Policy, Guideline and Procedure Manuals
Department: Galway/Roscommon Mental Health Service

Policy Title: Seclusion Policy (including restrictive practices reduction strategy).

Regulation: Part 4 (25) Premises; Use of Closed Circuit Television

Rule Applicable: Mental Health Commission Rules Governing The Use of Seclusion (2022)

Code of Practice Applicable: Use of Physical Restraint.

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1.0 Introduction:

1.1 Galway Roscommon Mental Health Services aims to reduce restrictive practices in line with Sharing the Vision (2020) Recommendation 92. However "*while a zero restraint and seclusion service may not always be achievable, due to safety requirements of service users and staff, there are examples where major reductions in the use of restraint are working effectively*" (Sharing the Vision (2020) p. 122).

1.2 Seclusion is only used in rare and exceptional circumstances as an emergency measure for the management of an individual's unsafe behaviour due to the:

a) Potential physical and psychological injury to the individual or staff, (Patients who are secluded are often physically restrained),
b) Potential damage to the therapeutic relationship between individuals and staff,
c) Risks of infringing the Human Rights of an individual, their dignity and autonomy,
d) Potential that people who have experienced Trauma are more likely to be secluded (Hammer et al, 2011, Steinert et al., 2007) and
e) The potential for re-traumatising the individual (Frueh et al, 2005, Hammer et al., 2011 & Litz and Gray, 2002).

1.3 Seclusion is the supervised confinement of a patient alone in a locked room to protect the patient or others from immediate harm. Seclusion is not a treatment and should only be used as a last resort. Where seclusion is used it is done so for the shortest period possible and in strict compliance with the Rules on the use of Seclusion (Mental Health Commission 2022).

1.4 The staff in Galway/Roscommon Mental Health Services are committed to providing a safe and therapeutic environment with the least possible restriction on patients admitted to the Approved Centre, consistent with legal requirements and principles of best practice.

1.5 Staff in Galway/Roscommon Mental Health Service shall respect, as far as is reasonably practicable, the rights of all patients to dignity, bodily integrity and privacy at all times while being treated in an approved Centre.

1.6 Seclusion:

a) Should not be used if there is a known current risk of suicide.
b) Cannot be used because of staff shortages.
c) Is not to be used as a punishment.
d) Solely to protect property.
e) As a substitute to less restrictive interventions.
f) Cannot be prescribed in advance.
g) Should only be used in rare and exceptional circumstances as a last resort and for the shortest period of time possible to prevent immediate and serious harm to the patient or others.
h) The use of seclusion is based on a risk assessment.
i) Persons who are secluded must be fully informed and involved in all decisions regarding their care and treatment to include all matters

relating to the use of seclusion. The views of persons who are secluded must be listened to, taken into account and recorded.

j)

k) Following each episode of seclusion the patient is offered a debrief within 2 working days.

l) An episode of seclusion should be reviewed by members of the Multidisciplinary team no later than 5 working days of the ending of the episode of seclusion.

1.7 If a patient demonstrates unsafe behaviour and where practicable, an individual assessment should be carried out. Alternatives to seclusion will be considered (see section 10.1). If seclusion is chosen, the reason for seclusion and alternatives considered should be documented in the patient clinical file and the seclusion register.

1.8 In some circumstances, the use of seclusion is the only option in the patient's best interest, where alternative approaches have proved ineffective and where there is an unacceptable risk to the patient, to other patients, to staff or to the general public. If seclusion is used, it is a time limited intervention, for the purpose of benefit and safety of the patient and shall not be prolonged beyond the period of time that is necessary for its purpose.

1.9 Seclusion may only be initiated by a registered medical practitioner, Consultant Psychiatrist or the most senior registered nurse on the ward.

1.10 All decisions about the use of seclusion shall involve a team approach, including consultation with the patient's next of kin or representative (with the patients consent) where possible and appropriate members of the multi-disciplinary staff, as far as is practicable.

1.11 Section 69(1) & Section 69(4b) of the Mental Health Act 2001 (as amended) (Appendix 1) provides for the deprivation of liberty by means of seclusion and mechanical means of bodily restraint for the voluntary patient (including a child).

1.12 Patients being nursed on one to one special nursing, in isolation (due to infection control measures), or on time out are not deemed to be in seclusion.

1.13 Patients can only be secluded in the designated seclusion room located in the Approved Centre of Galway/Roscommon mental health services.

1.14 The use of seclusion is guided by the general principles underpinning the use of seclusion (Mental Health Commission, 2022).

1.15 Galway/Roscommon Mental Health Services actively pursue and promote alternatives to seclusion and the reduction of the use of seclusion where practicable (see 23.0 & 24.0).

1.16 Galway Roscommon Mental Health Services has introduced a seclusion care pathway for the recording of episodes of seclusion. This is a quality improvement project and will be reviewed and amended as required.

2.0 Policy Statement:

2.1 It is the duty of the Galway/Roscommon Mental Health Service to ensure that seclusion is carried out in accordance with the terms of the Mental Health Act 2001 (as amended) and the Mental Health Commission Rules Governing The Use of Seclusion (Mental Health Commission, 2022).

3.0 Policy Purpose:

3.1 The purpose of this policy is to comply with Section 69 of the Mental Health Act 2001 (as amended) (Mental Health Commission, 2022)

3.2 To direct staff of Galway/Roscommon Mental Health Services in best practice related to seclusion of patients in the Approved Centres in accordance with the terms of the Mental Health Act 2001 (as amended) and the Mental Health Commission Rules Governing The Use of Seclusion (Mental Health Commission, 2022).

3.3 To ensure that as far as is reasonably practicable where a patient is secluded that their rights to dignity, bodily integrity and privacy are respected at all times. This includes cultural awareness and gender sensitivity.

4.0 Legislation/Other Related Policies:

4.1 Mental Health Act 2001 (as amended).

4.2 Statutory Instrument No. 551 of 2006: Mental Health Act 2001 (Approved Centres) Regulations 2006.

4.3 Rules Governing the use of Seclusion (Mental Health Commission 2022)

4.4 Code of Practice on the Use of Physical Restraint in Approved Centres (Mental Health Commission, 2022).

4.5 **PPG-GRMHS-CLN-6** Visitors Policy.

4.6 **PPG-GRMHS-CLN-12** Provision of Information to patients.

4.7 **PPG-GRMHS-CLN-17** Risk Management incorporating Death Notification and Incident reporting.

4.8 **PPG-GRMHS-CLN-27** Admission of a Child (including Family Liaison).

4.9 **PPG-GRMHS-CLN-28** One-to-one supervision of a child.

4.10 **PPG- GRMHS-CLN-18** Search of a Patient, His or Her Belongings and The Environment in Which He/She is Accommodated.

4.11 **PPG- GRMHS-CLN-19** CCTV.

4.12 **PPG-GRMHS-CLN-20** Physical restraint and the management of aggression and violence.

4.13 **PPG-GRMHS-CLN-34** Observation.

4.14 **PPG-GRMHS-CLN-2** Night Clothing.

4.15 **PPG-GRMHS-CLN-51** Clinical Risk Assessment and Management policy.

5.0 Scope of Policy:

5.1 This policy applies to all staff (including students under the supervision of qualified nursing staff) working in the Approved Centre of Galway/Roscommon Mental Health Service.

5.2 This policy applies to all episodes of seclusion of patients in the Approved Centre of Galway/Roscommon Galway Mental Health Service.

5.3 This policy should be read in conjunction with the documents in section 4.0.

5.4 In this policy the term patient covers both voluntary and involuntary patients. Where sections specifically relate to patients detained under the Mental Health Act 2001 (as amended) the term involuntary patient is used.

5.5 This policy will be reviewed annually or may be reviewed as a result of any changes to relevant legislation or identification of areas for improvement as a result of the learning accrued from practice, including any incidents or near misses or on the recommendations of the inspector of mental health services or other regulators.

6.0 Definitions:

6.1 Approved Centre: a hospital or in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder, which is registered on the Register of Approved Centres in accordance with Section 63 of the Mental Health Act 2001.

6.2 Patient: A patient includes voluntary or involuntary patient admitted to the approved centre.

6.3 Unsafe behaviour: When a patient acts in such a way that he or she may injure himself/herself or others.

6.4 Direct observation is defined as "*ongoing observation of a patient by a registered nurse who is within sight and sound of the seclusion room at all times but is outside the seclusion room. The observation of a patient by Closed Circuit Television (CCTV) does not constitute direct observation.*
(Mental Health Commission, 2022, p 5) "*Direct observation must occur for the first hour of an episode of seclusion*" (Mental Health Commission, 2022, Rule 5.1 p 12).

NOTE: The nurse should be able to reach the secluded patient i.e. the nurse is located immediately outside the locked seclusion room door.

6.5 Duty Consultant Psychiatrist: A consultant Psychiatrist who is acting for or covering for the Responsible Consultant Psychiatrist.

6.6 Continuous observation is defined as "*ongoing observation of a patient by a Registered Nurse, and a registered medical practitioner, who is in sight and sound of the person at all times, which may include the use of video or other electronic monitoring e.g. CCTV*" (Mental Health Commission, 2022, p 4).

6.7 Child means a person under the age of 18 years other than a person who is or has been married.

6.8 Medical Examination: includes a physical and mental examination of the patient in seclusion.

6.9 Representative: An individual chosen by the person who is being cared for (e.g. friend, family member, advocate) or a legal professional appointed by the person, statutory organisation or court to represent the person.

6.10 Responsible Consultant Psychiatrist: the consultant psychiatrist responsible for the care and treatment of the patient.

6.11 Seclusion Room: A dedicated and specifically designed room used only for the purposes of secluding a patient.

6.12 Seclusion: "*the placing or leaving of a person in any room alone, at any time, day or night, such that the person is prevented from leaving the room by any means*" (Mental Health Commission 2022).

6.13 Trauma: physical injury, or lasting emotional response that often results from living through a distressing event. Experiencing a traumatic event can harm a persons' sense of safety, sense of self and ability to regulate emotions and navigate relationships.

6.14 Trauma-informed care: "..an approach which acknowledges that many people who experience mental health difficulties may have experienced some form of trauma in their life. A trauma-informed approach seeks to resist traumatising or re-traumatising persons using mental health services and staff (Mental Health Commission, 2022).

6.15 Treatment: in relation to a detained patient includes the administration of physical, psychological and other remedies relating to the care and rehabilitation of a patient under medical supervision, intended for the purposes of ameliorating a mental disorder.

7.0 Responsibilities:

7.1 Organisational:

7.1.1 The Registered Proprietor is responsible for:

a) Ensuring that the resources required are allocated to Galway/Roscommon Mental Health Services to comply with the Mental Health Act 2001 (as amended) and the Rules Governing the use of Seclusion (Mental Health Commission, 2022) and HSE policies on the management of violence and aggression (2018).
b) Notifying the Mental Health Commission of the start time and date and the end time and date of each episode of seclusion.
c) Ensuring that a restrictive practice reduction policy is published on their website.
d) Appointing a named senior nurse manager responsible for the reduction of seclusion in the approved centre.
e) Ensuring a report on the use of seclusion is compiled and published on their website, within 6 months to the end of the calendar year and ensuring it is available to the public on request.
f) Ensuring that their nominee has established a review and oversight committee to analyse in detail each episode of seclusion.
g) Ensuring that each episode of seclusion is in compliance with the Rules governing the use of seclusion (Mental Health Commission 2022).
h) Having overall accountability for the use of seclusion in the Approved Centre.
i) Having overall accountability for the restrictive practice reduction policy.

