Hong Kong Journal of Emergency Medicine

A retrospective study of seclusion in an emergency department
在急症室隔離病人的一個回顧性研究

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Objectives: To study the practice of seclusion in an emergency department (ED) and to explore high-risk elements during seclusion. ***Methods:*** The study consisted of two parts: an in-depth analysis on all incidents associated with seclusion in a six-year period (1998-2004) and a two-year (2002-2004) retrospective analysis of secluded patient records to understand the rationale and patient outcome. ***Results:*** *Part 1:* A total of 9 incident records were collected. Four patients were related to setting fire. Five patients had violence or threat of violence. The median length of stay (LOS) in seclusion at the time of incident was 129 minutes. Although 66.7% of the patients had additional restraint prior to the seclusion, incidents still occurred. Two staff sustained injuries and hospital facilities were damaged in some of the incidents. Six patients were later admitted to psychiatric hospital. *Part 2:* 141 patient data were collected in the study (M: 89 and F: 52). The average monthly number of patients secluded was about 6. The mean age was 45 years (SD 19) and the mean LOS was 616 minutes (SD 478). There were three incidences (2.1%) during the two-year period. A total of 82 patients (58.2%) were associated with violence or threat of violence and 38 (46.3%) of the group had psychiatric illness; and 50 patients (35.5%) were associated with alcohol or drug intoxication. Ultimately, 56 patients (39.7%) were admitted to psychiatric hospital and 64 patients (45.4%) were treated and discharged from the ED. ***Conclusion:*** Seclusion is a high-risk practice. In our department, the most frequent indication was violence (58.2%), with nearly half of them having history of psychiatric illness. Psychiatric illness had the highest risk for incidents, especially those with violence or threat of violence. The LOS in seclusion was relatively long in the ED and might be one of the risk factors for incidents. Inadequate removal of potentially dangerous belongings from patients before seclusion may end up with catastrophic outcomes. Curiously, ED nurses are not allowed to search patients before seclusion. They are exposed to legal liability in exercising restraint and in searching for potentially dangerous items from patients. It is suggested that clear protocols and quality assurance programs should be instituted to ensure safe seclusion. (*Hong Kong j.emerg.med.* 2005;12:6-13)

目的：研究在急症室隔離病人的做法及探索隔離時的高危要素。**方法：**這研究由兩部份組成。一個六年內（1998-2004）所有有關隔離事故的深入分析及一個兩年的（2002-2004）隔離病人記錄回顧性分析，旨在了解其邏輯依據及病者的結局。**結果：**第一部份：共收集得 9 個事故記錄，其中 4 個是關於縱火，5 個病者有暴力行為或恐嚇使用暴力。事故發生時隔離時間的中位數為 129 分鐘，雖然 66.7% 病者隔離前有額外的約束措施，但事故仍然發生。其中有兩名員工受傷，而醫院的設備在一些事故中受損。 6 名

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病者事後被送進精神科醫院。第二部份：這研究收集得 141 名病人的數據（89 男及 52 女）。每月平均被隔離的人數大約為 6 名病人，年齡的平均值為 45 歲（標準差 19），及停留時間的平均值為 616 分鐘（標準差 478）。於這兩年期內，發生了 3 宗事故（2.1%）。共有 82 名病人（58.2%）有暴力行為或恐嚇使用暴力，當中 38 名病人（46.3%）有精神病，50 名病人（35.5%）與酒精或藥物中毒有關。最後，56 名病人（39.7%）被送進精神科醫院而 64 名病人（45.4%）經急症室治療後可以離院。**總結**：隔離病人是一種高危做法。在我們的部門中，最常見的適應症為暴力行為（58.2%），而其中接近一半病人有精神病的病歷。精神病有最高的事故風險，尤其是有暴力行為或恐嚇使用暴力的病人。在急症室隔離的時間相當長，這可能是導致事故其中之一的風險因素。隔離前沒有充份地從病人身上取去有潛在危險性的物品，亦可引致災難性的後果。奇怪地，急症室的護士是不被准許在隔離前搜查病人的，他們在執行約束措施及搜查病人身上潛在危險性物品時會涉及法律責任。建議應該制定清晰的規則及品質保証程序，以保証隔離病人的安全。

Keywords: Hospital emergency service, legal liability, patient isolation, physical restraint, violence

