

Use of seclusion in psychiatric setting



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Dilemmas in patient care are an inevitable outcome of nursing accountability. Nurses struggle to balance their responsibility to protect patients rights with their obligation to prevent harm to patients and staff. Coercive treatments such as seclusion are one of those common practices in psychiatric settings which involve ethical dilemma and places nurses in question. The Code of Practice (2008), defines seclusion as “ the supervised confinement of a patient in a room, which may be locked, to manage disturbed behavior, which is likely to cause harm to others.” In socio-cultural context, seclusion is considered as one of the most ethically and legally controversial practice. In western society, taking a client-centered approach, patient’s dignity and autonomy are given more importance as compared to Eastern society, where healthcare professionals are considered authoritative and given rights to do what is best for patients (Firoozabadi & Bahredar, 2009). However, in our society, nurses are expected to respect patient’s rights and treat them with dignity and not like an object (Videbeck, 2010).

The reason for selecting this topic is that being a nursing student, I found seclusion as an inhumane and highly coercive practice and felt that integration of theory and clinical skills performance is easier but application of ethical principles in nursing care is difficult. Since, seclusion is a matter conflicting between patient’s rights and safety, therefore this issue is of great concern for mental health nurses. This paper will elucidate the practice of seclusion, its impact on patient’s mental health, interventions during seclusion and alternatives to seclusion.

At Karwan-e-Hayat, I encountered a 36 years old male schizophrenic patient. Another male patient with same diagnosis was newly admitted in the

hospital. Both shared the same room. The newly admitted patient, having a history of violence and being in the acute stage of disease, showed aggression towards that patient. Several times he tried to block his way and seize his neck. The nursing staff shifted the victim to another ward room and restrained the violent patient along with antipsychotic medication to calm him. Even after restraining, the patient showed several attempts of inflicting harm to other patients. Therefore, the aggressive patient was secluded by the staff for few hours and then released. As a result, the secluded patient developed anger and fear towards nursing staff.

From the analysis of the above scenario, it is evident that seclusion was done to control patient's aggressive behavior but, this brought negative feelings in patient related to staff and the treatment. Moreover, according to Happell & Koehn (2011), seclusion has negative psychological outcomes on patients including feelings of anger towards staff, powerlessness, sensory deprivation, disempowerment, humiliation, feelings of rejection, fear of confined spaces and they also associate seclusion with punishment. All these are found to deteriorate patient's psychosocial functions and worsen symptoms of mental illness (Seo et al, 2012). However, other studies have shown seclusion as a safe environment in which patients regain control over their own actions and promote mental health (Happell & Koehn, 2011). Supporting this view, there are three underlying therapeutic principles for the use of seclusion which are containment, isolation and decrease in sensory input. Containment refers to restriction of patients to a place where they are safe from harming themselves and others. The isolation and decrease in sensory input are regarded as providing relief from distress

generated through interpersonal interactions and a heightened sensitivity to external stimulation. (Stuart, 2009).

In contrast, Boyd (2008) reported that during seclusion patient's trust and dignity is violated, constituting a humiliating breach of patient's rights and poses an ethical dilemma. Considering seclusion as an ethical dilemma, there is a four quadrant approach -an ethical framework proposed by Jonsen et al., (1982, as cited in Schumann & Alfandre 2008), describing elements to be considered while encountering an ethical issue. The four quadrants are medical indications, patient preferences, quality of life and contextual features (refer appendix 1). Medical indications includes patient's medical problems, history and treatment options. Underlying this quadrant are the ethical principles of beneficence and non-maleficence. Beneficence means doing good and non-maleficence means not to inflict harm. Together, these principles help in deciding which option is most beneficial and poses less harm. Relating this to above scenario, the decision to use seclusion was due to the patient's acute illness and history of violence. Initially restraining made the patient more aggressive, due to which seclusion was done at last. Here, seclusion was considered beneficial to prevent harm to other patients. Second quadrant focuses on the patient's current preferences if the patient is mentally competent and his presumed wishes if incompetent, representing the principle of autonomy. However, in our scenario the patient was mentally ill and had uncharacteristic behavior, so his preferences were not taken into account. Patient's anger towards staff and treatment indicates that seclusion was against patient's wish. Here, patient's autonomy was overridden by the principles of beneficence and non-maleficence. Third quadrant is quality of

life. Since the meaning of quality of life varies among individuals, clinical team needs to consider patient's choice as a guide to what best defines quality of life for that patient. All three abovementioned principles embody this quadrant. Autonomy here implies patient's judgement of his own quality of life. In our case, the intervention of seclusion deteriorated patient's state of mind. The patient showed fear, distrust and dissatisfaction with treatment. The last quadrant- contextual features include patient's cultural, religious, family and legal factors that can influence treatment decision. In our scenario, legal factors did have an impact over the issue. Viewing this case in the light of legal framework Code of Practice (2008), section 118; it says that "seclusion should be used only as a last resort. Decision to use seclusion is entirely a matter of professional judgement based on knowledge of patient and his inclination to inflict injury to others." (p. 123).

