Provincial Quality, Health & Safety Standards and Guidelines for

Secure Rooms

in Designated Mental Health Facilities
under the B.C. Mental Health Act

BRITISH COLUMBIA

These standards and guidelines apply to all secure rooms in any facility designated as a:

- Provincial Mental Health Facility
- Psychiatric Unit
- Observation Unit

Acknowledgments

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Executive Summary

In light of evidence supporting patient-centered and trauma-informed care, mental health clinicians are encouraged to employ less restrictive techniques and to prevent seclusion whenever possible. The *Standards & Guidelines* present preventive strategies known to help patients de-escalate, best practices for delivering seclusion when it is wholly unavoidable, and, design and construction standards to ensure the safest and most reassuring environment in which to deliver the intervention. The *Standards & Guidelines* emphasize protecting the rights, dignity, health, and safety of individuals admitted to psychiatric facilities, while simultaneously ensuring the safest, most effective, and most satisfying working conditions for caregivers.

Mental health clinicians are encouraged to employ less restrictive techniques and to prevent seclusion whenever possible.

The *Standards & Guidelines* apply to designated facilities in B.C. where secure room exist, specifically provincial mental health facilities, psychiatric units and observation units. Facility directors are expected to achieve 80 per cent compliance with the program and care standards and guidelines within 12 months of adoption. In some cases, units will be unable to comply with the physical environment and design standards and guidelines until renovation or new construction occurs. In the meantime, facilities are expected to continue using existing secure rooms to deliver seclusion as clinically necessary, in conformity with the program and care standards and guidelines. A formal review of the *Standards & Guidelines* will occur two years after implementation.

The health authorities will be supported to implement the *Standards & Guidelines*. Ongoing training and professional development within each health authority is crucial to ensure that all clinicians are well-informed about prevention strategies, alternatives to seclusion, at-risk populations, and key concepts such as trauma-informed practice, emergency assessment, and crisis intervention.

Foundational principles

Seclusion is a physical intervention during which a patient perceived to be in psychiatric crisis is contained either in a locked room, or in a space from which exit is denied (Mayers et al., 2010, p. 61). While no evidence exists to suggest that seclusion contributes to healing or recovery, substantial research supports the claim that it can be harmful to the individual being secluded, as well as to those who witness or deliver

Trauma-informed practice considers each patient's history and the multiple impacts trauma can have on an individual's mental wellness.

Patients themselves are central to creation of their care and comfort plans, and are engaged to identify triggers and strategies to de-escalate a crisis situation.

the intervention (Haimowitz et al., 2006; Borckhardt et al., 2007; Isherwood, 2006; Powell et al., 2008; Kontio, 2011; Payley, 2009; Frueh et al., 2005; Finke, 2001; Ashcraft & Anthony, 2008; Georgieva et al., 2010). Seclusion is therefore intended as an emergency containment measure only, when no other method of preventing an individual from harming him/herself or others has succeeded.

Seclusion should take place only in a room designed specifically for that purpose, and should never be utilized in a punitive fashion, or to prevent property damage or escape. The entire process must be documented thoroughly followed by debriefing sessions between several levels of caregivers, the patient, and family members.

Trauma-informed practice, paired with a recovery-oriented and person-centred approach, is fundamental to these *Standards & Guidelines*. Studies reveal that the majority of individuals hospitalized for a major mental illness have a history of trauma and are more likely to experience seclusion. Trauma-informed practice considers the multiple impacts of trauma and promotes awareness of how trauma can influence an individual's neurobiology, social function and ability to regulate emotion. Extreme care must be taken to introduce intervention strategies that heal rather than escalate the effects of that trauma.

Core Concepts: Program and Care Standards and Guidelines

Continuous contact and communication between staff and patient optimizes the seclusion experience and can foster a sense of calm. Caregivers shall be trained in compassionate, non-discriminatory, non-violent communication that demonstrates gender, sexual, and cultural competence. Patients will be engaged in the development of their own safety and comfort plans to identify triggers, preferred methods of intervention, and items or activities that are likely to promote serenity in a crisis situation. Recovery-oriented plans should integrate specific plans for a patient's safe and supported return to the community.

Preventive strategies and alternatives to seclusion must be available to de-escalate or prevent escalation, such as unlocked private bedrooms, comfort rooms, multisensory rooms, or safe outdoor spaces. Wherever feasible, multisensory Snoezelen-type rooms, comfort rooms, boxes, or carts, or relaxing activities are all highly recommended and can provide effective alternatives to seclusion.

Patients in seclusion should receive frequent and regular face-to-face monitoring and assessment through the in-door observation window, as well as via audio-visual technology including two-way intercoms, CCTV, and infrared cameras. Intercoms will always remain on so that staff can always hear patients who are in seclusion.

During the seclusion period, patients shall receive adequate food, fluids, access to sanitation facilities, and appropriate clothing. Step-down procedures should be enabled as soon as caregivers determine it is safe.

Every seclusion intervention triggers the need for follow-up reflection and review. A formal review will document all aspects of the intervention with the aim of improved practice. Assessing the preventive measures employed, rationale for seclusion, observation and care during the episode, and other details all help staff to prevent similar incidents in future.

Core Concepts: Environment and Design Standards and Guidelines

The physical environment is critical to preventing seclusion. Facilities must undergo detailed exterior and interior assessment by clinical staff as well as designers, architects and builders to determine improvements in entrances, paint, furnishings, signage, lighting and other design elements. Performance targets and checklists in *Standards & Guidelines* delineate standards for safety, hygiene, room size and placement, observation elements, and privacy. Features include impact-and tamper-proof doors, doorframes, locks, and hinges, along with unbreakable, shatterproof observation panels, and windows. Durable soft wall padding, cushioned floors, and abuse-resistant ceilings that eliminate opportunities for hanging or hiding dangerous materials are all critical considerations in secure room design. Anti-suicide combination lavatories will be provided within the secure room, and healthy airflow and temperature will be regulated remotely from outside the room. Blind spots must be eliminated with flush-mounted cameras out of the patient's reach, and alarms will increase safety and security. Only essential furnishings, including a thick floor mat or mattress will be included in the room. Calm, warm lighting will further elevate a sense of tranquility, and the patient will be able to request complete blackening of the room to facilitate sleep. A clock will be visible at all times to help orient the patient about dates and the time of day.

Conclusion

The patient-centred, recovery-oriented approach at the heart of the *Standards & Guidelines* aims to reduce the negative impact of trauma for both patients and staff in mental health facilities, to facilitate smooth transitions, and to foster a culture of collaboration and safety.

These detailed *Standards & Guidelines* ensure that the architectural design and decor within both seclusion rooms and their surrounding facilities foster a calm and safe environment for patients and caregivers alike.

Foreword

Qualifying Statement

This document identifies best practice and provides guidance based on thorough review of current research and expert consultation. It therefore reflects the best clinical knowledge and evidence available as of the date of publication. Notions of best practice will change over time as a result of new research and other evidence. For this reason, mental health and substance use policy makers, managers, clinicians and physicians are asked to consult further with other resources for updated information.

Alignments

The *Standards & Guidelines* comply with legal requirements set out in British Columbia's:

- ***Provincial Violence Prevention Curriculum***
- ***Occupational Health and Safety Regulation***
- ***Workers Compensation Act***
- ***Mental Health Act*** [1]

They are consistent with guidance provided in the:

- ***Accreditation Canada Requirements***
- ***Mental Health Commission of Canada's 2012 National Strategy***
- ***Canadian Standards Association Z8000 Facility Guidelines***
- ***CARF (Commission on Accreditation of Rehabilitation Facilities) Canada***
- ***Council on Accreditation standards for Canadian organizations, Behaviour Support and Management***

1 Note that care planning tools in the appendices are provided as examples only, and are not intended in any way to substitute for or override tools and strategies required by provincial legislation and regulations.

This document replaces the B.C. Ministry of Health's Hospital Based Psychiatric Emergency Services: Observation Units Standards (2000).

Provincial Violence Prevention Curriculum

Occupational Health and Safety Regulation

Worker's Compensation Act

Mental Health Act

Accreditation Canada Requirements

Mental Health Commission of Canada's 2012 National Strategy

Canadian Standards Association z8000 Facility Guidelines

CARF (Commission on Accreditation of Rehabilitation Facilities)

Council on Accreditation Standards for Canadian Organizations, Behaviour Support and Management

In some cases even renovation will not enable a unit to meet the standard as articulated here. Where conformity with the Physical Environment and Design Standards is not possible, clinical and administrative leaders must show evidence of a good-faith effort and document the reasons for any shortcomings, while continuing to use the secure room for seclusion interventions as clinically necessary, in conformity with the Program and Care Standards articulated in this document.

Applying the *Standards & Guidelines*

Seclusion should be prevented whenever possible using a variety of less restrictive techniques. When seclusion is deemed clinically necessary, however, the *Standards & Guidelines* indicate best practice for the delivery of seclusion and the construction and design of secure rooms. A secure room is the only acceptable environment in which to deliver seclusion. Note that the *Standards & Guidelines* apply to secure rooms only, not to larger secured units, and to the practice of seclusion, but not restraint. Although the foundational principles of these *Standards & Guidelines* (trauma informed practice, preventive approach) are applicable to the practice of restraint, the delivery of restraint is governed formally by regional health authority and facility policies.

The *Standards & Guidelines* define clear parameters for the safest possible delivery of seclusion. The safety of all individuals involved with the intervention (patients and staff) ultimately depends on the knowledge, skill and judgment of the clinicians responsible for delivery. These clinicians must receive critical supports including accountable and attentive leadership, professional development, and an appropriately designed and maintained physical environment.

Meeting the Standards for Construction and Design

The *Standards & Guidelines* identify ideal approaches to the design and construction of a secure room in provincial mental health facilities, psychiatric units, observation units (all designated facilities), acute care and emergency departments. They may indicate a significant departure from past practice, and in some cases even renovation will not enable a unit to meet the standard as articulated here (i.e., a unit with an existing secure room that is not placed on an exterior wall cannot be renovated to include the required exterior window).

Whereas new builds will be required to conform to the standards, existing units are expected to retrofit gradually in order to meet the standards. Not all existing conditions can be anticipated, so some judgment will be required to ensure that the intent of the standards is met. Where conformity with the Physical Environment and Design Standards is not possible, clinical and administrative leaders must show evidence of a good-faith effort and document the reasons for any shortcomings, while continuing to use the secure room for seclusion interventions as clinically necessary, in conformity with the Program and Care Standards articulated in this document.

Implementation: A Phased Approach

The intent is to implement the *Standards & Guidelines* through a phased approach. As of the date of implementation:

- Directors of designated facilities are encouraged to identify a regional expert/ lead that can guide the change and implementation process and work with the Ministry of Health.
- It is recommended that regional advisory committees be established to develop an implementation strategy including representation from the various key stakeholders including WorkSafeBC, unions, and Occupational Health and Safety, individuals and families.
- Directors of designated facilities are encouraged to develop an education plan to support staff and physicians in understanding the trauma-informed, prevention expectations, reviewing current practices and policies of the unit, physical environment, and quality improvement practices
- In collaboration with senior management and regional experts/leads of the health authorities, the Ministry of Health will develop a provincial action plan based on the *Standards & Guidelines* to monitor implementation and movement towards attaining the goal of preventing the use of seclusion and creating improvements in quality health and safety in inpatient care, and to receive feedback on further refinement necessary on the *Standards & Guidelines*.
- The Physical Environment and Design Standards will not require compliance until the unit is renovated or new construction occurs. This includes existing capital plans that have not been finalized by the Ministry of Health. In the meantime, facilities are expected to continue using existing secure rooms to deliver seclusion interventions as clinically necessary, in conformity with the Program and Care Standards articulated in these Standards& Guidelines.
- The Program and Care Standards will come into effect as of the date of approval and directors of designated facilities will be expected to have achieved 80 per cent compliance with these standards within 12 months from that time. (See Appendix B for a self-assessment tool that may assist with gauging compliance.)
- In keeping with the philosophy of continuous quality improvement, the *Standards & Guidelines* will be reviewed at 24 months post-implementation.

See Appendix B for a self-assessment tool that may assist with gauging compliance

Access

A copy of the *Standards & Guidelines* is available on the ***British Columbia Ministry of Health – Mental Health and Substance Use website***.

British Columbia Ministry of Health Mental Health & Substance Use

Glossary

Anteroom

A room just outside the door to the secure room, which stands between the secure room and the rest of the unit. It includes the closed-circuit television monitor and intercom, and may also include access to washroom/shower facilities. The anteroom provides private space for clinical staff to observe a patient in seclusion, and/or may receive a patient who is transitioning (i.e., stepping down) out of seclusion back to the unit.

Behavioural care plan

Behavioural care plans are required by violence prevention regulations in order to "communicate to other workers about the risk for violence and interventions that address the risks" (B.C. Provincial Violence Prevention Curriculum, Module 8, p. 11). Details for developing behavioural care plans are included in Module 8 of the ***B.C. Provincial Violence Prevention Curriculum***.

Module 8, B.C. Provincial Violence Prevention Curriculum

Care plan

A written statement of goals and strategies identified upon admission, and updated throughout the patient's stay, that will be used to meet a patient's assessed needs.

Child and adolescent psychiatry

The branch of psychiatry focusing specifically on diagnosing and treating children and adolescents suffering from a broad range of psychiatric disorders, including but not limited to developmental, attention and behaviour, psychotic, mood, anxiety and eating disorders. Children and adolescents are treated in a developmentally appropriate manner, and interventions are designed to assist them and their families/caregivers.

Module 6, B.C. Provincial Violence Prevention Curriculum

Code White

According to the Provincial Violence Prevention Curriculum, a Code White "is a term that is used to call for help when: workers perceive themselves or others to be in danger of physical harm from someone who is violent; someone is acting out in a way that is dangerous to self, others, or the environment; the situation is rapidly escalating out of control – the present staff does not have the capability to de-escalate the situation. Calling this code triggers an emergency response that varies by facility, sector and/or workplace" (***Module 6***, p. 12). A Code White team consists of three to five highly trained individuals who respond to Code White calls. Not all sites have a designated Code White team.

See Appendix C and D for samples of Comfort and Personal Safety Plans

Comfort and personal safety plans

A written guide developed collaboratively between clinical staff and a patient (or family member/caregiver/guardian in situations where a patient cannot verbalize his or her needs), which identifies strategies for recognizing an individual patient's triggers for and signs of distress; measures known to be comforting and calming to the patient; and methods of preventing seclusion and/or restraint (see samples in Appendix C and D). Many elements of comfort and personal safety plans are also included in behavioural care plans for violence prevention.

See Appendix E for samples of Comfort Rooms and Items

Comfort rooms/carts/boxes

Cited frequently in the evidence for seclusion prevention, comfort rooms, carts and boxes are relatively low-cost, easily implemented preventive measures that can be designed collaboratively between clinical staff and patients. Comfort items might include: yoga mats, music player, rocking chair, recliner, bean bag chair, mural, adjustable lighting, books, bubble wrap, hand lotion, aromatherapy products, weighted blankets, stress balls, and photos of nature (see example photos in Appendix E).

Cultural competence

Cultural competence refers to the ability to recognize and respect cultural difference and diversity. In the context of delivering psychiatric care, cultural competence is necessary to facilitate effective communication between patients and providers; to ensure a system of care that responds to a variety of culturally-dependent beliefs, needs and practices; to ensure that care is trauma-informed; and to improve patient outcomes and provider experiences by reducing power imbalances that result from systemic inequality, discrimination, stigma, and/or stereotypes.

Delivering care that is culturally competent is especially important when working with patients from minority population groups or any population group with a history of systemic oppression (e.g., First Nations, people of colour, people living in poverty), and/or whose cultural values and systems do not always align with mainstream health service delivery models designed for the dominant culture.

De-escalation

In the context of psychiatric care, de-escalation refers to psychosocial strategies that calm a patient who is experiencing a behavioural disturbance or crisis.

Designated facility

A provincial mental health facility, psychiatric unit or observation unit designated under the *Mental Health Act*. This document defines standards and guidelines specifically applicable to designated facilities in British Columbia.

Developmental disability

Developmental Disabilities Association

According to the ***Developmental Disabilities Association***, developmental disability describes "Life-long impairments that are attributable to mental and/or physical disabilities," including but not limited to autism spectrum disorder, cerebral palsy and Down's Syndrome. People with developmental disability have a higher rate of mental health disorders than the general population, yet are typically poorly diagnosed and served. Research indicates that people with developmental disability receiving inpatient psychiatric treatment are at higher risk of seclusion and restraint.

Dual diagnosis

The term dual diagnosis applies to individuals experiencing both a mental health disorder and developmental disability.

Family member

According to the Mental Health and Substance Use Community Advisory Committee's policies and guidelines, a family member is anyone "of significance in the life of the consumer related by blood, marriage or other personal relationships."

General psychiatry services

Provides short-term assessment, diagnosis, and treatment for adults aged 18 to 65 years who are in the acute phase of their illness, requiring a safe and therapeutic environment on a 24/7 basis. The majority of patients have a primary mental illness diagnosis and the current average length of stay is 15-20 days.

Neuropsychiatric disorders

Populations with neuropsychiatric disorders experience mental health disorders that may be attributable to diseases of the brain including but not limited to stroke, dementia and Alzheimer's disease. Individuals within these populations may exhibit extremely challenging behaviours as a result of their illness, and are thus at higher risk of seclusion and restraint.

Observation unit

The *Mental Health Act* of British Columbia, under Section 22, permits people with mental illness requiring involuntary treatment to be transported to a designated facility (provincial mental health facility or psychiatric unit or observation unit). Hospitals not designated under the *Mental Health Act* should only care for the patient while "in transit" to a designated facility. In order to provide involuntary treatment, these hospitals would require a designation under the *Mental Health Act*.

Hospitals designated under the *Mental Health Act* as observation units manage the care of and stabilize acutely ill psychiatric patients. If a hospital is designated as an observation unit, and a physician completes a medical certificate, the patient may be admitted to the hospital in order to receive involuntary treatment. Observation units are able to accept involuntary psychiatric patients for short periods of assessment and treatment. The prescribed period for purposes of detaining and treating a patient in an observation unit is a maximum of five days after the second certificate is completed.

A hospital designated as an observation unit (most typically a rural hospital) will have a secure capacity within the emergency room or a medical/surgical unit (or be adjacent to some other crisis stabilization program located within the hospital). This arrangement will enable staff working in other areas of the hospital to provide coverage in the location where patients are being held under the provisions of the *Mental Health Act*.

