

GENERAL				
Standard	Met	Partially Met	Not Met	Comments
Patients shall be treated with dignity and respect at all times.				
Seclusion shall only be delivered within a secure room, designated expressly for the delivery of seclusion.				
All standards and guidelines shall be translated into health authority policies and procedures.				
Seclusion shall be delivered within the context of trauma-informed, recovery-oriented, patient-focused care.				
Seclusion shall be a short-term emergency measure of last resort, used only when all efforts to prevent the use of seclusion have failed.				
Individuals experiencing withdrawal symptoms will not be placed in a secure room while not medically stable.				
Seclusion shall be used only to prevent a patient from harming him or herself or others.				
Policies and procedures shall be in place to ensure appropriate psychiatric, mental health and medical assessments of all patients.				
Post-incident reflection and review shall be conducted following seclusion interventions as part of a cycle of continuous quality improvement.				
The clinical team shall document and report out on all seclusion interventions.				
Clinical teams shall support and monitor prevention, performance and quality improvement.				
Clinical and administrative units shall monitor and report out on staff performance and accountability in order to support staff in delivering best-practice interventions.				
Clinical and administrative leadership shall be accountable for the use of seclusion.				
Staffing levels shall be adequate for appropriate provision of clinical care.				

PREVENTING SECLUSION				
Standard	Met	Partially Met	Not Met	Comments
Designated facilities shall define a clear and unwavering mandate for the prevention of seclusion.				
Designated facilities shall deliver recovery-oriented, trauma-informed care.				
Designated facilities shall implement specific and proactive strategies to prevent the need for seclusion and minimize its use.				
Designated facilities shall provide or support staff to undertake comprehensive and ongoing training in interventions to prevent seclusion.				
For units that have a comfort and/or multisensory room: Staff should utilize comfort or multisensory rooms fully and appropriately.				
ASSESSMENT AND CARE PLANNING				
Standard	Met	Partially Met	Not Met	Comments
Care plans shall be initiated upon a patient's admission to the facility. Care plans shall involve input from the patient and family/guardian/caregiver as well facility staff, and include strategies for managing risk and preventing seclusion.				
Care planning shall include the community case manager where appropriate.				
New patients shall receive routine medical and psychiatric risk assessments.				
All assessments shall be documented in the patient's health record.				
Any underlying medical causes for a behavioural disturbance shall be investigated and treated.				
Psychiatric symptoms shall be assessed and treated according to best-practice clinical indication.				
The risk of suicide and violence shall be assessed to determine immediate and serious risk of harm to self or others; this shall be documented according to provincial violence prevention regulations.				

RISK MANAGEMENT				
Standard	Met	Partially Met	Not Met	Comments
Trauma-informed practice shall be adopted as a default approach to care in order to minimize the traumatization of patients that might lead to risk of violence and aggression, and support the prevention of unnecessarily restrictive interventions.				
Within the parameters of legislated requirements, partnerships between patients, families and caregivers shall be the guiding force when developing inpatient psychiatric policies and practice.				
Each and every designated facility shall have a formal strategy, policy or protocol to support staff in identifying options to prevent seclusion.				
Thorough medical, psychiatric, violence and trauma risk assessments shall be performed upon admission to establish potential triggers that might require seclusion.				
Individualized behavioural care plans include measures to prevent seclusion.				
A RN or RPN shall be available within sight and sound of the secure room at all times when a patient is secluded (i.e., the secluded patient is always monitored at minimum via closed-circuit television and intercom at the nursing station), and patients shall be monitored closely throughout the intervention.				
The patient shall be included in post-intervention reflection and review in order to reverse or minimize the intervention's potential negative impact.				
Policies and procedures shall be in place to assist staff to provide care that is culturally competent.				
Policies and procedures shall be in place to assist staff to provide care that respects and accommodates an individual's needs resulting from that person's self-determined gender and/or sexual identities.				
Patients shall be supported to keep personal items of religious or cultural significance as long as they pose no safety risk.				
Policies and procedures shall be in place to ensure staff are aware of supports available to them following seclusion events.				