關鍵詞：醫院緊急服務、法律責任、隔離病人、約束身體的措施、暴力

Introduction

Seclusion of patient is the hospital equivalent of solitary confinement, and may be regarded as one form of physical restraint. It is a common practice in emergency departments (ED) in Hong Kong.[1-3] However, nurses may be in a dilemma when making such a decision because of professional, ethical and legal liabilities.[4,5] Koo et al suggested that seclusion rooms should be considered in the design of a new ED in Hong Kong for the safety of violent and other patients.[6] On the other hand, ED staff view seclusion and restraint as high risk procedures.[7] Evans et al reported increasing safety concern on the use of physical restraint in health care and a growing number of articles had reported a range of different injuries as the result of restraint use and suggested that restraint-related injuries might be under-reported. The use of restraint in the acute care setting might increase the risk of adverse outcomes, including death, falls, infection and prolonged hospitalisation.[8,9] Some hospitals have been found liable for unjustified seclusion and restraint.[2,9-11] In fact, the act may engender serious legal implications to hospital staff such as unlawful detention and unlawful body search, with respect to the Basic Laws of Hong Kong (The freedom of the person of Hong Kong residents shall be inviolable. No Hong Kong resident shall be subjected to arbitrary or unlawful arrest, detention or imprisonment. Arbitrary or unlawful search of the body of any resident or deprivation or restriction of the freedom of the person shall be prohibited. Torture of any resident or arbitrary or unlawful deprivation of the life of any resident shall be prohibited).[12]

The Accident and Emergency Department of the North District Hospital opened on 6th August 1998. The ED serves a population of about 300,000 with an average daily attendance of about 300. There are two seclusion rooms in the ED. Each room is about 3.5 meters long and 2 meters wide, padded with soft materials on the floor and walls. A system of closed circuit TV and nurse call button has been installed in each room for patient monitoring and communication. According to the hospital policy, doctor or nurse in-charge can initiate patient restraint in an emergency situation.[13] However, a few incidents have resulted from the seclusion. Therefore a study was conducted to obtain an idea of the practice of seclusion in the ED, to detect high-risk elements during seclusion, and to explore measures to ensure safe seclusion.

Methods

The study consisted of two parts. The first part was an in-depth analysis of all recorded incidents in the

seclusion rooms for a six-year period from August 1998 to August 2004 in order to identify the details of the seclusion and the reasons for the incident occurrence. Data extracted included sex, age, date, indication and purpose of seclusion, mode and nature of restraint, length of stay (LOS) at the time of incident, total LOS in the room, nature of incident and patient's final outcome.

The second part was a retrospective analysis of all patients put inside the seclusion rooms in order to study the rationale for seclusion in the ED. Data were retrieved from the hospital Accident & Emergency Information System (AEIS) computerised database, for a two-year period from July 2002 to June 2004. Data extracted included sex, age, indication and purpose of seclusion, mode and nature of restraint, LOS in the room, patient's final outcome and number of incidents.

Descriptive statistics were used for data analysis.

Results

Part 1

There were a total of 11 incidents in the six-year period since the opening of the ED on August 6, 1998. However, two patient records were missing. One incident occurred in 2000 in which a nurse sustained minor injury after being kicked by a drunken patient. The other incident occurred in 2001 in which a psychiatric patient broke the ceiling lamp cover with her shoes. These two cases were excluded from further analysis. For the remaining patients, there were 6 males and 3 females. The mean LOS in seclusion at the time of incident was 285 minutes (median 129, range 84-601) while that for total LOS in seclusion was 449 minutes (median 279, range 118-998). The mean age was 46 years (median 42, range 31-79). Two patients disappeared right after the incidents. The case particulars are summarised in Table 1. The indications for seclusion are illustrated in Table 2. The main indication was psychiatric illness (77.8%). Five

Table 1. Incident details (1998-2004)

