The Use of Safe Rooms for Inpatient Psychiatric Care: Clinical Effectiveness and Guidelines
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Acknowledgments:

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About CADTH: CADTH is an independent, not-for-profit organization responsible for providing Canada’s health care decision-makers with objective evidence to help make informed decisions about the optimal use of drugs, medical devices, diagnostics, and procedures in our health care system.
Research Questions
1. What is the clinical effectiveness of the use of safe rooms as part of inpatient psychiatric care?
2. What are the evidence-based guidelines regarding the use of safe rooms as part of inpatient psychiatric care?

Key Findings
Five non-randomized studies and two evidence-based guidelines were identified regarding the use of safe rooms as part of inpatient psychiatric care.

Methods
A limited literature search was conducted on key resources including Ovid Medline, PsycINFO, PubMed, The Cochrane Library, University of York Centre for Reviews and Dissemination (CRD) databases and a focused Internet search. No methodological filters were applied to limit retrieval by publication type. The search was limited to English language documents published between January 1, 2012 to September 27, 2017.

Selection Criteria
One reviewer screened citations and selected studies based on the inclusion criteria presented in Table 1.

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<th>Table 1: Selection Criteria</th>
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<td><strong>Population</strong></td>
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<td><strong>Study Designs</strong></td>
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Results

Rapid Response reports are organized so that the higher quality evidence is presented first. Therefore, health technology assessment reports, systematic reviews, and meta-analyses are presented first. These are followed by randomized controlled trials, non-randomized studies, and evidence-based guidelines.

Five non-randomized studies and two evidence-based guidelines were identified regarding the use of safe rooms as part of inpatient psychiatric care. No relevant health technology assessments, systematic reviews, meta-analyses, or randomized controlled trials were identified.

Additional references of potential interest are provided in the appendix.

Overall Summary of Findings

Five non-randomized studies (NRSs) were identified regarding the use of safe rooms or seclusion in psychiatric inpatient care. One study examined patient records in order to compare the outcomes of patients who were and were not managed using seclusion or admittance to a psychiatric intensive care unit (PICU). Patients who were managed using seclusion or the PICU were more likely to be aggressive after the intervention. The authors also found that other methods of containment, including tranquilization, were used in the absence of a seclusion room. Another NRS examined the records of patients who were involuntarily committed in order to assess the use of restraint and seclusion in a state-run psychiatric hospital. Over the 10 years of the study, the use of both seclusion and mechanical restraints were significantly reduced. The rates of patient-to-patient and patient-to-staff assaults did not change significantly during the same time period. Another NRS was conducted in a teaching hospital over a six month period and the authors determined that 9.1% of patients admitted to the psychiatric ward were secluded at some point during their stay. The majority of the seclusion incidents lasted two hours and most patients were secluded because of aggressive behaviours.

Two NRSs examined the use of a sensory or comfort room in an acute inpatient psychiatric unit. The sensory room included items meant to calm patients in distress. In the first study, patients who used the weighted blanket in the sensory room reported a significantly greater change in anxiety and distress compared with patients who did not use the blanket. There were no changes in overall aggression or rates of seclusion in the unit. In the second study, a reduction in the use of seclusion and restraints and a reduction in assaults by patients were observed. Of the patients who used the comfort room, 92.9% reported they found it helpful to reduce their levels of distress.

Two evidence-based guidelines were identified regarding the use of safe rooms or seclusion in psychiatric inpatient care. The National Institute for Health and Care Excellence (NICE) recommends seclusion should last for the shortest time possible and should be assessed at least every two hours. Seclusion rooms should contain furniture that can withstand damage, provide patients with access to a washroom, be well insulated and ventilated, and allow staff to observe and communicate with the patient while in the room. The British Columbia Ministry of Health recommends that the use of seclusion be prevented and minimized whenever possible and seclusion should only be used as a last resort when all other management options have been exhausted. Comfort rooms are recommended as a method to manage patients prior to escalating to a seclusion room.
References Summarized

Health Technology Assessments
No literature identified.

Systematic Reviews and Meta-analyses
No literature identified.

Randomized Controlled Trials
No literature identified.

Non-Randomized Studies


Guidelines and Recommendations


Appendix — Further Information

Qualitative Studies


Alternative Population


Clinical Practice Guidelines – Methodology Not Specified


Review Articles


13. Giles Newton-Howes
   Use of seclusion for managing behavioural disturbance in patients
   Advances in psychiatric treatment (2013), vol. 19, 422–428
   http://apt.rcpsych.org/content/19/6/422.full.pdf

Additional References