7.2 Senior Manager: (Nominated by the registered proprietor)

7.2.1 It is the responsibility of the nominated senior manager for reducing the use of seclusion in the approved centre.

7.3 Management:

It is the responsibility of the senior management of Galway/Roscommon Mental Health Service to:

7.3.1 Provide for the training of staff in relation to seclusion.

7.3.2 Monitor the implementation of this policy.

7.3.3 Ensure this policy is reviewed within the allocated time frame and or as a result/outcome of incidents accidents/complaints, changes to legislation or learning from practice.

7.3.4 It is the responsibility of the Clinical Nurse Manager/nurse in charge to ensure that all staff are familiar with and implement this policy.

7.3.5 To support in as far as reasonably practicable the implementation of a restrictive practice reduction strategy and to promote alternatives to restrictive practices where safe to do so.

7.4 Responsible Treating/Duty Consultant Psychiatrist:

It is the responsibility of the treating/duty consultant psychiatrist to:

7.4.1 To initiate and order seclusion where following an a comprehensive assessment of the patient and complete a medical examination of the patient within 2 hours of the commencement of the episode of seclusion.

7.4.2 No later than 30 minutes following the medical examination of the patient by the registered medical practitioner discontinue the use of seclusion or order the continued use of seclusion.

7.4.3 Undertake a medical examination of the patient and sign the seclusion register within 24 hours of the commencement of the seclusion episode.

7.4.4 Where a patient's seclusion order is renewed after a continuous period of 24 hours, undertake a medical examination of the patient and document the examination in the patient's clinical file.

7.4.5 If the person is secluded for a continuous period of seclusion beyond 72 hours undertake a medical examination of the person and record this in the patient's clinical file and indicate if the seclusion order is to be extended or discontinued.

7.4.6 Ensure a review of the seclusion episode is conducted by members of the multidisciplinary team within 5 working days.

7.4.7 Document the review of the patient's episode of seclusion in the clinical file.

7.4.8 Provide the Mental Health Commission with additional information in writing where a patient:

a. is continually secluded for a period exceeding 72 hours of:
   I. The reasonable attempts and outcomes to use alternative means of calming and de-escalation to enable the person regain self-control and
   II. The reasons why continued seclusion is ordered.
b. has had 4 or more seclusion episodes over 5 consecutive days notify the Mental Health Commission of.
   I. the reasonable attempts and outcomes to use alternative means of calming and de-escalation to enable the person regain self-control and
   II. The reasons why seclusion has been repeatedly ordered.

7.5 Registered Medical Practitioner:

It is the responsibility of the Registered Medical Practitioner to:

7.5.1 If seclusion is initiated by the most senior registered nurse, undertake a medical examination of the patient within 2 hours of the commencement of episode of seclusion.

7.5.2 If initiating seclusion to:

I. conduct as comprehensive an assessment of the person as practicable including a risk assessment,
II. undertake a medical examination of the patient,
III. Inform the patient of the reasons for and the likely duration of the period of seclusion (and record this in the patient's clinical file and on the seclusion register) **unless** the provision of such information might either be impracticable in given circumstances or be prejudicial to the patient's mental health, wellbeing or emotional condition. In such cases the decision to withhold information on seclusion from the patient must be clearly documented in the patient's clinical file.
IV. Notify the treating /duty consultant psychiatrist of the patient seclusion within 30 minutes of undertaking the medical examination of the patient,
V. Complete the relevant sections of the seclusion register,
VI. Document assessments and consultations with the treating /duty consultant psychiatrist in the patient's clinical file.

7.5.3 Complete a medical review of a patient in seclusion within 2 hours (if initiated by a registered nurse). Thereafter carry out a medical examination of the patient every 4 hours (Rule 5.5). Unless the patient is sleeping, medical examinations may be suspended.

7.5.4 Be on call during the night in the event the patient is awake and requires a medical examination.

7.5.5 Examine the patient and then complete a renewal order within the legal timeframe, where it is proposed to continue the use of seclusion. Renewal orders are made under the supervision of the treating/duty consultant psychiatrist and for a period not exceeding 4 hours.

7.5.6 Inform the consultant/duty consultant psychiatrist on each occasion where a renewal order is made.

7.5.7 Inform the consultant/duty consultant psychiatrist where a renewal order is being made to extend the episode of seclusion of a patient for a continuous period of greater than 24 hours (4 x 5 renewal orders=24 hours).

7.5.8 Inform the treating/duty consultant psychiatrist if the patient's episode of seclusion is renewed beyond 72 hours of continuous seclusion.

7.5.9 End the episode of seclusion as soon as it is safe to do so in consultation with the patient and relevant nursing staff.

7.6 Most Senior registered nurse of the ward:

It is the responsibility of the most senior nurse of the ward to:

7.5.10 If initiating seclusion:

I. Conduct as comprehensive an assessment of the person as is practicable (given the emergency situation) including a risk assessment,
II. Notify the registered medical practitioner within 30 minutes of the commencement of the episode of seclusion,
III. Notify the patients representative (with the consent of the patient) and record this in the seclusion register and patient's clinical file,
IV. Complete the relevant sections of the seclusion register,
V. Inform the patient of the reasons for and the likely duration of the period of seclusion (and record this in the patient's clinical file and on the seclusion register) **unless** the provision of such information might either be impracticable in given circumstances or be prejudicial to the patient's mental health, wellbeing or emotional condition. In such cases the decision to withhold information on seclusion from the patient must be clearly documented in the patient's clinical file.
VI. End an episode of seclusion following consultation with the patient and the Registered Medical Practitioner,
VII. If ending an episode of seclusion, notify the treating/duty consultant psychiatrist.
VIII. Ensure that the episode of seclusion is in compliance with the Rules on the use of Seclusion (Mental Health Commission, 2022).

7.7 Staff:

7.5.1 It is the responsibility of all staff to be aware of and to implement this policy.

7.3.1 It is the responsibility of the registered nurse assigned to seclusion duties to:

a. Directly observe the patient for the first hour,
b. Continuously observe the patient for the remainder of the episode of seclusion,
c. Develop a care plan for the patient in seclusion,
d. Observe and monitor the patient and complete records for this,
e. Undertake nursing observations and nursing reviews,
f. Document accurately and contemporaneously each episode of seclusion in the patient's record, including all observations and reviews.
g. Ensure that seclusion is conducted in compliance with Mental Health Act 2001 and the Mental Health Commission Rules Governing The Use of Seclusion (Mental Health Commission, 2022) and any regulations relating to the care of the patient while in seclusion (Statutory Instrument No. 551 of 2006: Mental Health Act 2001 (Approved Centres) Regulations 2006).

7.3.2 It is the responsibility of nursing and medical staff to ensure that the period of seclusion is for the minimum period of time necessary to prevent the patient causing immediate and serious harm to self or others.

7.3.3 It is the responsibility of all staff to ensure that seclusion is never used to ameliorate operational difficulties such as staff shortage.

7.3.4 It is the responsibility of all staff to ensure seclusion of a patient with a known psychosocial/medical condition, in which close confinement would be contraindicated, must only be used when all alternative options have been implemented and proven unsuccessful and only then with the necessary degree of monitoring and supervision.

7.3.5 It is the responsibility of all staff to acknowledge (on Q-Pulse where available) or sign that they have read and understood this policy.

8.0 Infection Prevention and Control:

8.1 Where infection prevention and control guidance are active, due to the Covid-19 Pandemic infection prevention and control measures must be adhered to protect the patient and staff.

8.2 If a patient is covid-19 positive or suspected Covid-19 positive Personal Protective Equipment be worn by staff prior to removal of a patient to or from the seclusion room. The type of Personal Protective Equipment required is guided by the clinical situation (Suspect of Covid positive patient) and the latest Infection Prevention and Control Guidance.

8.3 The Covid-19 status of the patient should be established. If the patient refuses a swab then staff should treat the patient as if they were Covid-19 positive.

8.4 The patient should be closely monitored for signs and symptoms of Covid-19 and any physical deterioration while in seclusion.

8.5 When the seclusion episode has ended the seclusion room cleaned and ventilated (for 60 minutes) before use again.

9.0 Principals Underpinning the use of seclusion:

9.1 Approved centres must recognise the inherent rights of a person to personal dignity and freedom in accordance with national and international human rights instruments and legislation.

9.2 The use of seclusion may increase the risk of trauma and may trigger symptoms of previous experiences of trauma. Therefore, it must only be used in rare and exceptional circumstances as an emergency measure.

9.3 Persons who are secluded must be treated with dignity and respect at all times before, during, and after the seclusion.

9.4 Persons who are secluded must be fully informed and involved in all decisions regarding their care and treatment to include all matters relating to the use of seclusion. The views of persons who are secluded must be listened to, taken into account and recorded.

9.5 As seclusion compromises a person's liberty, its use must be the safest and least restrictive option of last resort necessary to manage the immediate situation, be proportionate to the assessed risk, and employed for the shortest possible duration. Its use must only occur following reasonable attempts to use alternative means of de-escalation to enable the person to regain self-control.

9.6 Communication with persons who are secluded must be clear, open and transparent, free of medical or legal jargon, and staff must communicate with empathy, compassion and care. Persons who have a sensory impairment may experience an increased level of trauma during seclusion and staff must address the additional communication needs of these persons.

9.7 The views of family members, representatives and nominated support persons, must be taken into account, where appropriate.

9.8 Cultural awareness and gender sensitivity must be taken into account at all times and must inform the approved centre's policies and procedures for the use of seclusion.

9.9 Seclusion must be used in a professional manner and its use must be based within a legal and ethical framework (Mental Health Commission, 2022).

9.10 Principles of Trauma informed care:

a) **Safety:** The physical, psychological and emotional safety of service users and staff is prioritised, by:
   i. people knowing they are safe or asking what they need to feel safe
   ii. there being reasonable freedom from threat or harm
   iii. attempting to prevent re-traumatisation
   iv. putting policies, practices and safeguarding arrangements in place

b) **Trustworthiness:** Transparency exists in an organisation's policies and procedures, with the objective of building trust among staff, service users and the wider community, by:
   i. the organisation and staff explaining what they are doing and why
   ii. the organisation and staff doing what they say they will do
   iii. expectations being made clear and the organisation and staff not overpromising

c) Choice: Service users are supported in shared decision-making, choice and goal setting to determine the plan of action they need to heal and move forward, by:

i. ensuring service users and staff have a voice in the decision-making process of the organisation and its services
ii. listening to the needs and wishes of service users and staff
iii. explaining choices clearly and transparently
iv. acknowledging that people who have experienced or are experiencing trauma may feel a lack of safety or control over the course of their life which can cause difficulties in developing trusting relationships

d) **Collaboration:** The value of staff and service user experience is recognised in overcoming challenges and improving the system as a whole, by:
i. using formal and informal peer support and mutual self-help
ii. the organisation asking service users and staff what they need and collaboratively considering how these needs can be met
iii. focussing on working alongside and actively involving service users in the delivery of services

e) **Empowerment:** Efforts are made to share power and give service users and staff a strong voice in decision-making, at both individual and organisational level, by:
i. validating feelings and concerns of staff and service users
ii. listening to what a person wants and needs
iii. supporting people to make decisions and take action
iv. acknowledging that people who have experienced or are experiencing trauma may feel powerless to control what happens to them, isolated by their experiences and have feelings of low self-worth

f) **Cultural Consideration:** Move past cultural stereotypes and biases based on, for example, gender, sexual orientation, age, religion, disability, geography, race or ethnicity by:
i. offering access to gender responsive services
ii. leveraging the healing value of traditional cultural connections
iii. incorporating policies, protocols and processes that are responsive to the needs of individuals served

10.0 Procedure: (Appendix 2: Seclusion flow chart)

NB: A seclusion order may be made for a period of up to but <u>not exceeding</u> 4 hours.