Case	Year	Sex/Age	LOS (min.)		Diagnosis	Mechanical restraint	Chemical restraint	Outcome	Remark
			@ incident	Total					
1	1999	M/48	118	118	Drunk	Limbs	No	Disappeared	Broke smoke detector system
2	1999	F/39	129	129	Mental	No	No	Disappeared	Ran away while waiting psychiatric admission
3	1999	M/31	459	555	Mental	Safety vest	No	Admitted Psychiatric	Staff sustained injury while restraining patient
4	2001	F/35	601	687	Mental	No	Yes	Admitted Psychiatric	Burnt door. Staff sustained injury while restraining patient
5	2002	M/42	84	279	Mental	Limbs	No	Admitted Psychiatric	Burnt triangular bandage and bed sheet
6	2002	M/57	105	215	Mental	Limbs	Yes	Admitted Psychiatric	Broke into ceiling. Police and fireman called for assistance
7	2003	M/79	121	216	Confusion Hypo K^+	No	No	Admitted Medical	Burnt door
8	2003	M/35	580	998	Mental	No	No	Admitted Psychiatric	Broke smoke detector system, wall and door
9	2004	F/50	369	845	Mental	No	Yes	Admitted Psychiatric	Burnt blanket

Legend: Hypo K^+=hypokalaemia; LOS=length of stay

Table 2. Indications for seclusion

	I. Incident cases	II. 2-year study
Patient's background before seclusion	**No. of patients**	**No. of patients**
Psychiatric illness with violence or threat of violence	4 (44.4%)	38 (27.0%)
Psychiatric illness without violence or threat of violence	3 (33.3%)	23 (16.3%)
Alcohol or drug intoxication with violence	1 (11.1%)	31 (22.0%)
Alcohol or drug intoxication without violence	1 (11.1%)	19 (13.5%)
Acute organic brain syndrome with history of psychiatric illness		5 (3.5%)
Acute organic brain syndrome without history of psychiatric illness		12 (8.5%)
Violence without history of psychiatric illness		13 (9.2%)
Total	9 (100%)	141 (100%)

patients (55.6%) had violence or threat of violence. The modes of restraint are illustrated in Table 3. Six patients (66.7%) had mechanical and/or pharmacological restraint prior to seclusion. Five patients (55.6%) were waiting for the completion of formalities for admission to psychiatric hospital (Table 4).

In one case (Case 1), a drunken patient used his waist belt and broke the ceiling smoke detector system. This activated the automatic fire alarm and water sprinkler system and caused water flooding in the whole department. As a result, ambulances were diverted to other ED for about two hours, in order to allow the department to clean up the water.

Two ED staff sustained injury while restraining the mental patients (Case 3 and 4). Case 6 was a mental patient with limb and pharmacological restraints, but he could still manage to jump inside the false ceiling of the seclusion room and refused to come down. Finally, on a nursing officer's request, policemen and firemen broke the false ceiling and recovered the patient.

Four patients (2 men and 2 women) used lighters to set fire inside the rooms. They burnt the room doors, limbs holders, bed sheet or blanket. A supporting staff sustained injury while restraining the patient in one of the fire-setting incidences. Notably, three of the

Table 3. Modes of restraint

	I. Incident cases	II. 2-year study
Type of restraint used	**No. of patients**	**No. of patients**
Seclusion only	3 (33.3%)	78 (55.3%)
Seclusion & mechanical	3 (33.3%)	24 (17.0%)
Seclusion & pharmacological	2 (22.2%)	25 (17.7%)
Seclusion & mechanical & pharmacological	1 (11.1%)	14 (9.9%)
Total	9 (100%)	141 (100%)

Table 4. Initial purposes for seclusion

	I. Incident cases	II. 2-year study
Purpose	**No. of patients**	**No. of patients**
Observation only	2 (22.2%)	50 (35.5%)
Observation & psychiatric consultation	2 (22.2%)	74 (52.5%)
Waiting for psychiatric admission	5 (55.6%)	17 (12.1%)
Total	9 (100%)	141 (100%)

patients (75%) were under pharmacological and/or mechanical restraints. Eventually, three (75%) were admitted into psychiatric hospital.

Part 2

For the two-year period from July 2002 to June 2004, 141 patients were secluded as recorded in the AEIS. There were 89 males (63.1%) and 52 females (36.9%). The average number of patients secluded in our ED was about 6 per month. The indications for seclusion are illustrated in Table 2. The age range of 140 patients (one unknown) was from 14 to 92 years and the mean was 45 years (SD 19). The LOS ranged from 20 to 2,448 minutes and the mean was 616 minutes (SD 478). There were three recorded incidents (2.1%) during the period. Eighty-two patients (58.2%) were secluded for violence or threat of violence, and 38 out of the 82 violent patients (46.3%) had history of psychiatric illness. Seventy-five patients (53.2%) had no history of psychiatric illness. Fifty patients (35.5%) were associated with alcohol or drug intoxication.

