State of Iowa Department of Corrections
Policy and Procedures

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Chapter 10: Forensic Psychiatric Hospital
Sub Chapter: Treatment
Related DOC Policies: FPH-31, HSP-720, IO-SC-08
Administrative Code Reference: 481
Subject: Use of Seclusion
PREA Standards: NA
Responsibility: Warden Mike Heinricy, Dr. Theresa Clemmons
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Authority:

1. PURPOSE

The purpose of this policy is to describe the use of seclusion and the procedures that need to be followed in order to comply with national standards of care.

2. POLICY

To ensure that the use of seclusion is appropriately utilized, assessed properly, medically authorized, proper notifications are made, reassessed, released, documented and debriefed in accordance with nationally accepted standards of care. Seclusion may be utilized when less restrictive interventions have been determined to be ineffective and discontinued at the earliest possible time, balanced with the continuing need to effectively protect the patient and/or others from harm.

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3. DEFINITIONS - As used in this document:

Seclusion - The confinement of a person in a locked room.

4. PROCEDURE

A. Acceptable Uses of Seclusion

1. A patient may be so impaired and/or assaultive that the use of seclusion is required to reduce the risk of injury or harm to the patient and/or others.

2. Seclusion may be used when alternative measures, time and circumstance permitting, have been tried and failed. (See **HSP-720**, *Health Care Restraints* for alternatives, communication and de-escalation techniques).

B. Initial Assessment

Prior to the use of seclusion or within one hour following the immediate need to place a patient in seclusion, a member from the medical staff (Physician, Psychiatrist, Registered Nurse) will conduct a face-to face assessment. This assessment will include:

1. The behavior that warrants the use of seclusion.

2. The patient's immediate situation and location.

3. The patient's reaction/response to seclusion, if implemented.

4. The patient's medical or psychiatric conditions.

5. Any alternative interventions that have been utilized and/or failed in an attempt to avoid the use of seclusion.

6. The need to continue or terminate seclusion.

C. Orders and Notifications for the Use of Seclusion

1. A Physician's verbal, telephone or written order will be obtained prior to or within one hour after the placement of a patient in seclusion.

2. All seclusion orders shall be for the least amount of time necessary to prevent injury to the patient or others.

3. In some situations, MHO or SSIP order will accompany the order for seclusion.

4. Maximum initial duration of seclusion is up to 24 hours.

5. With each new order for seclusion, a new face-to-face assessment by a Physician or a Registered Nurse is required. If a Physician is available, the Physician must complete the face-to-face assessment.

6. All orders received verbally or by telephone must be signed by the Attending Physician on the next working day. This will include date and time of signature.

7. Seclusion orders must include

    a. Date/time of order.

    b. Reason for use.

8. The Shift Supervisor will be informed of all patient placements in seclusion.

D. Seclusion of Patients

1. When placed in seclusion, the patient will submit to a pat down search, ensuring the patient does not have property on his/her person. Shoes and belts will not be allowed while in seclusion.

2. If clothing is tampered with or destroyed while in seclusion, they may be removed and replaced with an alternative. This will be documented, and Physician notified.

3. Patients in seclusion will be given a mattress and blanket unless their behavior warrants otherwise. If the mattress and/or blanket are not

allowed, an entry in the unit log and a physician order must be entered in the patient's record.

4. Flex trays and flex utensils are to be used for serving hot meals to patients in seclusion.

5. Patients in seclusion will be given an opportunity to shower every other day.

6. Any observations by staff of changes in the patient's physical condition and/or mental status or behavior will be reported immediately to the appropriate medical staff.

E. Reassess the Use of Seclusion

1. A nursing assessment must occur to determine when the patient can safely be removed from seclusion. A thorough reassessment including vitals must occur and be documented every shift.

2. Any changes found during reassessments are to be communicated to the physician to make any appropriate changes to the existing order.

3. At 24 hours, the Physician or Registered Nurse is to provide a face-to-face assessment and determine the need for a new order which justifies the ongoing use of seclusion.

F. Release from Seclusion

1. After a documented assessment of the patient status, Physicians, Medical Practitioners, and Registered Nurses have the authority to discontinue seclusion. After removal from seclusion, the physician and Shift Supervisor will be notified.

2. A debriefing with the patient should be conducted within 24 hours following the release from seclusion.

G. Documentation

1. The written order for seclusion will be made and signed by the Physician by or on the next administrative day.

2. Security staff will make an entry in the unit log. These entries should be as detailed and specific as to the behavior that justified the action taken.

3. Checks will be completed by security staff at a minimum of every 15 minutes when a patient is in seclusion. These checks will be documented on the *Observation/Restraint/Seclusion Log* **(FPH-31 F-1)** by security staff. They will include:

    a. Meals served or refused at all regularly scheduled mealtimes.

    b. Toilet was available and toilet used when an offender completes this activity.

    c. Water was provided at least every hour in the event an offender does not have continuous access to water.

4. Nursing shall document their initial assessment and all reassessments every shift.

5. If a physician is available, they are expected to provide the face-to-face assessment establishing the need for seclusion. This is documented in the hospital medical record. If the Physician is not available, the Registered Nurse shall provide the assessment.

6. Physician/Medical Practitioner and/or nursing staff are to be notified of any significant changes in behaviors and/or concerns that are noted by staff while in seclusion.

7. When seclusion is discontinued, a note will be made by Registered Nurse.