the infographic being easy to follow, and the other two respondents provided positive feedback, but did not use the word “yes”.

The data shows that the presentation was effective in enhancing participants’ understanding of the seclusion room policy. This is essential as it will encourage staff to effectively use the policy in their future practice and potentially reduce the use of seclusion rooms over time. In addition, there was positive feedback on the infographic indicating it is easy

to follow showing promise that if this infographic is posted in the psychiatric facility, it could influence staff practice on a daily basis to reduce seclusion room use.

Limitations

The first limitation to this project is that the VCH seclusion room policy that is utilized at the Carlile unit is from 2008; meaning that this policy is 15 years old. Due to the policy being outdated, nurses may not be practicing in accordance with the best standards of practice. As per the British Columbia College of Nurses and Midwives (2020), it is essential that a nurse's practice is based on current evidence from nursing science. As the policy is 15 years old, current nursing knowledge is not being utilized, which can cause harm to patients.

Another limitation to this project is that the sample size is small, therefore the benefits of the project will be difficult to assess in a bigger capacity. The sample size for this project was 11 individuals, seven attended the first session and four attended the second session. In the first session, the manager only attended the first portion of the presentation, which brought the sample size down to six. Although all participants found this project to be beneficial, it is hard to judge if the project will be beneficial in practice.

Lastly, as the semester is only three months long, another limitation is determining if this project will be utilized in the future to reduce the use of seclusion rooms. In the capacity of this project, the writer will not be able to assess if the project has contributed to the reduction in seclusion room use in the unit. Moreover, due to the short duration of this project, there was no room to determine if alternative interventions that were taught during the presentation had been utilized on the unit.

Section 4: Reflection

Major Lessons Learned About the Development Process

While completing the master's in nursing degree over the past two years at the University of Lethbridge many lessons have been learned. To begin, the courses leading up to the final project provided insight into the different aspects of completing assignments at a master's level, and how to deal with conflict when completing assignments. Further, there was opportunity to discover topics that I am passionate about. Early in the program, there was a recognition of a passion related to the inappropriate use of seclusion rooms and this became the focus of my master's degree. Every semester, an effort was made to gather information and complete assignments based on seclusion room use in preparation for the final project.

In the final Project Development course, my existing skills were further developed such as time management skills, communicating with the team at work to complete the project, and how to effectively provide and receive feedback from peers. A major lesson learned was that it is essential to provide extra time to receive feedback from colleagues, as implementing these changes takes time. Moreover, there is back-and-forth communication with the instructor that is required to advance the project, and it is essential that time is allotted to fully engage in the process.

Another major lesson was to provide the nurse educator with the project material for feedback in a timely manner before the presentation date. In my case, I emailed the nurse educator two days before the presentation and received feedback the day before. There were a few changes that needed to be made, which caused me to panic as the presentation was the next day.

Throughout the creation of this project, another lesson that surfaced was to have confidence in yourself and your work. I created the infographic without asking colleagues for advice, and when creating the PowerPoint presentation and lesson plan, I asked other individuals for feedback and suggestions. When the first draft of all aspects of the project was emailed to the instructor, they stated that the infographic was well done, but that the lesson plan and PowerPoint were not my best work. It was then explained that the PowerPoint and lesson plan was created based on feedback from others, whereas the infographic was created solely by me. The advice given was to have confidence in myself and my work and to revise these two items based on my individuality and creativity, not the influence of others. This advice was taken very seriously, and the PowerPoint and lesson plan was improved, I felt more confident in the project and was overjoyed with the outcome when I completed the project from my heart.

Reflecting on this final semester, at the beginning and during the project development, feelings of anxiety, stress, failure, and a lack of confidence were experienced. This was due to not feeling confident in the original project and asking too many individuals for input. This caused feelings of overwhelm, as there was pressure to please everyone who had provided insight into the project. After meeting with the instructor and being reminded to have confidence in myself and to put faith in my work, the whole experience of completing the project changed. I felt more satisfied with the outcome of my project, which led to feelings of excitement and self-confidence.

Once the project was complete, I felt relief and happiness, and finally, I felt proud of all the hard work that had been put into this project. Participant feedback was extremely positive and allowed me to feel like I had accomplished something important. The team asked if my project could be used on the unit as they thought the infographic did an amazing job of concisely

outlining the policy, the effects of seclusion rooms, and other interventions that can be used. The team stated that it would be a resource they would use if a patient started to escalate. The team was made aware that this is a discussion for after completing this degree and the patient care coordinator was agreeable to wait. Knowing that the team that attended the presentation is so eager to use this infographic in the future allowed me to understand that this project was a success.