Table 3 shows that 63 patients (44.7%) had mechanical and/or pharmacological restraints. The initial purposes for seclusion are illustrated in Table 4. The outcomes of the patients are shown in Table 5. A total of 64 patients (45.4%) could be treated and discharged from the ED.

Discussion

No ED can avoid restraint or seclusion in emergency or potentially dangerous situations. It is a relatively frequent practice in emergency.[14] However, such action may engender risks to patients, hospital staff and the management. It violates principles of beneficence (doing good) and non-malfeasance (doing no harm). The use of restraint in psychiatry as well as in health and social care are controversial.[14,15] Patients can only be restrained on clinical grounds, when there are imminent threats of harm to self or others, whether inadvertent or deliberate. On the other hand, failure to restrain resulting in bodily harm can be liable to medical or nursing negligence. There may be clinical, ethical, medicolegal, occupational health and safety, infection and financial implications.[2] There are always staff anxiety, dilemma, and conflicts for potential patient injury.[3,4] Hospital staff have been found liable for both using (false imprisonment, battery) and not using restraint (negligence, abandonment).[2,4,16] However, cases in which providers were held liable for the absence of restraint have been far outweighed by cases of liability involving the use of physical restraint.[16]

Consequently, reduction in the use of restraints has become the direction of many hospitals, to minimise risks and to show respect to patient's dignity.[2,3,15,16] The Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) stated their standards for the use of restraint as follows: (i) The patient has the right to be free from restraints or seclusion or any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff. (ii) A 'restraint' can only be used if needed to improve the patient's well-being and less restrictive interventions have been

Table 5. Final outcomes of patients (2-year study)

Patient outcome	No. of patients
Discharge	44 (31.2%)
Discharge with emergency department follow-up	20 (14.2%)
Admission to psychiatric hospital, involuntary	29 (20.6%)
Admission to psychiatric hospital, voluntary	27 (19.1%)
Referral to another hospital for psychiatric consultation	1 (0.7%)
Admission to own (general) hospital	12 (8.5%)
Discharge against medical advice	5 (3.5%)
Disappearance	3 (2.1%)
Total	141 (100%)

determined to be ineffective. (iii) The use of restraint must be in accordance with the order of a physician or other licensed independent practitioner, and never written as a standing [or as needed] order. (iv) The condition of the restrained patient must be continuously assessed, monitored and reevaluated.[4,9] The Joint Commission on Accreditation of Healthcare Organizations stated their goal as follows: "To create a physical, social, and cultural environment limiting restraint and seclusion use to clinically appropriate and adequately justified situations or that actually reduces its use through preventive or alternative strategies".[2] Restraint should only be used as a last and limited resort.[2]

The monthly average of patients secluded in our ED was about 6 episodes. An ED in the USA reported a monthly average of seclusion of 22 episodes.[3] A study in Australia reported an overall estimated rate of restraint in its ED as 1.3 episodes per 1,000 visits,[1] and that of our ED was around 0.6. The results showed that the rate of seclusion in our ED was relatively low. However, the result might have been under-reported since some secluded patients might not be registered in the AEIS.

The LOS of seclusion ranged from 20 minutes to 40 hours 48 minutes in our ED. The mean was longer than 10 hours. In a six-year study in an UK psychiatric hospital, the mean LOS for seclusion was only 1 hour 29 minutes (range 15 minutes to 12 hours 10 minutes).[17] Incidents occurred in 2.1% of our seclusion in the study period. Seclusion and restraint have adverse physical, physiological, psychological, pathological, and infectious effects on patients. It is important to ensure that the patient's physiological and psychological needs are adequately attended to. The patient should be closely monitored and the need for restraint should be reassessed at specific time intervals, to be terminated as soon as possible.[2,7] One of our patients was secluded for more than 40 hours. Nurses should be aware that the longer the seclusion, the higher the risk to the patient, and subsequently to the staff. Physical well-being should be preserved through adequate exercise, nourishment, and personal care at least every four hours in adults.[7]