10.1 Initiation of Seclusion:

NOTE: Alternatives to seclusion should be considered before commencing an episode of seclusion.

Alternatives to Seclusion include (but are not limited to):
a) Early intervention and identification of unsafe behaviour,
b) Conflict resolution and de-escalation strategies,
c) Medication,

d) Higher levels of observation (See **PPG-GRMHS-CLN-34** Observation),
e) Time out,
f) Engaging with the patient to identify trigger factors,
g) Identification and removal of trigger factors/antecedents that lead to dangerous/unsafe behaviour,
h) Sensory modulation strategies (as directed by the patient's care plan),
i) Facilitating the patient to verbally ventilate feelings,
j) Positive behavioural support,
k) Individual care planning informed by previous debriefing/reviews of physical restraint and/or seclusion,
l) Interventions to address previous trauma (where known).

NOTE: Sensory Modulation training is facilitated by a senior Occupational Therapist who is competent in the delivery and use of Sensory Modulation to de-escalate a crisis or assist patient's to manage challenging behaviour.

10.1.1 If seclusion is initiated by a Consultant Psychiatrist:

a) It must only occur following as comprehensive an assessment of the patient as possible which must include a risk assessment.
b) The consultant psychiatrist records the medical examination in the patient's clinical file.
c) The consultant psychiatrist completes the seclusion order indicating the duration of the order. An order cannot exceed 4 hours.
d) The patient must be informed of the reason and likely duration of seclusion (see 13.0) and this is recorded in the clinical file and on section 17 or the seclusion register.
e) In accordance with the patient's preferences their representative must be informed of the patients seclusion. A record of this must be made in the patient's clinical record (see 13.2).
f) The consultant psychiatrist must ensure that a medical examination of the patient is undertaken if the seclusion order is to be extended.

10.1.2 If seclusion is initiated by the most senior registered Nurse:

g) It must only occur following as comprehensive an assessment of the patient as possible which must include a risk assessment.
h) The most senior registered nurse on duty on the ward initiating seclusion must record the matter in the clinical file and the seclusion register (Appendix 3).
i) The nurse initiating seclusion must complete sections 1 to 20 of the seclusion register, indicating the time and date of the commencement of the episode of seclusion and complete a record in the patient's clinical file,
j) As soon as is practicable and no later than 30 minutes after the commencement of the seclusion episode inform the registered medical practitioner of the commencement of seclusion.
k) There must be a medical examination of the patient by a registered medical practitioner as soon as practicable and in any event **no later than 2 hours** after the initiation of seclusion.
l) The patient must be informed of the reason and likely duration of seclusion (see 13.0) and this is recorded in the clinical file and on section 17 or the

seclusion register. Their representative may also need to be informed (see 13.2) if this is the patient's preference.

m) The patient must be under direct observation by a registered nurse for the first hour of seclusion,
n) A seclusion care plan must be initiated to address the needs of the patient while in seclusion.

10.1.3 If seclusion is initiated by a medical practitioner:

a) It must only occur following as comprehensive an assessment of the patient as possible which must include a risk assessment.
b) As soon as is practicable and no later than 30 minutes following the medical examination of the patient notify the treating/duty consultant of the patients seclusion. The treating consultant or duty consultant must indicate if the seclusion is to be discontinued or if continued advise on the duration of the seclusion order.
c) This consultation must be in the patient's clinical file and the duration of the seclusion order entered on the seclusion register.
d) He/she must record the examination of the patient in the clinical file and on the seclusion register. This must include an assessment and record of any physical, psychological and/or emotional trauma caused to the person as a result of the seclusion.
e) A seclusion order must not exceed a period of 4 hours from the commencement of that episode of seclusion.
f) The patient must be informed of the reason and likely duration of seclusion (see 13.0) and this is recorded in the clinical file and on section 17 or the seclusion register. Their representative may also need to be informed (see 13.2) if this is the patient's preference.
g) The patient must be informed that the episode of seclusion has been extended following a renewal order and of the reason and likely duration of seclusion (see 13.0) and this is recorded in the clinical file and on section 17 or the seclusion register.
h) The treating consultant/duty consultant psychiatrist must undertake a medical examination of the patient and sign the seclusion register **within 24 hours** of the commencement of the episode of seclusion.

11.0 Risk Assessment:

11.1 The basis of the risk assessment is to ensure the safety of all and to implement control measures (safety plan) to minimise risk.

11.2 Prior to the initiation of seclusion staff should assess the following:

a) Has the alternatives to seclusion failed?
b) Has the patient any known psycho-social/medical condition in which seclusion may be contraindicated?
c) Has the patient a known history of abuse where seclusion would re-traumatise the patient to the extent that seclusion would not be beneficial to the patient's or others safety?
d) Can the patient's behaviour be managed safely without the use of seclusion?

e) Is it safe to proceed to seclusion?
f) Has the patient any hazardous objects?
g) Can the patient be secluded safely in their own clothes?

11.3 Where a patient is in seclusion and staff are conducting a medical or nursing review they should assess:
a) Has the patient's dangerous behaviour abated sufficiently for staff to enter the room safely?
b) Is there a minimum of two staff entering the room?
c) Can the staff exit the room quickly and safely?

11.4 Where staff are considering ending seclusion they should assess:
a) Has the patient's dangerous behaviour abated sufficiently for seclusion to end?
b) Can alternatives to seclusion be safely used?
c) Can the patient be managed safely outside the seclusion facility?

12.0 Seclusion Orders:

12.1 Seclusion must be ordered by the treating consultant/duty consultant psychiatrist following medical examination of the patient (including a risk assessment) of the patient by a registered medical practitioner. This must be recorded in the patient clinical file and on the seclusion register.

12.2 Where seclusion is initiated by the most senior registered nurse of the ward, the patient must have a medical examination by a registered medical practitioner **no later than 2 hours** after the commencement of seclusion.

12.3 No later than 30 minutes following the medical examination of the patient, the registered medical practitioner must inform the treating consultant/duty consultant psychiatrist of the patient's episode of seclusion.

12.4 The treating consultant/duty consultant psychiatrist must discontinue the use of seclusion or order the use of seclusion and advise the duration of the order. A seclusion order cannot exceed **4 hours.**

12.5 The consultant/duty consultant psychiatrist must confirm that there are no other less restrictive ways available to manage the patient.

12.6 The treating consultant/duty consultant must undertake a medical examination of the patient and sign the seclusion register within 24 hours of the commencement of the episode of seclusion. The examination must be recorded in the patient's clinical file.

12.7 If seclusion is to continue the registered medical practitioner (under the supervision of the treating consultant/duty consultant psychiatrist) must undertake a medical examination of the patient, document the examination in the patient's clinical file and complete the seclusion register indicating the duration of the seclusion order. A seclusion order **must not exceed** a period of 4 hours from the ending of the previous seclusion order. The duration of the

seclusion order should be indicated on the relevant section of seclusion register and the patient's clinical notes.

12.8 If the episode of seclusion is to be extended (i.e. beyond the time indicated on the initial seclusion order) a renewal order must be completed (see 16.0). Each order or renewal order cannot exceed 4 hours.

13.0 Information for Patient and/or representative.

NOTE: There must be documentary evidence in the patient's clinical file that the patients preference for their representative informed of the patients seclusion or if not informed the rational for this i.e. patient did not wish to the communication to take place.

13.1 The patient must be informed of the reasons for, likely duration of and the circumstances which will lead to the ending of seclusion unless the provision of this information might be prejudicial to their mental health, well-being or emotional condition. **In the event that this information is not provided, a record of why it was not given must be recorded in the patient's case notes. This information must be given in a form and language the patient understands (Regulation 20: Provision of information).**

13.2 As soon as is practicable and in accordance with the patients preference as stated in their individual care plan their representative is informed of the use of seclusion. **If this is not done it must be recorded in the patient's case notes the reasons why it did not happen.**

13.3 Where the patient's wish is not to inform their representative no such communication should take place outside what is necessary to fulfil professional and legal requirements and this must be recorded in the patient's clinical file.

13.4 Visiting may be suspended while the patient is in seclusion (see **PPG-GRMHS-CLN-6** Visiting Policy) if the patient's privacy or dignity is at risk or if their preference is not to have visitors.

14.0 Patient Dignity and Safety During Seclusion:

14.1 Seclusion should only be used when all other alternatives have been considered and have failed.

14.2 All reasonable actions should be taken to prevent traumatising the patient, before, during and after an episode of seclusion and also to protect the privacy, dignity and autonomy of the patient as far as reasonably practicable.

14.3 Seclusion should not be used where the patient has known psycho-social/medical conditions which seclusion would be contraindicated unless an absolute last resort. A clear rational for seclusion in this case should be documented in the clinical file.

14.4 Patients in seclusion must not have access to hazardous objects. If searches are used to ensure this they must comply with Galway/Roscommon Mental Health Services Policy on Searching Patients (See **PPG- GRMHS-CLN-18** Search of a Patient, His or Her Belongings and The Environment in Which He/She is Accommodated).

14.5 Once the decision to seclude the patient is made the patient's clothes are searched to remove all potentially hazardous items Including;

a) Ignitables (matches/lighter),
b) sharp objects (keys etc.)
c) belts
d) pens/pencils
e) glass objects
f) Dressing gown cords
g) Shoes
h) Any other object that could be used to injure self or others.

14.6 A patient should be secluded in their own clothing (based on a risk assessment). If their own clothing is not worn reasons for this **must be documented in the patient's clinical file.**

14.7 If tear proof clothing is to be used:

I. A specific risk assessment must be completed and documented,
II. The rational for the use of such clothing is documented,
III. The patient is informed of the reasons of its use,
IV. The use of such clothing is reviewed regularly and no less than at each renewal order,
V. Each review is documented in the patient's clinical file.

14.8 The patient's own night attire (Flame resistant) may be used if appropriate during seclusion but this must be documented in the patients care plan/clinical notes (see Galway/Roscommon Mental Health Services Night clothing policy).

14.9 Refractive bed clothes (fire and tear resistant) or a weighted blanket may be used in the seclusion room for the safety of the patient.

15.0 Seclusion Duties and Monitoring of Patients During Seclusion (Appendix 4):

15.1 Seclusion should only be used when all other alternatives have been considered and shown to have failed.

15.2 The Clinical Nurse Manager/nurse in charge assigns a registered nurse to seclusion duties (Consideration is given to gender sensitivity when assigning a member of staff to seclusion duties). (Students are not to be assigned to seclusion duties).