Furthermore, if seclusion becomes necessary then it is important that throughout the seclusion the patient receives a high level of nursing care in a way which maintains his dignity. The legal framework obligates nurses to help patient meet biological needs by providing food and fluids, a comfortable environment and opportunity for the use of toilet. Besides this, frequent monitoring, observation and assessment of secluded patient's behavior, conditions and vital signs with proper documentation at least every 15 minutes, are also essential. Documentation entails whole incident and reason of seclusion, care given during seclusion, patient's response and assessment of further need of seclusion. Debriefing before and following seclusion is most important for staff and patient to clarify the rationale for

the seclusion, offer mutual feedback and identify alternative coping methods that might help the patient avoid seclusion in the future.

Since, seclusion is last option, there remains a need to use some least restrictive or alternative measures before going for the final decision to seclude. These include environmental manipulation, de-escalation technique, assessment, increased observation and pharmacological management (Petit, 2005). Manipulating environment involves reducing the stimulation from the environment after thorough assessment of patient's triggering factors, patient comfort (offering the patient chair or a glass of water to calm him/her down) and staff attitude (giving respect and time to the patient instead of shouting on the patient) (Ramadan, 2007). De-escalation or talking down involves psychosocial techniques aimed at calming the patient emphasizing on the assessment of the immediate situation, verbal and non- verbal communication and problem solving strategies (Davison, 2005). Staff needs to assess and observe patients' disturbed behavior frequently before they pose any risk to other patients. For this, staff to patient ratio needs to be increased. Moreover, there is an immense need to have a policy of staff training about emergency psychiatric care, crisis management and therapeutic communication.

In conclusion, respect for patient's rights, dignity, autonomy, and safety are important aspects of providing care in the mental health field. Since the practice of seclusion is still controversial issue and reflects ethical dilemma, therefore, we cannot come to a single conclusion. It is recommended that autonomy and dignity of clients should remain paramount at all times.

Seclusion should be considered only as a very last resort for ensuring safety

and if it is to be used then all the guidelines given by the Mental Health Act Code of Practice should be followed to ensure the improvement of client's mental health rather than deterioration. Staff training, de-escalation, ...???

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Alternatives: prior to initiating restraint and seclusion, alternative techniques must be attempted. These may include asking the patient to stop the dangerous behavior, reducing the stimulation in the environment or offering medication to help the patient calm down. If alternatives fail and seclusion becomes necessary, the least restrictive method that contains the dangerous behavior should be used. (Aghababian, 2010).

Express your empathy and concern; statements such as, " I understand you are feeling frustrated, that you're having a hard time", and " you're here to get help, let's try to figure out what's going on", convey both. Emphasize that they are safe, that the staff is there for them. However, you also need to clearly define limits for patient behavior, and consequences of their actions. Provide reasonable alternatives to aggressive behavior. http://www.osuem.com/downloads/m_m/Violent_Patient-1.pdf Manipulating one's work environment to maximize safety and understanding how to de-escalate potentially mounting violence are two steps in the approach to the violent patient. Restraint, seclusion, and psychopharmacologic interventions also are important and often are necessary components to the management of the violent patient. <http://www.ispub.com/journal/the-internet-journal-of-emergency-medicine/volume-4-number-1/managing-psychiatric-emergencies.html#sthash.vpPx0wzB.dpbs> The next step would be rapid

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tranquillization using emergency medications that have the benefits of reducing the agitated and psychotic state. wide variety of classes of medications has been reported to be effective in the treatment of agitation. However, benzodiazepines and typical or atypical antipsychotics are the main classes widely used.

Code of practice... All hospitals should have a policy on training of staff who work in areas where they may be exposed to aggression or violence.

