Policy on Seclusion and Restraint of Mental Health Care Users

Version control

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Vision, Mission and Values

Vision

Health Service Excellence for All

Mission

Working together, we are committed to provide quality health care services.We will promote a healthy society in which we care for one another and take responsibility for our own health.Our caring, multi-skilled professionals will integrate comprehensive services, using evidence-based care-strategies and partnerships to maximize efficiencies for the benefit of all.

Values

- Respect (towards colleagues and clients, rule of law and cultural diversity)
- Integrity (Honesty, Discipline, and Ethics)
- Excellence through effectiveness, efficiency, innovation and quality health care.
- Humanity (Caring Institution, Facility and Community)
- Empower our people (Staff and Community)

PolicyAim

1. To purpose of this policy is to provide guidelines on the use of seclusion and restraint of mental health care users in order to prevent injury to aggressive mental health care users admitted at the mental health facility as well as Mental Health Care Professionals.

Policy Scope

2. This Policy is applicable to all Health Care Providers and Mental Health Care Users in the Northern Cape Province.

Policy Statement

3. It is the policy of the Northern Cape Department of Health that:-

3.1. Seclusion shall be prescribed by a qualified Medical Officer attending to the health care needs of the mental health care user or a psychiatrist appointed by the Northern Cape Department of Health.

3.2. Before implementing seclusion, the mental health care practitioner must explain the process to the mental health care user or his/ her family members and if possible get their consent to seclude the mental health care user.

3.2.1. If the situation does not allow obtaining consent, seclusion will be applied without the mental health care user's consent, as long as it does not endanger the life of the mental health care user and it is used to prevent harm and violent behaviour.

3.3. Indications for the use of seclusion and mechanical restraint are:-

3.3.1. Only be used when there is reason to believe that the mental health care user is likely to inflict harm to self or others or destroy property.

3.3.2. Be used only in an emergency situation, where there is an occurrence of, or serious threat of extreme violence by the mental health care user and

alternative less restrictive interventions have been determined to be ineffective.

3.3.3. Must be used as an adjunct to planned care and treatment or as a component of the clinical management of a physically aggressive and disruptive mental health care user.

3.3.4. Provided when a mental health care user requires reduced environmental stimulation.

3.3.5. The decision to restrain or seclude a mental health care user must be regularly reviewed to determine when safer, less restrictive management alternatives can be implemented and there must be recorded evidence in writing showing that attempts to explain to the mental health care user and his/her family about the importance of seclusion to calm the mental health care users has been unsuccessful.

3.4. **Contraindications for the use of the seclusion and mechanical restraint:**

3.4.1. If the mental health care user is suicidal.

3.4.2. For children up to 12 years.

3.4.3. Where alternative interventions can work.

3.4.4. As a punishment.

3.4.5. For convenience of personnel.

3.4.6. As a management strategy to compensate for a shortage of staff.

3.4.7. Where there are clinical or medical conditions requiring physical proximity and monitoring by staff.

3.4.8. Where the mental health care user has lost consciousness.

3.5. **Special considerations on the use of the seclusion and mechanical restraint**

3.5.1. Older mental health care users may be at particular risk of adverse events resulting from physical health problems or frailty. They should be monitored closely if seclusion or restraint cannot be avoided.

3.5.2. Mental health care users with a history of trauma (physical or psychological) may be at particular risk of compounded trauma through the use of seclusion and mechanical restraint. This should be noted in the care plan when known and alternative strategies such as early behavioural and pharmacological interventions should be implemented.

3.5.3. Mental Health care users who may for any reason be at particular risk of self-harm whilst in seclusion, should be monitored closely if seclusion cannot be avoided.

3.5.4. The mental health care user's head and face must not be obstructed during seclusion and restraint.

3.5.5. All medication administered to the mental health care user must be prescribed by a qualified mental health care practitioner.

3.5.6. Where restraint is required in order to administer pharmacological treatment, such means should be applied for as short a period as possible, depending on the condition of the mental health care user concerned, as is necessary to effect the treatment.

3.6. **Duration of seclusion and mechanical restraint**

3.6.1. Individual prescription should specify the duration of seclusion and restraint, which should be less than 4 hours for adults and a maximum of 2 hours for adolescents.

3.6.2. The period of seclusion and restraint must be limited to minimum time required to remove the risk.

3.6.3. Seclusion and mechanical restraint must be terminated once indications of risk for harm have ceased to be present.