15.3 The duration of time a registered nurse is assigned to seclusion duties should not exceed 4 hours.

15.4 Staff assigned to seclusion duties and those staff (Nursing and Medical) entering the seclusion room to conduct reviews, must at all times have a personal alarm.

15.5 If an emergency occurs, the observing nurse activates the personal alarm to summon help, but does not enter the seclusion room until sufficient staff are present to help. An individual staff member must never enter the occupied seclusion room alone.

15.6 A seclusion care plan will be implemented for the patient (Appendix 5). This plan will address the needs of the patient in seclusion with the goal of bringing seclusion to an end.

15.7 The seclusion care plan will include:

a) Patients personal details;
b) known clinical needs (including mental and physical considerations);
c) how de-escalation strategies will continue to be used;
d) the person's preferences in relation to seclusion, where known (e.g. access to music or reading material while in the seclusion room), and take into account outcomes of any previous debrief with the person, if applicable and if safe,
e) recognising signs where the person's behaviour is no longer deemed an unmanageable risk towards themselves or others, e.g. evidence of tension reduction, improved communication etc;
f) how potential risks may be managed;
g) reference to specific support plans for the person and details of how the person's mental health needs will continue to be met while in seclusion;
h) meeting of food/fluid needs;
i) meeting of needs in relation to personal hygiene/dressing;
j) meeting of elimination needs (with specific reference to how privacy and dignity will be managed);
k) medication reviews (in consultation with a registered medical practitioner);
l) monitoring of physical observations; and
m) a strategy for ending seclusion; indicating the criteria required for this to be reached.

15.8 When handing over the responsibility for the observation of the secluded patient both nurses will sign an entry in the patient's seclusion pathway of the patient's condition (mental state, physical state and behaviour).

15.9 A patient in seclusion must have direct observation by a Registered Nurse for the first hour and then continuous observation for the remainder of the episode of seclusion by a Registered Nurse.

15.10 The patient should be within sight and sound of the observing nurse during the direct observation period. The nurse should be able to reach the secluded patient i.e. the nurse is located immediately outside the locked seclusion room door and can unlock the door to gain access.

15.11 During the period of continuous observation CCTV may be used unless this is distressful for the patient (see CCTV policy).

15.12 A written record of the patient in seclusion must be made every fifteen minutes by the observing registered nurse. This must include:

a) The patient's observed level of distress.
b) The patient's observed behaviour. What they are doing or saying. (If during seclusion the patients unsafe behaviour has abated his/her release from seclusion must be considered. This should be discussed with the Clinical Nurse Manager/nurse in charge),
c) the person's level of awareness;
d) the person's physical health, especially with regard to breathing, pallor or cyanosis;
e) whether elimination/hygiene needs were met; and
f) whether hydration/nutrition needs were met.

15.13 Following a risk assessment a nursing review of the patient must take place every **two hours,** unless to do so would place the patient or staff at a high risk of injury. This review must be completed by a minimum of two staff members, one of whom must be a Registered Nurse, who was not involved directly in the decision to seclude the patient (where possible).

15.14 Where safe to do so at least two staff (one of whom is a registered nurse) will enter seclusion room to observe patient to consider if seclusion can be ended. The number of nurses entering the occupied seclusion room will depend on the presentation of the patient.

15.15 The seclusion room remains unlocked when staff are inside.

15.16 The review Includes:

a) Patients observed level of distress,
b) Patients observed behaviour,
c) Colour of skin
d) Physical health (Breathing & Pallor of skin),
e) Level of consciousness and patients level of awareness,
f) Any injuries,(these must be reviewed by the registered medical practitioner),
g) Mental and Physical state,
h) Temperature, pulse, respirations and Blood Pressure,
i) Actions, effects and/or side effects of medication,
j) Time medication was taken (oral or injection),
k) Patients food and fluid intake,
l) Urinary output,
m) Bowel motions,
n) Any other relevant observations.

NOTE: This is not an exhaustive list.

15.17 Staff must also consider other individual care needs of patient in their care plan (Appendix 5) and any factors that could end the episode of seclusion.

15.18 A medical review must take place **every four hours** by a Registered Medical Practitioner and must take account of the nursing reviews, nursing observations and previous medical examinations. Consideration should be given to ending the episode of seclusion where safe to do.

15.19 Where a patient is sleeping clinical judgement will be used to decide if the patient needs to be woken for review. Medical reviews can be suspended in this case but a Registered Medical Practitioner must be on call should a need arise. Nursing reviews must continue every **two hours**. However the nature of the nursing review will be such that the patient is not woken (Mental Health Commission, 2022).

15.20 Where a person appears to be asleep the nurse on seclusion duties must be alert to the possibility of altered levels of consciousness and respiratory distress.

15.21 Where medical reviews are not conducted because the patient is asleep this must be clearly recorded by the medical staff, in the patient's clinical file and other relevant documentation related to seclusion.

16.0 Renewal of Seclusion Orders :

16.1 The initial seclusion order may be made up to a maximum period of 4 **hours** from the time of its making.

16.2 A seclusion order may be extended by a Registered Medical Practitioner under the supervision of a Consultant Psychiatrist for a further period **not exceeding** 4 **hours** to a maximum of 5 renewals i.e. **a total of twenty four hours continuous seclusion.**

16.3 If a patient's seclusion order is to be extended beyond **twenty fours hour's** continuous seclusion they must be examined by the treating /duty consultant psychiatrist and this **must** be documented in the patient's clinical file.

16.4 If the episode of seclusion is to be renewed beyond 72 hours of continuous seclusion:

a) The treating/duty consultant psychiatrist must undertake a medical examination of the patient,
b) Document the examination in the patient's clinical file,
c) Discontinue or order the continued use of seclusion for a further period not exceeding 4 hours.

16.5 If a decision is made by the treating /duty consultant psychiatrist to seclude a patient for a total continuous period of seclusion **exceeding seventy two hours** the Mental Health Commission must be notified in writing of :

I. the reasonable attempts and outcomes to use alternative means of calming and de-escalation to enable the person regain self-control, and
II. The reasons why continued seclusion is ordered.

16.6 If a patient has **four or more seclusion orders over a period of five consecutive days** the Mental Health Commission must be notified in writing of :

I. the reasonable attempts and outcomes to use alternative means of calming and de-escalation to enable the person regain self-control, and
II. The reasons why seclusion has been repeatedly ordered.

17.0 Ending Seclusion:

17.1 Ending seclusion should be considered when the patient's unsafe behaviour has abated so as to no longer constitute a serious threat to staff or to others.

17.2 Seclusion can be ended at any time by:

I. A registered medical practitioner following discussions with the patient and relevant nursing staff,
II. The most senior registered nurse in the ward in consultation with the patient and the registered medical practitioner.

17.3 The treating/duty consultant psychiatrist must be notified of the ending of the episode of seclusion by the person ending the seclusion. This should be recorded in the patient's clinical file.

17.4 The patient must be informed of the ending of seclusion and a record of this made in the patients clinical file.

17.5 Where the patient's representative was informed of the patient's seclusion they must be informed of the ending of the episode of seclusion by the person ending the seclusion. A record of this is made in the patient clinical file. In the event this communication does not take place a record of this must be made in the patient's clinical file.

17.6 The time, date and reasons for ending seclusion must be entered in the patient's clinical file and on the seclusion register.

17.7 Leaving the seclusion room for a toilet break or medical examination does not end an episode of seclusion.

17.8 Following seclusion the patient must be given an opportunity to attend a debrief and a review of the episode of seclusion with a members of the Multidisciplinary Team.

17.9 A post seclusion care plan (Appendix 6) should be undertaken, which may last up to 12 hours post seclusion.

17.10 The patient should have the opportunity to attend a face to face person-centred debrief following every episode of seclusion and must:

a) give the person the opportunity to discuss the seclusion with members of the multidisciplinary team involved in the person's care and treatment as part of a structured debrief process;
b) occur within **two working days** (i.e. days other than Saturday/Sunday and bank holidays) of the episode of seclusion unless it is the preference of the person who was secluded to have the debrief outside of this timeframe. The person's preferences regarding the timing of the debrief must be recorded;
c) respect the decision of the person not to participate in a debrief, if that is their wish. If the person declines to participate in the debrief, a record of this must be maintained and recorded in the person's clinical fle;
d) include a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future;
e) include a discussion regarding the person's preferences in the event where a restrictive intervention is needed in the future e.g. preferences in relation to which restrictive intervention they would not like to be used;
f) give the person the option of having their representative or their nominated support person attend the debrief with them, and, if the person's representative or nominated support person does not attend the debrief, a record of the reasons why this did not occur must be recorded in the person's clinical file.

NOTE: Multiple episodes of seclusion occurring within 48-hours may be reviewed in one debrief.

17.11 A record of the debrief (and all attending) and the outcome must be maintained in the patient's clinical file. If the patient chooses not to participate this should be recorded. The patient's care plan should be updated following the debrief with a view to prevention of future episodes of seclusion.

17.12 Due to potential trauma of restrictive practices patient's and staff may require additional emotional support following an episode of restrictive practices.

18.0 Recording of Seclusion Episodes:

18.1 All episodes of seclusion must be clearly recorded in the patient's clinical file.

18.2 All episodes of seclusion must be clearly recorded, as soon as is practicable, on the Register for (Appendix 3) and in the patient's clinical file.

18.3 A copy of the Register must be placed in the patient's clinical file and a copy must be available to the Inspector of Mental Health Services and/or the Mental Health Commission upon request.

19.0 Seclusion of Children:

19.1 Children are particularly vulnerable to trauma and harm as a result of restrictive interventions. Seclusion can have particularly adverse implications for the emotional development of a child. These points must be taken into account in any decision to seclude a child.

19.2 A risk assessment must be undertaken of the child on admission by a registered medical practitioner or registered nurse of the potential adverse effects of restrictive practices on the child/adolescent. This assessment should inform the decision to use/not use restrictive practices based on the emotional development/physical status of the child/adolescent. Restrictive practices may have a more harmful than beneficial effect on children/adolescents.

19.3 An approved centre secluding a child must ensure the child's parent or guardian is informed as soon as possible of the child's seclusion and when the episode of seclusion has ended.

19.4 Staff involved in secluding a child must have received appropriate training.

19.5 An approved centre secluding a child must have in place child protection policies and procedures in line with relevant legislation and regulations thereunder.

19.6 The child should be informed of the reason for seclusion, the length of time seclusion will be used for and when seclusion has ended (see 13.0) in age appropriate language.

20.0 Governance:

20.1 Seclusion must never be used:

a) to ameliorate operational difficulties including where there are staff shortages;
b) as a punitive action;
c) where mechanical means of bodily restraint is also in use;
d) solely to protect property;
e) as a substitute for less restrictive interventions.