Concerning the indication of restraint, a report on Australasian ED restraint practices revealed that the most frequently cited indication for restraint was violence or potential violence cases (52%). Psychiatric illness was the second commonest indication (32%) and there was only 4% drug or alcohol intoxication in the report.[1] In our department, the most frequent indication was also violence (58.2%), with nearly half of them having history of psychiatric illness. Sixty-six secluded patients had psychiatric illness (46.8%) and 50 patients had alcohol or drug intoxication (35.5%). Most of our incidents involved psychiatric patients (77.8%), especially those with violence or threat of violence (44.4%). There may be potential conflicts among ED medical and nursing staff in the perception of the patient's best interest.[18] Therefore, a clear seclusion/restraint guideline or protocol to facilitate staff decision and to ensure staff/patient safety is necessary.

Our result showed that restraints were frequently used in addition to seclusion. The use of restraint in the acute care setting might result in adverse outcomes, including death, asphyxiation, falls, fractures, nerve injuries, vascular injuries, infection and prolonged hospitalisation. Multiple restraint devices may increase the risk.[8] In general, medication is preferable to prolonged mechanical restraint.[15] Staff should be educated and properly trained in the application of restraints, and manufacturers' recommendations must be followed.[8] The patient should be closely monitored and the need for restraint should be reassessed at specific time intervals. The restraint should be adjusted and the position changed periodically, to be discontinued as soon as possible.[2,7] Remember that patient has the right to be free from restraints at the earliest moment, when the need no longer exists.[9,10,19] One report stated that 65.6% of the nurses were unsure on how to care for a restrained patient.[16,20] Staff should be educated to understand the underlying principles and to enhance their competency.[12,21] Knowledge of distraction technique and crisis intervention may reduce the need for seclusion or restraint.

However, despite the additional restraint measures, incidents still occurred. The design of the seclusion

room requires improvement, as the false ceiling and smoke detector system are potentially risky structures. Four incidents were due to fire, resulting from inadequate body search and the presence of flammable objects. One case used a waist belt to break the water sprinkler system. It is apparent that potentially dangerous patient belongings such as cigarette lighter and waist belt must be removed completely before seclusion. However, it is unimaginable that ED staff are authorised to seclude or restrain patients without consent but at the same time are not allowed to do body search which should be regarded as part and parcel of a safe seclusion process. In order to avoid unlawful body search, nurses should seek help from the police. Two patients escaped immediately after the seclusion room door was opened. These incidents might be prevented by higher staff vigilance and by summoning adequate staff for assistance before opening the door. A good video and audio system to monitor and communicate with the secluded patient might also help. As staff were injured in some of the restraining processes, adequate manpower as a team with proper skill training is necessary to ensure safe operations. One interesting phenomenon was that incidents still occurred even with additional restraints. This can only mean that the restraint was grossly inadequate or ineffective. The choice and dosage of sedatives have to be reviewed. The technique of mechanical restraint application has to be improved.

Seclusion is not a solution for inadequate manpower or time.[15] Patients should be individually assessed for adequate and appropriate clinical justifications, as well as for the safest, most effective and least restrictive method to be used.[7] Patients, relatives and staff should be well informed.[15] Patients should be constantly monitored. Most ED do not have enough manpower to ensure continuous observation, frequent assessment, and proper documentation.[10] Relatives are encouraged to stay with the patient in the seclusion room, if there are no contraindications. Continuous audio and visual monitoring, a window or a doorway are acceptable.[22] A new design of seclusion rooms providing a soft and warm environment can promote calmness, reduce stress and agitation and de-escalate potentially dangerous behaviour of patients.[7] Air sofa, floor mattress with blanket, warm wall stickers with lighting, music and patient communication system can enhance a safe and quality stay for patients under seclusion.

Audit on the use of restraints in ED was uncommon.[1] A quality assurance program or audit,[3] including review of proper documentation during seclusion and debriefing of staff and patient after application,[15] is indispensable to ensure the safety of both patients and staff.

Conclusion

Seclusion is a high-risk practice. In our department, the most frequent indication was violence (58.2%), with nearly half of them having history of psychiatric illness. The LOS of seclusion was relatively long in the ED and might be one of the risk factors provoking incidents, which occurred more frequently with psychiatric patients. Nurses are always exposed to legal liability in exercising restraint and in searching for potentially dangerous items from patients. It is suggested that clear protocols and quality assurance programs should be instituted to ensure a safe seclusion standard. Reduction of restraint and seclusion should be the ultimate goal and direction of the ED.