Module 8, B.C. Provincial Violence Prevention Curriculum

Patient Violence Risk Assessment (PVRA)

The PVRA considers "a patient's potential for violence or observed violent behaviours" (B.C. Provincial Violence Prevention Curriculum, Module 8, p. 2). The PVRA determines the need for developing a behavioural care plan for violence prevention. For details on how to use a PVRA and how it relates to behavioural care planning, please see ***Module 8 of the B.C. Provincial Violence Prevention Curriculum***.

Person-centered treatment

Treatment that emphasizes collaboration between clinicians and individuals receiving care, prioritizes individualized patient-specific care, and involves patients whenever possible as active agents in clinical decision-making. The Mental Health Commission of Canada offers a further definition: "Being person-centered means a measure of success will be the actual impact of treatments, services, and supports on the health and well-being of people themselves" (MHCC 2009, p. 15). Person-centered treatment includes family members, guardians or other caregivers as appropriate (e.g., when treating children and youth, when treating individuals who are non-verbal, etc.). As such, services also consider the client's developmental needs (i.e., age, neurologic disorders, developmental disorders) and adapt treatment approaches/options accordingly.

Physical intervention

Interventions such as restraint and seclusion, which are designed to contain a patient who is perceived as violent or aggressive and a threat to him/herself and/or others.

Psychiatric assessment unit

Provides short term assessment and treatment, and emergency care with a typical length of stay of five days.

Psychiatric emergency unit

Provides emergency psychiatric care to stabilize individuals and assess treatment needs prior to transfer to an inpatient setting. Units are generally developed in close proximity to the emergency department or may be part of the emergency department, and may have a separate entrance for police/ambulance escort. Typical length of stay is under 24 hours.

Psychiatric intensive care unit (PICU)

A locked psychiatric unit providing intensive assessment and stabilization for individuals who require intensive care and/or separation from other patients. The PICU is similar to a psychiatric assessment unit.

Translating Principles of Psychogeriatric Care into Practice: Process and Outcomes: A Report on Sandringham Care Centre

Simon Fraser University Psychogeriatric Client Identification Project

B.C. Psychogeriatric Association Report Meeting Seniors' Mental Health Care Needs in British Columbia

Psychogeriatric

Psychogeriatric populations are composed of ***"older adults with serious and persistent mental illness."*** Comprehensive discussion of the scope of psychogeriatric illness can be found in the final report of Simon Fraser University's ***psychogeriatric client identification project***. Further information is provided in a document from the B.C. Psychogeriatric Association's report, ***Meeting Seniors' Mental Health Care Needs in British Columbia***.

Recovery

According to the Mental Health Commission of Canada, recovery "involves a process of growth and transformation as the person moves beyond the acute distress often associated with a mental health problem or illness and develops new-found strengths and new ways of being." Key components include: hope, belief in oneself and optimism about the future; defining a positive identity that may incorporate illness; building a meaningful life that may include illness; a sense of responsibility and control over one's life (MHCC 2009, p. 28).

Recovery-oriented practice

A model that emphasizes hope, autonomy and engagement in order for a patient experiencing mental illness to live a satisfying, meaningful and purposeful life despite the constraints of his/her illness.
Restraint (chemical and physical)

Chemical or physical interventions that are administered involuntarily, and are designed to restrict an individual's mobility and physical activity. Seclusion is a method of restraint. Physical restraint includes holds as well as mechanical intervention (e.g., four-point restraints).

Chemical restraint results from use of medications with the specific intent of reducing a patient's mobility or to promote sedation beyond that required for a normal sleep cycle. By contrast, sedation results from medication administered to treat drug-responsive behavioural or neuropsychiatric symptoms associated with a specific medical and/or psychiatric diagnosis.

Seclusion

Seclusion is a method of restraint during which a patient perceived to be in psychiatric crisis is contained in a room that is either locked or "from which free exit is denied" (Mayers et al., 2010, p. 61). An individual who has been contained and prevented from leaving a space in the course of a psychiatric intervention is considered to be experiencing seclusion whether or not the intervention is carried out in a formal secure room or other alternatively-labeled environment, including a patient's hospital bedroom.

Secure room

A room designed expressly for the purpose of delivering seclusion interventions. Consistent with Accreditation Canada's approach, the *Standards & Guidelines* use the term secure room exclusively to refer to the room in which seclusion should be delivered.

Sensory interventions (also: sensory modulation, multisensory options)

An intervention employing techniques designed to stimulate multiple senses; a component of person-centered, trauma-informed practice. Sensory interventions can help people to organize their thoughts, prevent behavioural crises, and function better in their environment. Interventions may be calming or activating, depending on individual need, and include strategies addressing all senses. Sensory techniques include aromatherapy, therapeutic touch, brushing, joint compression, weight, and should be delivered by a trained occupational therapist. In the context of preventing seclusion, such interventions may include provision of multisensory environments such as the trademarked Snoezelen rooms or generic comfort rooms, carts or boxes.

Sex and gender competence

In the context of psychiatric care, sex and gender competence refers to the ability to recognize and respect sex and gender diversity (including gender nonconformity) and the ways in which sex and gender determine a person's experience of health services. Although the theoretical issues are different, competence around sexual identity is equally important, and in practice often related to sex and gender competence.

Like cultural competence, sex and gender competence is also necessary to facilitate effective communication between patients and providers; to ensure a system of care that responds to variation in sexual and gender identities; to respond to an individual's specific needs arising from that person's self-determined sexual and gender identities; to ensure that care is trauma-informed; and to improve patient outcomes and provider experiences by reducing power imbalances that result from systemic inequality, discrimination, stigma, and/or stereotypes.

Time-out room, quiet room

Facilities around British Columbia and across jurisdictions frequently use terms including quiet room or time-out room to refer to the room in which seclusion is delivered. This is not consistent with the practice of national accreditation bodies such as Accreditation Canada, and, therefore, is not endorsed in the Standards and Guidelines. Rather, the Standards and Guidelines recognize time-out or quiet rooms as environments that are useful for preventing seclusion, or offer potential alternatives to seclusion for patients who are not at risk of violence but require an environment set aside from the rest of the unit in order to de-escalate or alter their own behaviour.

Trauma-informed practice

Trauma-informed practice takes into account an understanding of trauma in all aspects of service delivery and place priority on the individual's safety, choice and control (Harris & Fallot, 2001). A key aspect of trauma-informed services is to create an environment where service users do not experience further traumatization or re-traumatization. This is supported, in part, through awareness of the wide-ranging impacts of trauma on an individual. This includes the ways in which trauma changes an individual's neurobiology and capacity for adaptive social functioning and emotional regulation, which often cause behaviours associated with a need for seclusion. The majority of individuals hospitalized for major mental illness have a history of trauma, and individuals with trauma histories are more likely to experience seclusion.

Introduction and Rationale

In 2010-11, there were 29,497 admissions (21,048 unique individuals) to designated facilities across British Columbia, with approximately 45 per cent of those admissions being involuntary.[2] These people and their families, caregivers and communities require evidence-based, client-centered treatment that: ensures the health and safety of every person in psychiatric care; continues to improve service development; and furthers the integration of services within a continuum of care.

While there are a variety of regulatory and quality standards governing B.C.'s designated facilities, no single approach is comprehensive enough to address all health and safety risk elements. Moreover, a review of B.C.'s *Mental Health Act*, *Hospital Act*, and *Patient Property Act* demonstrates that no specific legislated quality, health and safety rules apply specifically to care provided in designated facilities.

The Ministry of Health thus identified the practice of seclusion in facilities designated under the *Mental Health Act* as an area of particular concern requiring a set of clear, evidence-informed, measurable minimum standards and guidelines to ensure the delivery of high quality, safe and effective services that reflect the best available evidence and leading practice in the field.

Seclusion is defined as a physical intervention during which a patient is contained in a room that is either locked or "from which free exit is denied."

Mental Health Act

Guide to the Mental Health Act

Developing standards and guidelines for secure rooms and the practice of seclusion is particularly important because of the vulnerability of individuals admitted to designated facilities for often involuntary psychiatric care. Please consult the ***Guide to the Mental Health Act*** for more information on regulations for emergency procedures and/or involuntary admission, as well as a current list of designated facilities.

2 *Mental Health and Substance Use Services Overview, 2010/11, provided by the Ministry of Health MHSU Branch*

Occupational health and safety

Developing standards and guidelines for secure rooms and the practice of seclusion is also crucial to ensure that staff work in environments that meet the legal specifications set out in the provincial Occupational Health and Safety Regulation, Workers Compensation Act, and violence prevention requirements.

An environment that promotes prevention and minimization is a prerequisite for the safe delivery of seclusion when the intervention is necessary and unavoidable.

Terminology

There is significant variation in the terminology used to describe the places in which seclusion interventions occur. Consistent with Accreditation Canada's approach, the *Provincial Quality, Health and Safety Standards and Guidelines for Secure Rooms in Designated Mental Health Facilities under the B.C. Mental Health Act* (the *Standards & Guidelines*) use the term *secure room* exclusively to refer to the room in which a seclusion intervention should be delivered. Facilities around the province use additional terms including quiet room and time-out room to refer to the same or essentially the same type of space. The *Standards & Guidelines* will not use those terms for two primary reasons:

- ☑ to emphasize that there is only one type of highly specialized space in which it is acceptable for seclusion to be delivered; and,
- ☑ to standardize the language used to refer to spaces designated for seclusion, which will benefit the overall system of care in British Columbia.

In terms of the intervention itself, the *Standards & Guidelines* address the practice of **seclusion**. Seclusion is defined as a physical intervention during which a patient perceived to be in psychiatric crisis is contained in a room that is either locked or "from which free exit is denied" (Mayers et al., 2010, p. 61). An individual who has been contained and prevented from leaving a room in the course of a psychiatric intervention is considered to be experiencing seclusion, whether or not the intervention is carried out in a formal secure room or other alternatively-labeled room, including a patient's hospital bedroom.

Guiding principles: prevention and minimization

The overall framework for the *Standards & Guidelines* reflects the consensus among researchers and clinicians that seclusion should be prevented whenever possible using a variety of less restrictive techniques. To date, there is no evidence that seclusion contributes to healing or recovery, and there is strong support for the claim that it can be harmful to the individual being secluded as well as to those who witness or deliver the intervention (Haimowitz et al., 2006; Borckhardt et al., 2007; Isherwood, 2006; Powell et al., 2008; Kontio, 2011; Payley, 2009; Frueh et al., 2005; Finke, 2001; Ashcraft & Anthony, 2008; Georgieva et al., 2010).

The most often cited and implemented structure for preventing and minimizing seclusion is the National Association of State Mental Health Program Directors' (NASMHPD) *Six Core Strategies for the Reduction of Seclusion and Restraint in Inpatient Facilities*© (Huckshorn, 2006b; see Appendix F), first developed in 2003. The *Six Core Strategies* are rooted in trauma-informed practice, and have been validated as an effective approach to reducing the prevalence of seclusion (Azeem, 2011). The *Standards & Guidelines* draw heavily on these strategies, as well as well as other important research and clinical evidence.

Recovery-oriented, person-centered, trauma-informed practice

In situations when seclusion cannot be prevented, it should be delivered in a manner that is trauma-informed, recovery-oriented and person-centered; ensures the safety of both patients and service providers; accounts for any unique clinical considerations; is developmentally appropriate; and conforms to clear standards of practice. Facilities delivering seclusion provide an environment with high levels of oversight and accountability, and emphasize continuous quality improvement to support prevention and minimization.

A recovery-oriented, person-centered approach is consistent with the Mental Health Commission of Canada's position that the outcome of an intervention should be measured according to its impact on a person or population's well-being, and emphasis on delivering interventions that empower, build on individuals' strengths, and reinforce people's sense of hope (MHCC, 2009; MHCC, 2012).

A trauma-informed approach is similarly crucial to delivering appropriate services within inpatient psychiatric settings. According to expert researchers and clinicians, the majority of individuals hospitalized for major mental illness have a history of trauma – estimates range anywhere from 51 to 98 per cent – and individuals with trauma histories are more likely to experience seclusion (Murphy & Bennington-Davis, 2005, p. ix and p. 9; Champagne & Stromberg, 2004, p. 36; Hammer et al., 2006). One study in the US indicates that among individuals experiencing seclusion and restraint most frequently, 70 per cent had histories of childhood sexual or physical abuse (Hammer et al., 2006). Finally, there is evidence that it helps decrease conflict between patients and staff by avoiding power-based practice (Murphy & Bennington-Davis, 2005).

Trauma-informed practice takes into account the wide-ranging impacts of trauma (e.g, physical, emotional, behavioural, interpersonal, spiritual). It promotes an awareness of the ways in which trauma changes, for example, an individual's neurobiology and capacity for adaptive social functioning and emotional regulation, often causing the behaviours associated with a need for seclusion (Murphy & Bennington-Davis, 2005; Azeem et al., 2011; Delaney, 2006; Borckhardt et al., 2007; Bills & Bloom, 1998; Hammer et al., 2006; Ashcraft & Anthony, 2008; Champagne & Stromberg, 2004). The neurobiology of trauma can lead individuals who perceive a new threat — whether precipitating admission, through the admission process, or during their stay in a psychiatric unit — to experience "heightened vigilance, increased adrenaline…, fear that interferes with clear cognitive processes and impulse control, and interference with verbal processes." It is critical for staff to respond to patients in this state with empathy and understanding, recognizing that the behaviour they see may be an involuntary response to particular stimuli based on that individual's biochemistry (Murphy & Bennington-Davis, 2005, pp. 107-8).

When a person's escalated behaviour is understood as a result of trauma, it makes little sense to respond to that behaviour with an intervention that most patients say is traumatic in and of itself, and which they typically perceive to be coercive, shameful, humiliating, punitive, confusing and alienating, no matter how carefully it is delivered (Murphy & Bennington-Davis, 2005; Georgieva et al., 2010; Kontio, 2011; Hyde et al., 2009; Bowers & Flood, 2006; Van Der Merwe et al., 2012).

Scope

Seclusion and restraint

Research literature often addresses seclusion in tandem with restraint (physical and chemical) because of the significant overlap between the two practices. The *Standards & Guidelines*, however, address policy and practice relating only to seclusion. While chemical and physical restraint are outside the scope of this document, it is critical that prevention or minimization of seclusion does not contribute to increased use of these interventions.

Variation in environments and populations

While developing the *Standards & Guidelines*, seclusion was delivered in a variety of different environments for a range of populations across B.C. The spaces available for seclusion in designated facilities vary widely depending on whether they are located in inpatient psychiatric, observation or tertiary units; in urban or rural hospitals; or in emergency departments (EDs). The *Standards & Guidelines* are applicable to the following designated facilities in B.C. where secure rooms exist:

- Provincial and tertiary facilities
- Psychiatric units
  - General psychiatric inpatient units (adolescent, adult, psycho-geriatric)
  - Intensive psychiatric units (adolescent, adult)
- Observation units

The literature and stakeholder consultations indicate strongly that standards of care (both program and environmental) are to apply equally across populations, including children and adolescents, people with developmental disability[3], and psycho-geriatric populations. With minimal noted exceptions (see pp. XX and XX), therefore, these *Standards & Guidelines* have been developed according to the principle that a standard or guideline for seclusion must be safe and appropriate for all populations if it is to be considered safe and appropriate for any population.

While evidence indicates that a trauma-informed, preventive approach will be effective for the vast majority of people receiving inpatient psychiatric treatment, there will be some individuals whose developmental, neurological or extreme aggressive behaviour warrant a different approach. Clinicians may determine that seclusion is the only way to ensure that the individual, staff and/or other patients are safe, and should use their experience and judgment to identify the most appropriate intervention.

A standard or guideline for seclusion must be safe and appropriate for all populations if it is to be considered safe and appropriate for any population.

3 The Ministry of Health publication, *Planning Guidelines for Mental Health and Addiction Services for Children, Youth and Adults with Developmental Disability [hyperlink]*

Note: Due to the unique requirements associated with the legal status of individuals receiving care in designated forensic facilities, these facilities are excluded from the *Standards & Guidelines* at this time.

Methodology

The *Standards & Guidelines* for secure rooms and the delivery of seclusion are based on the best available evidence in the published academic and gray literature, a cross-jurisdictional scan of existing standards and guidelines, and comprehensive consultation with international experts in the field as well as a broad collection of stakeholders in B.C.

The standards and guidelines were drafted following a thorough review of published evidence and consultations with research and clinical experts across jurisdictions.[4] A multidisciplinary steering committee provided ongoing guidance throughout this process. Throughout the drafting process, guidance was received from a multidisciplinary steering committee, and a comprehensive series of consultations was conducted with a variety of stakeholders in B.C., representing clinical and administrative staff and leaders across departments at all regional and provincial health authorities, as well as with representatives of relevant organizations including the Provincial Violence Prevention Safety Committee, WorkSafeBC, Provincial Community Advisory Committee (child and youth), BC Nurses' Union, Union of Registered Psychiatric Nurses, and Occupational Health and Safety Directors.

Clients' experiences with seclusion were also sought through examination of published literature, the Ministry of Health's client survey, and consultation with client and family groups. Formal and informal consultations with clients and family members took place throughout the drafting process, and the standards were developed with client-focused intervention as a core value.

The standards and guidelines in this document therefore represent best practice as defined in the current literature and among experts in the field, as well as the consensus opinion of a broad range of stakeholders. They conform to all legal requirements in the province of B.C., and to regulations already defined by the Canadian Standards Association (CSA), and align with both the Mental Health Commission of Canada's National Strategy and all Accreditation Canada requirements. (See Appendix A for a complete listing of all consultations performed in the development of these *Standards & Guidelines*).

http://www.health.gov.bc.ca/library/publications/year/2007/MHA_Developmental_Disability_Planning_Guidelines.pdf provides further guidance on the care approach appropriate for these individuals.

4 See the *Secure Rooms and Seclusion Standards and Guidelines: A Literature and Evidence Review* **http://www.health.gov.bc.ca/library/publications/year/2012/secure-rooms-seclusion-guidelines-lit-review.pdf** *for details on the methodology behind the evidence review.*

Best practice standards vs. guidelines

In the last 15 years, researchers appear to have shifted their focus away from delivery of seclusion in and of itself, and toward delivery in the context of prevention, reduction, and/or elimination of seclusion. In the process, they have generated a rich complementary body of literature, which expands the issue's scope and complexity, and introduces evidence gleaned from both quantitative and qualitative research designs.

Standards are based on evidence of best practice. Designating an element/practice as a standard required a high level of support within the literature on delivery, reduction, elimination, and/or prevention, in most cases combined with strong clinical consensus reflected in the testimony of key expert clinicians and administrators consulted across several jurisdictions. Standards are requirements to which a facility will be held accountable.

Guidelines have been developed to reflect practice that is strongly recommended, but drawn from evidence that is weaker or equivocal. Guidelines therefore allow for flexibility in application and may be updated as new evidence becomes available.