3.6.4. The seclusion is valid from the time the seclusion room door is locked until it is unconditionally unlocked.

3.6.5. The seclusion period is not broken when the mental health care user is attending to personal needs, or being given the medication, foods or fluids.

3.6.6. The medical officer or psychiatrist must renew the prescription for seclusion and restraint at least every 24 hours with a concurrent face-to- face re-evaluation of the mental health care users.

3.7. **Care of mental health care user who is secluded or mechanically restrained**

3.7.1. All objects or material that may pose a safety risk must be removed in the room and the mental health care user must be searched before being secluded.

3.7.2. There should be ongoing assessment of the mental health care user's presenting problems, identification of precipitants to the aggressive behaviour and other environment specific triggers.

3.7.3. There should be a complete bio-psychological assessment of the user, which should include the developmental history, any history of trauma (physical or sexual and other traumatic events), particular cultural needs which may affect the delivery of care, physical condition (hydration status, and bowel and bladder needs, etc.) and mental status.

3.7.4. Medication contraindications, side effects and infections must be excluded.

3.7.5. There should be concurrent screening and assessment for co-morbid illness (including the possibility of substance intoxication or withdrawal) to ensure the emergent physiological needs are addressed.

3.7.6. While the mental health care user is mechanically restrained or secluded, he or she must be subject to observation at least every 30 minutes and such observations should be recorded in the clinical progress notes.

3.7.7. The half hourly observation should include, but not limited to:

3.7.7.1. The mental health care user's behaviour while in seclusion or under restraint.

3.7.7.2. Medication administered and response to the drugs given.

3.7.7.3. Attention to hydration, nutrition, comfort and toileting.

3.7.7.4. Attention to the general cleanliness of the mental health care user.

3.7.7.5. The vital signs (if possible) and mental health status.

3.8. **Recording Keeping**

3.8.1. Wherever a seclusion or restraint is utilised, a register in the form of form MHCA 48 shall be completed and be signed by the medical officer or psychiatrist.

3.8.2. The time period of seclusion and the reason for secluding such mental health care user must be outlined in the relevant register by such medical officer or psychiatrist.

3.8.3. The head of the health establishment concerned shall receive a daily report indicating all incidents of secluding and those involving mechanical restraint.

3.8.4. The transcript of the register must be submitted by the head of the health establishment concerned to the Review Board quarterly on form MHCA 48.

3.8.5. Reports on injuries and loss of life during seclusion and restraint must be submitted to the Mental.

3.9. **Quality monitoring of seclusion and restraint practice**

3.9.1. The multidisciplinary team must frequently review all incidents of seclusion and restraint.

3.9.2. Consideration should be given to the factors and conditions that ultimately precipitate the use of seclusion and restraint. Alternate interventions strategies, which should be incorporated into the user's care plan to prevent future application of seclusion and restraint measures, should be instituted, where possible.

3.9.3. Any untoward incidents related to seclusion and restraint should be noted and recorded in the clinical progress notes.

Roles and Responsibilities

4. The Mental Health Practitioner must:

4.1. Ensure the safety of all mental health care users that are admitted at the mental health facility.

4.2. Explain the seclusion process to the mental health care user or his/ her family members and if possible get their consent for the seclusion of the mental health care user.

4.3. Ensure that the period of seclusion and restraint must be limited to a minimum time required to remove the risk.

4.4. Terminate the seclusion and mechanical restraint once the indication of harm for risk have ceased

Review and Distribution

5. The Programme Director for Mental Health Care is the responsible manager for this Policy and for ensuring it is reviewed and updated.

6. This policy will be reviewed after 3 year but no later than 5 years after the last publishing date. If necessary an updated version will be issued, if not a formal cover letter will be issued to supplement the cover of this Policy (identifying a revised publication date).

7. The Director for Policy & Planning will distribute updated versions to:

   - Member of the Executive Council for Health
   - Head of Department of Health
   - All Chief Directors, Directors and Deputy Directors (who will in turn distribute to their staff as appropriate.)
   - The Chairperson(s) of the Mental Health Review Board(s)

Acknowledgements and Sources

This Policy is based on the requirements of the following legislation:

- Mental Health Care Act (No. 17 of 2002)
- Mental Health Care Act General Regulations (2003)
- Policy and Guidelines on 72-Hour Assessment of Involuntary Mental Health Care Users. National Department of Health (2012)
- Patient Rights Charter