20.2 A review of seclusion should take place by members of the Multidisciplinary team within **Five working days** of the seclusion episode. The review should consider:

a) What antecedents lead to the initiating of seclusion,
b) What alternatives could be used in the future,
c) Any missed opportunities for early intervention in line with positive behavioural support,
d) the identification of alternative de-escalation strategies to be used in future;
e) The duration of the seclusion episode and was it for the shortest period possible,
f) The behaviour of the patient prior to initiation of seclusion,
g) The management of the episode,
h) The patients understanding of the need for seclusion and their behaviour that resulted in the use of seclusion,
i) Alternatives methods that the patient can use to ventilate their feelings,
j) Methods to improve patient's self-control and early interventions to manage behaviour safely,
k) Outcomes from the patient's debrief,
l) The seclusion care plan,

m) The patients experience of seclusion,
n) Assessment of physical environmental factors that may have contributed to the initiation of seclusion,
o) A seclusion reduction plan.

20.3 The review should be documented in the patient's clinical file.

20.4 The review should also focus on the reduction of seclusion for the individual patient in the future.

20.5 The outcomes of the review and follow up plans should be used to inform the restrictive practice reduction strategy of the approved centre.

NOTE : where a patient is also physically restrained the review of the physical restraint and the use of seclusion can occur at the same time, but must be documented separately.

20.6 A multidisciplinary review and oversight committee (accountable to the Registered Proprietor) will;

a) Meet quarterly,
b) Analyse in detail every episode of restrictive practices,
c) Determine if an episode is in compliance with the relevant code of practice, rule, regulation or the Mental Health Act 2001 (as amended) ,
d) Determine if the episode of restrictive practice is in compliance with the approved centre's own policies, procedures and guidelines,
e) Identify, document and action any areas for improvement,
f) Identify a person or persons responsible and timeframes for completion of any actions,
g) Promote learning from episodes of restrictive practices including any suggestions for reducing same,
h) Assure the registered proprietor that episodes of restrictive practices are in compliance with the relevant code or practice, rule, regulation and/or the Mental Health Act 2001 (as amended),
i) Produce a report following each meeting on the quarterly review of restrictive practices made available for all staff involved in the use of restrictive practices and the Mental Health Commission and the inspector of Mental Health Services as required.

20.7 The Registered Proprietor has overall accountability for the use of seclusion in the approved centre.

21.0 Seclusion Facilities:

21.1 Seclusion facilities must provide access to adequate toilet/washing facilities. Leaving the seclusion room to use toilet/washing facilities shall not be considered to end seclusion.

21.2 Seclusion facilities must be furnished, maintained and cleaned in such a way that ensures the patients inherent right to dignity and ensures his/her privacy is respected.

a) The construction of the seclusion room must be designed to withstand high levels of violence with the potential to damage the physical environment e.g. walls, windows, doors, locks.
b) There must be no ligature points or electrical fixtures.
c) There must be an anti-barricade door.
d) The room must allow for staff to be able to clearly observe the person within the seclusion room. Seclusion rooms must have externally controlled heating and air conditioning, which enables those observing the person to monitor the room temperature.
e) The seclusion room must include limited furnishings which must include a pillow, mattress, and blanket or covering, all of which must meet current health and safety requirements.
f) The room must be large enough to support the person and team of staff who may be required to use physical interventions during transition to seclusion.
g) The person must have sight of a clock displaying the time, day and date.
h) As far as is possible, the seclusion room must be in an area away from communal sitting rooms and sleeping accommodation, but not isolated.

In addition, the below requirements are applicable to all new seclusion facilities where construction is commenced after 1 January 2023:

I. The seclusion room must have a window which provides the person in seclusion with a clear view of the outdoor environment.
II. The seclusion room must not be visible to unauthorised persons from the outdoor environment.

21.3 All furniture and fittings in the seclusion facility must be of such a design and quality as not to endanger patient safety.

21.4 Seclusion facilities shall not be used as bedrooms. When not in use the seclusion facility must be locked so that no patient can enter the facility.

21.5 Bedrooms cannot be used a seclusion facilities.

21.6 The seclusion room should be ready for use at all times. **NOTE: Only one patient at a time can be secluded.**

21.7 Subject to the outcome of a documented, suitable risk assessment, the person must be permitted periods of access to secure outside areas (where available). A record of daily outdoor access must be maintained.

22.0 Staff Training:

22.1 All relevant staff involved in seclusion must receive training on the use of seclusion i.e. training is mandatory.
22.2 This training will be provided by appropriately qualified person(s).

22.3 This training will be provided every two years.

22.4 Areas covered in the training includes:

a) Alternatives to the use of seclusion,
b) Trauma informed care,
c) Culture and ethnicity,
d) Human Rights,
e) Legal and ethical frame work,
f) Principles on the use of seclusion,
g) Rules & policy on seclusion,
h) Mental Health Act 2001 (Relevant sections),
i) Management of Aggression and violence (including breakaway and de-escalation),
j) Positive behavioural support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic.
k) Physical Restraint and dangers of restraint,
l) Monitoring patient while in seclusion,
m) Reviews of patient while in seclusion (Medical & Nursing),
n) Needs of the patient while in seclusion,
o) Documentation,
p) Risk assessment,
q) Ending seclusion,
r) Review of episode of seclusion,
s) Amending care plan and safety plan,
t) Seclusion reduction strategy.
u) Safewards Model.

22.5 Additional training will be provided on Sensory Modulation assessment, strategies and planning by Occupational Therapy staff.

22.6 A bean bag is used in the seclusion room to enable staff to de-escalate physical restraint and place the patient in a comfortable position so that the staff can exit the seclusion room safely. Staff training covers the use of a beanbag to exit the seclusion room safely.

22.7 Recommend Training modules are also available on HSELand also include:

a) Equality and Human rights in the public service,
b) Person Centred Cultures,
c) Becoming trauma aware,
d) Positive behavioural support,

23.0 Restrictive Practice Reduction Strategy:

23.1 Galway/Roscommon Mental Health Services aims to reduce seclusion by:

a) Education and training of staff on the use of physical restraint with emphasis on,
   i. Building positive therapeutic relationships,
   ii. Supporting positive behaviour,
   iii. Understanding the patients individual life story (trauma, abuse, etc.),
   iv. Emphasis on observation and de-escalation,

v. Identification of triggers specific to the individual,
vi. Proportionate restraint as a last resort.

b) Alternatives to seclusion,
i. Use of time out/step down area,
ii. Increased nursing observation level,
iii. Quiet area/Bedroom/low stimulus environment,
iv. Ensure a recovery approach to care (patient participation in care planning),
v. Safety Plan/individual Care Plan interventions for behaviour,
vi. Medication,
vii. Sensory Modulation tool kit (Appendix 7),
viii. Combination of interventions.

c) Reviewing Data:
i. Times of incidents
ii. Locations of incidents,
iii. Length of time of restraint,
iv. Initiation of restraint,
v. Reasons for initiating restraint,
vi. Analysis of audit results.

d) Reviewing annually the seclusion policy,

e) Conducting the review of an episode of seclusion with a focus on:
i. Identification of antecedents individual to the person,
ii. Interventions/strategies for the individual to appropriately avoid or manage behaviours.
iii. Giving the patient an opportunity to discuss episode of restraint with members of the multidisciplinary team,
iv. Giving staff an opportunity to discuss episode of restraint,
v. Review of medication management.
vi. Updating the safety and care plan for the individual patient.

f) Premises:
i. Maintain privacy of individuals,
ii. Provide appropriate recreational activities for patients,
iii. Maintenance programme to ensure the decor of the unit is maintained,
iv. Provide where possible relaxation areas.
v. Comfortable warm environment that promotes recovery, rest and sleep at night.

g) Patient engagement:
i. Patient staff meetings,
ii. Patients are involved in planning their care,

h) Staffing:
i. Appropriately qualified and trained staff,
ii. Staffing appropriate to patient dependency levels,
iii. Staff supports available for staff including clinical supervision, employee support, counselling

i) Leadership/governance:
i. Senior staff to take a lead in the restrictive practice reduction strategy.
ii. The service regularly reviews episodes of restrictive practice at business meetings.
iii. Strategy is communicated across the service.
iv. Complaints process utilised by patients and/or relatives.

j) Regulation:
   i. Compliance with rules and codes of practice.
k) Audit of practice.
l) The sustainment of the Safewards model and the 10 associated interventions.
NOTE: This is not and exhaustive list.

24.0 Safewards:

24.1 Galway/Roscommon Mental Health Services has commenced the Safewards Model (Bowers 2014) within each Approved Centre. Safewards Model is an evidenced with the aim of reducing conflict and containment (Lee et al, 2021).

24.2 A Safewards steering committee provides oversight for local Safewards implementation groups and the introduction, monitoring and evaluation of Safewards.

24.3 Staff and Service users are involved in the implementation of 10 key interventions and work together to make improvements within Approved Centres. These are:

I. Mutual Expectations,
II. Soft words,
III. Positive words,
IV. News Mitigation,
V. Reassurance,
VI. Know each other,
VII. Discharge messages,
VIII. Self soothe box,
IX. Mutual help meetings,
X. Talk down.

25.0 Audit:

25.1 Seclusion will be audited against the rules for the use of seclusion or comparable audit tools.
25.2 As part of the Restrictive Practices Reduction Strategy episodes of seclusion will be reviewed for quality and compliance.

26.0 Abbreviations:

12.1 CCTV= Closed Circuit Television.
12.2 HSE = Health Service Executive.
12.3 MDT= Multidisciplinary Team.
12.4 MHA = Mental Health Act 2001 (as amended).
12.5 MHC= Mental Health Commission.

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29.0 Production and Consultation Trail:

This document was reviewed in December 2023. The amended document was circulated by e-mail to the policy group and staff for comment in January 2024, before passing on to the Governance Group for approval. The policy was agreed at Governance in January 2024 and sign/electronically approved by the executive management team in January 2024.