Implications for Nursing Practice and Future Direction

While completing this project, it has become evident that there is a need for an up-to-date VCH policy for the seclusion room at the Hope Centre as the policy used is from 2008. By utilizing a policy that is so old, ethical concerns arise as the care being provided to patients may not be current and can lead to negative health outcomes for patients. As stated by the British Columbia College of Nurses and Midwives [BCCNM] (2020), it is essential that the patient is the focus when providing patient care. In addition, the care provided to a patient needs to be delivered in a manner that protects their dignity.

Furthermore, throughout the literature review, it was difficult to find data related to the number of patients that experience negative effects when seclusion rooms are used. In addition, data related to the number of deaths that occur due to seclusion room use were difficult to locate and data was only found in the article by Sivak in 2012. Sivak (2012) retrieved this data from the Substance Abuse and Mental Health Services Administration, which is an American resource. This shows that there is a lack of data related to the number of deaths caused by seclusion rooms in Canada. In addition, there was no data found regarding how often seclusion rooms are utilized in a mental health setting. This data is essential as this controversial intervention is still used in mental health settings. By having this data readily available, staff will be able to identify that the

use of seclusion rooms is potentially harmful to patients, and the hope is that there is a reduction in the use of seclusion rooms.

More research should be conducted and published on the effectiveness of seclusion rooms and if there are any long-term benefits of this intervention (Kuosmanen et al., 2015). In addition, more data needs to be collected on the design of seclusion rooms to determine if they are effective in reducing escalations and psychotic behaviours that a patient is experiencing (Karr et al., 2017). This is essential as there are many negative effects associated with the use of seclusion rooms. It needs to be determined if there are any benefits that occur when seclusion rooms are used and if the benefits outweigh the harms.

Section 5: Conclusion

As stated by Newton-Howes (2018), the use of secure rooms dates to the 18th century. Throughout history, there is a stigma towards individuals who are diagnosed with a mental illness. In the past, patients have been confined in asylums that were dirty, unhealthy, and inhumane. In the present-day, the use of seclusion rooms is a controversial practice that still exists in mental health. Seclusion rooms are a last-resort intervention that should only be used when a patient is at risk of harming themselves or others (VCH, 2008). Unfortunately, that is not always the case, and seclusion rooms are used as a first-line intervention to benefit staff.

The misuse of seclusion rooms leads to many negative effects for both staff and patients (Beames & Onwumere, 2021). Staff may experience psychical injuries while taking the patient to seclusion rooms (Varpula et al., 2020). In addition, staff may experience psychological effects while initiating this intervention. For patients, the use of seclusion rooms can lead to feelings of neglect, fear, hopelessness, helplessness, depression, and anger just to name a few. Moreover, as

per Varpula et al. (2020), the use of seclusion rooms can lead to psychological distress and post-traumatic distress disorders. Seclusion room use can increase the risk of cardiac and vascular injuries to patients, respiratory injuries, blunt force trauma, falls, and self-harm (Varpula et al., 2020). There is also a risk of death for patients who are in seclusion rooms and approximately 150 patients die a year due to this intervention (Sivak, 2019). This MN project demonstrates that current evidence-based education provided to the interdisciplinary team and point of care reminders like an infographic on units can increase awareness and has the potential to reduce and eventually eliminate this intervention from mental health care.

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Appendix A: Lesson Plan

Effects Associated with Seclusion Room Use

SUBJECT	EDUCATOR	DATE
NURS 6002	Kajal Parmar	06/15/2023

OVERVIEW

Seclusion rooms are an intervention that has been used to confine patients and the use of seclusion rooms dates to the 19th century. A seclusion room is utilized when a patient is at risk of harming themselves or others (Vancouver Coastal Health [VCH], 2023). Before a seclusion room is utilized it is essential that all other interventions have been exhausted and prove to be ineffective (VCH, 2023). This lesson will provide an overview of the negative and positive effects that are associated with the use of seclusion rooms. In addition, this lesson will explore other alternative first-line interventions that must be utilized before seclusion rooms are used. Lastly, the lesson will focus on how to safely and effectively use seclusion rooms to reduce any harm that can be caused to staff and patients.