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legal factors that can influence treatment decision. Relating this approach to the above described scenario, the decision to use seclusion was due to the patient's disease condition and history of frequent violence with other patients. It is obvious that to be kept in seclusion was not patient's wish or preference. As far as the quality of life is concerned, in this scenario the intervention of seclusion deteriorated patient's state of mind. It was noted that the patient showed anger and fear towards staff and was dissatisfied with the treatment. Furthermore, legal factors did have an impact over the issue in our scenario. Viewing this case in the light of legal framework Code of Practice (2008), section 118; it says that " seclusion should be used only as a last resort. Decision to use seclusion is entirely a matter of professional judgement based on knowledge of patient and his inclination to inflict injury to others."

Relating this approach to above scenario, the decision to use seclusion was due to the patient's acute illness and history of violence. The initial use of restraint made the patient more aggressive, due to which seclusion was done at last. Here, seclusion was considered beneficial to prevent harm to other patients. Since, the patient was mentally ill and had uncharacteristic behavior, so his preferences were not taken into account. Patient's anger towards staff and treatment indicates that seclusion was against patient's wish. Here, patient's autonomy was overridden by the principles of beneficence and non-maleficence. As far as the quality of life is concerned, the intervention of seclusion deteriorated patient's state of mind. The patient showed fear, distrust and dissatisfaction with treatment. Furthermore, in our scenario, legal factors did have an impact over the issue.

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References

Aghababian, R. V. (2010). Essentials of emergency medicine. (2nded.). London: Jones &

Bartlett. ???

Boyd, M. A. (2008). Psychiatric nursing: Contemporary practice. (4thed.). New York, NY:

Lippincott Williams &Wilkins.

Code of Practice Mental Health Act (2008). Department of Health. Retrieved from

[http://www. dh. gov.](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/document)

[uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/document](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/document)

[s/digitalasset/dh_087073. pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/document)

Davison, S. E., (2005). The management of violence in general psychiatry.

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Psychiatric Treatment, 11(3), 362-370. doi: 10. 1192/apt. 11. 5. 362

Firoozabadi, A., & Bahredar, M. J. (2009). Coercive therapy in east and west: A brief review.

Iranian Journal of Psychiatry, 4(2), 44-45. Retrieved from

http://journals.tums.ac.ir/upload_files/pdf/_/14227.pdf

Happell, B., & Koehn, S. (2011). Impacts of seclusion and the seclusion room: Exploring the

perceptions of mental health nurses in Australia. Archives of Psychiatric Nursing,

25(2), 109-119.

Kuosmanen, L. (2009). Personal liberty in psychiatric care towards service user involvement

1-66. Retrieved from

[https://www.doria.](https://www.doria.fi/bitstream/handle/10024/43990/AnnalesD841Kuosmanen.pdf)

[fi/bitstream/handle/10024/43990/AnnalesD841Kuosmanen.pdf](https://www.doria.fi/bitstream/handle/10024/43990/AnnalesD841Kuosmanen.pdf)

OR ???

Kuosmanen, L., Hatonen, H., Malkavaara, H., Kylma, J., & Valimaki, M. (2007).

Deprivation

of liberty in psychiatric hospital care: the patient's perspective. Nursing Ethics, 14

<https://assignbuster.com/use-of-seclusion-in-psychiatric-setting/>

(5), 597-607.

Petit, J. R. (2005). Management of the acutely violent patient. *Psychiatric Clinics of North*

America, 28, 701-711. doi: 10. 1016/j. psc. 2005. 05. 011

Quinn, G., & Degener, T. (2002). *Human rights and disability*. New York, NY.
Retrieved

from <http://www.ohchr.org/Documents/Publications/HRDisabilityen.pdf>

Ramadan, M. I. (2007). Managing psychiatric emergencies. *The Internet Journal of*

Emergency Medicine, 4(1), 41-48. doi: 10. 5580/291d

Schumann, J. H., & Alfandre, D. (2008). Clinical ethical decision making: The
Four topics

approach. *Seminar in Medical Practice*, 11, 36-42. Retrieved from

http://www.turner-white.com/memberfile.php?PubCode=smp_dec08_ethical.pdf

Seo, M. K., Kim, S. H., & Rhee, M. K. (2012). Coercion in psychiatric care: Can
paternalism

justify coercion? *International Journal of Social Psychiatry*, 1(1), 1-7. doi:

10. 1177/0020764011431543

<https://assignbuster.com/use-of-seclusion-in-psychiatric-setting/>

Videbeck, S. L. (2010). Psychiatric-Mental health nursing. (5thed.). New York, NY:

Lippincott Williams & Wilkins.