INITIATING SECLUSION				
Standard	Met	Partially Met	Not Met	Comments
A patient shall be deemed medically stable by a qualified physician or registered nurse prior to experiencing a seclusion intervention.				
Seclusion shall be ordered by a qualified physician and the order is reviewed as soon as possible by a psychiatrist, or the director appointed under the <i>Mental Health Act</i> (or designate approved by the health authority).				
Trained and qualified, authorized staff shall initiate and deliver seclusion.				
Orders for the use of seclusion shall be time-limited and specific.				
Facilities shall have policies and procedures regarding the role of police, code white team, and security guards in initiation of seclusion.				
OBSERVATION AND EVALUATION				
Standard	Met	Partially Met	Not Met	Comments
Patients shall be evaluated face-to-face by a qualified physician as soon as possible within 24 hours of the initiation of seclusion.				
Patients in seclusion for extended periods (i.e., longer than 8 hours continuous) shall receive a mental health assessment by a qualified registered clinical professional at least once every 24 hours. This assessment shall be documented in the client file.				
If seclusion lasts more than one hour, a care plan shall be developed for the seclusion period.				
Unit staff shall review the need to continue seclusion throughout the intervention, at 30 minutes, 2 hours, and every 4 hours for the duration.				
Face-to-face monitoring and evaluation of patients in seclusion shall take place at regular intervals, at a minimum of once every 15 minutes, throughout the duration of the intervention. If seclusion persists past 8 hours continuous or 12 hours intermittent, the review shall include at least one qualified senior clinician, and, whenever possible, the initiating and supporting clinician(s).				
Face-to-face monitoring and evaluation of patients in seclusion shall take place at regular intervals, at a minimum of once every 15 minutes, throughout the duration of the intervention.				
The secure room shall be fitted with an audio-visual system for continuous staff observation of the patient and to facilitate patient-staff engagement.				
Monitoring and evaluation shall not take place via audio-visual observation system alone (i.e., CCTV monitors and intercom).				

ENDING SECLUSION				
Standard	Met	Partially Met	Not Met	Comments
Periods of seclusion shall end as quickly as possible, when a nurse and/or physician on the clinical team determines that there is no longer any threat to any person's safety.				
The clinical team shall implement a step-down process to end seclusion, unlocking or opening the door once they have determined it is safe to do so, enabling the patient to decide when he or she is ready to leave the room, and incorporating a period of observation to ensure that it is safe for the patient to return to the open unit.				
The seclusion episode shall be considered over when the patient leaves the conditions of seclusion without expectation of return, or for more than one hour.				
Seclusion shall be concluded with a plan for re-integrating the patient into the general unit and managing future emergencies.				

PROTECTING EMOTIONAL AND PSYCHOLOGICAL SAFETY				
Standard	Met	Partially Met	Not Met	Comments
Families/caregivers shall be notified of the decision to use seclusion, with consideration for the patient's wishes and consent.				
Patients shall have options/means for constant contact and communication with staff throughout seclusion episode.				
The reasons for initiating, continuing and ending seclusion shall be explained to the patient, and the explanation and patient's observed level of understanding shall be documented.				
Patients shall be kept aware of the time and date, verbally or via a clock viewable from the secure room.				

PROMOTING PHYSICAL SAFETY				
Standard	Met	Partially Met	Not Met	Comments
Neither patients nor staff shall be subjected to injury or degradation.				
Seclusion shall be delivered in an appropriate environment, in a manner that is safe for and respectful of all involved.				
Patients in seclusion shall receive adequate food and fluids without undue delays.				
Patients shall have constant access to toilet and washing facilities.				
Patients shall be clothed appropriately, with due concern for safety (e.g., removal of potentially dangerous accessories such as belts and shoes). Under no circumstances shall a patient be left without the option of wearing clothing.				