Organization of the *Standards & Guidelines*

For ease of use, the *Standards & Guidelines* are presented in two sections — program and environment — in order to provide clinicians, facility planners, builders and decision-makers with guidance specific to either the delivery of seclusion or the secure room environment. However, the clinical and experiential dimensions of seclusion are linked to the physical surroundings in which the intervention takes place. The Program and Care section is further organized based on the foundation of trauma-informed care and prevention, and therefore presented in three parts: Preventing Seclusion, Seclusion Interventions, and Post-Seclusion. According to best practice evidence, physical environments in designated facilities must include features that promote the prevention of seclusion and support the delivery of trauma-informed, patient-centered care.

An environment that promotes prevention and minimization is a prerequisite for the safe delivery of seclusion when the intervention is necessary and unavoidable.

1. Program and Care Standards & Guidelines

The evidence base for seclusion

Seclusion is losing legitimacy in jurisdictions that endorse evidence-based health policy because it has no proven therapeutic value (Sailas & Fenton, 2009; Happell & Harrow, 2010). **There is no evidence that seclusion contributes to healing or recovery, and there is strong indication that it can be harmful to the individual being secluded as well as to those who witness or deliver the intervention** (Haimowitz et al., 2006; Borckhardt et al., 2007; Isherwood, 2006; Powell et al., 2008; Kontio, 2011; Payley, 2009; Frueh et al., 2005; Finke, 2001; Ashcraft & Anthony, 2008; Georgieva et al., 2010). Some experts have argued that seclusion is not a treatment at all, but a treatment failure, and if it is ever a suitable intervention, it functions as an emergency containment measure only, when no other method of preventing an individual from harming him/herself or others has succeeded (US DHSS, 2011; McGann, 2011).

All evidence suggests that an environment that promotes prevention is a prerequisite for the safe delivery of seclusion when the intervention is necessary and unavoidable. A preventive approach can become part of the underlying philosophy of care or facility culture that emphasizes the simultaneous need to ensure staff and patient safety; prioritizes staff education and support so that staff have the tools with which to provide patient-centered care in a safe and appropriate environment; and recognizes the need for strong leadership committed to transparency, monitoring and oversight.

Safe delivery

Treatment facilities that encourage healing and recovery and discourage introducing or reinforcing trauma need to consider carefully the evidence that many patients are likely to find seclusion distressing and confusing at best, no matter how carefully it is delivered (Kontio, 2011; Hyde et al., 2009; Bowers & Flood, 2006; Van Der Merwe et al., 2012).

Seclusion should take place only in a room designed specifically for that purpose, conform to protocols that are part of a facility's standard operating procedure, and not be delivered on an ad hoc basis.

When prevention is carried out according to evidence-based guidance, the typical result is lower staff injury, lower staff turnover and absenteeism, and increased job satisfaction. Minimizing physical interventions and adopting a trauma-informed approach to care is likely to reduce the risk of assault to both patients and staff.

Given the known risks involved, it is critical that clinicians and other professionals prioritize safety and quality of care when delivering seclusion. When seclusion must take place, it is a short-term, emergency intervention designed to protect and enhance the safety of the individual patient and others on the unit. Seclusion should take place only in a room designed specifically for that purpose, conform to protocols that are part of a facility's standard operating procedure, and not be delivered on an ad hoc basis (Pereira et al., 2007).

The *Standards & Guidelines* are built upon a simultaneous commitment to both staff and patient safety. Because of the vulnerability of patients in the inpatient setting, staff must ensure that they treat patients with dignity and respect, and monitor their physical and emotional health and wellbeing. Following any incident of seclusion, staff must document the entire process thoroughly, and conduct debriefing sessions that involve the facility's clinical and administrative leaders, and the patient and/or an advocate/family/guardian.

Patient assaults on staff are a serious concern and there is little research evidence to support the common claim that seclusion may protect staff from violent assaults. Indeed, according to research performed by the American federal Substance Abuse and Mental Health Services Administration (SAMHSA), seclusion and restraint often cause rather than prevent or respond to violence (US DHSS, 2011). This is particularly the case when secluding individuals with histories of trauma, as retraumatization may lead to additional behavioural disregulation, which increases the risk of physical injury to clients and staff (Hammer et al 2006, p. 574). When prevention and minimization efforts are carried out according to evidence-based guidance, the typical result is lower staff injury, lower staff turnover and absenteeism, and increased job satisfaction. A facility with leaders and an overall culture that minimize physical interventions, and create an environment rooted in trauma-informed care, is likely to reduce the risk of assault to both patients and staff (Flannery et al., 2007, p. 88).

Culture shift required to implement the Standards & Guidelines

Implementing the *Standards & Guidelines* is likely to require a significant culture shift within a specific facility or health authority, and in acute care overall. Evidence indicates great value in shifting away from authoritarian styles of practice typically associated with the use of seclusion, and moving instead to a culture of collaboration and engagement, where staff are supported rather than simply directed, and where patients are encouraged to be active partners in their own care (Murphy & Bennington-Davis, 2005).

1. GENERAL

Standards

☑ Patients shall be treated with dignity and respect at all times.

☑ Seclusion shall only be delivered within a secure room, designated expressly for the delivery of seclusion.

- Seclusion is said to have occurred when a person is contained in and prevented from leaving a room, whether or not the room is designated formally as a secure room. When a patient is denied free exit from a bedroom or any other room, the patient is considered to be in seclusion. Being admitted to a locked unit does not qualify as seclusion.
- Policies related to the secure room design and use shall be approved by a vice president within the health authority.

☑ All standards and guidelines shall be translated into health authority policies and procedures.

☑ Seclusion shall be delivered within the context of trauma-informed, recovery-oriented, patient-focused care.

☑ Seclusion shall be a short-term emergency measure of last resort, used only when all efforts to prevent the use of seclusion have failed.

☑ Individuals experiencing withdrawal symptoms will not be placed in a secure room while not medically stable.

- Use of the secure room needs to align with facility protocols/policies related to withdrawal management.

- ☑ Seclusion shall be used only to prevent a patient from harming him or herself or others.
  - Seclusion shall never be used as a disciplinary or punitive measure.
  - Seclusion shall not be used solely to prevent damage to property.
  - Seclusion shall not be used solely to prevent absconding.
  - Each patient should be assessed for risk of elopement, and to ascertain the value of providing options for containment (but not seclusion) specifically to prevent elopement.
  - The required behavioural care plan for violence prevention as well as any other care planning tools deemed appropriate shall be used to identify when aggression involving property damage or absconding is understood to pose a risk to the patient or others that could warrant seclusion.
  - Police may be called to a designated facility to enforce public safety in the event of an incident where onsite resources (e.g., code white team, security guards) are unable to provide adequate intervention and the use of seclusion is required.

- ☑ Hospital security staff shall follow facility-based policies and procedures regarding the role of security in the initiation of seclusion.
  - Hospital security staff may receive Code White training, which will clearly define the role of the security and clinical teams during a seclusion intervention.

- ☑ Policies and procedures shall be in place to ensure appropriate psychiatric, mental health and medical assessments of all patients.

- ☑ Post-incident reflection and review shall be conducted following seclusion interventions as part of a cycle of continuous quality improvement (see Appendix G for more information).
  - Reflection and review is not required more than once for a single patient within a 24-hour period (i.e., if a patient experiences more than one seclusion intervention within a 24-hour period, that patient does not require a separate reflection and review process for each seclusion intervention).

- ☑ The clinical team shall document and report out on all seclusion interventions.

- ☑ Clinical teams shall support and monitor prevention, performance and quality improvement.

- ☑ Clinical and administrative units shall monitor and report out on staff performance and accountability in order to support staff in delivering best-practice interventions.

- ☑ Clinical and administrative leadership shall be accountable for the use of seclusion.

- ☑ Staffing levels shall be adequate for appropriate provision of clinical care:
  - Clinical units shall be staffed in a manner that facilitates prevention of seclusion. For example, inpatient unit staff should include an occupational therapist, recreational therapist or other staff who may deliver recreational and/or rehabilitative daily programming.
  - Clinical units shall be staffed in a manner that facilitates appropriate levels of observation. For example, units require the capacity to provide increased levels of observation for patients at risk of seclusion in order to prevent the need for a seclusion intervention. Similarly, units shall have enough nursing staff to enable close observation and monitoring of patients in seclusion.

2. PREVENTING SECLUSION

All evidence indicates that a proactive focus on prevention is a prerequisite for the safe delivery of seclusion when the intervention is necessary and unavoidable. An emphasis on prevention meets clinical best-practice standards, and has a strong business case: studies have shown relatively minor to no additional costs associated with prevention, and some research indicates significant cost savings.[5]

Primary and secondary preventive measures, such as trauma-informed practice to prevent escalation and de-escalation techniques to reduce aggression, minimize the need for seclusion overall. When seclusion does occur, practice shall be designed to reduce the negative consequences of the intervention for both patients and staff. ALL staff on a unit (clinical and support) can play a role in supporting prevention activities and creating an environment that is ***trauma-informed***.

Trauma-Informed Practice Guide

Secure Rooms and Seclusion Standards and Guidelines: A Literature and Evidence Review

5 For evidence of the value of a prevention focus, see ***Secure Rooms and Seclusion Standards and Guidelines: A Literature and Evidence Review***

Standards

☑ Designated facilities shall define a clear and unwavering mandate for the prevention of seclusion.
- Physicians shall be engaged in the development and delivery of prevention strategies.

☑ Designated facilities shall deliver recovery-oriented, trauma-informed care that includes:
- Patient-centered admissions practices that demonstrate respect, compassion and empathy for the individual being admitted;
- Non-discriminatory language, and non-hierarchical, non-violent communication;
- Sex and gender competent practice, including respect for an individual patient's needs based on the patient's sexual and/or gender identity;
- Culturally competent practice, including respect for an individual patient's needs based on the patient's cultural and/or religious practice;
- Trauma history assessment; and
- Safety and comfort plans developed with patients to identify and prevent known triggers of violence and aggression, and identify non-physical interventions that may calm a patient whose behaviour escalates in response to such triggers. These may be developed in addition to behavioural care plans for violence prevention required by violence prevention regulations.

☑ Designated facilities shall implement specific and proactive strategies to prevent the need for seclusion and minimize its use. These include provision of:
- increased levels of observation for patients known to be at risk of seclusion or showing signs of escalation that may lead to seclusion (this could include one-to-one observation as appropriate);
- meaningful daily activities that prevent aggression by promoting engagement;
- a non-coercive, collaborative approach to care;
- private or alternative spaces to lower stress and encourage relaxation (e.g., single-occupancy bedrooms; quiet or comfort rooms);
- effort to identify a patient's individual triggers and coping strategies;
- sensory interventions to promote self-management.
- Designated facilities shall provide or support staff to undertake comprehensive and ongoing training in interventions to prevent seclusion.

☑ For units that have a comfort and/or multisensory room: Staff should utilize comfort or multisensory rooms fully and appropriately.
- They shall not be used as or considered time-out, containment or punitive spaces.
- Staff shall not enforce the use of comfort rooms.
- Staff shall support patients to use comfort rooms voluntarily as needed.
- Patients shall be oriented to the comfort room upon admission.
- Staff shall be trained regarding the benefits and appropriate use of comfort rooms.
- Staff shall maintain a log tracking the comfort room's usage and document use in each patient's individual record.

Guidelines

☑ Sample prevention strategies include but are not limited to:
- Comfort boxes, carts or rooms (see below);
- Multisensory rooms (e.g., Snoezelen and other type);
- Sensory modulation options (e.g., interventions that regulate behaviour by focusing attention on a particular sensation; can be delivered through a variety of means including but not limited to weighted blankets, brushing, hot shower/bath, exercise, arts and crafts, music or sound therapy, aromatherapy, light therapy, and so forth);
- Walking, talking, writing, resting, crying, deep breathing, hot shower;
- Music or music therapy;
- Time alone;
- Spiritual practice.

☑ Staff should work with patients to assemble portable comfort boxes or carts.
- Bring to patients as needed.
- Include items that are identified as helpful to individual patients, and respond to needs identified in their care plans.

☑ Sensory interventions and other preventive techniques shall be delivered by appropriately trained clinical staff (e.g., occupational therapist).

FIG. 1 : Summary of where seclusion fits within recovery-oriented, trauma-informed practice

RECOVERY-ORIENTED, TRAUMA-INFORMED PRACTICE	SAMPLE PREVENTION STRATEGIES	LAST RESORT
Warm, caring admissions practices	Comfort carts	Seclusion
Person-first, non-discriminatory language	Comfort, sensory rooms	
Risk assessment including trauma history	Sensory modulation	
Work with patients to develop safety/comfort plan, identify triggers and coping strategies	Walking, talking, writing, resting, crying, deep breathing, hot shower	
Ensure patients can access what they need	Music/music therapy	
Daily community meetings	Time alone	
Non-hierarchical, non-violent communication	Spiritual practice	

Assessment and care planning

Following the principles of recovery-oriented, patient-centered care, assessment and care planning shall be carried out collaboratively, with patients and staff working as partners to mitigate risk and promote the best possible outcomes.

Care plans shall be timely, patient-centered, recovery-oriented, and individualized. They shall include specific interventions planned, desired outcomes, modifications based on change in the patient's condition and progress as well as discharge plans with specific arrangements for after-care in the community. The care plan shall include risk assessments to be conducted, interventions and desired outcomes with the aim of assisting the person in regaining self-control. As part of this process, care plans shall include individualized de-escalation techniques that may prevent the use of seclusion. Reassuring the patient and family/guardian that they are partners in care, and explaining to them the reasons for the use of seclusion, the steps being undertaken while seclusion is initiated and the ongoing care plan are critical for allaying fear and reducing anxiety.

Standards

☑ Care plans shall be initiated upon a patient's admission to the facility. Care plans shall involve input from the patient and family/guardian/caregiver as well facility staff, and include strategies for managing risk and preventing seclusion.
- If a patient is deemed at risk of violence, a behavioural care plan for violence prevention shall be developed in accordance with violence prevention regulations.
- Comfort and/or personal safety plans are components of the care plan and identify specific strategies to address increased agitation in alignment with a trauma-informed, prevention approach. A comfort and/or personal safety plan shall be developed for all patients, and completed in collaboration with the care staff.

☑ Care planning shall include the community case manager where appropriate.

☑ New patients shall receive routine medical and psychiatric risk assessments.

☑ All assessments shall be documented in the patient's health record.

☑ Any underlying medical causes for a behavioural disturbance shall be investigated and treated.

- ☑ Psychiatric symptoms shall be assessed and treated according to best-practice clinical indication.

- ☑ The risk of suicide and violence shall be assessed to determine immediate and serious risk of harm to self or others; this shall be documented according to provincial violence prevention regulations.[6]

Risk management

Risk assessment and management are central to preventing seclusion, and ensuring that when it is delivered, it is done safely and appropriately.[7]

Appendix 2, Ministry of Health's Trauma Informed Practice Guide

The high incidence of trauma in individuals experiencing a psychiatric emergency, and particularly individuals at risk of restraint and seclusion, indicates the need to approach care and service delivery from a trauma-informed perspective and to be vigilant in ensuring that interventions do not risk or result in re-traumatizing the patient (please consult the organizational checklist in Appendix 2 of the Ministry of Health's Trauma Informed Practice Guide [hyperlink http://www.bccewh.bc.ca/publications-resources/documents/TIP-Guide-May2013.pdf]).

Relevant assessments and appropriate care are made possible when the patient and the family/guardian are viewed through a lens that is trauma-informed, sensitive to needs across developmental stages, and gender and culturally competent. In particular, because of increased risk of trauma for these populations, care must be responsive to people who identify as lesbian, gay, bisexual, transgender, two-spirit or queer (LGBT2SQ). Similarly, care must be taken not to overuse seclusion with populations at particular risk of the intervention, including people with a dual diagnosis of developmental disability and mental health disorders, and those with dementia. For these patients, a functional analysis of behaviour can be particularly helpful in identifying risks and triggers, and positive behaviour supports and intervention strategies could play a role in preventing the need for seclusion.

6 See, for example, Provincial Violence Prevention Curriculum, Module 8 (**http://www.phsa.ca/NR/rdonlyres/A5D4428F-C00F-4044-A6C8-6B1A53756B0F/59722/WorkbookProvincialViolencePreventionModule8Behavio.pdf**)

7 Note that it is a legal requirement to implement risk assessments identified within Occupational Health and Safety Regulations, including violence risk assessments.

No individual demonstrating signs of medical instability should be secluded. It is critical that the underlying medical causes for the presenting problem are investigated and treated. Effective triaging processes are critical in order to ensure that the patient receives optimal care promptly and through the setting that would best assist the patient in the recovery process. Accurate and efficient triaging of the patient to available services is based on comprehensive assessments of the patient to determine the level of acuity and severity of the patient's condition, including additional factors that may contribute to or impede early recovery.

Standards

- ☑ Trauma-informed practice shall be adopted as a default approach to care in order to minimize the traumatization of patients that might lead to risk of violence and aggression, and support the prevention of unnecessarily restrictive interventions.

- ☑ Within the parameters of legislated requirements, partnerships between patients, families and caregivers shall be the guiding force when developing inpatient psychiatric policies and practice.

- ☑ Each and every designated facility shall have a formal strategy, policy or protocol to support staff in identifying options to prevent seclusion.

- ☑ Thorough medical, psychiatric, violence and trauma risk assessments shall be performed upon admission to establish potential triggers that might require seclusion.
  - In inpatient settings, seclusion shall only be delivered to patients who have been deemed medically stable and for whom the intervention poses no known additional medical risk. (For specific standards related to emergency departments and observation units, please see the section on specialized practice, p. XX.)

For specific standards related to emergency departments and observation units, see the section on specialized practice, p XX

- ☑ Individualized behavioural care plans include measures to prevent seclusion.

- ☑ A RN or RPN shall be available within sight and sound of the secure room at all times when a patient is secluded (i.e., the secluded patient is always monitored at minimum via closed-circuit television and intercom at the nursing station), and patients shall be monitored closely throughout the intervention.
  - Patients shall receive direct, close observation (i.e., through the observation window) at minimum every 15 minutes, and more frequently or continuously if staff or the patient deem necessary.
  - Close observation applies to patients whether sleeping or awake.

- ☑ The patient shall be included in post-intervention reflection and review in order to reverse or minimize the intervention's potential negative impact.

- ☑ Policies and procedures shall be in place to assist staff to provide care that is culturally competent.

- ☑ Policies and procedures shall be in place to assist staff to provide care that respects and accommodates an individual's needs resulting from that person's self-determined gender and/or sexual identities.