30.0 Review History:

PPG-GRMHS-CLN-21 (Changes)	
Section	**Changes Made**
1.7	Added (see 10.1)
10.1	10.1 h) added (As directed by the patient's care plan) & Note also added
9.10	New section added Trauma informed care principles
25.2	New point added

31.0 Appendix 1: MHA 2001 Section 69 Miscellaneous

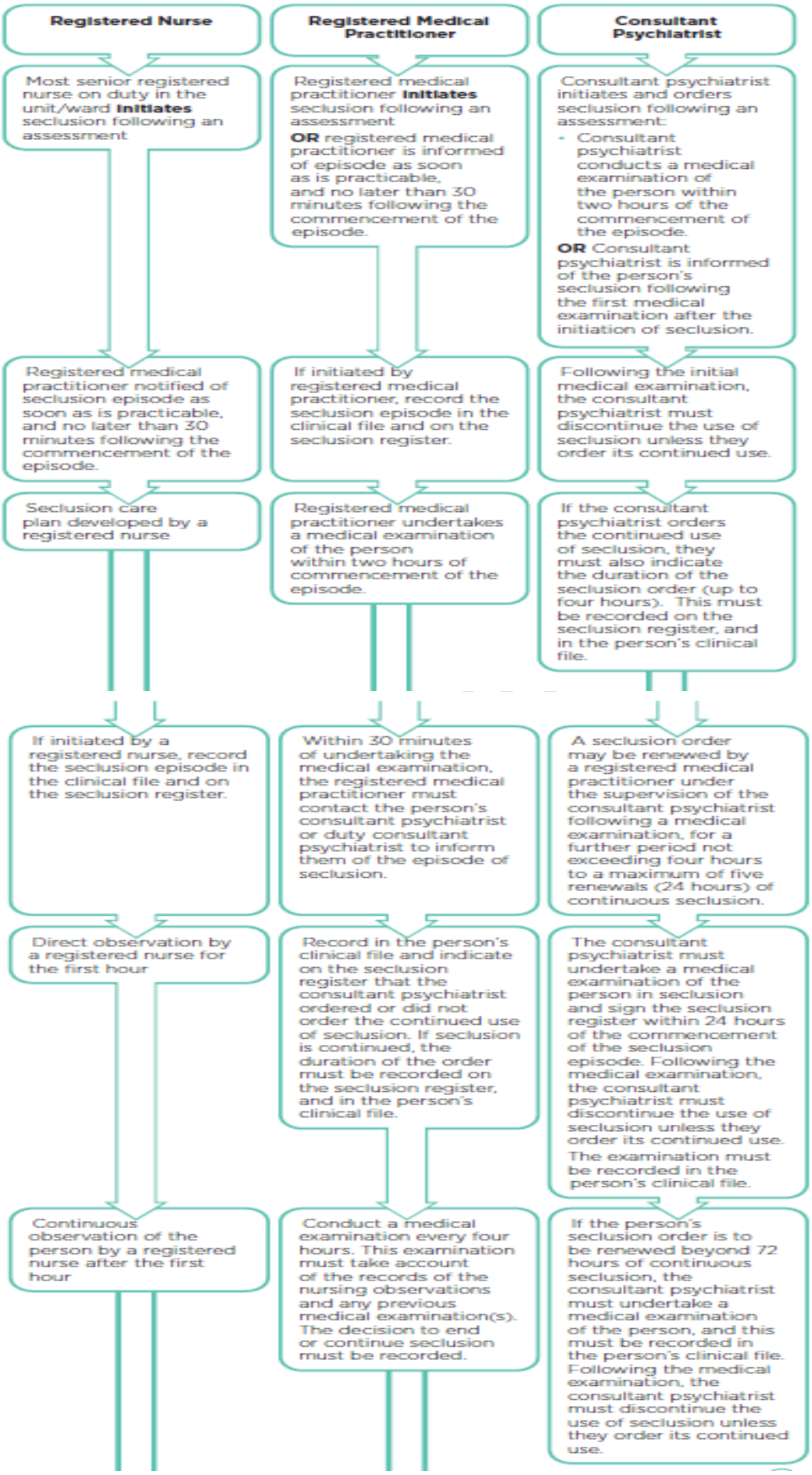
69.—(1) A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under *subsection (2)*, to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.

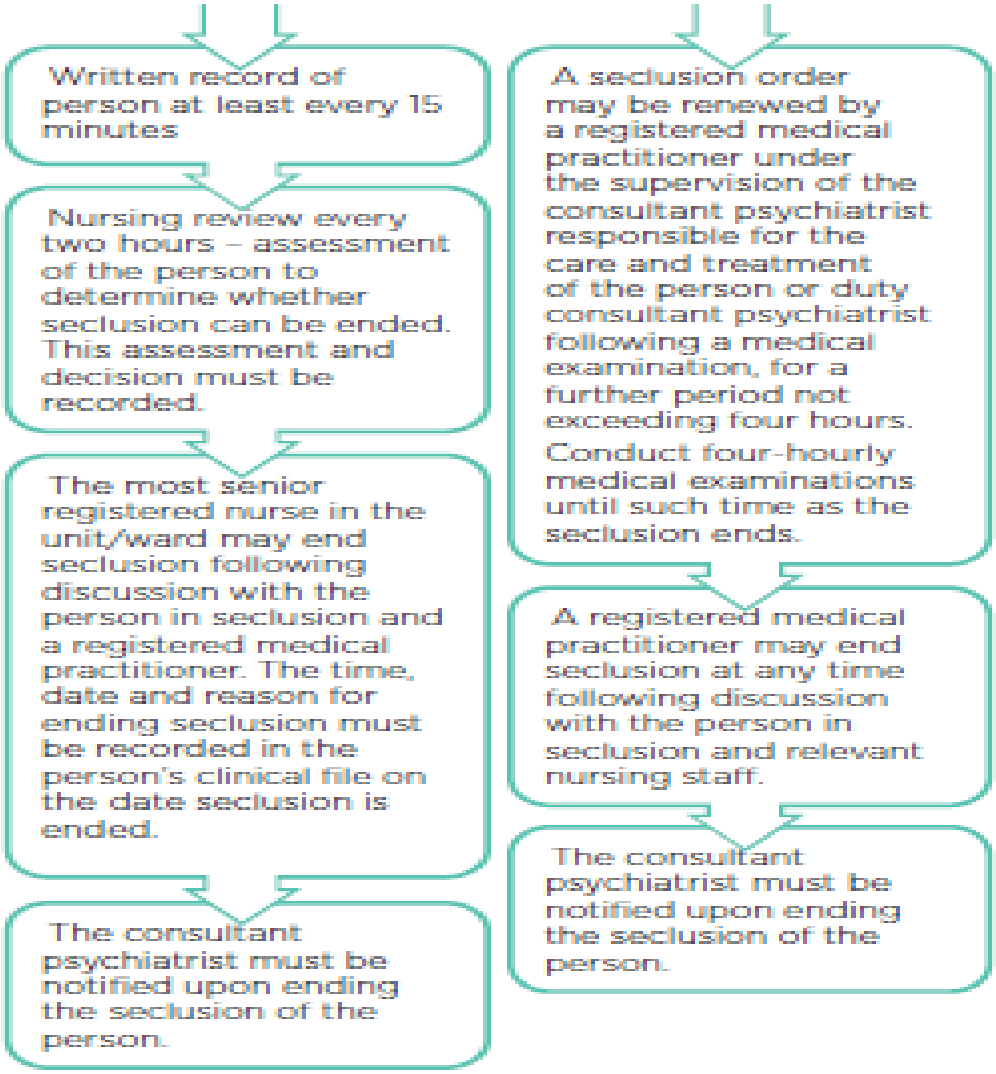
(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.

(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1,500.

(4) In this section ''patient'' includes—
(*a*) a child in respect of whom an order under *section 25* is in force, and
(*b*) a voluntary patient.

32.0 Appendix 2: Seclusion Flow chart




Written record of person at least every 15 minutes
Nursing review every two hours – assessment of the person to determine whether seclusion can be ended. This assessment and decision must be recorded.
The most senior registered nurse in the unit/ward may end seclusion following discussion with the person in seclusion and a registered medical practitioner. The time, date and reason for ending seclusion must be recorded in the person's clinical file on the date seclusion is ended.
The consultant psychiatrist must be notified upon ending the seclusion of the person.
A seclusion order may be renewed by a registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the person or duty consultant psychiatrist following a medical examination, for a further period not exceeding four hours. Conduct four-hourly medical examinations until such time as the seclusion ends.
A registered medical practitioner may end seclusion at any time following discussion with the person in seclusion and relevant nursing staff.
The consultant psychiatrist must be notified upon ending the seclusion of the person.

33.0 Appendix 3: Seclusion Register.

Person's Details	
1. First Name:	**2. Surname:**
3. Date of Birth: _____/_____/_____ (dd/mm/yyyy)	**4. Gender:** Male ☐ Female ☐ Other ☐
5. Person's Medical Record Number:	

Location	
6. Approved Centre Name:	**7. Unit/ward Name:**

Seclusion Details	
8. Seclusion Order Type: First seclusion order ☐ Renewal order* ☐ As per Rule 3.8, a seclusion order shall last for a maximum of four hours. A renewal order must be made if it is necessary to renew the episode of seclusion beyond four hours. **If **renewal order**, please complete sections 9-10, 12 and 23-25 only. 23 is applicable to renewal orders only.*	
9. Date seclusion episode commenced: _____/_____/_____ (dd/mm/yyyy)	**10. Time seclusion episode commenced:** ____:____ (24hr clock e.g. 2.41pm is written as 14.41)
11. Who initiated seclusion: Name (print): _____ Job title (print): _____ Signed: _____	

12. Why is seclusion being ordered or renewed?

Immediate threat of serious harm to self ☐

Actual harm caused to self ☐

Immediate threat of serious harm to others ☐

Actual harm caused to others ☐

Other (please specify) ☐ _____

Please provide further details on the above:

13: Did the medical examination of the person take place within two hours of the commencement of the seclusion episode?

Yes ☐ No ☐

If yes, please complete the following:

Name of the registered medical practitioner who conducted the medical examination:

_____

Date and time of medical examination:

Date: ____/____/_____ at ____hrs ____mins

Date and time that the consultant psychiatrist was contacted following the medical examination:

Date: ____/____/_____ at ____hrs ____mins

"If no", please provide further details:

14. Alternative means of de-escalation attempted prior to the use of seclusion:

Verbal Intervention ☐ Medication offered/administered ☐
Time Out/One to One Nursing/Observation ☐ Physical restraint ☐
No alternatives attempted ☐

Other (please specify) ☐ _____

Please provide further details on the above:

15. Was the person secluded in their own clothing?

Yes ☐ No ☐

If no, please explain the reasons why this did not occur and what clothing was provided to the person:

16. Was a seclusion care plan developed and implemented for the person?

Yes ☐ No ☐

If no, please explain the reasons why this did not occur:

17. Was the person's representative informed of the person's seclusion?

Yes ☐ No ☐

If no, please explain the reasons why this did not occur:

Use of physical restraint/mechanical means of bodily restraint for immediate threat to self or others

18. Was mechanical means of bodily restraint used?

Yes ☐ No ☐

If yes, complete the Register for Mechanical Means of Bodily Restraint for Immediate Threat to Self or Others

19. Was physical restraint used?

Yes ☐ No ☐

If yes, complete the Clinical Practice Form for Physical Restraint

Initiation of seclusion by the most senior registered nurse in the unit/ward or a registered medical practitioner

20. Initiation:

Initiation of seclusion by the **most senior registered nurse** in the unit/ward **or a registered medical practitioner**:

If seclusion is initiated by the most senior registered nurse on duty in the unit/ward, or a registered medical practitioner, they must complete this section.