LEGAL RIGHTS				
Standard	Met	Partially Met	Not Met	Comments
Policies and procedures shall be in place to inform patients and family members/guardians of their rights under the <i>Mental Health Act</i> . While the Act authorizes involuntary admission and treatment of people with mental disorders, there is a need to ensure these provisions are appropriately used.				
In accordance with the <i>Freedom of Information and Protection of Privacy Act</i> (FOIPPA), policies and procedures shall be in place to share information among health care team members and third parties.				
Patients in seclusion shall have their rights explained verbally and in writing, and the explanation shall be documented.				
A staff member from a designated facility (or its agent) must verbally inform the person and provide written notification of their rights promptly upon admission. Rights information requirements, as they apply to involuntary patients, are set out in section 34 of the <i>Mental Health Act</i> . For patients under 16, the requirements are in section 34.1.				
REFLECTION AND OVERVIEW				
Standard	Met	Partially Met	Not Met	Comments
Leaders and staff shall participate in the reflection and review process as soon as possible after the end of seclusion.				
The designated facility shall have a formal review and documentation process involving clinical and administrative leaders in order to address potential service-wide performance improvement.				
Clinicians shall reflect on and review the incident with the patient and family/caregivers/guardians (where appropriate) as soon as possible within 24 hours after the end of seclusion.				
Reflection and review procedures shall be transparent, and communicated to patients through brochures or other easily accessible formats.				
DOCUMENTATION AND QUALITY IMPROVEMENT				
Standard	Met	Partially Met	Not Met	Comments
Designated facilities shall collect and analyze data on seclusion interventions in order to inform practice and improve internal performance. Seclusion interventions shall be tracked in each health authority and reported to the Ministry of Health through the Patient Safety Learning System (PSLS). Designated facilities shall collect and report units' use of seclusion via the PSLS at regular intervals.				
Policies and procedures shall be in place for documenting assessment and care of the patient and family members/guardians when a patient is at risk of or experiences seclusion.				

DOCUMENTATION AND QUALITY IMPROVEMENT continued				
Standard	Met	Partially Met	Not Met	Comments
Policies and procedures shall be in place for documenting and reporting of seclusion, including the evaluation conducted and follow-up steps initiated.				
Clinical and/or administrative staff shall document in the patient's clinical record and via the PSLs all aspects of the use of seclusion.				
An accurate account of each episode of seclusion shall be recorded, demonstrating the delivery of treatment that conforms to provincial standards and guidelines and facility policy.				
Clinical and administrative leaders shall review all seclusion interventions.				
Clinicians and administrators shall establish and adhere to written policy and procedures for the use of seclusion.				
Clinical and administrative leaders shall communicate the facility's policy and philosophy on the use of seclusion to all relevant staff.				
Clinical and administrative leaders shall work actively to minimize or prevent the use of seclusion.				
Clinical and administrative leaders shall implement a performance improvement process related to seclusion in order to ensure accountability.				
Patients shall be involved in the evaluation of a facility's seclusion practices as part of ongoing quality improvement.				

DEVELOPMENTAL DISABILITY, NEUROPSYCHIATRIC PSYCHO-GERITRIC POPULATIONS				
Standard	Met	Partially Met	Not Met	Comments
Clinical staff shall receive training that alerts them to the increased risk of seclusion faced by people with developmental disabilities and neuropsychiatric disorders including dementia.				
When engaging in prevention and/or delivery of seclusion, consideration shall be given to the specific developmental needs of youth with highly complex disorders.				
Geriatric and neuropsychiatric populations shall be provided with alternatives to a secure room in order to ensure the safety of individuals who are at risk of elopement, but not imminent violence.				
Because of the specific characteristics of their disorders, individuals with developmental disabilities and/or neuropsychiatric disorders may not respond to preventive techniques such as verbal de-escalation, re-direction or medication. Such patients shall have access to both emergency and planned seclusion interventions in order to prevent them from being targets of violence or from harming themselves or others.				