- ☑ Patients shall be supported to keep personal items of religious or cultural significance as long as they pose no safety risk.

- ☑ Policies and procedures shall be in place to ensure staff are aware of supports available to them following seclusion events.

3. DELIVERING SECLUSION INTERVENTIONS

Physical interventions pose a clear risk to patients' health and wellbeing. For this reason, designated facilities shall be vigilant in their efforts to protect patients from harm by providing a safe environment and reassuring approach to delivering care. Patients' basic needs—both physical and emotional—shall be addressed at all times. A patient's perception of support and respect throughout the intervention is optimized when communication is maintained between patient and staff, and the patient is less likely to have a negative experience of seclusion. Patients have stated that they appreciate continuous contact with a nurse or other clinician. It is considered good practice for nursing staff to stay in close communication with the patient throughout the seclusion episode, talking with and showing interest in the patient in order to offer reassurance and information, and to help provide positive stimuli that can promote a sense of calm and reduce stress.

Standards

Initiating seclusion

- ☑ A patient shall be deemed medically stable by a qualified physician or registered nurse prior to experiencing a seclusion intervention.

- ☑ Seclusion shall be ordered by a qualified physician and the order is reviewed as soon as possible by a psychiatrist, or the director appointed under the *Mental Health Act* (or designate approved by the health authority).

- ☑ Trained and qualified, authorized staff shall initiate and deliver seclusion.
  - A nurse or physician may initiate seclusion during a psychiatric emergency or crisis. The attending physician will be notified immediately of the patient's mental and physical status and an order for seclusion obtained.

- ☑ Orders for the use of seclusion shall be time-limited and specific.
  - Barring exceptional circumstances (see standards for specialized practice – developmental disability, psycho-geriatric and neuropsychiatric populations, p. XX), each and every seclusion intervention requires a unique seclusion order (i.e., if a patient whose seclusion intervention has ended requires a subsequent seclusion intervention, the subsequent intervention requires a new seclusion order).
  - The following standard relating to PRN seclusion does not apply to children and youth, for whom PRN seclusion orders are not acceptable. For adults clients only: PRN seclusion orders shall only be used in exceptional situations where the clinical team, supported by a written second opinion from another physician who has reviewed the treatment plan, determines that short, intermittent periods of seclusion are the safest, most appropriate care strategy (e.g., for individuals who, as a result of the specific nature of their disorder, are unresponsive to preventive techniques). In such situations, PRN seclusion orders are limited to a 48-hour period, and are documented clearly in the patient's file.

For exceptions, see standards for specialized practice (developmental disablity, psycho-geriatric and neuropsychiatric populations, p. XX

- ☑ Facilities shall have policies and procedures regarding the role of police, code white team, and security guards in initiation of seclusion.

Observation and evaluation

- ☑ Patients shall be evaluated face-to-face by a qualified physician as soon as possible within 24 hours of the initiation of seclusion.

- ☑ Patients in seclusion for extended periods (i.e., longer than 8 hours continuous) shall receive a mental health assessment by a qualified registered clinical professional at least once every 24 hours. This assessment shall be documented in the client file.

- ☑ If seclusion lasts more than one hour, a care plan shall be developed for the seclusion period.

- ☑ Unit staff shall review the need to continue seclusion throughout the intervention, at 30 minutes, 2 hours, and every 4 hours for the duration. If seclusion persists past 8 hours continuous or 12 hours intermittent, the review shall include at least one qualified senior clinician, and, whenever possible, the initiating and supporting clinician(s).

- ☑ Face-to-face monitoring and evaluation of patients in seclusion shall take place at regular intervals, at a minimum of once every 15 minutes, throughout the duration of the intervention.

- ☑ The secure room shall be fitted with an audio-visual system for continuous staff observation of the patient and to facilitate patient-staff engagement.
  - Audio-visual equipment ensures that the patient can always contact a staff member and staff can always hear and see the patient.
  - The audio-visual system shall include a two-way intercom and closed-circuit television (CCTV).
  - Controls at the nurses' station shall allow the intercom to be adjusted but not turned off so that the nurses always monitor sound.
    - Audio-visual equipment shall not be considered a replacement for one-to-one, in-person contact.

- ☑ Monitoring and evaluation shall not take place via audio-visual observation system alone (i.e., CCTV monitors and intercom).
  - Face-to-face monitoring and evaluation shall be delivered through the observation panel in the secure room door.
  - Observation via audio-visual equipment shall be an adjunct to but not a substitute for face-to-face monitoring and evaluation.
  - High-resolution cameras with infrared technology are tools that should be used to enhance face-to-face clinical assessments.

Ending seclusion

- ☑ Periods of seclusion shall end as quickly as possible, when a nurse and/or physician on the clinical team determines that there is no longer any threat to any person's safety.

- ☑ The clinical team shall implement a step-down process to end seclusion, unlocking or opening the door once they have determined it is safe to do so, enabling the patient to decide when he or she is ready to leave the room, and incorporating a period of observation to ensure that it is safe for the patient to return to the open unit.

- ☑ The seclusion episode shall be considered over when the patient leaves the conditions of seclusion without expectation of return, or for more than one hour.
  - In most cases, subsequent seclusion interventions require a new seclusion order (see standards for delivering seclusion , p. XX).

See standards for delivering seclusion, p XX

- ☑ Seclusion shall be concluded with a plan for re-integrating the patient into the general unit and managing future emergencies.

Promoting emotional and psychological safety

- ☑ Families/caregivers shall be notified of the decision to use seclusion, with consideration for the patient's wishes and consent.

- ☑ Patients shall have options/means for constant contact and communication with staff throughout seclusion episode.
  - Patients shall be informed about how to contact staff, including senior staff, while in seclusion, and the explanation is documented.
  - Patients shall be informed of their rights under all legislation including the *Mental Health Act*.

- ☑ The reasons for initiating, continuing and ending seclusion shall be explained to the patient, and the explanation and patient's observed level of understanding shall be documented.

- ☑ Patients shall be kept aware of the time and date, verbally or via a clock viewable from the secure room.

Promoting physical safety

☑ Neither patients nor staff shall be subjected to injury or degradation.

☑ Seclusion shall be delivered in an appropriate environment, in a manner that is safe for and respectful of all involved.

☑ Patients in seclusion shall receive adequate food and fluids without undue delays.

☑ Patients shall have constant access to toilet and washing facilities.

Patients shall be clothed appropriately, with due concern for safety (e.g., removal of potentially dangerous accessories such as belts and shoes). Under no circumstances shall a patient be left without the option of wearing clothing.

Legal rights

☑ Policies and procedures shall be in place to inform patients and family members/guardians of their rights under the *Mental Health Act*. While the Act authorizes involuntary admission and treatment of people with mental disorders, there is a need to ensure these provisions are appropriately used.

- The *Mental Health Act* requires a notice be sent to a near relative immediately after a patient's admission, discharge, or an application to the Review Panel.

☑ In accordance with the *Freedom of Information and Protection of Privacy Act* (FOIPPA), policies and procedures shall be in place to share information among health care team members and third parties.

☑ Patients in seclusion shall have their rights explained verbally and in writing, and the explanation shall be documented.

- A patient's assessed level of understanding shall be documented.

☑ A staff member from a designated facility (or its agent) must verbally inform the person and provide written notification of the following rights promptly upon admission. Rights information requirements, as they apply to involuntary patients, are set out in section 34 of the *Act*. For patients under 16, the requirements are in section 34.1.

- The hospital's name and location;
- The right to be informed promptly of the reasons why the person was admitted and is being kept in hospital;
- The right to contact, retain and instruct a lawyer or advocate without delay;
- The right to regulate reviews of detention by a physician (renewal certificates);
- The right to apply for a Review Panel hearing;
- The right to have the validity of the detention determined by a court (by way of a procedure known as *habeas corpus*, where the court is asked to determine whether there is legal authority for the detention);
- The right to apply to the court for discharge; and
- The right to a second medical opinion on the appropriateness of treatment.[8]

4. POST-SECLUSION

Staff and patients both benefit from an opportunity to reflect on and review circumstances after an incident of physical intervention. The purpose of post-incident reflection and review is to prevent future use of seclusion, reverse or minimize the negative effects of the episode, and to address organizational issues and make improvements.

Reflection and review

See Appendix G for sample debriefing process that may guide reflection and review.

The post-incident reflection and review process shall treat seclusion events as very serious and unusual, and signals the need for a clinical team to review a patient's treatment plan and make adjustments that correspond with the patient's increased acuity. Senior leaders shall be involved, acknowledging the degree to which staff and patients might both have found the intervention distressing, the facility's responsibility for what has occurred, leaders' accountability, and a shared desire to improve practice. See Appendix G for sample debriefing processes that may guide reflection and review.

8 For information, please consult the *Guide to Mental Health Act* (2005 Edition) (**http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf**)

Standards

- ☑ Leaders and staff shall participate in the reflection and review process as soon as possible after the end of seclusion.
  - Reflection and review shall include senior clinical and administrative leadership as well as unit supervisors and/or managers.

- ☑ The designated facility shall have a formal review and documentation process involving clinical and administrative leaders in order to address potential service-wide performance improvement.

- ☑ Clinicians shall reflect on and review the incident with the patient and family/caregivers/guardians (where appropriate) as soon as possible within 24 hours after the end of seclusion.

- ☑ Reflection and review procedures shall be transparent, and communicated to patients through brochures or other easily accessible formats.

Documentation and quality improvement

Collecting, monitoring, reporting, reviewing and acting on relevant data is critical to assessing the quality and outcomes of seclusion interventions and ensuring that staff are delivering best-practice care.

Meaningful documentation processes help to reduce the incidence of seclusion, assist facilities with performance improvement, and increase the safety of physical interventions when they are required. Documentation provides a record of the events that took place prior to, during and after each seclusion episode, and thus enables accountability and quality improvement. There are significant risks associated with seclusion, and having clear documentation both protects the facility in the event of a negative outcome, and facilitates communication and good practice among staff responsible for delivering the intervention (Muir-Cochran et al., 2002).

Designated facilities utilize seclusion less frequently and deliver the intervention more appropriately with strong and supportive leadership, and when leaders and senior staff model communication and practice styles that reinforce every individual's dignity and empowerment (Ashcraft & Anthony, 2008; Scanlan, 2010; Murphy & Bennington-Davis, 2005; George et al., 2010; Happell & Harrow, 2010; Georgieva et al., 2010). Clinical and administrative leaders play a particularly important role in establishing a workplace culture that values prevention of physical interventions; monitors performance and accountability; commits to continuous quality improvement; and supports staff in delivering best practice treatment and developing alternate approaches to care (Pollard et al., 2007; Qurashi et al., 2010; Scanlan, 2010; D'Orio et al., 2007; Hyde et al., 2009).

Standards

- ☑ Designated facilities shall collect and analyze data on seclusion interventions in order to inform practice and improve internal performance.
  - Seclusion interventions shall be tracked in each health authority and reported to the Ministry of Health at regular intervals (see the provincial reporting form in Appendix XX).

See the provincial reporting form, Appendix XX

- ☑ Policies and procedures shall be in place for documenting assessment and care of the patient and family members/guardians when a patient is at risk of or experiences seclusion.

- ☑ Policies and procedures shall be in place for documenting and reporting of seclusion, including the evaluation conducted and follow-up steps initiated.

- ☑ Clinical and/or administrative staff shall document in the patient's clinical record all aspects of the use of seclusion including:
  - preventive techniques employed or attempted;
  - less restrictive interventions employed or attempted;
  - the rationale for use of a physical intervention;
  - observation and care provided during and after the episode (including evidence that the patient's food, fluid, hygiene and toilet needs were met);
  - times when seclusion began and ended;
  - evidence of clinical decision-making procedures;
  - indication of how staff will endeavor to prevent seclusion in the future;
  - if a Code White was called;
  - if security assisted in the intervention; and
  - if hands-on restraint was required while transferring a patient into seclusion.

- ☑ An accurate account of each episode of seclusion shall be recorded, demonstrating the delivery of treatment that conforms to provincial standards and guidelines and facility policy.

- ☑ Clinical and administrative leaders shall review all seclusion interventions.

- ☑ Clinicians and administrators shall establish and adhere to written policy and procedures for the use of seclusion.

- ☑ Clinical and administrative leaders shall communicate the facility's policy and philosophy on the use of seclusion to all relevant staff.

- ☑ Clinical and administrative leaders shall work actively to minimize or prevent the use of seclusion.

- ☑ Clinical and administrative leaders shall implement a performance improvement process related to seclusion in order to ensure accountability.
  - Clinical and administrative leaders shall review data on seclusion at least once annually to identify trends and determine opportunities for practice improvement.

- ☑ Patients shall be involved in the evaluation of a facility's seclusion practices as part of ongoing quality improvement.

Guidelines

- ☑ CCTV images may be recorded, and become part of the patient's record.
  - Health authorities shall develop policies governing retention and storage of these images.

5. SPECIALIZED PRACTICE

The *Standards & Guidelines* are intended to apply equally to all individuals receiving treatment in designated facilities. However, individuals with developmental disabilities and neuropsychiatric disorders, and psychogeriatric populations are at elevated risk of seclusion. Some special considerations therefore apply, in addition to the standards and guidelines already described above.

Similarly, while the *Standards & Guidelines* apply across all identified hospital environments, additional standards and guidelines have also been developed to address unique circumstances in settings such as observation units and emergency departments (EDs).

Developmental disability, neuropsychiatric and psycho-geriatric populations

Standards

- ☑ Clinical staff shall receive training that alerts them to the increased risk of seclusion faced by people with developmental disabilities and neuropsychiatric disorders including dementia.

- ☑ Geriatric and neuropsychiatric populations shall be provided with alternatives to a secure room in order to ensure the safety of individuals who are at risk of elopement, but not imminent violence.

- ☑ Policies and procedures shall be in place to ensure facilities engaging in prevention and/or delivery of seclusion meet the specific developmental needs of youth with highly complex disorders.

- ☑ Because of the specific characteristics of their disorders, individuals with developmental disabilities and/or neuropsychiatric disorders may not respond to preventive techniques such as verbal de-escalation, re-direction or medication. Such patients shall have access to both emergency and planned seclusion interventions in order to prevent them from being targets of violence or from harming themselves or others.
  - PRN seclusion orders shall only be used in exceptional situations where the clinical team, supported by a written second opinion from another physician who has reviewed the treatment plan, determines that short, intermittent periods of seclusion are the safest, most appropriate care strategy (e.g., for individuals who, as a result of the specific nature of their disorder, are unresponsive to preventive techniques). In such situations, PRN seclusion orders are limited to a 48-hour period, and are documented clearly in the patient's file. (See standards and guidelines for initiating seclusion, p. XX).

See standards and guidelines for initiating seclusion, p XX

Observation units

The development of observation units under the *Mental Health Act* reflects the need in many rural hospitals in B.C. for access to short-term stabilization for individuals who require inpatient care but are awaiting transport to a designated inpatient facility.

See diagram of secure room plus anteroom in Appendix H

An observation unit consists of a secure room plus anteroom (see diagram in Appendix H) to allow for the ability to manage the care of and stabilize acutely ill psychiatric patients for a maximum of five days (after the second certificate has been completed). So while the room is designed as a secure room and has the capability to ensure the safety of an individual through a seclusion intervention, the room is also considered to be the assigned bedroom for the individual while he or she awaits transfer.

These units often exist in the emergency department or adjacent to a medical/surgical unit or crisis stabilization program, and therefore may not necessarily be staffed by people with specialization in mental health treatment. As such, observation units adhere to the *Standards & Guidelines* overall, as well as the following specialized standards.

Standards

- ☑ Policies and procedures are in place for staff responsible for the oversight of care of an individual in the observation unit to have knowledge and skills in emergency psychiatric assessment, crisis intervention and the safe management of patients with psychosis, delirium, suicidal and aggressive behaviours.
  - As some of these areas may not be utilized on a regular basis, staff will require ongoing education and training

- ☑ A facility designated as an observation unit must have access to psychiatric consultation in order to clarify and confirm a patient's diagnosis and/or treatment plan.

- ☑ Protocols exist with community mental health and substance use services and other relevant community resources (e.g., child and youth mental health services, friendship centres, primary care providers, family/guardian) to provide care and treatment to an individual while that person awaits transfer in order to support stabilization and prevent the need for seclusion interventions.

Emergency departments

The majority of individuals in psychiatric crisis requiring inpatient care will first present at a hospital's ED. The primary goal of staff in the ED is to assess the patient's immediate health needs, both medical and psychiatric. This includes the need for certification under the *Mental Health Act*, and the level of medical stability that will determine the best location for the patient in the ED environment until the individual can be transferred to the appropriate care service.

The ED is not the location where most psychiatric treatment is to be provided, and the ability to explore alternatives as outlined in these *Standards & Guidelines* is limited. However, an ED can take steps toward preventing the use of seclusion.

Standards

- ☑ All individuals will be triaged by a trained triage nurse and moved immediately to the appropriate location in the ED, considering their own and others' safety.

- ☑ Only individuals who have been assessed as medically stable (and require seclusion for their immediate safety or the safety of others will be considered appropriate to be placed in a secure room in the ED.

- ☑ Clinical decision tools shall be in place to support ED staff in assessing the psychiatric patient in crisis.

- ☑ Education processes shall be in place to explore the concept of trauma-informed practice in the ED.

Role of police in the ED

According to provincial legislation, police may attend the ED in the following situations:

- Police may be involved in bringing the mental health patient to the hospital's ED, a designated facility or wherever a physician may be located with the intent to have the patient assessed according to the *Mental Health Act* [hyperlink XX].
- As per the Police Act [hyperlink XX] the role of police in this context is primarily to "ensure public safety for all citizens."

Mental Health Act

Police Act

The police role will not cover situations such as:

- Assisting a certified mental health patient in the ED who is an admitted patient of the designated facility.
- Assisting in the delivery of medication or medical services, which the patient voluntarily declines.

Guidelines

☑ Clinical staff shall assess to determine if the presence of uniformed officers creates increased agitation for the patient or a calming sense of order and control.

☑ Police, hospital security staff and clinical staff shall understand their counterparts' training and roles to improve consistency in approach.

- Health authorities shall work with local police detachments to develop a protocol to ease the transition from police to hospital responsibility for patients detained under Section 28 of the *Mental Health Act*.

6. STAFF EDUCATION, TRAINING AND SUPPORT

In addition to developing a highly trained workforce, evidence supports the prevention of seclusion as key to promoting safety for both patients and staff. Whereas seclusion increases the risk of physical injury, judicious use of seclusion is associated with lower staff injury, turnover and absenteeism, as well as increased job satisfaction (US DHSS, 2011). Prevention and minimization of seclusion shall be components of overall violence prevention in designated facilities.