Acknowledgement

We would like to thank Ms Florence ML Yeung for coordinating the ED staff in collecting the two-year data and Ms KK Ma for entering all data into the computer. We would also like to express our appreciations to Ms WF Tang, Department Operations Manager (A&E), and all team members of our Quality Assurance Team for their effort in supporting the project.

References

1. Cannon ME, Sprivulis P, McCarthy J. Restraint practices in Australasian emergency departments. Aust N Z J Psychiatry 2001;35(4):464-7.

2. Kapp MB. Physical restraint use in critical care: legal issues. AACN Clin Issues 1996;7(4):579-84.
3. Emde K, Merkle S. Reducing use of restraints in the emergency department: one level III community hospital's experience. J Emerg Nurs 2002;28(4):320-2.
4. Lee G, Gurney D. The legal use of restraints. J Emerg Nurs 2002;28(4):335-7.
5. Marangos-Frost S, Wells D. Psychiatric nurses' thoughts and feelings about restraint use: a decision dilemma. J Adv Nurs 2000;31(2):362-9.
6. Koo YL, Lee DWS, Tong SL. A study on current practice of restraining violent patients in emergency department of Hong Kong. Hong Kong J Emerg Med 1998;5(1): 11-5.
7. Joint Commission on Accreditation of Healthcare Organizations. Comprehensive Accreditation Manual for Hospitals. Restraint and seclusion standards plus scoring: Standards TX.7.1 - T.X.7.1.3.3. Oakbrook Terrace, IL: JCAHO; 1996:191-193j.
8. Evans D, Wood J, Lambert L. Patient injury and physical restraint devices: a systematic review. J Adv Nurs 2003;41(3):274-82.
9. Annas GJ. The last resort--the use of physical restraints in medical emergencies. N Engl J Med 1999;341(18): 1408-12.
10. Blank FS, Keyes M, Maynard AM, Provost D, Santoro JP. A humane ED seclusion/restraint: legal requirements, a new policy, procedure, "psychiatric advocate" role. J Emerg Nurs 2004;30(1):42-6.
11. Dyer C. Unjustified seclusion of psychiatric patients is breach of human rights. BMJ 2003;327(7408):183.
12. The Basic Law of Hong Kong: Chapter III, Article 28. Fundamental rights and duties of the residents. [cited 2004 Dec 16]. The Hong Kong Special Administrative Region of the People's Republic of China. Available from: http://www.info.gov.hk/basic_law/flash.html
13. Hospital Authority medico-legal guidelines. Points to note on the use of restrainers. Hong Kong: Hospital Authority; 1995.
14. Guedj MJ, Raynaud P, Braitman A, Vanderschooten D. The practice of restraint in a psychiatric emergency unit. Encephale 2004;30(1):32-9.
15. Horsburgh D. How, and when, can I restrain a patient? Postgrad Med J 2004;80(939):7-12.
16. Martin B. Restraint use in acute and critical care settings: changing practice. AACN Clin Issues 2002; 13(2):294-306.
17. Savage L, Salib E. Seclusion in psychiatry. Nurs Stand 1999;13(50):34-7.
18. Maccioli GA, Dorman T, Brown BR, et al. Clinical practice guidelines for the maintenance of patient physical safety in the intensive care unit: use of restraining therapies--American College of Critical Care Medicine Task Force 2001-2002. Crit Care Med 2003; 31(11):2665-76.
19. Hellwig K. Alternatives to restraints: what patients and caregivers should know. Home Healthc Nurse 2000; 18(6):395-402.
20. Janelli LM, Scherer YK, Kuhn MM. Acute/critical care nurses' knowledge of physical restraints--implications for staff development. J Nurs Staff Dev 1994;10(1): 6-11.
21. Staten PA. Restraint, seclusion standards raise questions. Nurs Manage 2001;32(7):17.
22. Wynaden D, Chapman R, McGowan S, McDonough S, Finn M, Hood S. Emergency department mental health triage consultancy service: a qualitative evaluation. Accid Emerg Nurs 2003;11(3):158-65.