I _____ have assessed/examined _____ on

Date: ____/____/_____ at ____ hrs ____ mins and I initiated the use of seclusion from

Date: ____/____/_____ at ____ hrs ____ mins

Name (print): _____ Signed: _____

21. Order:

To be completed by the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist

I _____ have been informed of the outcome of

the medical examination of _____ on

Date: ____/____/____ at ____hrs ___mins and I order/do not order the use of

seclusion from Date: ____/____/____ at ____ hrs ____ mins for no later

than ____hrs ___mins

Name (print): _____ Signed: _____

Date: ____/____/_____ at ____hrs ____mins

Initiation of seclusion by a consultant psychiatrist:

22. Initiation and Order:

I _____ have assessed/examined _____ on

Date: ____/____/____ at ____hrs ___mins and I initiated and ordered the use of seclusion from

Date: ____/____/____ at ____ hrs ____ mins for no later than ____hrs ___mins

Name (print): _____ Signed: _____

Renewing/Ending Seclusion

Applicable to a renewal order only:

23. The seclusion order has been renewed and ordered under the supervision of the:

Please tick as appropriate and sign below:

Consultant psychiatrist responsible for the care and treatment of the person ☐

Duty consultant psychiatrist ☐

Name (print): _____ Signed: _____

Date: ____/____/_____ at ____hrs ____mins

24. Seclusion ended ☐ **Seclusion renewed*** ☐

Who ended or renewed seclusion:

Name (print): _____ Signed: _____

Date seclusion ended / renewed: _____/_____/_____ (dd/mm/yyyy)

Time seclusion ended / renewed: _____ : _____ (24 hr clock e.g. 2.41pm is written as 14.41)

** If seclusion is renewed, a new entry on the Register for Seclusion and an Order must be completed.*

To be completed by the person who ended/renewed seclusion

25. Did the seclusion episode result in any injury to the person?

Yes ☐ No ☐

If yes, please provide further details:

34.0 Appendix 4: Monitoring (Nursing & Medical) of a Patient During Seclusion:

15 Minute Nursing observations:

- The observing nurse will make an entry on the seclusion recording sheet **every 15 minutes** indicating the
  - **I.** The patients level of distress,
  - **II.** patent's condition (mental and physical) including breathing and pallor of skin,
  - **III.** their behaviour and verbal indicators if significant e.g. threats / demonstrations of insight into incident.
  - **IV.** Elimination and hygiene needs,
  - **V.** Hydration and nutrition intake.

The observing nurse will ensure that the patient's physical and psychological condition is carefully observed and alert colleagues immediately there are concerns. ***(NOTE: If the patient has injuries pre-seclusion these should be recorded and medically reviewed).***

- The observing nurse must be aware whether the patient has been medicated or sedated (date, time, type and dose of medication) and observe and record its effects.
- Due to the intensive nature of the observations, the allocated nurse must be replaced by another nurse every 4 hour.
  The observing nurse will continue to work towards the ending of the episode of seclusion.

Two (2) Hour Nursing Review:

- Every **two hours** a nursing review of the patient must be conducted.
- A risk assessment is conducted before the review to ensure the safety of the patient and staff before entering the seclusion room to conduct the nursing review.
- If the patient is asleep clinical judgement needs to be used as to whether it is appropriate to wake the patient to conduct the review. If the decision is not to wake the patient the nature of the nursing review will be such that the patient is not woken.

- If safe to do so a minimum of two (2) nurses (one of whom must be a registered nurse) will enter the seclusion room and directly observe the patient to consider if the episode of seclusion can be ended.
- The review will involve assessment of the patient's mental and physical state, observed level of distress and their observed behaviour. (These will provide indicators for the ending of seclusion).
- Physical observations :
- Respiration,
- Blood Pressure
- Pulse
- Posture
- Skin pallor,
- Level of Consciousness
- Behaviour
- Mental State observations:
  Content of speech
  Thought content
  Mood
  Affect
  Concentration
  Attention
  Level of motor activity.
- The secluded patient is offered drinks and food.
- A review will be conducted of the patients access to dangerous objects, patients clothes are searched to remove all potentially hazardous items Including;
    - Ignitables (matches/lighter),
    - sharp objects (keys etc.)
    - belts
    - pens/pencils
    - glass objects
    - Dressing gown cords
    - Shoes
    - Any other object that could be used to injure self or others.
- The seclusion plan is discussed with the patient **if this does not cause distress**.
- The outcome of the review is discussed with the duty doctor with a view to continuing/ending seclusion. This is clearly documented in the seclusion record and the patients care plan.
- The staff of the unit are to be informed of the outcome of the review.

Monitoring of a Patient During Seclusion: Four (4) Hour Medical Review:

- A medical review must be conducted by a registered medical practitioner every **four hours**.
- The purpose of the review is to:

    a) Review the situation and decide if seclusion should continue or terminate.
    b) Where seclusion is continued: to formulate a treatment plan aimed at ending seclusion.
    c) Where seclusion is terminated: to formulate a post seclusion treatment plan.
    d) To ensure the patients mental and physical well being is appropriately cared for.

If the patient is sleeping clinical judgement is used as to whether is appropriate to wake the patient for the medical review.

- In cases where it is clinically judged not to be appropriate to wake a patient, the medical review may be suspended and a note to the effect documented in the clinical file. However a registered

medical practitioner must be available during the night to conduct a medical review should the need arise.

- If safe to do so a minimum of two nurses and the registered medical practitioner will enter the seclusion room.
- The medical review will include:

Patient's mental state examination:

- ❖ Symptoms or signs of mental disorder
- ❖ Anxiety
- ❖ Level of insight.

Behaviour prior to seclusion, risks and indicators;

- ❖ Physical aggression and or threats of physical violence.
- ❖ Description of aggressive behaviour
- ❖ Level of arousal and anger/verbal abuse
- ❖ Recent past episodes of violence
- ❖ Use of or possession of implements without reasonable/plausible explanation.

Present Behaviour:

- ❖ Whether threatening.
- ❖ Level of cooperation with treatment plan to end seclusion.

General Physical state:

- ❖ Temperature, Pulse, Respirations, Blood Pressure.
- ❖ Pallor of skin
- ❖ Diet and fluid intake/output
- ❖ Evidence of injuries and treatment of any injuries
- ❖ Medication administration
- ❖ Sleep.

- The outcome of the review is discussed with the Clinical Nurse Manager/ nurse in charge, and documented in the patient's seclusion observation sheet and a summary made in the patient's file.

35.0 Appendix 5: Galway/Roscommon Mental Health Services Seclusion Care and Treatment Plan.

Patient Name: **D.O.B:** **Consultant:**

Care Needs /problems:	Short Term Goals:	Nursing Intervention:	Evaluation Date:	Evaluating Nurse's Signature:
Requires to be nursed in seclusion because:_____ or Patient presents extreme physical danger to self or others.	Keep patient safe. Ensure patients dignity.	❖ As comprehensive an Assessment as possible (including risk) of patient. ❖ If possible before seclusion, ensure the route to seclusion room is clear. ❖ Patient searches to be conducted in accordance with the patient searching policy. ❖ Remove all hazardous objects from the patient e.g. jewellery, dentures, belts, laces, sharp objects, lighter/matches or any other object deemed to be a risk. ❖ Patients own Clothing to be worn if at all possible. If patient is to be nursed in night clothes this must be documented in the patient's clinical file (see night clothes policy) or if tear proof clothes to be used. ❖ Risk assessment before each nursing review. ❖ Minimum of two nursing staff to enter the seclusion room (if safe to do so) to observe the patient. ❖ Commence and document direct observation for the first hour. ❖ Commence and document continuous observation for the remainder of the episode of seclusion. ❖ Notify the treating consultant/duty consultant of the commencement of seclusion if initiated by a nurse. ❖ Conduct and document nursing reviews every **2 hours.** ❖ Document instances where it is unsafe to enter the seclusion room for the purposes of observing vital signs/conducting the nursing review. ❖ Ensure patient is offered opportunity to use toilet facilities before or following each review or more frequently if requested. ❖ Ensure adequate fluid and diet intake.		

Nurses Name:_____ Signature:_____ Date:_____

Galway/Roscommon Mental Health Services Seclusion Care and Treatment Plan.

Patient Name: **D.O.B:** **Consultant:**

Care Needs/ Problem:	Short Term Goals:	Nursing Intervention:	Care Planning Nurses Signature: Evaluation Date:	Evaluating Nurse's Signature:
Patient needs to be informed of the reasons for seclusion (unless prejudicial to patients condition).	Provide patient with information relevant to their seclusion (e.g. how long seclusion may last, reasons for seclusion)	❖ Provide the patient with rationale for staff intervention and the need for seclusion and the possible length of time the patient may be secluded. ❖ Document information given to the patient. ❖ Document if information was not given to the patient. ❖ Patients preference to inform representative of patient's episode of Seclusion inform representative. ❖ Where patients preference is not to inform representative of seclusion record this.		
Patient should only be secluded for the shortest period possible.	Identify with the patient the behaviour that needs to change before seclusion can be ended.	❖ Provide the patient with the opportunity to identify unsafe behaviour. ❖ Make it clear to the patient that you accept them as a person, but that certain specific behaviours are a serious risk. ❖ Continue to evaluate the situation with a view to discontinuing seclusion ❖ Continually assess the patient's mental state. ❖ De-escalation techniques to be used to end the episode of seclusion.		
Physical/ Biological/ Psychosocial care	Attend to all biological, psychosocial and physical needs during the seclusion period.	❖ Observe and document vital signs 4 hourly or at prescribed frequencies. ❖ Observe and document actions and effects of medications. ❖ Maintain fluid balance chart. ❖ Maintain diet chart. ❖ Provide reading material/activities for the patient if safe to do so.		

Nurses Name:_____ **Signature:**_____ **Date:**_____

Galway/Roscommon Mental Health Services Seclusion Care and Treatment Plan.

Patient Name: **D.O.B:** **Consultant:**

Care Needs:	Short Term Goals:	Nursing Intervention:	Care Planning Nurses Signature: Evaluation Date:	Evaluating Nurse's Signature:
Physical/ Biological/ Psychosocial care	Attend to all biological, psychosocial and physical needs during the seclusion period.	Patient preferences from a previous debrief: detail if available: _____ _____ _____ _____ _____ _____ _____		
	Personal hygiene	Access to toilet/shower as required. Accompanied to toilet to meet elimination needs		
Signs and symptoms of dangerous behaviour	Observation of the person to ensure safety .	Assess evidence of reduction in dangerous behaviour Reduced tension/aggression Communicating with staff Understanding of situation		

Nurses Name:_____ Signature:_____ Date:_____

Galway/Roscommon Mental Health Services Seclusion Care and Treatment Plan.

Patient Name: **D.O.B:** **Consultant:**

Care Needs:	Short Term Goals:	Nursing Intervention:	Care Planning Nurses Signature: Evaluation Date:	Evaluating Nurse's Signature:
Ending Seclusion	End the episode of seclusion.	Discuss with patient their behaviour and ending the episode of seclusion. Consider if unsafe behaviour has abated to end the seclusion episode		
Mental Health Needs	Assist the patient regain control of their behaviour/ Minimise the potential negative effects of seclusion	Engage with the patient to express how they feel Review for signs of trauma/isolation/distress/anxiety/agitation Reassure patient while in seclusion Positive behavioural support		

Nurses Name:_____ **Signature:**_____ **Date:**_____

36.0 Appendix 6: Galway/Roscommon Mental Health Services Post Seclusion Care and Treatment Plan.

Patient Name: **D.O.B:** **Consultant:**

Care Needs /problems:	Short Term Goals:	Nursing Intervention:	Evaluation Date:	Evaluating Nurse's Signature:
Patient's mental state and behaviour warrants being nursed on an open ward.	The patient can identify events/behaviour(s) which resulted in the need for seclusion.	❖ Provide the patient with the opportunity to ventilate their feelings prior to and during the incident. ❖ Review with the patient the events leading up to the incident. ❖ Identify with the patient the antecedent to the incident. ❖ Document antecedents or factors that trigger patient's behaviour, e.g. level of stimuli, time of incident, presence of staff or others. ❖ Conduct mental state examination. ❖ Review the possibility of psychotic symptoms (delusions etc) ❖ Out rule drug and/or alcohol use and/or withdrawals		
Patient is on the open ward	The patient functions at a level for him/her to maintain self on an open ward.	❖ Give the patient positive feedback for controlling his/her aggressive behaviour, expressing feelings appropriately. ❖ Encourage the patient to talk to a staff member when they feel upset or feel they are losing control of their behaviour. ❖ Give the patient responsibility for recognizing and appropriately dealing with their feelings. ❖ Assist the patient to maintain control using self soothe box, relaxation. ❖ Discuss with the patient alternative ways of expressing emotions and releasing physical energy. ❖ Continually assess the patient's mental state. ❖ Perform risk assessment on patient		

Nurses Name:_____ **Signature:**_____ **Date:**_____

Galway/Roscommon Mental Health Services Post Seclusion Care and Treatment Plan.