Reducing both the potential for violent responses by patients, and the violence that researchers, clinicians and patients attest is inherent in physical interventions is the best way to prevent injury and mitigate risk. An effective response to the risk of violence meets regulatory requirements for risk assessment and control; provides education and support to staff; ensures rapid and supportive responses to incidents; and offers investigative and corrective measures. It also improves staff attitudes and working practices, and is multi-factorial: it encompasses a simultaneous focus on everything from security measures, through individual, team and organizational work practices, to organizational policies, and arrangements for everything from job and work design to post incidence support and counselling.

Knowledge of psychiatric illnesses across the age-range and differential diagnosis of a range of psychiatric conditions, knowledge of neurocognitively-based disorders (delirium, dementia), sex, gender and cultural competence, trauma-informed practice, and the ability to perform mental status examinations are necessary in the care of acutely ill patients. Regardless of the type of inpatient unit or where the secure room is located in a facility, staff must have knowledge and skills in emergency psychiatric assessment, crisis intervention and the safe management of patients with psychosis, delirium, suicidal and aggressive behaviours, intoxication, and histories of trauma, and they must have received training that meets regulatory requirements for violence prevention.

Standards

☑ Health authorities shall work with their occupational health and safety, union, and professional bodies to set clear requirements identifying standardized competencies for entry to practice, demonstration of skills, number of training hours and refresher cycles.

☑ Clinical staff shall be able to articulate sound knowledge of the key principles, legal requirements, guidelines and local policies and procedures relating to seclusion.

- All staff shall receive education and training related to relevant legislation including the *Hospital Act*, *Mental Health Act*, *Freedom of Information and Protection of Privacy Act*, *Workers Compensation Act*, Occupational Health and Safety Regulation, B.C. Provincial Violence Prevention Curriculum, and employer violence prevention program, as well as position statements and evidence-based practice commonly accepted in the field.

☑ Staff shall be trained and competent to deliver seclusion interventions safely and in accordance with the facility's policies and procedures.

B.C. Provincial Violence Prevention Curriculum

See Appendix I for a summary of competencies and corresponding PVPC modules

☑ Health care staff shall receive continual training and professional development to maintain and enhance their skills, and to ensure key competencies as required by the B.C. Provincial Violence Prevention Curriculum (PVPC) [hyperlink: http://www.preventviolence.ca/]. See Appendix I for a summary of competencies and corresponding PVPC modules.

- For staff involved in specialized practice (e.g., developmental disability) this standard may be met by completing basic certification and refreshers as required in interventions related to behaviour support and safety planning through a competency-based training program that focuses on building healthy relationships and developing a system-wide integrated approach to preventing and/or de-escalating challenging circumstances.

☑ Staff shall receive continual training and professional development to maintain and enhance their skills, and to ensure additional key competencies for prevention and safe delivery of seclusion:

- Knowledge of safe and appropriate use of seclusion and restraint.
- Ability to monitor a patient's physical and psychological wellbeing.
- Ability to recognize symptoms of trauma that may impact both the patient and staff member following a seclusion intervention.
- Certification in CPR and First Aid as determined by a staff person's professional requirements.

☑ Staff shall receive training in trauma-informed care, non-violent crisis intervention (including de-escalation), and collaborative problem-solving.

- Staff shall work towards improving their interactions with patients by understanding how and when to use de-escalation, problem solving and conflict resolution techniques with patients.

☑ Staff shall receive education and training to develop skills for managing behavioural emergencies; assessing potential aggression/violence; and preventing and managing disturbed behaviour and aggression/violence.

☑ Staff shall be trained and competent to deliver interventions intended to prevent and/or minimize the use of seclusion.

☑ Staff shall receive training in functional analyses of behaviour, and of positive behavioural supports and interventions to help with prevention of dangerous behavior/teaching of alternative behaviors.

☑ Nursing staff shall be trained to recognize signs/symptoms of side effects/adverse reactions to treatment associated with the seclusion episode (e.g., any medications administered, environmental impact of the secure room).

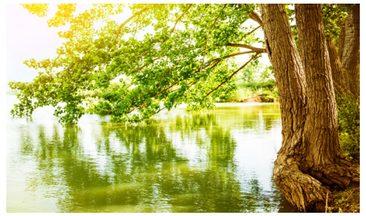
☑ Staff shall work in a well-trained team with the proven capacity to deliver required services in keeping with provincial standards and guidelines for safety, health and quality of care.

☑ Staff shall have access to an expert who may provide guidance regarding issues and questions about relevant legislation including the *Hospital Act, Mental Health Act, Workers Compensation Act, Freedom of Information and Protection of Privacy Act,* occupational health and safety regulations, and violence prevention regulations.

Guidelines

☑ In addition to meeting the regulatory requirements for violence prevention training, additional training shall cover the following key issues:

- Attitudinal changes among staff toward patients and seclusion. Patients who may be at risk of becoming violent should still be treated with respect, care and compassion.
- Common assumptions about seclusion.
- Systematic and regulatory efforts to prevent seclusion.
- Engaging patients rather than increasing control. Staff who use active listening techniques, validate the patients feelings and acknowledge the patient's needs will be more successful at preventing and/or minimizing episodes of seclusion.
- Early recognition of agitation and aggression.



2. Physical Environment and Design Standards & Guidelines

The design of a secure room and its placement in a given unit plays a critical role in both preventing seclusion and ensuring safe delivery when the intervention must be delivered.

Designing an environment that supports prevention and safe delivery

In terms of prevention, it is important to consider not only the secure room itself, but the entire unit in which it is located. Evidence indicates that a facility with a welcoming physical environment overall supports the prevention of seclusion. A thorough assessment of the facility's physical environment shall establish the degree to which it either increases or aims to decrease agitation. Multidisciplinary teams including clinicians, administrator, planners and designers, and service users should begin their assessment outside the building to observe the appearance of the entrance in detail, and imagine the impact on patients and families of arriving at the facility for admission. Every detail shall be assessed—from the appearance of the doorway, to paint on the walls, to arrangement of furniture, to the type of signage and so forth—in order to determine whether there are changes that could make the environment more welcoming, calming and reassuring. The assessment shall be repeated on a regular basis to gauge the success of changes and ensure continuous improvement (Gaskin et al., 2007; Murphy & Bennington-Davis, 2005) and considered in the process of capital planning overall.

The design of the secure room has a direct impact on a patient's treatment. Patients often perceive secure rooms negatively as the rooms frequently lack features that enable patients to maintain their dignity and at least a minimal degree of privacy, autonomy and engagement, while ensuring their safety. In order to reduce the likelihood of patients perceiving their seclusion experiences as punitive, it is beneficial to offer secure rooms that are as reassuring and comforting as possible (Vaaler et al., 2005; Kontio et al., 2011).

Adherence to the *Standards & Guidelines* is only expected with new builds. Renovations are expected to bring facilities as close as possible to compliance with the *Standards & Guidelines* given the physical limitations of the existing structure/ footprint.

For new buildings, as early as possible in the design process, clinical leaders who are well-informed regarding best practice in preventing and delivering seclusion interventions shall advise administrators and facility planners on the appropriate location of the secure room in order to ensure that it meets clinical requirements. All decisions about the secure environment should be made jointly between the architect, planner and/or builder and appointed clinical liaisons representing the multidisciplinary team (Curran et al., 2005). Individuals with occupational health and safety expertise must also be consulted to ensure that the environment meets occupational health and safety requirements, and frontline staff must have opportunities to provide feedback throughout the design process.

See checklist in Appendix J to assist planners and program staff with the design process

Using the Standards & Guidelines

The *Standards & Guidelines* indicate environmental requirements that enable designated facilities to meet performance-based objectives. Since particular products may become obsolete or change over time, the *Standards & Guidelines* avoid referencing particular products and instead identify the performance target, e.g., glass that is unbreakable, mattresses that are sealed, fixtures that resist tampering, etc. A checklist is provided in Appendix J to assist planners and program staff with the design process. It provides a mechanism for recording progress toward meeting a standard, and preserves institutional memory regarding challenges encountered over time. The checklist is not intended as a tool for external evaluation; it is, rather, a tool intended to support internal development and planning.

1. GENERAL

Secure environments shall be designed and built to support best-practice delivery of services, and ensure the safety of staff, patients, and others on the unit. The environment shall be designed and built to mitigate the risk of harm to self and others, and to conform to all requirements for health and hygiene.

Standards

- ☑ All designated facilities delivering seclusion interventions shall include a secure room that meets provincial design/environmental standards and guidelines contained in this document, and is approved by a vice president within each health authority.

- ☑ Capital and security planners shall work with clinical programmers well-informed about prevention and delivery of seclusion interventions to review expected outcomes and ensure that the secure room or area meets clinical needs and ensures staff safety.

- ☑ Secure rooms shall not be counted in a unit or facility's bed census. Secure rooms shall not be used as an assigned bed or for any other purpose than seclusion, although a room designed to meet secure room specifications may be repurposed as a bedroom or other non-secured space should a unit determine that the secure room is not needed (e.g., in units with more secure room capacity than necessary).

- ☑ Clinical staff and facility planners shall collaborate to design spaces appropriate to the facility and patient population/program needs, including alternate spaces to support prevention efforts.

- ☑ Where available, devices installed in the room shall be designed specifically for use within a secure environment.

- ☑ The secure room shall be built to prevent harm to self or others.
  - The secure room shall be free from projections or protuberances that might allow climbing or hanging, as well as weak points, corners, edges, seams, and other features that pose risks.

- ☑ The secure room shall meet infection control and hygiene requirements.
  - All surfaces in the secure room shall be easy to clean.

- ☑ Facilities shall prioritize prompt and thorough repairs of damage and/or deficiencies in the secure room.
  - Patients shall be removed from the secure room immediately if damage poses a risk of harm to staff or the patient.
  - A clear plan for repairs is developed as soon as damage is noted, indicating a reasonable time-frame for completion (generally within two working days) and outlining clearly the target completion date and alternatives for staff.

- ☑ Secure rooms shall be designed to assist patients to feel as comfortable, safe and secure as possible.
  - The secure room shall be designed to enable a patient to maintain a sense of dignity and autonomy, within safe limits.

- ☑ The secure room shall be large enough to enable 4-sided access to the secluded patient.
  - The secure room shall be a minimum of 13.9 square meters.

2. PLACEMENT OF SECURE ROOMS IN THE UNIT

The secure room shall be placed to ensure easy and prompt access by nursing staff in order to deliver appropriate patient care. The placement of the secure room shall enable continuous observation of the patient by nursing staff, while also sparing the patient the disruption of conversation and nonclinical interaction in immediately adjacent areas.

Standards

☑ If secure rooms are proposed for a unit, the secure room shall be placed adjacent to the nurses' station.
- Placement shall enable close observation of the patient by nursing staff.
- Placement shall enable prompt access by nursing staff.
- The secure room shall be placed to help non-secluded patients avoid potentially troubling episodes of physical intervention.

☑ If secure rooms are proposed for a unit and resources permit, the design shall accommodate the inclusion of an anteroom just outside the secure room door.
- An anteroom is not required for existing facilities where structural constraints make it impossible to renovate/retrofit in this manner.
- The anteroom shall be a minimum of 5.5 square metres.
- The anteroom shall include access to a patient washroom and/or shower facilities.
- The anteroom shall include a closed circuit television monitor and intercom enabling clinical observation of the patient in seclusion.

☑ The secure room shall be placed away from elevators, stairs, exits, common patient areas, and areas where staff and/or patients typically congregate for non-clinical purposes.
- Placement shall spare the patient the disruption of conversation and non-clinical interaction.

☑ For new builds, the secure room shall be placed to include an exterior window.

☑ Geriatric and neuropsychiatric populations shall be provided with alternatives to a secure room in order to ensure the safety of individuals who are at risk of elopement, but not imminent violence.

☑ Clinical leaders shall work with facility planners, designers and builders to ensure that appropriate step-down options are planned for on the unit.
- When space permits, options such as sensory, comfort or quiet rooms shall be included for patient use.

3. DOORS AND LOCKS TO SECURE ROOM

Doors and locks are critical elements to ensure safety and security. Doors, locks, door frames and hinges shall be robust enough to withstand extreme force, and resist buckling or loosening.

Standards

☑ Doors, door frames, and locking mechanisms shall meet all relevant regional and provincial fire, flooding and emergency codes.

☑ Doors shall be composed of material that is impact- and tamper-resistant.
- Doors shall be ultra-heavy duty construction three-ply Laminated Veneer Lumber (LVL) for high impact interior use.
- Wood doors shall be solid hardwood core manufactured from high density hardwood (minimum 800Kg m^2), with all hardwood joints finger jointed in length and edge.
- Doors shall be finished in a manner that meets all infection control standards.

☑ Doors shall be tall and wide enough to enable at least two staff to accompany a patient on either side in and out of the secure room, e.g., at minimum 2.13 m high by 1.7 m (84" by 42") wide.

☑ Doors shall be equipped with both magnetic and mechanical locking mechanisms.
- Magnetic locks shall release in the event of a Stage 2 fire alarm.
- The remote release shall be placed in a secure location inaccessible to patients and non-clinical staff.
- All door locks shall be able to withstand a 1360-kilogram (3000-lb.) force.
- Doors equipped with only a mechanical locking system must be accompanied by written procedures for what to do in the event of an emergency.

☑ Door locks shall be impact- and tamper-resistant, with a multiple (three-point) bolting system simultaneously securing the door at the top, bottom and centre.
- To avoid potential hygiene and operational problems, no locking point shall go into the finished floor.
- All locking points shall secure into a dedicated strike plate with a minimum of 25 mm throw, minimum diameter of 15 mm, and be case hardened steel.

☑ Door locks shall be operated by key from inside the secure room. The locking system shall be compatible with other secure room key mechanisms on site.
- Door locks shall be operated externally by an anti-ligature guarded pull handle.
- The remote release shall be placed in a secure location inaccessible to patients and non-clinical staff.

☑ The door frame shall be constructed of material and installed in a manner that ensures it is impact- and tamper-resistant, and will not buckle or loosen under extreme force.
- The frame may be one-piece welded steel, 14GA galvanized welded and factory primed with six (12.7 mm/1.5") wall anchors at equal distance; top fixing positioned at 190 mm down from the top and bottom fixing located 90 mm up from the bottom. Wall anchors at 2.13 m (84"), 1.7 m (42") and 17.8 cm (7"). The steel frame shall be filled with concrete.

☑ Door handles shall be built to prevent use as a ligature point, and located on the exterior of the door.

☑ Door hinges shall be constructed of material and installed in a manner that ensures they are impact- and tamper-resistant, and will not buckle or loosen under extreme force.
- Stainless steel piano hinge or five duty five-knuckle security hinges with stainless steel centre pin and welded ends should be used, preventing tampering to the hinge pin. Hinge screws in stainless steel, countersunk with security screws.

☑ The door of the secure room shall be fitted with a shatterproof, scratch-resistant, unbreakable glazed observation panel allowing staff a full view of the secure room when the door is closed. See standards for in-door observation panel, p. ?.

☑ The door shall swing outward to prevent barricading inside the secure room.
- When an anteroom is present, the door swing shall not impede circulation in and out of the space.

4. WALLS, FLOORS AND CEILINGS

Walls, floors and ceilings shall be designed to provide the safest environment possible, which minimizes the likelihood of harm to self, others or the facility, and supports a patient to de-escalate as quickly as possible.

Standards

Walls

☑ Walls shall be extremely durable, able to resist impact (forceful kicking/punching/body slamming) and tampering.
- Walls shall be constructed of a minimum of one layer 1.6 cm (5/8") plywood with impact-resistant drywall.

☑ Soft wall padding shall be installed to increase safety for patients in the event of hitting walls with limbs or heads, and reduce the need for chemical restraint or sedation.
- Soft wall padding should be installed to 2.44 m (8') high.

☑ Soft wall padding shall conform to the following characteristics:
- Composed of synthetic resinous material (no closed cell polyvinyl chloride or other types of polyvinyl chloride surfacing material).
- Contain a flame spread and smoke index with a class A fire rating when tested in accordance with ASTM E84.
- Weight: 24.41 kg per square meter (5 lbs. per square foot).
- Tensile strength range 300 PSI minimum ASTM D412.
- Temperature stability: unaffected from -6 to 48.9 degrees C.
- Moisture absorption 0.8% to 1.05% by weight.
- Compression set 90% recovery after 72 hours.
- Compression properties 30 PSI to 70 PSI at 50% modulus.
- Elongation at break 150% typical ASTM D412.
- Fungus resistance complete.

☑ Walls shall be smooth with no objects that could pose a risk of self-harm or be used for hanging.
- Walls shall be bare, with no projections, splinters, fragments, mouldings or free edges.
- Thermostats, outlets and switches shall be outside the room in an area easily accessible by staff.

- ☑ Walls shall be thick enough to provide structural security and reduce noise transmission to adjacent areas. There shall be no transmission of intelligible speech outside the secure room.
  - Secure rooms shall have acoustical confidential privacy rating (STD=45-55dB). This can be enhanced using insulation with a high sound-dampening factor in the wall (e.g., Safe and Sound Roxul Insulation).

- ☑ Walls shall be washable, and scratch/graffiti resistant.

- ☑ Walls shall be painted in a single neutral/natural colour, which most people find calming.
  - Walls shall not be painted white or grey, and no patterns should be used.

Floors

- ☑ Floors shall be resistant to damage and composed of material that cushions the patient in the event of body slamming or falling.
  - Flooring shall be seamless or have heat-welded seams to prevent tampering and damage.
  - Floor material shall have some cushioning to decrease the risk of injury to the patient in the event of body slamming or falling.

- ☑ Floors shall have a gradual slope to the floor drain in order to facilitate cleaning (e.g., if the toilet overflows or the patient vandalizes the room) while ensuring that the patient can lie relatively flat.
  - Floors shall have a maximum slope of 2 degrees to the floor drain.
  - The floor drain shall have a trap primer for effective cleaning of the room and toilet overflow.
  - The drain shall have a tamperproof cover.

- ☑ Floors shall have a washable finish and be slip-resistant.
  - Floors shall not be linoleum or bare concrete.

- ☑ There shall be no gap between the floor and the secure room door.

Ceilings

- ☑ Ceilings shall be composed of material that resists tampering and abuse.
  - Ceilings may be composed of abuse-resistant solid gypsum board.

- ☑ Ceilings shall be inaccessible to patients.
  - Ceilings shall be at least 2.74 m (9') high.

- ☑ The ceiling surface shall be solid and smooth. Where there are projections inset (e.g., sprinkler heads), they shall be placed in an area that cannot be reached, including when standing on the toilet in the room.