OBSERVATION UNITS				
Standard	Met	Partially Met	Not Met	Comments
Policies and procedures are in place for staff responsible for the oversight of care of an individual in the observation unit to have knowledge and skills in emergency psychiatric assessment, crisis intervention and the safe management of patients with psychosis, delirium, suicidal and aggressive behaviours.				
A facility designated as an observation unit must have access to psychiatric consultation in order to clarify and confirm a patient's diagnosis and/or treatment plan.				
Protocols exist with community mental health and substance use services and other relevant community resources (e.g., child and youth mental health services, friendship centres, primary care providers, family/guardian) to provide care and treatment to an individual while that person awaits transfer in order to support stabilization and prevent the need for seclusion interventions.				
EMERGENCY DEPARTMENTS				
Standard	Met	Partially Met	Not Met	Comments
All individuals will be triaged by a trained triage nurse and moved immediately to the appropriate location in the ED, considering their own and others' safety.				
Only individuals who have been assessed as medically stable (by the triage nurse or a physician) and require seclusion for their immediate safety or the safety of others will be considered appropriate to be placed in a secure room in the ED.				
Clinical decision tools shall be in place to support ED staff in assessing the psychiatric patient in crisis.				
Education processes shall be in place to explore the concept of trauma-informed practice in the ED as the term 'trauma' has a different meaning in that environment.				
ROLE OF THE POLICE IN THE ED (Note: guidelines only)				
Standard	Met	Partially Met	Not Met	Comments
Clinical staff shall assess to determine if the presence of uniformed officers creates increased agitation for the patient or a calming sense of order and control.				
Police, hospital security staff and clinical staff shall understand their counterparts' training and roles to improve consistency in approach.				
Health authorities shall work with local police detachments to develop a protocol to ease the transition from police to hospital responsibility for patients detained under Section 28 of the <i>Mental Health Act</i> .				

STAFF EDUCATION, TRAINING AND SUPPORT				
Standard	Met	Partially Met	Not Met	Comments
Health authorities shall work with their occupational health and safety, union, and professional bodies to set clear requirements identifying standardized competencies for entry to practice, demonstration of skills, number of training hours and refresher cycles.				
Clinical staff shall be able to articulate sound knowledge of the key principles, legal requirements, guidelines and local policies and procedures relating to seclusion.				
Staff shall be trained and competent to deliver seclusion interventions safely and in accordance with the facility's policies and procedures.				
Health care staff shall receive continual training and professional development to maintain and enhance their skills, and to ensure key competencies as required by the BC Provincial Violence Prevention Curriculum (PVPC).				
Staff shall receive continual training and professional development to maintain and enhance their skills, and to ensure additional key competencies for prevention and safe delivery of seclusion.				
Staff shall receive training in trauma-informed care, non-violent crisis intervention (including de-escalation), and collaborative problem-solving.				
Staff shall receive education and training to develop skills for managing behavioural emergencies; assessing potential aggression/violence; and preventing and managing disturbed behaviour and aggression/violence.				
Staff shall be trained and competent to deliver interventions intended to prevent and/or minimize the use of seclusion.				
Staff shall receive training in functional analyses of behaviour, and of positive behavioural supports and interventions to help with prevention of dangerous behavior/teaching of alternative behaviours.				
Nursing staff shall be trained to recognize signs/symptoms of side effects/adverse reactions to treatment associated with the seclusion episode (e.g., any medications administered, environmental impact of the secure room).				
Staff shall work in a well-trained team with the proven capacity to deliver required services in keeping with provincial standards and guidelines for safety, health and quality of care.				
Staff shall have access to an expert who may provide guidance regarding issues and questions about relevant legislation including the <i>Hospital Act</i> , <i>Mental Health Act</i> , <i>Workers Compensation Act</i> , <i>Freedom of Information and Protection of Privacy Act</i> , occupational health and safety regulations, and violence prevention regulations.				