LESSON PLAN OUTLINE

DETERMINING GOALS AND NURSE'S CHARACTERISTICS	Target Audience: nurses, a nursing student, nurse educator, patient care coordinator, manager, psychiatrist, occupational therapist, social worker, clinicians 1. To increase the interdisciplinary team's awareness of the effective use of seclusion rooms in accordance with VCH seclusion room policies and procedures
PRESENTATION CONTENT AND TIMELINE	1. 12:00-12:15 team arrives and settles in 2. 12:15-12:20 introduction 3. 12:20- 12:50 PowerPoint presentation and questions 2. 12:50-1:00 Introduction of infographic 3. 1:00-1:10 Overview of seclusion rooms supplies/documentation station 4. 1:10-1:30 role-play activity • The group will be split in half and each group will have 10 minutes to participate in the role-play activity • My friend (psychiatric nurse) will play an escalated patient • The participants need to work together to utilize alternative interventions to de-escalate the patient

LESSON PLAN OUTLINE

OBJECTIVES	**Bloom's Taxonomy: Remember and Understand** 1. The interdisciplinary team will recall their knowledge and fill in knowledge gaps related to seclusion rooms policies by answering questions throughout the presentation 2. The interdisciplinary team will understand the positive and negative effects associated with seclusion room use for patients and staff 3. The interdisciplinary team will become aware of first-line interventions (PRN and de-escalation techniques) to prevent the use of seclusion rooms 4. The interdisciplinary team will gain an understanding of the policies and procedures associated with seclusion room use: steps and documentation
EVALUATE	1. Ask questions throughout the presentation to ensure the team is understanding the content 2. Complete the feedback survey after the presentation is completed
SUMMARY	By engaging in this 1.5-hour presentation the staff at the HOPE Centre will: 1. Gain insight into the negative effects that are associated with the misuse of seclusion rooms 2. Understand the positive effects associated with the proper use of seclusion rooms 3. Practice how to utilize first-line interventions during role-play activity

REQUIREMENTS

- Attend 1.5-hour session
- Complete the feedback survey
- Utilize skills learned in practice

RESOURCES

- Infographic
- VCH policies

Appendix B: Feedback Form

Did the presentation help enhance your understanding of the VCH seclusion room policies? Please explain.

Did the presentation include information that was important to your practice at Carlile?

When and why should seclusion rooms be used?

What are the two other interventions that were discussed that should be utilized before seclusion rooms?

From the two first-line interventions discussed, can you name two from each?

Did you find the role-play activity beneficial in practicing first-line interventions?

Is the infographic easy to follow?

Appendix C: Infographic

Seclusion Room Use

Policy

- Last resort intervention
- Only to be used when a patient is an immediate risk to themselves or others
- Short term intervention
- Patient needs to be certified under the Mental Health Act
- In emergency cases voluntary patients can be placed in seclusion for 1 hour

(Vancouver Coastal Health [VCH], 2008)

Negative Effects

- Staff
  - Sprains, strains, concussions, bruises, fractures, stress, and anxiety[9]
- Patients
  - Distress[1]
  - Associate experience to being in prison[1]
  - Trauma, PTSD, psychological distress[9]
  - Cardiac, respiratory and vascular injuries[9]
  - Blunt force trauma[9]
  - Approximately 150 patients die a year[7]
  - Negative emotions: fear, powerlessness, abused, neglected, helpless, hopeless, depressed, isolated, abandoned, and angry[1]

Positive Effects

- Staff
  - Managing disruptive behavior[6]
  - Provides safety for staff[6]
- Patients
  - Settles and improve behavior[4]
  - Safe environment[4]
  - Happy with experience[4]
  - Relief and calmness[1]
  - Provides time to reflect[1]

Alternative Interventions

- Pro Re Nata (PRN)
  - Help reduce psychosis and agitation[5]
  - Common PRN: Benzodiazepines, Chlorpromazine, Haloperidol, Olanzapine, Zuclopenthixol, Loxapine, Quetiapine, and Risperidone[3]
- De-Escalation Techniques
  - Utilize verbal and physical expressions to settle patient[2]
  - Utilize empathy and be non-confrontational[2]
  - Verbal communication, body language, risk assessments, nurse's attitude, and safe environment[3]

When and How to Utilize Seclusion

- Last resort when all other interventions do not work
- When seclusion is warranted
  - Physician's order is needed (new order Q 24 hrs)
  - Call a Code White (security and interdisciplinary team discuss plan of action)
  - Escort patient to seclusion room
  - Ensure all items that can cause harm are taken away
  - Change into hospital pajamas
  - Ensure following items in seclusion room: mattress, pillow (no pillow case) when safe, seclusion room blanket, toilet paper, water, finger food
  - If patient is at risk for flooding room, turn off water
  - Complete documentation
    - Restraint/Seclusion Initiation
    - Restraint/Seclusion Monitoring and Evaluation (every 15 minutes)
    - Nursing narrative: describe behavior, other interventions used, if the patient was cooperative, any injuries, and any changes in status/updates
    - Seclusion room entry Q 2hrs when is patient awake and Q 4hrs when is patient asleep

(VCH, 2008)

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