- ☑ Ceilings shall be built to prevent patients from hiding things (e.g., drugs, weapons) in the ceiling area, or from hanging themselves from pipes above the tiles.
  - Non-accessible solid gypsum board shall be used, with access panels outside the secure room.
  - Hanging potential shall be limited by installing HVAC grilles with small perforations or mesh in behind the grille. Grilles shall be installed with tamper-resistant screws.

- ☑ Ceilings shall be built such that there shall be no transmission of intelligible speech outside the secure room.

5. WINDOWS

Secure rooms shall have an unbreakable, shatterproof observation panel (window) set into the door, and an unbreakable, shatterproof exterior window that provides the patient with natural light. Most people find natural light calming, and access to natural light allows patients to remain acquainted with normal day/night cycles.

Standards

All windows

- ☑ Window glazing shall be impact-resistant and able to withstand severe abuse. Glazing shall be unbreakable and shatterproof even if hit with considerable force.
  - Windows shall not be composed of glass block because of the risk of breakage.

- ☑ Windows shall be installed in a manner that prevents breaking/collapsing on impact (kicking/punching/force), and can withstand tampering.

- ☑ Windows shall include no sharp edges, projections or accessible hardware.

Exterior window

- ☑ New builds shall include an exterior window to provide calming natural light in the secure room, assisting the patient to remain engaged by staying acquainted with normal day/night cycles.
  - The exterior window shall be large enough to provide ample natural light into the room during the day.
  - The window shall be mounted flush to the wall.
  - The window sill shall be designed to prevent climbing or standing on the sill.

- ☑ Privacy shall be protected with reflective or frosted film on the exterior, and/or blinds/shades that are not accessible to the patient and shall be controlled remotely.

In-door observation panel

- ☑ The door of the secure room shall be fitted with a shatterproof, scratch-resistant, unbreakable glazed observation panel allowing staff a full view of the secure room when the door is closed.
  - The panel shall be at least 25.4 cm by 25.4 cm (10" by 10").

- ☑ The panel shall be installed securely to withstand impact (kicking/punching/force) and tampering.
  - The observation panel shall be set into the door leaving a flush rounded finish internally.

- ☑ Where there is no anteroom, the observation panel shall have a curtain to protect privacy.

6. SANITATION

The design of the secure room shall ensure staff and patient safety and also enable a patient to maintain a sense of dignity. Therefore, all secure rooms shall allow independent access to adequate and safe sanitary facilities.

Standards

- ☑ Toilet and washing areas shall be provided in the secure room.

- ☑ Toilet and sink shall be robust, stainless steel, anti-suicide combination lavatory.

- ☑ Because of the high risk of flooding (e.g., should a patient clog the toilet), the water shut-off valve shall be located outside the secure room, easily and quickly accessible to staff but secured to avoid access by unauthorized individuals.

- ☑ The sink shall have a single push-button water supply with mixing valve for hot and cold water.

- ☑ There should be a sealed floor drain inside the secure room.

7. AIRFLOW AND TEMPERATURE

In order to avoid illness or death, secure rooms shall have adequate airflow and maintain a healthy air temperature.

Standards

- ☑ Temperature sensors shall be installed in secure, recessed enclosures inside the secure room, on the ceiling.

- ☑ Control of internal secure room temperature shall be managed remotely, e.g., from nursing station.

- ☑ All heating and ventilation mechanisms shall be fully recessed and secured.

- ☑ Adequate airflow and a healthy temperature shall be maintained.

- ☑ The secure room shall be air-conditioned.

- ☑ Airflow mechanisms shall be built to ensure that ensure there is no transmission of intelligible speech outside the secure room.

8. FIRE AND SAFETY PRECAUTIONS

Fire and safety precautions shall be taken for overall protection of the patient, staff and facility.

Standards

Fire safety

- ☑ The secure room shall comply with all fire regulations.

☑ Tamperproof institutional sprinkler heads shall be installed with tamper-resistant screws and made to break away under a 22.7-kg (50-lb.) load to reduce the risk of suicide by hanging.

☑ Smoke/heat detectors shall be security-type, tamper-proof, and resistant to self-harm/hanging.

☑ A policy and procedure exists for unlocking the doors in order to evacuate patients in the event of a Stage 2 or higher fire alarm or other emergency situation.

Staff safety

☑ Blind spots shall be eliminated in the secure room to enable full staff visualization of the patient and thus prevent the patient from harming him/herself or others.
- A camera shall be used to enable full visualization of the room by staff if blind spots exist when looking in through the observation window.
- The cameras shall be mounted flush and away from the location of the bed to prevent the patient from reaching and/or breaking the device.

☑ A wireless, staff-operated alarm system shall be provided.
- The alarm system shall include panic buttons and personal alarms.

☑ A fixed, hard-wired panic device shall be installed within three feet of the secure room door.
- Where there is an anteroom, the device shall be installed within 91.44 cm (3') of the secure room door in the anteroom.

9. FURNISHINGS

To prevent harm to patients and staff, furnishings in the secure room shall be limited to items that are essential to providing appropriate patient care.

Standards

☑ The secure room shall contain only essential equipment and furnishings.

☑ The secure room shall contain a mattress on the floor or thick floor mat. To prevent injury to self or others:
- The mattress shall be manufactured specifically for use in a secure area.
- The mattress shall be made of dense material (foam) in order to avoid hanging or other self-harm risks.
- The mattress shall be tamper-resistant and sealed.
- The mattress shall contain no metal parts.

☑ Blankets (e.g., a "strong blanket") shall be manufactured specifically for use in a secure environment.

10. LIGHTING

In addition to calming/orienting natural light, secure rooms shall have lighting fixtures that meet safety requirements and provide illumination appropriate to the patient's and staff's needs.

Standards

☑ The secure room shall be fitted with moisture-resistant, inset, tamper-proof fixtures installed with secure screws.

☑ Lighting shall be warm medium bright.

☑ Light switches and dimmers shall be located immediately outside the secure room, and externally controlled.
- Staff shall increase or decrease light levels to accommodate patient requests or care needs.

☑ The secure room shall receive natural light from an exterior window.

☑ The secure room shall be able to be darkened completely upon patient request in order to facilitate appropriate patient rest.

11. COMMUNICATIONS, MONITORING AND ENGAGEMENT TOOLS

Patients are less likely to have a negative experience of seclusion when staff take steps to engage them through constant contact. To foster contact and to mitigate a patient's risk of harm to self or staff during the intervention, it is critical for staff to have a full view of the entire secure room at all times, with no blind spots, from both the nursing station and outside the secure room door.

Standards

☑ The secure room shall be fitted with an audio-visual system with capacity for night vision for continuous staff observation of the patient in the secure room.
- The audio-visual system shall include a two-way intercom and CCTV enabling a full view of the entire room including the toilet and sink.
- The CCTV shall be equipped with infrared illumination enabling a full view of the entire room in low-light situations.

☑ CCTV monitors and intercom devices shall be placed at the nurses' station and in the anteroom, where an anteroom exists.
- Care shall be taken to protect the privacy of patients in seclusion by limiting viewing of CCTV monitors to staff.

☑ Controls and equipment in the secure room shall be installed to prevent damage, tampering or self-harm.

☑ Controls at the nurses' station/staff viewing area shall allow the intercom volume to be adjusted but not turned off (i.e., nurses must always monitor sound).

☑ Where there is an anteroom, it shall contain a clock that is fully visible to the patient through the in-door observation panel, and can be read in all lighting conditions.
- Where there is no anteroom, the clock shall be placed outside the secure room in a way that ensures visibility.

Guideline

☑ The audio-visual system may have capacity to record CCTV images for the patient's record.
- The images shall only be available for viewing by clinical staff.
- Patients shall be informed verbally and in writing that these images are being recorded, and how the images will be stored and used in accordance with FOIPPA.

12. ACOUSTICS

An acoustical environment that prevents as much noise transmission as possible between the secure room and the rest of the unit protects the secluded patient's privacy, provides a more calming space for the patient being secluded, limits disruption for patients and staff outside the secure room, and helps to prevent agitation of patients outside the secure room.

The standards for acoustics shall be utilized in combination with the standards for doors, floors, walls, ceilings, airflow and temperature, and lighting.

Standards

☑ There shall be no transmission of intelligible speech between the secure room and the remainder of the unit.
- The secure room's STC rating shall be at least 45.

13. PREVENTIVE AND ALTERNATIVE SPACES

While these *Standards & Guidelines* are specific to secure rooms, the following guidelines regarding preventive and alternative spaces are intended to provide some general direction regarding alternate space needs and options that support a trauma-informed, preventive approach. In this context, it is important for units in designated facilities to include spaces that support the prevention of seclusion. Patients who can access private space or time away from the general milieu of the unit as required, and who are supported to access this space with autonomy, may avoid the kind of crisis that leads to seclusion. See Appendix E for examples of possible adaptations for comfort rooms.

Guidelines

☑ Patients should have autonomous access to spaces that are less restrictive than the secure room in which to prevent escalation or de-escalate, providing there is no danger of imminent harm to self or others.

- The secure room should not be the only space available for patients who need lower or no stimulation.

☑ Preventive and alternative, unlocked spaces that should be considered in the design of any unit include:

- Private bedrooms
- Comfort rooms
- Multisensory rooms
- Courtyard or other safe outdoor space

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Appendix A:
Consultations Performed in the Development of the Standards & Guidelines

The following list identifies the external tables and/or organizations consulted in the development of the *Standards & Guidelines*.

- Fraser Health
- Interior Health
- Island Health
- Northern Health
- Provincial Health Services Authority
- Vancouver Coastal Health
- Providence Health Care
- Ministry of Health – Capital Planning
- Ministry of Health – Hospital Branch
- Ministry of Children and Family Development
- Ministry of Justice – Police Services
- Facilities – Fraser Health, Interior Health (Leslie Gamble), Lower Mainland Facility Planners, Vancouver Coastal Health
- Occupational Health and Safety: Vancouver Coastal Health, Island Health
- WorkSafeBC
- Provincial Violence Prevention Safety Committee
- Provincial Emergency Department Working Group
- Vancouver Police Department
- RCMP – Policing
- Integrated Protection Services
- Union of Psychiatric Nurses of B.C.
- B.C. Nurses' Union
- Community Living B.C.
- Community Advisory Committee (child & youth)
- Families and consumers – Fraser Health, Northern Health
- Accreditation Canada
- CARF Canada (Commission on the Accreditation of Rehabilitation Facilities)
- Council on Accreditation
- Canadian Standards Association
- Mental Health Commission of Canada
- St. Joseph's Hospital (Hamilton, Ontario)
- Ontario Shores (Whitby, Ontario)

Appendix B:
Checklist — Compliance Self-Assessment for Program and Care Standards & Guidelines

CATEGORY	STANDARD	MET	PARTIALLY MET	NOT MET	COMMENTS
General	Patients shall be treated with dignity and respect at all times.				
	Seclusion shall only be delivered within a secure room, designated expressly for the delivery of seclusion.				
	All standards and guidelines shall be translated into health authority policies and procedures.				
	Seclusion shall be delivered within the context of trauma-informed, recovery-oriented, patient-focused care.				
	Seclusion shall be a short-term emergency measure of last resort, used only when all efforts to prevent the use of seclusion have failed.				
	Individuals experiencing withdrawal symptoms will not be placed in a secure room while not medically stable.				
	Seclusion shall be used only to prevent a patient from harming him or herself or others.				
	Policies and procedures shall be in place to ensure appropriate psychiatric, mental health and medical assessments of all patients.				
	Post-incident reflection and review shall be conducted following seclusion interventions as part of a cycle of continuous quality improvement.				
	The clinical team shall document and report out on all seclusion interventions.				

Appendix B cont.: Checklist — Compliance Self-Assessment for Program and Care Standards & Guidelines

CATEGORY	STANDARD	MET	PARTIALLY MET	NOT MET	COMMENTS
General (cont.)	Clinical teams shall support and monitor prevention, performance and quality improvement.				
	Clinical and administrative units shall monitor and report out on staff performance and accountability in order to support staff in delivering best-practice interventions.				
	Clinical and administrative leadership shall be accountable for the use of seclusion.				
	Staffing levels shall be adequate for appropriate provision of clinical care.				
Preventing seclusion	Designated facilities shall define a clear and unwavering mandate for the prevention of seclusion.				
	Designated facilities shall deliver recovery-oriented, trauma-informed care.				
	Designated facilities shall implement specific and proactive strategies to prevent the need for seclusion and minimize its use.				
	Designated facilities shall provide or support staff to undertake comprehensive and ongoing training in interventions to prevent seclusion.				
	For units that have a comfort and/or multisensory room: Staff should utilize comfort or multisensory rooms fully and appropriately.				
Assessment and care planning	Care plans shall be initiated upon a patient's admission to the facility. Care plans shall involve input from the patient and family/guardian/caregiver as well facility staff, and include strategies for managing risk and preventing seclusion.				

Appendix B cont.: Checklist — Compliance Self-Assessment for Program and Care Standards & Guidelines

CATEGORY	STANDARD	MET	PARTIALLY MET	NOT MET	COMMENTS
Assessment and care planning (cont.)	Care planning shall include the community case manager where appropriate.				
	New patients shall receive routine medical and psychiatric risk assessments.				
	All assessments shall be documented in the patient's health record.				
	Any underlying medical causes for a behavioural disturbance shall be investigated and treated.				
	Psychiatric symptoms shall be assessed and treated according to best-practice clinical indication.				
	The risk of suicide and violence shall be assessed to determine immediate and serious risk of harm to self or others; this shall be documented according to provincial violence prevention regulations.				
Risk management	Trauma-informed practice shall be adopted as a default approach to care in order to minimize the traumatization of patients that might lead to risk of violence and aggression, and support the prevention of unnecessarily restrictive interventions.				
	Within the parameters of legislated requirements, partnerships between patients, families and caregivers shall be the guiding force when developing inpatient psychiatric policies and practice.				
	Each and every designated facility shall have a formal strategy, policy or protocol to support staff in identifying options to prevent seclusion.				

Appendix B cont.: Checklist — Compliance Self-Assessment for Program and Care Standards & Guidelines

CATEGORY	STANDARD	MET	PARTIALLY MET	NOT MET	COMMENTS
Risk management (cont.)	Thorough medical, psychiatric, violence and trauma risk assessments shall be performed upon admission to establish potential triggers that might require seclusion.				
	Individualized behavioural care plans include measures to prevent seclusion.				
	A RN or RPN shall be available within sight and sound of the secure room at all times when a patient is secluded (i.e., the secluded patient is always monitored at minimum via closed-circuit television and intercom at the nursing station), and patients shall be monitored closely throughout the intervention.				
	The patient shall be included in post-intervention reflection and review in order to reverse or minimize the intervention's potential negative impact.				
	Policies and procedures shall be in place to assist staff to provide care that is culturally competent.				
	Policies and procedures shall be in place to assist staff to provide care that respects and accommodates an individual's needs resulting from that person's self-determined gender and/or sexual identities.				
	Patients shall be supported to keep personal items of religious or cultural significance as long as they pose no safety risk.				
	Policies and procedures shall be in place to ensure staff are aware of supports available to them following seclusion events.				

Appendix B cont.: Checklist — Compliance Self-Assessment for Program and Care Standards & Guidelines

CATEGORY	STANDARD	MET	PARTIALLY MET	NOT MET	COMMENTS
Initiating seclusion	A patient shall be deemed medically stable by a qualified physician or registered nurse prior to experiencing a seclusion intervention.				
	Seclusion shall be ordered by a qualified physician and the order is reviewed as soon as possible by a psychiatrist, or the director appointed under the Mental Health Act (or designate approved by the health authority).				
	Trained and qualified, authorized staff shall initiate and deliver seclusion.				
	Orders for the use of seclusion shall be time-limited and specific.				
	Facilities shall have policies and procedures regarding the role of police, code white team, and security guards in initiation of seclusion.				
Observation and evaluation	Patients shall be evaluated face-to-face by a qualified physician as soon as possible within 24 hours of the initiation of seclusion.				
	Patients in seclusion for extended periods (i.e., longer than 8 hours continuous) shall receive a mental health assessment by a qualified registered clinical professional at least once every 24 hours. This assessment shall be documented in the client file.				
	If seclusion lasts more than one hour, a care plan shall be developed for the seclusion period.				
	Unit staff shall review the need to continue seclusion throughout the intervention, at 30 minutes, 2 hours, and every 4 hours for the duration.				

Appendix B cont.: Checklist — Compliance Self-Assessment for Program and Care Standards & Guidelines

CATEGORY	STANDARD	MET	PARTIALLY MET	NOT MET	COMMENTS
Observation and evaluation (cont.)	Face-to-face monitoring and evaluation of patients in seclusion shall take place at regular intervals, at a minimum of once every 15 minutes, throughout the duration of the intervention. If seclusion persists past 8 hours continuous or 12 hours intermittent, the review shall include at least one qualified senior clinician, and, whenever possible, the initiating and supporting clinician(s).				
	Face-to-face monitoring and evaluation of patients in seclusion shall take place at regular intervals, at a minimum of once every 15 minutes, throughout the duration of the intervention.				
	The secure room shall be fitted with an audio-visual system for continuous staff observation of the patient and to facilitate patient-staff engagement.				
	Monitoring and evaluation shall not take place via audio-visual observation system alone (i.e., CCTV monitors and intercom.				
Ending seclusion	Periods of seclusion shall end as quickly as possible, when a nurse and/or physician on the clinical team determines that there is no longer any threat to any person's safety.				
	The clinical team shall implement a step-down process to end seclusion, unlocking or opening the door once they have determined it is safe to do so, enabling the patient to decide when he or she is ready to leave the room, and incorporating a period of observation to ensure that it is safe for the patient to return to the open unit.				
	The seclusion episode shall be considered over when the patient leaves the conditions of seclusion without expectation of return, or for more than one hour.				

Appendix B cont.: Checklist — Compliance Self-Assessment for Program and Care Standards & Guidelines

CATEGORY	STANDARD	MET	PARTIALLY MET	NOT MET	COMMENTS
Ending seclusion (cont.)	Seclusion shall be concluded with a plan for re-integrating the patient into the general unit and managing future emergencies.				
Protecting emotional and psychological safety	Families/caregivers shall be notified of the decision to use seclusion, with consideration for the patient's wishes and consent.				
	Patients shall have options/means for constant contact and communication with staff throughout seclusion episode.				
	The reasons for initiating, continuing and ending seclusion shall be explained to the patient, and the explanation and patient's observed level of understanding shall be documented.				
	Patients shall be kept aware of the time and date, verbally or via a clock viewable from the secure room.				
Promoting physical safety	Neither patients nor staff shall be subjected to injury or degradation.				
	Seclusion shall be delivered in an appropriate environment, in a manner that is safe for and respectful of all involved.				
	Patients in seclusion shall receive adequate food and fluids without undue delays.				
	Patients shall have constant access to toilet and washing facilities.				
	Patients shall be clothed appropriately, with due concern for safety (e.g., removal of potentially dangerous accessories such as belts and shoes). Under no circumstances shall a patient be left without the option of wearing clothing.				