Patient Name: **D.O.B:** **Consultant:**

Care Needs/ Problem:	Short Term Goals:	Nursing Intervention:	Care Planning Nurses Signature: Evaluation Date:	Evaluating Nurse's Signature:
Patient needs to review seclusion episode.	Review the seclusion episode with the patient	❖ Allow the patient to express their feelings about the episode of seclusion. ❖ Assist the patient with the debrief and review of seclusion episode ❖ Document patent preferences following the debrief and review. ❖ Document patients review of the seclusion episode.		
Patient is a potential risk from self harm	Keep the patient safe from self harm	Step down care from seclusion (CONSIDER): ❖ Altered level of observation (observation policy) ❖ Nursing on an open ward ❖ Complete Risk screening/risk assessment.		

Nurses Name:_____ **Signature:**_____ **Date:**_____

Galway/Roscommon Mental Health Services Post Seclusion Care and Treatment Plan.

Patient Name: **D.O.B:** **Consultant:**

Care Needs:	Short Term Goals:	Nursing Intervention:	Care Planning Nurses Signature: Evaluation Date:	Evaluating Nurse's Signature:

Nurses Name:_____ **Signature:**_____ **Date:**_____

Galway/Roscommon Mental Health Services Post Seclusion Care and Treatment Plan.

Patient Name: **D.O.B:** **Consultant:**

Care Needs:	Short Term Goals:	Nursing Intervention:	Care Planning Nurses Signature: Evaluation Date:	Evaluating Nurse's Signature:

Nurses Name:_____ **Signature:**_____ **Date:**_____

37.0 Appendix 7: Sensory Modulation

Sensory modulation :

Guide for management of aggression in an Adult Acute Mental Health Unit:

Alternative options for the use of seclusion and physical restraint.

Anna Glynn (Senior OT AAMHU)

What is Sensory modulation?

It is the neurological regulation of response to sensory stimuli (Kinnealey et al., 2011). Problems with sensory processing can result from difficulties in how the nervous system receives, organises, and uses sensory information from the body and the physical environment. This is necessary for self-regulation, motor planning and skill development. Sensory processing refers to an individual's ability to take in information through the senses (touch, movement/balance, smell, taste, vision) and make a meaningful response (Brown & Nicholson, 2011).

For example auditory hallucinations may impact on self-concept, emotional regulation, attention, problem solving, behaviour control, skill performance, and the capacity to develop and maintain interpersonal relationships. In adults they may negatively impact on occupations, sense of self and occupational performance skills (parenting, working, home management, social and leisure activities) (AOTA, 2011; Brown & Nicholson, 2011; Champagne 2011). Interventions include activities or modalities offering specific types and amounts of sensation, at strategic times of use, for therapeutic purposes. Examples offered in the table below:

Research to support the use of sensory strategies in a Mental Health setting to reduce the use of seclusion:

Champagne and Stromberg (2004) examined the sensory approaches used in an inpatient psychiatric setting as an alternative to seclusion and restraint. It was found that 89% of the sensory room sessions had a positive effect. During the year of implementation the facility's rates of seclusion and restraint decreased by 54%. Sivak (2012) found that following the introduction of comfort rooms (similar to sensory rooms/modulation) in a mental health facility, positive outcomes were noted with decreased rates of assaults as well as zero use of seclusion and mechanical restraints. Chalmers et al. (2012) showed a significant reduction in patient distress levels when using sensory modulation strategies. Novak (2012) found that a sensory room was an effective intervention to lessen distress and aggressive behaviour in an inpatient setting. Lloyd et al. (2014) completed 2 sensory modulation studies: In study 1, they found that most patients had a marked reduction in disturbance after using sensory modulation. In study 2, they found that frequency of seclusion dropped dramatically in the unit that introduced sensory modulation but rose slightly in the unit that did not have access to sensory modulation. Sutton, et al. (2013) suggested that sensory approaches have a valuable role in regulating emotion and that they improve the options in managing aggression. Bjorkdahl et al. (2016) reported an increase in patients' self-confidence, emotional self-care, and well-being with the use of sensory rooms in psychiatric care. Wiglesworth and Farnworth (2016) identified a decrease in stress with the use of a sensory room in an inpatient setting. Reed (2017) found patients did not exhibit acting out behaviours within 24 hours post sensory intervention.

A sensory programme is meant to help calm versus alert the senses. The goal of a sensory modulation programme is to provide patients the opportunity for self-regulation of emotions and learning new coping skills to de-escalate aggressive behaviours. A sensory programme is intended to help patients who are becoming escalated in behaviour (i.e. increased agitation and defensive behaviours: including questioning authority, refusal, verbal venting, and intimidation) in order to help them calm and regulate their own emotions. Sensory modulation and sensory rooms are deliberately intended to be sensory calming with the goal of crisis de-escalation and/or prevention (Champagne, 2015).

Weighted Blankets (WB):

Prescribed only by OT staff.

A review of literature found the use of weighted blankets to be effective and safe in reducing the signs and symptoms of anxiety. Numerous quantitative and qualitative studies showed that a multitude of physiological symptoms and self-reported levels of anxiety were consistently reduced after use of a weighted blanket (Eron et al, 2020).

Trauma-informed care is a national mental health initiative promoting a model of care and advocates for the offering of interventions that are empathic, empowering, client-centered, nurturing, sensory supportive and do not contribute to re-traumatization (DOH Sharing the Vision, 2020; NETI, 2003, 2009; Van der Kolk, 2006, 2014). WBs are particularly promising in the area of trauma-informed care because they can be used to help foster self-care, self-nurturance, rest/sleep, and stabilization.

The aim of using the weighted blanket is to provide a patient with a sustained deep pressure sensation to their body to aid them in maintaining a calm and alert state, reduce their arousal level and for their sensory proprioceptive system be more organised to function. Parasympathetic nervous system (PNS) influences the "rest and digest" and polyvagal responses which aids social engagement and the ability to participate in meaningful life roles (Boucsein, 1992; Porges, 1992).

Advice for use:

Prescribed only by OT staff.

The following is the recommended protocol for using the weighted blanket with a person. If a person objects to wearing the blanket, the blanket can be placed on their lap when sitting.

If they continue to object to this, please remove the blanket and contact the Occupational Therapist as soon as possible.

The person should not be forced to wear the blanket or have it on their bed if they are uncomfortable with it. Consent is required.

It is recommended that any applied weighted object to the body is no more than 10% of body weight, to ensure that the weight is not putting an excessive strain on the body.

Place the blanket on a person for 10 minutes approximately every 2 hours. This is to help the person's sensory proprioceptive system to register the blanket and help the effects last.

Sensory Modulation suggestions: where possible alongside the use of the sensory room

Proprioceptive • Weighted blanket • Resistive had-squeeze equipment • Use of therapy ball • Use of weighted ball activities • Dance/yoga/tai chi	Vestibular • Rocking chair • Glider rocker • Therapy ball activities • Swinging • Dance/yoga/tai chi • Getting in and out of beanbag chair
Tactile • Loofahs • Sitting in a bean bag • Self-massage tools • Weighted therapy tools • Fleece blankets/pillowcases • Microwaveable hot packs • Manicure • Hand/face lotion • Chew/ crunchy foods • Vibration	Auditory • Guided imagery CDs • Various types of music – fast/slow pace • Stereo or personal audio system • Musical instruments • Flowing rock/waterfall
Visual • Bubble lamp • Wall murals/various pictures • Bubbles • Glitter wands • Various lights/lighting • Computer use • Coloured sunglasses	Olfaction • Scented bath/body wash • Scented lotions/balms • Aromatherapy (100% essential oils) • Lemon • Spices • Eucalyptus • Candles • Herbal teas
Gustatory • Carrot sticks • Celery sticks • Pretzels • Sour lollies • Gummy bears • Fruit snacks • Ice blocks/frozen fruit bars • Ice • Biting on a lemon • Chewy foods • Strong mints • Herbal teas • Lollipops • Trail mix • Yoghurt	

Occupational Therapy Recommendations for Use of a Weighted Blanket

Name of Patient	
Date of Birth	
Name of Occupational Therapist Recommending the WB	
Date	

It is recommended that a weighted blanket be used with this person, for a trial period.

The aim of using the weighted blanket is to provide this person with a sustained deep pressure sensation to their body to aid them in maintaining a calm and alert state, reduce their arousal level and for their sensory proprioceptive system to be more organised to function.

The following is the recommended protocol for using the weighted blanket with a person. If a person objects to wearing the blanket, the blanket can be placed on their lap when sitting.

If they continue to object to this, please remove the blanket and contact the Occupational Therapist as soon as possible.

The person should not be forced to wear the blanket or have it on their bed if they are uncomfortable with it. Consent is required.

Protocol for Weighted Blanket

Blanket
It is recommended that any applied weighted object to the body is no more than 10% of body weight, to ensure that the weight is not putting an excessive strain on the body.

Application
The weighted blanket if needed should be placed on the person by staff. If agreed prior with the person the weighted blanket could be placed on the bed when the person is asleep.

When - Activity
The weighted blanket could also be placed on the person when they are seated; on the lap or draped around themselves.
It should not be used when he is engaging in movement activities.
This is because the blanket aims to calm the person, movement is exciting to the sensory system, and the effects are reduced if he is moving around with weighted blanket.
It is ok if they walk in the room for a brief time when the blanket is on.
Encourage them to stay sitting and provide them with activities to engage in at the table.

When - Time Frame
The **weighted blanket should be left on the person for initially 10 minutes at a time**, then after a week, or gradually over a few days build up to 15 minutes.
After a period of having the blanket on for 15 minutes at a time, it can be gradually increased again up to 20 minutes, but should not be left on for longer than 20 minutes or the effectiveness will be reduced.

Occupational Therapy Recommendations for Use of a Weighted Blanket

Name of Patient	
Date of Birth	
Name of Occupational Therapist Recommending the WB	
Date	

- Place the blanket on the person for initially 10 minutes approximately every 2 hours. This is to help the person's sensory proprioceptive system to register the blanket and help the effects last.
- Try putting the blanket on the person before times of transition, e.g. for 10 minutes on before into dining room and before their break time.
- Select regular times for the person to wear the blanket, so they can become familiar and more comfortable with it as part of their sensory toolbox routine.
- As this is a new experience for the person, it would be very useful if it could be noted how they are reacting to the weighted blanket and if it has any impact on him, especially on their attention, arousal levels and their behaviours.