Appendix B cont.: Checklist — Compliance Self-Assessment for Program and Care Standards & Guidelines

CATEGORY	STANDARD	MET	PARTIALLY MET	NOT MET	COMMENTS
Legal rights	Policies and procedures shall be in place to inform patients and family members/guardians of their rights under the Mental Health Act. While the Act authorizes involuntary admission and treatment of people with mental disorders, there is a need to ensure these provisions are appropriately used.				
	In accordance with the Freedom of Information and Protection of Privacy Act (FOIPPA), policies and procedures shall be in place to share information among health care team members and third parties.				
	Patients in seclusion shall have their rights explained verbally and in writing, and the explanation shall be documented.				
	A staff member from a designated facility (or its agent) must verbally inform the person and provide written notification of their rights promptly upon admission. Rights information requirements, as they apply to involuntary patients, are set out in section 34 of the Act. For patients under 16, the requirements are in section 34.1.				
Reflection and review	Leaders and staff shall participate in the reflection and review process as soon as possible after the end of seclusion.				
	The designated facility shall have a formal review and documentation process involving clinical and administrative leaders in order to address potential service-wide performance improvement.				
	Clinicians shall reflect on and review the incident with the patient and family/caregivers/guardians (where appropriate) as soon as possible within 24 hours after the end of seclusion.				

Appendix B cont.: Checklist — Compliance Self-Assessment for Program and Care Standards & Guidelines

CATEGORY	STANDARD	MET	PARTIALLY MET	NOT MET	COMMENTS
Reflection and review (cont.)	Reflection and review procedures shall be transparent, and communicated to patients through brochures or other easily accessible formats.				
Documentation and quality improvement	Designated facilities shall collect and analyze data on seclusion interventions in order to inform practice and improve internal performance. Seclusion interventions shall be tracked in each health authority and reported to the Ministry of Healthhrough the Patient Safety Learning System (PSLS). Designated facilities shall collect and report units' use of seclusion via the PSLS at regular intervals.				
	Policies and procedures shall be in place for documenting assessment and care of the patient and family members/ guardians when a patient is at risk of or experiences seclusion.				
	Policies and procedures shall be in place for documenting and reporting of seclusion, including the evaluation conducted and follow-up steps initiated.				
	Clinical and/or administrative staff shall document in the patient's clinical record and via the PSLS all aspects of the use of seclusion.				
	An accurate account of each episode of seclusion shall be recorded, demonstrating the delivery of treatment that conforms to provincial standards and guidelines and facility policy.				
	Clinical and administrative leaders shall review all seclusion interventions.				
	Clinicians and administrators shall establish and adhere to written policy and procedures for the use of seclusion.				

Appendix B cont.: Checklist — Compliance Self-Assessment for Program and Care Standards & Guidelines

CATEGORY	STANDARD	MET	PARTIALLY MET	NOT MET	COMMENTS
Documentation and quality improvement (cont.)	Clinical and administrative leaders shall communicate the facility's policy and philosophy on the use of seclusion to all relevant staff.				
	Clinical and administrative leaders shall work actively to minimize or prevent the use of seclusion.				
	Clinical and administrative leaders shall implement a performance improvement process related to seclusion in order to ensure accountability.				
	Patients shall be involved in the evaluation of a facility's seclusion practices as part of ongoing quality improvement.				
Developmental disability, neuropsychiatric and psycho-geriatric populations	Clinical staff shall receive training that alerts them to the increased risk of seclusion faced by people with developmental disabilities and neuropsychiatric disorders including dementia.				
	When engaging in prevention and/or delivery of seclusion, consideration shall be given to the specific developmental needs of youth with highly complex disorders.				
	Geriatric and neuropsychiatric populations shall be provided with alternatives to a secure room in order to ensure the safety of individuals who are at risk of elopement, but not imminent violence.				
	Because of the specific characteristics of their disorders, individuals with developmental disabilities and/or neuropsychiatric disorders may not respond to preventive techniques such as verbal de-escalation, re-direction or medication. Such patients shall have access to both emergency and planned seclusion interventions in order to prevent them from being targets of violence or from harming themselves or others.				

Appendix B cont.: Checklist — Compliance Self-Assessment for Program and Care Standards & Guidelines

CATEGORY	STANDARD	MET	PARTIALLY MET	NOT MET	COMMENTS
Observation units	Policies and procedures are in place for staff responsible for the oversight of care of an individual in the observation unit to have knowledge and skills in emergency psychiatric assessment, crisis intervention and the safe management of patients with psychosis, delirium, suicidal and aggressive behaviours.				
	A facility designated as an observation unit must have access to psychiatric consultation in order to clarify and confirm a patient's diagnosis and/or treatment plan.				
	Protocols exist with community mental health and substance use services and other relevant community resources (e.g., child and youth mental health services, friendship centres, primary care providers, family/guardian) to provide care and treatment to an individual while that person awaits transfer in order to support stabilization and prevent the need for seclusion interventions.				
Emergency departments	All individuals will be triaged by a trained triage nurse and moved immediately to the appropriate location in the ED, considering their own and others' safety.				
	Only individuals who have been assessed as medically stable (by the triage nurse or a physician) and require seclusion for their immediate safety or the safety of others will be considered appropriate to be placed in a secure room in the ED.				
	Clinical decision tools shall be in place to support ED staff in assessing the psychiatric patient in crisis.				
	Education processes shall be in place to explore the concept of trauma-informed practice in the ED as the term 'trauma' has a different meaning in that environment.				

Appendix B cont.: Checklist — Compliance Self-Assessment for Program and Care Standards & Guidelines

CATEGORY	STANDARD	MET	PARTIALLY MET	NOT MET	COMMENTS
Role of police in the ED Note: guidelines only	Clinical staff shall assess to determine if the presence of uniformed officers creates increased agitation for the patient or a calming sense of order and control.				
	Police, hospital security staff and clinical staff shall understand their counterparts' training and roles to improve consistency in approach.				
	Health authorities shall work with local police detachments to develop a protocol to ease the transition from police to hospital responsibility for patients detained under Section 28 of the Mental Health Act.				
Staff education, training and support	Health authorities shall work with their occupational health and safety, union, and professional bodies to set clear requirements identifying standardized competencies for entry to practice, demonstration of skills, number of training hours and refresher cycles.				
	Clinical staff shall be able to articulate sound knowledge of the key principles, legal requirements, guidelines and local policies and procedures relating to seclusion.				
	Staff shall be trained and competent to deliver seclusion interventions safely and in accordance with the facility's policies and procedures.				
	Health care staff shall receive continual training and professional development to maintain and enhance their skills, and to ensure key competencies as required by the ***BC Provincial Violence Prevention Curriculum (PVPC).***				
	Staff shall receive continual training and professional development to maintain and enhance their skills, and to ensure additional key competencies for prevention and safe delivery of seclusion.				

Appendix B cont.: Checklist — Compliance Self-Assessment for Program and Care Standards & Guidelines

CATEGORY	STANDARD	MET	PARTIALLY MET	NOT MET	COMMENTS
Staff education, training and support (cont.)	Staff shall receive training in trauma-informed care, non-violent crisis intervention (including de-escalation), and collaborative problem-solving.				
	Staff shall receive education and training to develop skills for managing behavioural emergencies; assessing potential aggression/violence; and preventing and managing disturbed behaviour and aggression/violence.				
	Staff shall be trained and competent to deliver interventions intended to prevent and/or minimize the use of seclusion.				
	Staff shall receive training in functional analyses of behaviour, and of positive behavioural supports and interventions to help with prevention of dangerous behavior/teaching of alternative behaviours.				
	Nursing staff shall be trained to recognize signs/symptoms of side effects/adverse reactions to treatment associated with the seclusion episode (e.g., any medications administered, environmental impact of the secure room).				
	Staff shall work in a well-trained team with the proven capacity to deliver required services in keeping with provincial standards and guidelines for safety, health and quality of care.				
	Staff shall have access to an expert who may provide guidance regarding issues and questions about relevant legislation including the Hospital Act, Mental Health Act, Workers Compensation Act, Freedom of Information and Protection of Privacy Act, occupational health and safety regulations, and violence prevention regulations.				

Appendix C:
Sample Comfort Plan[9]

Note: Enlarge and print this sample Comfort Plan at 138 per cent to fit a US Letter-sized sheet.

❍ I developed this plan with my nurse _____ (*name of nurse*) or other provider _____ (*name of person*).

Comfort Plan

I like to be called:
_____

I.D. Tag
(Please do not label individual's personal copy)

My Distress Signs & Signals

My warning signals, or things that others might see when I am upset or losing control are:

❍ Sweating
❍ Crying
❍ Breathing hard
❍ Yelling
❍ Hurting others
❍ Throwing objects
❍ Pacing
❍ Injuring self by: _____
❍ Clenching teeth
❍ Not taking care of myself
❍ Running
❍ Clenching fist
❍ Swearing
❍ Not eating
❍ Overeating/Binging
❍ Being rude
❍ Other: _____

Comfort & Calming Measures

These five activities have helped me to feel better when having a hard time:

❍ Listening to music
❍ Reading a book
❍ Wrapping myself in a cozy blanket
❍ Writing in a journal
❍ Watching TV
❍ Talking with staff
❍ Talking with peers on the unit
❍ Calling a friend or family member
❍ Taking a shower or bath
❍ Exercise
❍ Pacing in the halls
❍ Going for a walk
❍ Drinking a beverage
❍ Eating certain foods: _____
❍ Working on a craft/artwork
❍ Medication
❍ Reading religious/spiritual material
❍ Writing a letter
❍ Hugging a stuffed animal
❍ Spending voluntary time in quiet/comfort room

Other:_____

My Triggers or Irritants

Some things that make me angry, very upset, or cause me to go into crisis include:

❍ Being touched
❍ Security in uniform
❍ Yelling
❍ Loud noises
❍ Being restrained
❍ Being hungry
❍ Being tired
❍ Staff telling me to come back later
❍ Being called names, made fun of
❍ Being forced to do something
❍ Physical force
❍ Being isolated
❍ Being threatened
❍ Being anxious
❍ Being lonely
❍ Personal space violated
❍ Contact with person who upsets me
❍ Someone else lying about me
❍ Other: _____

Seclusion & Restraints

In extreme emergencies, seclusion and/or restraint may be used as a last resort. In emergencies, I would find the following helpful in trying to prevent these from being used:

❍ Comfort or quiet room
❍ Medications by mouth
❍ Emergency injection
❍ Other: _____

I have experienced seclusion and/or restraint in the past:
❍ yes ❍ no

Physical Contact:

I find it helpful to be touched appropriately when I am upset:
❍ yes ❍ no
Comments: _____

❍ I am aware that staff may prefer not to touch me.

Medications

If I need or want medications to help calm me, these would be my preference:

_____
_____
_____

Gender Concerns

I am aware that gender of staff is out of my control, but in an emergency I would prefer to speak with:
❍ male staff ❍ female staff
(if at all possible).

9 Used with permission from St. Joseph's Hospital, Hamilton, Ontario

Appendix D:
Sample Personal Safety Plan[10]

Note: Enlarge and print this sample Personal Safety Plan at 138 per cent to fit a US Letter-sized sheet.

Providence HEALTH CARE

Personal Safety Plan

This form is part of the patient's permanent health record and MUST be completed in pen.

When I become upset, I experience:
- ❍ Changes in my body
- ❍ Sweating
- ❍ Breathing hard
- ❍ Clenching teeth/fists
- ❍ Red face
- ❍ Cannot sit still
- ❍ Pacing
- ❍ Other: _____

My major trigger or irritant:
- ❍ Not being listened to
- ❍ Being touched
- ❍ Yelling
- ❍ Loud noises
- ❍ Feeling anxious
- ❍ Not having control
- ❍ Not having my needs met
- ❍ Cravings for alcohol/drugs/nicotine
- ❍ Other: _____

_____

_____

Changes in how I talk:
- ❍ Become loud
- ❍ Become quiet
- ❍ Yell
- ❍ Swear
- ❍ Cry
- ❍ Other: _____

Changes in my behaviour:
- ❍ Become rude
- ❍ Hurt self
- ❍ Isolate (withdraw)
- ❍ Other: _____

_____

_____

Things that will help to calm me:
- ❍ Talking with members of my treatment team
- ❍ Talking with family/friends
- ❍ Taking medications
- ❍ Going to my room
- ❍ Exercising
- ❍ Listening to music
- ❍ Quiet activity
- ❍ Journaling
- ❍ Other: _____

_____

_____

In extreme emergencies, seclusion and/or restraint may be used and this will be discussed with my nurse. However, before this happens, I would like to try any of these things to help calm me:
- ❍ Going to my room and closing the door
- ❍ Going into a seclusion room with the door open
- ❍ Taking medications by mouth
- ❍ Other: _____

_____

_____

Completed by:

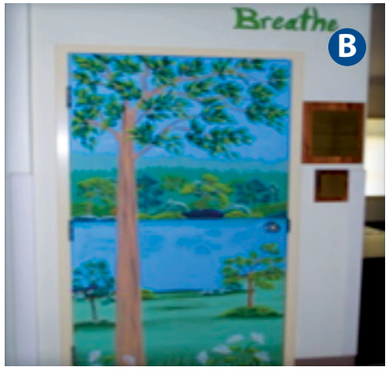
Patient signature: _____ Date: _____

Staff signature: _____ Date: _____

Form No. PS192 (Mar 28-12)

10 Used with permission from Providence Health Care. The format of this Personal Safety Plan has been altered for inclusion in this document. Alterations have no bearing on the content.

Appendix E:
Sample Photos — Comfort & Sensory Rooms at Jack Ledger House in Victoria



- **A** Ledger Children's Unit Comfort Room
- **B** Door to Comfort Room
- **C** Sensory Modulation Room
- **D** Sensory Modulation Room
- **E** Sensory Modulation Room

Appendix F:
Six Core Strategies to Recude the Use of Seclusion and Restraint in Inpatient Facilities©

Published in 2002 by the American National Association of State Mental Health Program Directors (NASMHPD), the *Six Core Strategies* were developed via a thorough evidence review and consultation with national experts. The Strategies are based on a public health disease prevention and health promotion approach to trauma-informed care, and focused on "identifying risk factors for conflict and violence before they occur, along with any intervention strategies to immediately respond to conflict so that violence and the use of restraint and seclusion can be prevented" (Haimowitz et al., 2006). Subsequent research suggests that the strategies are effective in reducing physical interventions (Azeem et al., 2011).

1. **Leadership Toward Organizational Change.** Reduction efforts require the commitment of senior leaders, and development of a specific plan spearheaded by leaders and involving consumers, family members, advocates, and staff. The plan should be based upon trauma-informed principles.

2. **Use of Data to Inform Practice.** Effective reduction efforts use facility data in a transparent, non-punitive manner to encourage change. Data on seclusion and restraint "should be collected by unit, shift, day, and by staff member involved," then "graphed and posted in all areas of the facility so that it is clearly visible for staff and patients."

3. **Workforce Development.** "Efforts to reduce restraint and seclusion are most successful in facilities where policy, procedures, and practices are based on the principles of recovery and the characteristics of trauma-informed systems of care." The Core Strategies require that staff receive training to this effect and to resolve conflict. They also require facility leaders to develop policies that avoid the rigidity that can cause conflict on the unit, and empower staff to make "in the moment" decisions.

4. **Use of Prevention Tools.** Staff use clinical and other tools to prevent restraint and seclusion, including: assessments to identify patient's risk for violence; assessments to identify medical risk factors for death and injury; assessments to identify psychological risk factors and history of trauma; development with patients of de-escalation or safety plans; changes to physical environment; daily implementation of engaging treatment activities.

5. **Supporting Consumer and Advocate Roles in Inpatient Settings.** Include these stakeholders to send the message that "recovery is real, that recovery happens…" Administrators take steps to integrate mental health consumers and advocates into the inpatient environment.

6. **Debriefing Tools.** Debriefing serves two purposes: it provides information to inform policy and reduce future use of seclusion and restraint; and it addresses the adverse effects of these interventions on patients and staff. Debriefing follows a two-step process and includes the patient as an active participant.

Appendix G:
Sample Two-Step Debriefing Process

Researchers and clinicians support implementing a two-step debriefing process. There is broad consensus that the first session should take place immediately following the incident of seclusion and the second should occur several days later. The evidence is more equivocal, however, regarding the sequence of content addressed in each step. This review, therefore, offers the following steps as examples of how a facility might approach debriefing; in practice, there should be significant leeway in determining the specific focus of each session.

Step 1

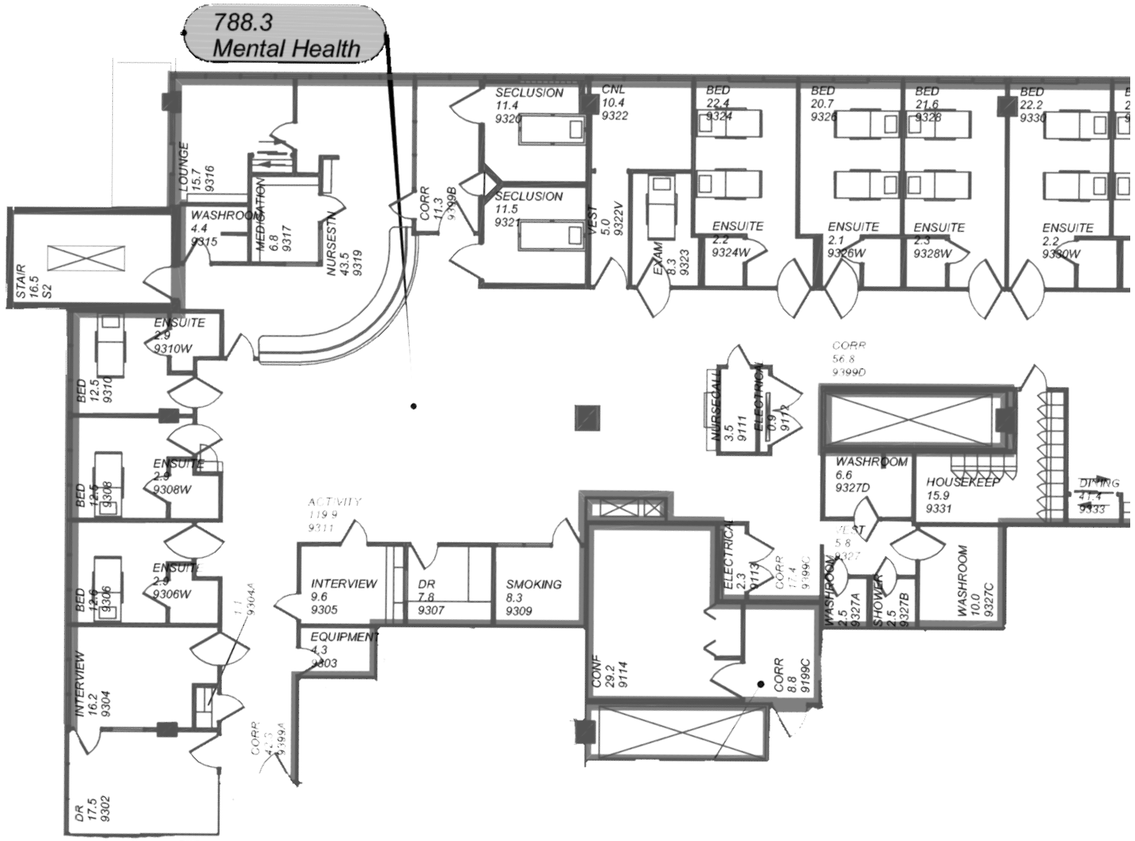
A synthesis of the evidence suggests that the first session might address the details of the incident itself to confirm the safety of the practice, review documentation, and connect with both staff and the patient to share feelings and perceptions, review clinical data, and revise the patient's treatment plan. A senior staff member should lead the session with participation from as many of the people present during the incident as possible, including the patient and/or an advocate.

Step 2

The second step could be a formal critical incident review that takes a more systematic approach to determining whether or not the situation could have been handled differently, and addresses potential service-wide improvements. Participants would include the treatment team, the attending psychiatrist, a representative from the facility's management team, and perhaps the patient and/or an advocate if appropriate.

(Source: Huckshorn, 2006b; Glassheim, 2008; Allen et al., 2002; Vanderpool, 2004; O'Hagan et al., 2008.)

Appendix H:
Sample Diagram of a Secure Room with Anteroom



Appendix I:
Summary of Required Competencies and Corresponding Provincial Violence Prevention Curriculum Modules

As required by provincial legislation, health care staff who deliver seclusion interventions shall receive Provincial Violence Prevention training to ensure they demonstrate the following competencies:

- Ability to prevent and manage episodes of seclusion by adhering to PVPC guidance for mitigating violent encounters and preventing an escalation of behaviour that can lead to seclusion interventions.

- Ability to engage with patients by validating their concerns, clarifying information, responding appropriately, avoiding power struggles and using appropriate body language (PVPC Module 5).

- Ability to recognize and assess patient and environmental risk factors and stressors that may lead to violence (PVPC Modules 2 & 3).

- Ability to identify issues or events for patients that may trigger challenging behaviour. Identifying risk-associated behaviours (e.g., verbal violence, a change in behaviour) and controlling staff responses to those behaviours can prevent violent interventions and escalations (PVPC Modules 2 & 3).

- Possession of nonphysical intervention skills, such as de-escalation and team response techniques found in the PVPC.

- Ability to choose the least restrictive intervention possible, e.g., using the team response outlined in the PVPC.

- Ability to recognize when to discontinue seclusion and restraint. By adequately assessing and responding to patients' emotional distress while in seclusion, staff can mitigate the risk of violence and trauma to patients (PVPC Module 2).

- Ability to communicate with clients experiencing severe behavioural disturbance using specific verbal, non-verbal and vocal communication techniques outlined in the PVPC.

Appendix I cont.: Summary of Required Competencies and Corresponding Provincial Violence Prevention Curriculum Modules

- Ability to use objective reporting methods, e.g., reporting only the patients' observed behaviours or verbal remarks, and not using general terms such as 'aggressive +++'. The PVPC outlines five factors to consider when filling out a Patient Violence Risk Assessment, as well as instructions on reporting violent incidences after they have occurred. Both of these documents focus on the objective events, behaviours and stressors that exist in the patient's environment, while balancing the need for respect and compassion towards these individuals.

- Ability to respond to cognitively impaired patients, some of whom may be unable to comprehend the consequences of their actions. The PVPC Module 5 provides training for de-escalation and communication with this population.

- Knowledge of resources available to staff as supports following seclusion interventions. Some of these resources, as well as a list of individuals who might help staff members locate further assistance can be found in PVPC Module 7.

- Knowledge of personal protective actions identified in the PVPC to keep staff safe and prevent dangerous situations from occurring.

- Knowledge of necessary reporting required if staff have experiences of physical or emotional harm (PVPC Module 7).

Appendix J:
Summary of Required Competencies and Corresponding Provincial Violence Prevention Curriculum Modules

Because of the high risks seclusion poses to both patients and staff, it is critical that designated facilities providing a secure room meet the standards and guidelines ensuring health, safety and quality of care. The following checklist assists with maintaining a record of the degree to which select physical environment and design standards have been met. Space is provided to include an explanation of barriers to full compliance. Note that while designated facilities must comply with all standards and guidelines listed in this document, the checklist targets only those that are immediately quantifiable/objective (i.e., appropriate room size, inclusion of an exterior window, etc.) and/or central to the planning, design and construction process. Not all required standards and guidelines are included in the checklist.

CATEGORY	RATIONALE	STANDARD	STANDARD	PARTIALLY MET	NOT MET	COMMENTS
General	Secure environments shall be designed and built to support best-practice delivery of services, and ensure the safety of staff, patients, and others on the unit. The environment shall be designed and built to mitigate the risk of harm to self and others, and to conform to all requirements for health and hygiene.	The secure room shall meet infection control and hygiene requirements.				
		The secure room shall be large enough to enable 4-sided access to the secluded patient (min. 13.9 square meters).				
Placement	The secure room shall be placed to ensure easy and prompt access by nursing staff in order to deliver appropriate patient care. The placement of the secure room shall enable close observation of the patient by nursing staff, while also sparing the patient the disruption of conversation and nonclinical interaction in immediately adjacent areas.	The secure room shall be placed adjacent to the nurses' station and, space and resources permitting, separated from other patients by a vestibule or anteroom.				
		The secure room shall be placed away from elevators, stairs, exits, common patient areas, and areas where staff and/or patients typically congregate for non-clinical purposes.				

Appendix J cont.: Summary of Required Competencies and Corresponding Provincial Violence Prevention Curriculum Modules

CATEGORY	RATIONALE	STANDARD	STANDARD MET	PARTIALLY MET	NOT MET	COMMENTS
		The secure room shall be placed to include an exterior window.				
		Geriatric and neuropsychiatric populations shall be provided with alternatives to a secure room in order to contain individuals who are at risk of elopement, but not imminent violence.				
		Clinical leaders shall work with facility planners, designers and builders to ensure that appropriate step-down options are planned for on the unit.				
Doors & locks	Doors and locks are critical elements to ensure safety and security. Doors, locks, door frames and hinges shall be robust enough to withstand extreme force, and resist buckling or loosening. Doors shall be composed of material that is impact- and tamper-resistant.	Doors, door frames, and locking mechanisms shall meet all relevant regional and provincial fire, flooding and emergency codes.				
		Doors shall be tall and wide enough to enable at least two staff to accompany a patient on either side in and out of the secure room.				
		Doors shall be equipped with both magnetic and mechanical locking mechanisms.				

Appendix J cont.: Summary of Required Competencies and Corresponding Provincial Violence Prevention Curriculum Modules

CATEGORY	RATIONALE	STANDARD	STANDARD MET	PARTIALLY MET	NOT MET	COMMENTS
Doors & locks cont.		Door lock shall be impact- and tamper-resistant, with a multiple (three-point) bolting system simultaneously securing the door at the top, bottom and centre.				
		Door locks shall be operated by key from inside the secure room. The locking system shall be compatible with other secure room key mechanisms on site.				
		The door frame shall be constructed of material and installed in a manner that ensures it is impact- and tamper-resistant, and will not buckle or loosen under extreme force.				
		Door handles shall be built to prevent use as a ligature point, and located on the exterior of the door.				
		The door of the secure room shall be fitted with a shatterproof, scratch-resistant, unbreakable glazed observation panel allowing staff a full view of the secure room when the door is closed.				

Appendix J cont.: Summary of Required Competencies and Corresponding Provincial Violence Prevention Curriculum Modules

CATEGORY	RATIONALE	STANDARD	STANDARD	PARTIALLY MET	NOT MET	COMMENTS
Doors & locks cont.		The door shall swing outward to prevent barricading inside the secure room.				
Walls, floors & ceilings	Walls, floors and ceilings shall be designed to provide the safest environment possible, which minimizes the likelihood of harm to self, others or the facility, and supports a patient to de-escalate as quickly as possible. Walls shall be extremely durable, able to resist impact (forceful kicking/ punching/body slamming) and tampering.	Soft wall padding meeting required characteristics shall be installed to increase safety for patients in the event of hitting walls with limbs or heads, and reduce the need for chemical restraint or sedation.				
		Walls shall be smooth with no objects that could pose a risk of self-harm or be used for hanging.				
		Walls shall be thick enough to provide structural security and reduce noise transmission to adjacent areas.				
		Walls shall be washable, and scratch/graffiti resistant.				
		Walls shall be painted in a neutral/natural colour, which most people find calming (not white or gray, no patterns).				

Appendix J cont.: Summary of Required Competencies and Corresponding Provincial Violence Prevention Curriculum Modules

CATEGORY	RATIONALE	STANDARD	STANDARD	PARTIALLY MET	NOT MET	COMMENTS
Walls, floors & ceilings cont.		Floors shall be resistant to damage and composed of material that cushions the patient in the event of body slamming or falling.				
		Floors shall have a gradual slope to the floor drain in order to facilitate cleaning (i.e., if the toilet overflows or the patient vandalizes the room) while ensuring that the patient can lie relatively flat.				
		Floors shall have a washable finish and be slip-resistant.				
		There shall be no gap between the floor and the secure room door.				
		Ceilings shall be composed of material that resists tampering and abuse.				
		Ceilings shall be inaccessible to patients (at least 9' high).				
		The ceiling surface shall be solid and smooth. Where there are projections inset (e.g., sprinkler heads), they shall be placed in an area that cannot be reached, including when standing on the toilet in the room.				

Appendix J cont.: Summary of Required Competencies and Corresponding Provincial Violence Prevention Curriculum Modules

CATEGORY	RATIONALE	STANDARD	STANDARD	PARTIALLY MET	NOT MET	COMMENTS
Walls, floors & ceilings cont.		Ceilings shall be built to prevent patients from hiding things (e.g., drugs, weapons) in the ceiling area, or from hanging themselves from pipes above the tiles.				
		Ceilings shall be built such that there shall be no transmission of intelligible speech outside the secure room.				
Windows	Secure rooms shall have an unbreakable, shatterproof observation panel (window) set into the door, and an unbreakable, shatterproof exterior window that provides the patient with natural light. Most people find natural light calming, and access to natural light allows patients to remain acquainted with normal day/night cycles. New builds shall include an exterior window to provide calming natural light in the secure room, assisting the patient to remain engaged by staying acquainted with normal day/night cycles.	Window glazing shall be impact-resistant and able to withstand severe abuse. Glazing shall be unbreakable and shatterproof even if hit with considerable force.				
		Windows shall be installed in a manner that prevents breaking/collapsing on impact (kicking/punching/force), and can withstand tampering.				
		Windows shall include no sharp edges, projections or accessible hardware.				
		Privacy shall be protected with reflective or frosted film on the exterior, and/or blinds/shades that are not accessible to the patient and shall be controlled remotely.				

Appendix J cont.: Summary of Required Competencies and Corresponding Provincial Violence Prevention Curriculum Modules

CATEGORY	RATIONALE	STANDARD	STANDARD	PARTIALLY MET	NOT MET	COMMENTS
Windows cont.		The door of the secure room shall be fitted with a shatterproof, scratch-resistant, unbreakable glazed observation panel allowing staff a full view of the secure room when the door is closed.				
		The panel shall be installed securely to withstand impact (kicking/punching/force) and tampering.				
		Where there is no anteroom, the observation panel shall have a curtain to protect privacy.				
Sanitation	The design of the secure room shall ensure staff and patient safety and also enable a patient to maintain a sense of dignity. Therefore, all secure rooms shall allow independent access to adequate and safe sanitary facilities. Toilet and washing areas shall be provided in the secure room.	Toilet and sink shall be robust, stainless steel, anti-suicide combination lavatory.				
		Because of the high risk of flooding (e.g., should a patient clog the toilet), the water shut-off valve shall be located outside the secure room, easily and quickly accessible to staff but secured to avoid access by unauthorized individuals.				
		The sink shall have a single push-button water supply with mixing valve for hot and cold water.				

Appendix J cont.: Summary of Required Competencies and Corresponding Provincial Violence Prevention Curriculum Modules

CATEGORY	RATIONALE	STANDARD	STANDARD	PARTIALLY MET	NOT MET	COMMENTS
Sanitation cont.		There should be a sealed floor drain inside the secure room.				
Airflow & temperature	In order to avoid illness or death, secure rooms shall have adequate airflow and maintain a healthy air temperature. Temperature sensors shall be installed in secure, recessed enclosures inside the secure room, on the ceiling to avoid protuberances accessible for self-harm.	Control of internal secure room temperature shall be managed remotely, e.g., from nursing station.				
		All heating and ventilation mechanisms shall be fully recessed and/or secured.				
		Adequate airflow and a healthy temperature shall be maintained.				
Fire & safety precautions	Fire and safety precautions shall be taken for overall protection of the patient, staff and facility. The secure room shall comply with all fire regulations.	The secure room shall be air-conditioned.				
		Airflow mechanisms shall be built to ensure that there shall be no transmission of intelligible speech outside the secure room.				
		Tamperproof institutional sprinkler heads shall be installed with tamper-resistant screws and made to break away under a 50-lb. load to reduce the risk of suicide by hanging.				

Appendix J cont.: Summary of Required Competencies and Corresponding Provincial Violence Prevention Curriculum Modules

CATEGORY	RATIONALE	STANDARD	STANDARD	PARTIALLY MET	NOT MET	COMMENTS
Fire & safety precautions cont.		Smoke/heat detectors shall be security-type, tamper-proof, and resistant to self-harm/ hanging.				
		A policy and procedure exists for unlocking the doors in order to evacuate patients in the event of a Stage 2 or higher fire alarm or other emergency situation.				
		Blind spots shall be eliminated in the secure room to enable full staff visualization of the patient and thus prevent the patient from harming him/ herself or others.				
		A wireless, staff-operated alarm system shall be provided.				
		A fixed, hard-wired panic device shall be installed within three feet of the secure room door.				
Furnishings	To prevent harm to patients and staff, furnishings in the secure room shall be limited to items that are essential to providing appropriate patient care. The secure room shall contain only essential equipment and furnishings.	The secure room shall contain a mattress on the floor or thick floor mat manufactured specifically for use in a secure area, and to prevent harm to the patient or others.				

Appendix J cont.: Summary of Required Competencies and Corresponding Provincial Violence Prevention Curriculum Modules

CATEGORY	RATIONALE	STANDARD	STANDARD	PARTIALLY MET	NOT MET	COMMENTS
Furnishings		Blankets (e.g., a "strong blanket") shall be manufactured specifically for use in a secure environment.				
Lighting	In addition to calming/ orienting natural light, secure rooms shall have lighting fixtures that meet safety requirements and provide illumination appropriate to the patient's and staff's needs. The secure room shall be fitted with moisture-resistant, inset, tamper-proof fixtures installed with secure screws.	Lighting shall be warm medium bright.				
		Light switches and dimmers shall be located immediately outside the secure room, and externally controlled.				
		The secure room shall receive natural light from an exterior window.				
		The secure room shall be able to be darkened completely upon patient request in order to facilitate appropriate patient rest.				
Communications, monitoring & engagement tools	Patients are less likely to have a negative experience of seclusion when staff take steps to engage them through constant contact. To foster contact and to mitigate the risk of harm to patients (self-harm) or staff during the intervention, it is critical for staff to have a full view of the entire secure room at all times, with no blind spots from both the nursing station and outside the secure room door.	The secure room shall be fitted with an audio-visual system with the capacity for night vision for continuous staff observation of the patient in the secure room.				
		CCTV monitors and intercom devices shall be placed at the nurses' station and in the anteroom, where an anteroom exists.				

Appendix J cont.: Summary of Required Competencies and Corresponding Provincial Violence Prevention Curriculum Modules

CATEGORY	RATIONALE	STANDARD	STANDARD	PARTIALLY MET	NOT MET	COMMENTS
Communications, monitoring & engagement tools cont.		Controls and equipment in the secure room shall be installed to prevent damage, tampering or self-harm.				
		Controls at the nurses' station/ staff viewing area shall allow the intercom volume to be adjusted but not turned off (i.e., nurses must always monitor sound).				
		Where there is an anteroom, it shall contain a clock that is fully visible to the patient through the in-door observation panel, and can be read in all lighting conditions. Where there is no anteroom, the clock shall be placed outside the secure room in a way that ensures visibility.				
Acoustics	An acoustical environment that prevents as much noise transmission as possible between the secure room and the rest of the unit protects the secluded patient's privacy, provides a more calming space for the patient being secluded, limits disruption for patients and staff outside the secure room, and helps to prevent agitation of patients outside the secure room.	The standards for acoustics shall be utilized in combination with the standards for doors, floors, walls, ceilings, airflow and temperature, and lighting.				
		There shall be no transmission of intelligible speech between the secure room and the remainder of the unit.				

Appendix J cont.: Summary of Required Competencies and Corresponding Provincial Violence Prevention Curriculum Modules

CATEGORY	RATIONALE	STANDARD	STANDARD	PARTIALLY MET	NOT MET	COMMENTS
Preventive & alternative spaces	It is important for units in designated facilities to include spaces that support the prevention of seclusion. Patients who can access private space or time away from the general milieu of the unit as required, and who are supported to access this space with autonomy, may avoid the kind of crisis that leads to seclusion.	Patients should have autonomous access to less restrictive spaces than the secure room in which to prevent escalation or de-escalate, providing there is no danger of imminent harm to self or others.				
		Preventive and alternative, unlocked spaces that should be considered in the design of any unit include: private bedrooms, comfort rooms, multisensory rooms, and/or time-out rooms.				

Notes

Notes

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British Columbia Provincial Mental Health and Substance Use Planning Council

www.gov.bc.ca/health
www.health.gov.bc.ca/healthy-minds/publications.html